Psychotherapy

Psychotherapy, or personal counseling with a psychotherapist, is an intentional interpersonal relationship used by trained psychotherapists to aid a client or patient in problems of living.

It aims to increase the individual’s sense of their own well-being. Psychotherapists employ a range of techniques based on experiential relationship building, dialogue, communication and behavior change that are designed to improve the mental health of a client or patient, or to improve group relationships (such as in a family).

Psychotherapy may also be performed by practitioners with a number of different qualifications, including psychiatry, clinical psychology, clinical social work, counseling psychology, mental health counseling, clinical or psychiatric social work, marriage and family therapy, rehabilitation counseling, play therapy, music therapy, art therapy, drama therapy, dance/movement therapy, occupational therapy, psychiatric nursing, psychoanalysis and those from other psychotherapies. It may be legally regulated, voluntarily regulated or unregulated, depending on the jurisdiction. Requirements of these professions vary, but often require graduate school and supervised clinical experience. Psychotherapy in Europe is increasingly being seen as an independent profession, rather than being restricted to being practiced only by psychologists and psychiatrists as is stipulated in some countries.

Regulation

Continental Europe

In Germany, the Psychotherapy Act (PsychThG, 1998) restricts the practice of psychotherapy to the professions of psychology and psychiatry. In Italy, the Ossicini Act (no. 56/1989, art. 3) restricts the practice of psychotherapy to graduates in psychology or medicine who have completed a four-year postgraduate course in psychotherapy at a training school recognised by the state; French legislation restricts use of the title "psychotherapist" to professionals on the National Register of Psychotherapists; The inscription on this register requires a training in clinical psychopathology and a period of internship which is only open to physicians or titulars of a master’s degree in psychology or psychoanalysis. Austria and Switzerland (2011) have laws that recognize multidisciplinary approaches; other European countries have not yet regulated psychotherapy.

United Kingdom

In the United Kingdom, psychotherapy is voluntarily regulated. National registers for psychotherapists and counsellors are maintained by three main umbrella bodies:

- the United Kingdom Council for Psychotherapy (UKCP)
the British Association for Counselling and Psychotherapy (BACP)
the British Psychoanalytic Council (BPC - formerly the British Confederation of Psychotherapists).

There are many smaller professional bodies and associations such as the Association of Child Psychotherapists (ACP) and the British Association of Psychotherapists (BAP).

The United Kingdom Health Professions Council (HPC) have recently consulted on potential statutory regulation of psychotherapists and counsellors. The HPC is an official state regulator that regulates some 15 professions at present.

**Etymology**

Psychotherapy is an English word of Greek origin, deriving from Ancient Greek psyche (meaning "breath; spirit; soul") and therapia ("healing; medical treatment").

According to the Oxford English Dictionary, psychotherapy first meant "hypnotherapy" instead of "psychotherapy". The original meaning, "the treatment of disease by ‘psychic’ [i.e., hypnotic] methods", was first recorded in 1853 as "Psychotherapeia, or the remedial influence of mind". The modern meaning, "the treatment of disorders of the mind or personality by psychological or psychophysiological methods", was first used in 1892 by Frederik van Eeden translating "Suggestive Psycho-therapy" for his French "Psychothérapie Suggestive". Van Eeden credited borrowing this term from Daniel Hack Tuke and noted, "Psycho-therapy ... had the misfortune to be taken in tow by hypnotism."

The psychiatrist Jerome Frank defined psychotherapy as the relief of distress or disability in one person by another, using an approach based on a particular theory or paradigm, and a requirement that the agent performing the therapy has had some form of training in delivering this. It is these latter two points which distinguish psychotherapy from other forms of counseling or caregiving.

**Forms**

Most forms of psychotherapy use spoken conversation. Some also use various other forms of communication such as the written word, artwork, drama, narrative story or music. Psychotherapy with children and their parents often involves play, dramatization (i.e. role-play), and drawing, with a co-constructed narrative from these non-verbal and displaced modes of interacting. Psychotherapy occurs within a structured encounter between a trained therapist and client(s). Purposeful, theoretically based psychotherapy began in the 19th century with psychoanalysis; since then, scores of other approaches have been developed and continue to be created.

Therapy is generally used in response to a variety of specific or non-specific manifestations of clinically diagnosable and/or existential crises. Treatment of everyday problems is more often referred to as counseling (a distinction originally adopted by Carl Rogers). However, the term counseling is sometimes used interchangeably with "psychotherapy".
While some psychotherapeutic interventions are designed to treat the patient using the medical model, many psychotherapeutic approaches do not adhere to the symptom-based model of "illness/cure". Some practitioners, such as humanistic therapists, see themselves more in a facilitative/helper role. As sensitive and deeply personal topics are often discussed during psychotherapy, therapists are expected, and usually legally bound, to respect client or patient confidentiality. The critical importance of confidentiality is enshrined in the regulatory psychotherapeutic organizations' codes of ethical practice.

**Systems**

**There are several main broad systems of psychotherapy:**

- **Psychoanalytic** - it was the first practice to be called a psychotherapy. It encourages the verbalization of all the patient's thoughts, including free associations, fantasies, and dreams, from which the analyst formulates the nature of the unconscious conflicts which are causing the patient's symptoms and character problems.
- **Behavior Therapy**/applied behavior analysis focuses on changing maladaptive patterns of behavior to improve emotional responses, cognitions, and interactions with others.
- **Cognitive behavioral** - generally seeks to identify maladaptive cognition, appraisal, beliefs and reactions with the aim of influencing destructive negative emotions and problematic dysfunctional behaviors.
- **Psychodynamic** - is a form of depth psychology, whose primary focus is to reveal the unconscious content of a client's psyche in an effort to alleviate psychic tension. Although its roots are in psychoanalysis, psychodynamic therapy tends to be briefer and less intensive than traditional psychoanalysis.
- **Existential** - is based on the existential belief that human beings are alone in the world. This isolation leads to feelings of meaninglessness, which can be overcome only by creating one's own values and meanings. Existential therapy is philosophically associated with phenomenology.
- **Humanistic** - emerged in reaction to both behaviorism and psychoanalysis and is therefore known as the Third Force in the development of psychology. It is explicitly concerned with the human context of the development of the individual with an emphasis on subjective meaning, a rejection of determinism, and a concern for positive growth rather than pathology. It posits an inherent human capacity to maximize potential, 'the self-actualizing tendency'. The task of Humanistic therapy is to create a relational environment where this tendency might flourish. Humanistic psychology is philosophically rooted in existentialism.
- **Brief** - "Brief therapy" is an umbrella term for a variety of approaches to psychotherapy. It differs from other schools of therapy in that it emphasizes (1) a focus on a specific problem and (2) direct intervention. It is solution-based rather than problem-oriented. It is less concerned with how a problem arose than with the current factors sustaining it and preventing change.
- **Systemic** - seeks to address people not at an individual level, as is often the focus of other forms of therapy, but as people in relationship, dealing with the interactions of
groups, their patterns and dynamics (includes family therapy & marriage counseling). Community psychology is a type of systemic psychology.

- Transpersonal - Addresses the client in the context of a spiritual understanding of consciousness.
- Body Psychotherapy - Addresses problems of the mind as being closely correlated with bodily phenomena, including a person's sexuality, musculature, breathing habits, physiology etc. This therapy may involve massage and other body exercises as well as talking.

There are hundreds of psychotherapeutic approaches or schools of thought. By 1980 there were more than 250; by 1996 there were more than 450. The development of new and hybrid approaches continues around the wide variety of theoretical backgrounds. Many practitioners use several approaches in their work and alter their approach based on client need.

**History**

In an informal sense, psychotherapy can be said to have been practiced through the ages, as individuals received psychological counsel and reassurance from others.

According to Colin Feltham, "The Stoics were one of the main Hellenistic schools of philosophy and therapy, along with the Sceptics and Epicureans (Nussbaum, 1994). Philosophers and physicians from these schools practised psychotherapy among the Greeks and Romans from about the late 4th century BC to the 4th century AD."

Psychoanalysis was perhaps the first specific school of psychotherapy, developed by Sigmund Freud and others through the early 20th century. Trained as a neurologist, Freud began focusing on problems that appeared to have no discernible organic basis, and theorized that they had psychological causes originating in childhood experiences and the unconscious mind. Techniques such as dream interpretation, free association, transference and analysis of the id, ego and superego were developed.

Starting in the 1950s Carl Rogers brought Person-centered psychotherapy into mainstream focus.

Many theorists, including Anna Freud, Alfred Adler, Carl Jung, Karen Horney, Otto Rank, Erik Erikson, Melanie Klein, and Heinz Kohut, built upon Freud's fundamental ideas and often formed their own differentiating systems of psychotherapy. These were all later categorized as psychodynamic, meaning anything that involved the psyche's conscious/unconscious influence on external relationships and the self. Sessions tended to number into the hundreds over several years.

Behaviorism developed in the 1920s, and behavior modification as a therapy became popularized in the 1950s and 1960s. Notable contributors were Joseph Wolpe in South Africa, M.B. Shipiro and Hans Eysenck in Britain, and John B. Watson and B.F. Skinner in the United States. Behavioral therapy approaches relied on principles of operant conditioning,
classical conditioning and social learning theory to bring about therapeutic change in observable symptoms. The approach became commonly used for phobias, as well as other disorders.

Some therapeutic approaches developed out of the European school of existential philosophy. Concerned mainly with the individual’s ability to develop and preserve a sense of meaning and purpose throughout life, major contributors to the field in the US (e.g., Irvin Yalom, Rollo May) and Europe (Viktor Frankl, Ludwig Binswanger, Medard Boss, R.D. Laing, Emmy van Deurzen) and later in the 1960s and 1970s both in the United Kingdom and in Canada, Eugene Heimler attempted to create therapies sensitive to common 'life crises' springing from the essential bleakness of human self-awareness, previously accessible only through the complex writings of existential philosophers (e.g., Søren Kierkegaard, Jean-Paul Sartre, Gabriel Marcel, Martin Heidegger, Friedrich Nietzsche). The uniqueness of the patient-therapist relationship thus also forms a vehicle for therapeutic enquiry. A related body of thought in psychotherapy started in the 1950s with Carl Rogers. Based on existentialism and the works of Abraham Maslow and his hierarchy of human needs, Rogers brought person-centered psychotherapy into mainstream focus. The primary requirement of Rogers is that the client should be in receipt of three core 'conditions' from their counsellor or therapist: unconditional positive regard, also sometimes described as 'prizing' the person or valuing the humanity of an individual, congruence [authenticity/genuineness/transparency], and empathic understanding. The aim in using the 'core conditions' is to facilitate therapeutic change within a non-directive relationship conducive to enhancing the client’s psychological well being. This type of interaction enables the client to fully experience and express themselves. Others developed the approach, like Fritz and Laura Perls in the creation of Gestalt therapy, as well as Marshall Rosenberg, founder of Nonviolent Communication, and Eric Berne, founder of Transactional Analysis. Later these fields of psychotherapy would become what is known as humanistic psychotherapy today. Self-help groups and books became widespread.

During the 1950s, Albert Ellis originated Rational Emotive Behavior Therapy (REBT). A few years later, psychiatrist Aaron T. Beck developed a form of psychotherapy known as cognitive therapy. Both of these included generally relative short, structured and present-focused therapy aimed at identifying and changing a person's beliefs, appraisals and reaction-patterns, by contrast with the more long-lasting insight-based approach of psycho-dynamic or humanistic therapies. Cognitive and behavioral therapy approaches were combined and grouped under the heading and umbrella-term Cognitive behavioral therapy (CBT) in the 1970s. Many approaches within CBT were oriented towards active/directive collaborative empiricism and mapping, assessing and modifying clients core beliefs and dysfunctional schemas. These approaches gained widespread acceptance as a primary treatment for numerous disorders. A "third wave" of cognitive and behavioral therapies developed, including Acceptance and Commitment Therapy and Dialectical behavior therapy, which expanded the concepts to other disorders and/or added novel components and mindfulness exercises. Counseling methods developed, including solution-focused therapy and systemic coaching. During the 1960s and 1970s Eugene Heimler, after training in the new discipline of psychiatric social work, developed Heimler method of
Human Social Functioning, a methodology based on the principle that frustration is the potential to human flourishing.

Postmodern psychotherapies such as Narrative Therapy and Coherence Therapy did not impose definitions of mental health and illness, but rather saw the goal of therapy as something constructed by the client and therapist in a social context. Systems Therapy also developed, which focuses on family and group dynamics—and Transpersonal psychology, which focuses on the spiritual facet of human experience. Other important orientations developed in the last three decades include Feminist therapy, Brief therapy, Somatic Psychology, Expressive therapy, applied Positive psychology and the Human Givens approach which is building on the best of what has gone before. A survey of over 2,500 US therapists in 2006 revealed the most utilized models of therapy and the ten most influential therapists of the previous quarter-century.

**General description**

Psychotherapy can be seen as an interpersonal invitation offered by (often trained and regulated) psychotherapists to aid clients in reaching their full potential or to cope better with problems of life. Psychotherapists usually receive remuneration in some form in return for their time and skills. This is one way in which the relationship can be distinguished from an altruistic offer of assistance.

Psychotherapists and counselors often require to create a therapeutic environment referred to as the frame, which is characterized by a free yet secure climate that enables the client to open up. The degree to which client feels related to the therapist may well depend on the methods and approaches used by the therapist or counselor.

Psychotherapy often includes techniques to increase awareness and the capacity for self observation, change behavior and cognition, and develop insight and empathy. A desired result enable other choices of thought, feeling or action; to increase the sense of well-being and to better manage subjective discomfort or distress. Perception of reality is hopefully improved. Grieving might be enhanced producing less long term depression. Psychotherapy can improve medication response where such medication is also needed. Psychotherapy can be provided on a one-to-one basis, in group therapy, conjointly with couples and with entire families. It can occur face to face (individual), over the telephone, or, much less commonly, the Internet. Its time frame may be a matter of weeks or many years. Therapy may address specific forms of diagnosable mental illness, or everyday problems in managing or maintaining interpersonal relationships or meeting personal goals. Treatment in families with children can favorably influence a child’s development, lasting for life and into future generations. Better parenting may be an indirect result of therapy or purposefully learned. As parenting techniques, Divorce can be prevented, or made far less traumatic. Treatment of everyday problems is more often referred to as counseling (a distinction originally adopted by Carl Rogers) but the term is sometimes used interchangeably with "psychotherapy". Therapeutic skills can be used in mental health consultation to business and public agencies to improve efficiency and assist with coworkers or clients.
Psychotherapists use a range of techniques to influence or persuade the client to adapt or change in the direction the client has chosen. These can be based on clear thinking about their options; experiential relationship building; dialogue, communication and adoption of behavior change strategies. Each is designed to improve the mental health of a client or patient, or to improve group relationships (as in a family). Most forms of psychotherapy use only spoken conversation, though some also use other forms of communication such as the written word, artwork, drama, narrative story, or therapeutic touch. Psychotherapy occurs within a structured encounter between a trained therapist and client(s). Because sensitive topics are often discussed during psychotherapy, therapists are expected, and usually legally bound, to respect client or patient confidentiality.

Psychotherapists are often trained, certified, and licensed, with a range of different certifications and licensing requirements depending on the jurisdiction. Psychotherapy may be undertaken by clinical psychologists, counseling psychologists, social workers, marriage-family therapists, adult and child psychiatrists and expressive therapists, trained nurses, psychiatrists, psychoanalysts, mental health counselors, school counselors, or professionals of other mental health disciplines.

Psychiatrists have medical qualifications and may also administer prescription medication. The primary training of a psychiatrist uses the 'Bio-Psycho-Social' model, medical training in practical psychology and applied psychotherapy. Psychiatric training begins in medical school, first in the doctor patient relationship with ill people, and later in psychiatric residency for specialists. The focus is usually eclectic but includes biological, cultural, and social aspects. They are advanced in understanding patients from the inception of medical training. Today there are two doctoral degrees in psychology, the PsyD and PhD. Training for these degrees overlap, but the PsyD is more clinical and the Phd stresses research. Both degrees have clinical education components. Clinical Social Workers have specialized training in clinical casework. They hold a masters in social work which entails two years of clinical internships, and a period of at least three years in the US of post-masters experience in psychotherapy. Marriage-family therapists have specific training and experience working with relationships and family issues. A licensed professional counselor (LPC) generally has special training in career, mental health, school, or rehabilitation counseling to include evaluation and assessments as well as psychotherapy. Many of the wide variety of training programs are multiprofessional, that is, psychiatrists, psychologists, mental health nurses, and social workers may be found in the same training group. All these degrees commonly work together as a team, especially in institutional settings. All those doing specialized psychotherapeutic work, in most countries, require a program of continuing education after the basic degree, or involve multiple certifications attached to one specific degree, and 'board certification' in psychiatry. Specialty exams are used to confirm competence or board exams with psychiatrists.

**Medical and non-medical models**

A distinction can also be made between those psychotherapies that employ a medical model and those that employ a humanistic model. In the medical model the client is seen as
unwell and the therapist employs their skill to help the client back to health. The extensive use of the DSM-IV, the diagnostic and statistical manual of mental disorders in the United States, is an example of a medically-exclusive model.

The humanistic model of non medical in contrast strives to depathologise the human condition. The therapist attempts to create a relational environment conducive to experiential learning and help build the client’s confidence in their own natural process resulting in a deeper understanding of themselves. An example would be gestalt therapy.

Some psychodynamic practitioners distinguish between more uncovering and more supportive psychotherapy. Uncovering psychotherapy emphasizes facilitating the client’s insight into the roots of their difficulties. The best-known example of an uncovering psychotherapy is classical psychoanalysis. Supportive psychotherapy by contrast stresses strengthening the client’s defenses and often providing encouragement and advice. Depending on the client’s personality, a more supportive or more uncovering approach may be optimal. Most psychotherapists use a combination of uncovering and supportive approaches.

**Specific schools and approaches**

In practices of experienced psychotherapists, the therapy is typically not of one pure type, but draws aspects from a number of perspectives and schools.

**Psychoanalysis**

Psychoanalysis was developed in the late 19th century by Sigmund Freud. His therapy explores the dynamic workings of a mind understood to consist of three parts: the hedonistic id (German: das Es, "the it"), the rational ego (das Ich, "the I"), and the moral superego (das Überich, "the above-I"). Because the majority of these dynamics are said to occur outside people’s awareness, Freudian psychoanalysis seeks to probe the unconscious by way of various techniques, including dream interpretation and free association. Freud maintained that the condition of the unconscious mind is profoundly influenced by childhood experiences. So, in addition to dealing with the defense mechanisms used by an overburdened ego, his therapy addresses fixations and other issues by probing deeply into clients’ youth.

Other psychodynamic theories and techniques have been developed and used by psychotherapists, psychologists, psychiatrists, personal growth facilitators, occupational therapists and social workers. Techniques for group therapy have also been developed. While behaviour is often a target of the work, many approaches value working with feelings and thoughts. This is especially true of the psychodynamic schools of psychotherapy, which today include Jungian therapy and Psychodrama as well as the psychoanalytic schools.

**Gestalt therapy**
Gestalt Therapy is a major overhaul of psychoanalysis. In its early development it was called "concentration therapy" by its founders, Frederick and Laura Perls. However, its mix of theoretical influences became most organized around the work of the gestalt psychologists; thus, by the time 'Gestalt Therapy, Excitement and Growth in the Human Personality' (Perls, Hefferline, and Goodman) was written, the approach became known as "Gestalt Therapy."

Gestalt Therapy stands on top of essentially four load bearing theoretical walls: phenomenological method, dialogical relationship, field-theoretical strategies, and experimental freedom. Some have considered it an existential phenomenology while others have described it as a phenomenological behaviorism. Gestalt therapy is a humanistic, holistic, and experiential approach that does not rely on talking alone, but facilitates awareness in the various contexts of life by moving from talking about situations relatively remote to action and direct, current experience.

**Group psychotherapy**

The therapeutic use of groups in modern clinical practice can be traced to the early 20th century, when the American chest physician Pratt, working in Boston, described forming 'classes' of 15 to 20 patients with tuberculosis who had been rejected for sanatorium treatment. The term group therapy, however, was first used around 1920 by Jacob L. Moreno, whose main contribution was the development of psychodrama, in which groups were used as both cast and audience for the exploration of individual problems by reenactment under the direction of the leader. The more analytic and exploratory use of groups in both hospital and out-patient settings was pioneered by a few European psychoanalysts who emigrated to the USA, such as Paul Schilder, who treated severely neurotic and mildly psychotic out-patients in small groups at Bellevue Hospital, New York. The power of groups was most influentially demonstrated in Britain during the Second World War, when several psychoanalysts and psychiatrists proved the value of group methods for officer selection in the War Office Selection Boards. A chance to run an Army psychiatric unit on group lines was then given to several of these pioneers, notably Wilfred Bion and Rickman, followed by S. H. Foulkes, Main, and Bridger. The Northfield Hospital in Birmingham gave its name to what came to be called the two 'Northfield Experiments', which provided the impetus for the development since the war of both social therapy, that is, the therapeutic community movement, and the use of small groups for the treatment of neurotic and personality disorders. Today group therapy is used in clinical settings and in private practice settings. It has been shown to be as or more effective than individual therapy.

**Cognitive behavioral therapy**

Cognitive behavioral therapy refers to a range of techniques which focus on the construction and re-construction of people's cognitions, emotions and behaviors. Generally in CBT, the therapist, through a wide array of modalities, helps clients assess, recognize and deal with problematic and dysfunctional ways of thinking, emoting and behaving.
Behavior therapy

Behavior therapy focuses on modifying overt behavior and helping clients to achieve goals. This approach is built on the principles of learning theory including operant and respondent conditioning, which makes up the area of applied behavior analysis or behavior modification. This approach includes acceptance and commitment therapy, functional analytic psychotherapy, and dialectical behavior therapy. Sometimes it is integrated with cognitive therapy to make cognitive behavior therapy. By nature, behavioral therapies are empirical (data-driven), contextual (focused on the environment and context), functional (interested in the effect or consequence a behavior ultimately has), probabilistic (viewing behavior as statistically predictable), monistic (rejecting mind-body dualism and treating the person as a unit), and relational (analyzing bidirectional interactions).

Body-oriented psychotherapy

Body-oriented psychotherapy or Body Psychotherapy is also known as Somatic Psychology, especially in the USA. There are many very different psychotherapeutic approaches. They generally focus on the link between the mind and the body and try to access deeper levels of the psyche through greater awareness of the physical body and the emotions which gave rise to the various body-oriented based psychotherapeutic approaches, such as Reichian (Wilhelm Reich) Character-Analytic Vegetotherapy and Orgonomy; neo-Reichian Alexander Lowen’s Bioenergetic analysis; Peter Levine’s Somatic Experiencing; Jack Rosenberg’s Integrative body psychotherapy; Ron Kurtz’s Hakomi psychotherapy; Pat Ogden’s sensorimotor psychotherapy; David Boadella’s Biosynthesis psychotherapy; Gerda Boyesen’s Biodynamic psychotherapy; etc. These body-oriented psychotherapies are not to be confused with alternative medicine body-work or body-therapies that seek primarily to improve physical health through direct work (touch and manipulation) on the body because, despite the fact that bodywork techniques (for example Alexander Technique, Rolfing, and the Feldenkrais Method) can also affect the emotions, these techniques are not designed to work on psychological issues, neither are their practitioners so trained.

Expressive therapy

Expressive therapy is a form of therapy that utilizes artistic expression as its core means of treating clients. Expressive therapists use the different disciplines of the creative arts as therapeutic interventions. This includes the modalities dance therapy, drama therapy, art therapy, music therapy, writing therapy, among others. Expressive therapists believe that often the most effective way of treating a client is through the expression of imagination in a creative work and integrating and processing what issues are raised in the act.

Interpersonal psychotherapy

Interpersonal psychotherapy (IPT) is a time-limited psychotherapy that focuses on the interpersonal context and on building interpersonal skills. IPT is based on the belief that interpersonal factors may contribute heavily to psychological problems. It is commonly distinguished from other forms of therapy in its emphasis on interpersonal processes.
rather than intrapsychic processes. IPT aims to change a person's interpersonal behavior by fostering adaptation to current interpersonal roles and situations.

**Narrative therapy**

Narrative therapy gives attention to each person's "dominant story" by means of therapeutic conversations, which also may involve exploring unhelpful ideas and how they came to prominence. Possible social and cultural influences may be explored if the client deems it helpful.

**Integrative psychotherapy**

Integrative psychotherapy is an attempt to combine ideas and strategies from more than one theoretical approach. These approaches include mixing core beliefs and combining proven techniques. Forms of integrative psychotherapy include multimodal therapy, the transtheoretical model, cyclical psychodynamics, systematic treatment selection, cognitive analytic therapy, Internal Family Systems Model, multitheoretical psychotherapy and conceptual interaction. In practice, most experienced psychotherapists develop their own integrative approach over time.

**Hypnotherapy**

Hypnotherapy is therapy that is undertaken with a subject in hypnosis. Hypnotherapy is often applied in order to modify a subject's behavior, emotional content, and attitudes, as well as a wide range of conditions including dysfunctional habits, anxiety, stress-related illness, pain management, and personal development.

**Adaptations for children**

Counseling and psychotherapy must be adapted to meet the developmental needs of children. Many counseling preparation programs include courses in human development. Since children often do not have the ability to articulate thoughts and feelings, counselors will use a variety of media such as crayons, paint, clay, puppets, bibliocounseling (books), toys, board games, et cetera. The use of play therapy is often rooted in psychodynamic theory, but other approaches such as Solution Focused Brief Counseling may also employ the use of play in counseling. In many cases the counselor may prefer to work with the caretaker of the child, especially if the child is younger than age four. Yet, by doing so, the counselor risks the perpetuation of maladaptive interactive patterns and the adverse effects on development that have already been affected on the child's end of the relationship Therefore, contemporary thinking on working with this young age group has leaned towards working with parent and child simultaneously within the interaction, as well as individually as needed.

**Confidentiality**
Confidentiality is an integral part of the therapeutic relationship and psychotherapy in general.

**Criticisms and questions regarding effectiveness**

Within the psychotherapeutic community there has been some discussion of empirically-based psychotherapy, e.g.

Virtually no comparisons of different psychotherapies with long follow-up times have been done. The Helsinki Psychotherapy Study is a randomized clinical trial, in which patients are monitored for 12 months after the onset of study treatments, of which each lasted approximately 6 months. The assessments are to be completed at the baseline examination and during the follow-up after 3, 7, and 9 months and 1, 1.5, 2, 3, 4, 5, 6, and 7 years. The final results of this trial are yet to be published because follow-up evaluations continued up to 2009.

There is considerable controversy about which form of psychotherapy is most effective, and more specifically, which types of therapy are optimal for treating which sorts of problems. Furthermore, it is controversial whether the form of therapy or the presence of factors common to many psychotherapies best separates effective therapy from ineffective therapy. Common factors theory asserts it is precisely the factors common to the most psychotherapies that make any psychotherapy successful: this is the quality of the therapeutic relationship.

The dropout level is quite high; one meta-analysis of 125 studies concluded that the mean dropout rate was 46.86%. The high level of dropout has raised some criticism about the relevance and efficacy of psychotherapy.

Psychotherapy outcome research—in which the effectiveness of psychotherapy is measured by questionnaires given to patients before, during, and after treatment—has had difficulty distinguishing between the success or failure of the different approaches to therapy. Those who stay with their therapist for longer periods are more likely to report positively on what develops into a longer-term relationship. This suggests that some "treatment" may be open-ended with concerns associated with ongoing financial costs.

As early as 1952, in one of the earliest studies of psychotherapy treatment, Hans Eysenck reported that two thirds of therapy patients improved significantly or recovered on their own within two years, whether or not they received psychotherapy.

Many psychotherapists believe that the nuances of psychotherapy cannot be captured by questionnaire-style observation, and prefer to rely on their own clinical experiences and conceptual arguments to support the type of treatment they practice.

In 2001, Bruce Wampold of the University of Wisconsin published the book The Great Psychotherapy Debate. In it Wampold, a former statistician who went on to train as a counseling psychologist, reported that
• psychotherapy is indeed effective,
• the type of treatment is not a factor,
• the theoretical bases of the techniques used, and the strictness of adherence to those techniques are both not factors,
• the therapist’s strength of belief in the efficacy of the technique is a factor,
• the personality of the therapist is a significant factor,
• the alliance between the patient(s) and the therapist (meaning affectionate and trusting feelings toward the therapist, motivation and collaboration of the client, and empathic response of the therapist) is a key factor.

Wampold therefore concludes that "we do not know why psychotherapy works".

Although the Great Psychotherapy Debate dealt primarily with data on depressed patients, subsequent articles have made similar findings for post-traumatic stress disorder and youth disorders. There have also been studies of Panic Disorder, where treatment effectiveness is measured in the abatement of panic attacks. Psychoanalytic psychotherapy has been found to be as effective as Cognitive Behavioral Therapy for immediate relief and more effective over the long term.

Some report that by attempting to program or manualize treatment, psychotherapists may be reducing efficacy, although the unstructured approach of many psychotherapists cannot appeal to patients motivated to solve their difficulties through the application of specific techniques different from their past "mistakes."

Critics of psychotherapy are skeptical of the healing power of a psychotherapeutic relationship. Because any intervention takes time, critics note that the passage of time alone, without therapeutic intervention, often results in psycho-social healing. Social contact with others is universally seen as beneficial for all humans and regularly scheduled visits with anyone would be likely to diminish both mild and severe emotional difficulty.

Many resources available to a person experiencing emotional distress—the friendly support of friends, peers, family members, clergy contacts, personal reading, healthy exercise, research, and independent coping—all present considerable value. Critics note that humans have been dealing with crises, navigating severe social problems and finding solutions to life problems long before the advent of psychotherapy. Of course, it may well be something in the patient that does not develop these "natural" supports that requires therapy.

Further critiques have emerged from feminist, constructionist and discursive sources. Key to these is the issue of power. In this regard there is a concern that clients are persuaded—both inside and outside the consulting room—to understand themselves and their difficulties in ways that are consistent with therapeutic ideas. This means that alternative ideas (e.g., feminist, economic, spiritual) are sometimes implicitly undermined. Critics suggest that we idealise the situation when we think of therapy only as a helping relation. It is also fundamentally a political practice, in that some cultural ideas and practices are
supported while others are undermined or disqualified. So, while it is seldom intended, the therapist-client relationship always participates in society's power relations and political dynamics.
4

Theory of psychodynamic psychotherapy

Introduction ● The contribution of Sigmund Freud (1856–1939) ● Freud’s topographical theory and the unconscious mind ● The concept of conflict ● Freud’s structural theory: the place of innate instincts ● Eric Berne and transactional analysis (a modification of the structural theory) ● Freud’s developmental theory: early determinants of personality and behaviour ● The Oedipus complex ● The present status of Freud’s ideas ● The contribution of Melanie Klein ● Attachment theory and attachment behaviour ● Psychological defence mechanisms ● The therapeutic relationship: working alliance, transference and countertransference ● Other psychoanalytic terms used in psychodynamic psychotherapy ● A dynamic formulation of psychiatric diagnoses

Introduction

This is a highly selected and brief outline of some of the most important theoretical ideas in psychoanalytic psychotherapy. Many of these ideas originated with Sigmund Freud, who has been a major figure in twentieth-century thought not only in psychiatry, but also in literature, history and anthropology. Some of Freud’s ideas which are well known but are not now entirely accepted are described, and later developments are mentioned alongside them.
The contribution of Sigmund Freud (1856–1939)

MAIN POINTS

- As a neurologist, Freud was aware that some physical symptoms did not relate to the neuroanatomical structures serving the afflicted area.
- He proposed that psychological organisation might sometimes take precedence over anatomical organisation in symptom development.
- Freud outlined three main theories to account for mental process, namely the topographical, the structural and the developmental.
- Although psychoanalysis and psychodynamic psychotherapy have changed a lot since Freud’s time, many of his ideas have been the starting point for further theoretical and clinical developments.

Freud trained as a physiologist and a physician, and was accustomed to using the clinical anatomical method to understand how his patients’ symptoms related to the underlying pathological process. Using this method, a patient’s symptoms were carefully recorded, and when he died the post-mortem would reveal the anatomical changes associated with the symptoms that he had experienced in life. Gradually a picture was built up of the anatomical changes underlying particular diseases.

Freud became aware that this method did not always work when the patient was suffering from a nervous disease. This was particularly striking when the patient had a physical symptom that did not relate to the known anatomical structures serving the area. For example, a patient might have paralysis of a limb which did not correspond to the known distribution of the nerves to that limb.

Freud realised that the illness in this case was related not to an anatomical process but to a psychological one, and proposed that the functions of the mind are not always organised anatomically, but that they have a psychological organisation which is somewhat independent of a primary anatomical organisation.

Although Freud was not the first person to suggest that the mind is a dynamic entity, his outline of psychoanalysis as a theory and method of treatment has brought a systematic approach to psychodynamic therapy.

Psychoanalysis and psychodynamic psychotherapy have changed since Freud’s time. However, some of his concepts have remained important in theory and practice, and even those that have been discarded as not clinically
useful or accurate have often been a starting point for later clinicians and researchers to develop their ideas.

Three important ideas that have been influential in psychoanalysis and psychotherapy derive from Freud’s three main theories.

1. That our behaviour is influenced by unconscious thoughts and feelings, and that symptoms may arise because of conflict between conscious thoughts and wishes and unconscious thoughts and wishes. This was part of Freud’s topographical theory.

2. That we are born with innate instincts which affect our behaviour. This was part of Freud’s structural theory.

3. That early development has an important influence on adult behaviour. This was part of Freud’s developmental theory.

Freud’s topographical theory and the unconscious mind

**MAIN POINTS**

- Freud was not the first person to suggest that there is an unconscious part of the human mind.
- Neuropsychological research in the late twentieth century has confirmed that much mental process is outside conscious awareness.
- Freud postulated that there are unconscious thoughts and feelings in the mind which may influence behaviour.
- A thought may be unconscious because it is consciously suppressed, or it may be unconscious because it is unconsciously repressed.

Freud was not the first person to suggest the existence of an unconscious part of the mind. In the nineteenth century the psychologist Herbart and the philosopher Schopenhauer both anticipated Freud’s ideas. In the later twentieth century, neuropsychology confirmed via subliminal perception and pre-conscious processing that much mental life takes place outside conscious awareness (Dixon and Henley, 1991).

Freud began with the rational premise that our feelings, behaviours, thoughts and symptoms are not random or arbitrary, and that there is some reason or meaning behind their happening. This assumption is called psychic determinism. If we believe that thoughts, feelings and behaviours are not
random, but have some reason for being there, then we look for a cause that will explain them or give meaning to them.

To give meaning to mental events (feelings, symptoms and behaviours), Freud postulated the existence of thoughts in the patient’s mind which are unconscious but which can affect his conscious mind and behaviour. It may be preferable to think in terms of different levels of consciousness and to use the word ‘unconscious’ as an adjective rather than a noun. We can identify three kinds of unconscious thoughts.

1. Something may be unconscious because it is not thought about at a particular moment in time – for example, what you had for lunch last Sunday.
2. It may be unconscious because it is a painful memory, which has been consciously suppressed rather than remembered – for example, the exam viva that went badly. Freud used the word ‘preconscious’ to describe these levels of unconscious thought, which are available to the conscious mind if we choose to look at them.
3. It may be unconscious because it has been unconsciously repressed and therefore cannot be recalled at will. Freud suggested that an idea or a memory may be extremely painful to us, or may conflict with our view of ourselves in such a way that it would cause acute anxiety or guilt if it were acknowledged. From his experience as a doctor, Freud observed that repressed feelings could cause physical as well as psychological symptoms.

**Scenario 1**
A young man, Dave, suffers severe headaches after the sudden death of his much loved mother. After six months with no improvement, his GP suggests that they spend time thinking about his relationship with his mother, and arranges four half-hour appointments with his patient. In the third session the GP suggests that Dave is angry with his mother for leaving him. The young man thinks about this and reluctantly agrees that this is possibly so. To his surprise his headaches disappear during the following few days.

Dave felt both love for his mother and anger towards her because she had left him when he still felt that he needed her. The feelings of anger conflicted with his view of how he ought to feel about his mother, and he repressed these unacceptable feelings. He suffered inexplicable tension, however, with painful headaches which only got better when his unacceptable conflictual feelings could be acknowledged.
The concept of conflict

**MAIN POINTS**

- The experience of having conflicting wishes is familiar to everyone.
- Conflict may be conscious or unconscious.
- According to Freud, unconscious conflict may lead to the development of symptoms.

We are all familiar with the experience of conscious conflict.

**Scenario 2**
Mrs A wants her 70-year-old mother to come and live with her rather than go into a home for the elderly, but she knows that her mother hates noise and will make her young children’s lives a misery. Mrs A wants to be a caring daughter and a caring mother, and she cannot be both. She is in conflict.

Sometimes, as in the case of Dave, conflict is not conscious.

**Scenario 3**
Mrs B wants her elderly mother to come and live with her. She has no children at home, but she has recently begun to have severe backache which has led to her postponing her mother’s move into her home.

Mrs B may be suffering from a physical back problem, but is it possible that she could also be in conflict – this time unconscious conflict?

**Freud’s structural theory: the place of innate instincts**

**MAIN POINTS**

- Freud suggested that the mind could be conceptualised as having three parts: the ego, the superego and the id.

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- The ego is the rational part of the mind which accepts external reality and negotiates between the wishes and needs of the person and the demands of the outside world. The ego is mainly conscious.
- The superego is what we think of as conscience. It is part conscious and part unconscious. It may be helpful or punitive.
- The id is the part of the mind that contains the instincts of sexuality and aggression. It is mainly unconscious.

In 1923, Freud introduced his structural theory of the mind. He described the mind as having three parts, the ego, the superego and the id. Roughly speaking:

- the id corresponds to the basic instincts of sex and aggression, and is largely unconscious
- the ego corresponds to the rational, thinking part of the mind which recognises other people’s needs as well as one’s own and is largely conscious
- the superego corresponds to what we would know as conscience, and is built from identifications with important authority figures such as parents and teachers. The superego is part conscious and part unconscious.

According to this way of conceptualising the mind, the baby is born with strong instincts towards satisfaction (id instincts) and with no awareness of the needs of other people. Gradually, as he becomes more biologically mature, he begins to realise that there is a world out there and that his needs must be negotiated with those of other people. This is the beginning of what Freud called ‘ego function’.

Also during the early years, the baby both realises and imagines that other people can be aggressive just as he can, and begins to fear that he could be hurt or punished if he offends someone. This is the beginning of the development of superego or conscience. This is a simplistic description of a complex idea developed by Freud as a way to understand how the mind works.

The term ‘ego function’ is sometimes used to refer to a person’s capacity for rational thinking, and the term ‘superego’ is used in a psychoanalytic setting to denote the capacity for self-criticism. The term ‘id’ is less commonly used now in either psychoanalysis or psychotherapy, and the notion of innate instincts seeking release has been modified to include ideas about how such feelings may develop in the context of relationships.
Eric Berne and transactional analysis (a modification of the structural theory)

**MAIN POINTS**

- Eric Berne used Freud’s ideas of the ego, superego and id to develop an easily accessible formulation of how the mind works.
- He proposed that there are three parts to the mind, which he called adult, parent and child.
- He incorporated the notion of mental representations so that each of these parts had an associated expected relationship or transaction.
- His ideas have been widely used in the practice of transactional analysis.

A more easily accessible, if somewhat bowdlerised version of Freud’s structural model of the mind has been described by Eric Berne. His popular books — for example, *Games People Play* (Berne, 1966) — are highly effective in showing how we relate to each other and how there may be internal conflict between different parts of ourselves. His entertaining accounts of transactional analysis are also useful in that they show how we bring mental representations of relationships to new situations.

Like Freud, Berne also postulated that there are three parts to the mind, namely parent (superego), adult (ego) and child (id). He suggested a simplified version of mental representation of self and other in which we adopt a ‘set’ of behaviours that corresponds to a version of child, adult or parent, and expect another person to fulfil the complementary role. He postulated that any one of these three parts of the personality may be dominant at any time and will determine how we conduct a relationship or a transaction. The degree and nature of the emotion in the transaction will partly determine the chosen role. For example, taking the car to the garage for a service is probably an emotionally neutral transaction in which there is a business arrangement with the mechanic. This will be an adult–adult transaction. A patient who consults his GP about a sore throat and feels calm and sensible, and wants a simple diagnosis and treatment, is another adult–adult transaction.

However, if the patient has vomited blood he may visit the casualty department feeling very frightened and helpless, desperately wanting the situation to be sorted out. In his mind he feels like a child again, needing his
mother to fix things, and he turns to the casualty doctor to take control, perhaps attributing exaggerated ability to her. This would be a *child–parent* transaction.

Suppose that a student visits his tutor to tell her he is behind with his essay because he can’t find the recommended references. He expects criticism and a lecture on laziness, but is pleasantly surprised to be treated like an adult and advised where to get what he needs. He expected an unpleasant *child–parent* transaction and got an *adult–adult* one instead.

Once again it is clear that we bring certain expectations to new situations and new relationships, and that these are related to our existing mental representations. We shall return to this concept of expected transactions when we think about the therapeutic relationship.

**Freud’s developmental theory: early determinants of personality and behaviour**

**MAIN POINTS**

- Freud proposed that children’s mental development proceeds in a series of stages corresponding to their bodily development.
- Freud’s oral stage occurs in the first year, and corresponds to the time when the child uses his mouth a great deal for pleasure and to relate to the world.
- Freud’s anal stage takes place in the second and third years and corresponds to the time when the child gains sphincter control and his interest is focused on this new skill.
- Freud’s genital stage takes place in the third to fifth years and corresponds to the child’s awareness of difference between the sexes, ability to find pleasure in his own genitals, and curiosity about other people’s bodies.

The practice of psychoanalysis and psychodynamic psychotherapy has a strong developmental bias. That is, it works on the assumption that personality and behaviour are determined partly by innate, inherited factors, partly by the environment in which a person is brought up and overall by the way in which the interaction between these leads to representations of self and other in the mind.
Freud took a Darwinian view of human development and believed that aspects of infant behaviour were biologically programmed to ensure survival of the species. He considered that the infant drive for contact with other humans was biologically determined and represented a way to maximise behaviours that would ultimately lead to opportunities for sexual contact and thus propagation of the human species. It was this idea that human activity must somehow be directed towards species survival and therefore sexual activity which led to the misunderstanding that Freud interpreted everything in terms of sex.

In addition, Freud suggested that psychological development takes place in a series of stages that correspond to the physical stages of children’s development. He observed that the child is most aroused or excited by different parts of the body at different developmental times, and that this arousal is likely to shape or at least influence the way in which the child conceptualises other aspects of the world and his experiences. He thought that a child could become stuck or fixated at a particular stage, and that certain undesirable character traits would result from this.

Freud proposed the existence of three stages during the child’s first five years.

1. The oral stage corresponds to the first year. During this time the child relates to the world to a large extent through his mouth, and derives much pleasure from sucking and tasting. Freud thought that the child’s mental process during this time was structured around images of feeding, and of taking things in and spitting them out. According to this way of thinking, a person who is fixated at this stage would show excessive dependency and demands or greed for other people. Alternatively, such a person might be fearful of other people’s dependency, or of their greedy demands on him.

2. The anal stage corresponds to the second and third years. During this time the child learns sphincter control, and becomes capable of holding on to or expelling the contents of his rectum and bladder. It is also the time when he learns to crawl and walk, and begins to be able to move independently away from his mother. Freud thought that issues in the child’s mental development at this time were independence and control. Fixation at this stage would lead to anxiety about control, including obsessional control, meanness and rigidity. It might also lead to sensitivity and anxiety about being controlled by others.

3. The genital stage corresponds to the third to fifth years. During this time the child becomes aware of his own and other people’s gender and of his own genitals, which are also a source of pleasure. This is the stage at which Freud introduced the notion of the Oedipus complex.
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The Oedipus complex

**MAIN POINTS**

- Children show a particular interest in their own and other people’s sexuality at around three to five years of age. However, this interest is not confined to this time.
- They are aware that their parents have a relationship from which they are excluded. They may feel rivalry with one or the other parent.
- This developmental hurdle highlights important aspects of development, including the acceptance of difference, the limits to what one can be and can have, the necessity of tolerating being left out of others’ relationships and the ability to be curious about one’s own and other people’s sexual activity.
- Later difficulties linked with this developmental stage include fear of rivalry, excessive anxiety about sexuality and fear of commitment to a sexual relationship.

Although children can identify themselves as male or female from about two years of age, they often become particularly interested in their own and other people’s genitals at about three to five years. They also have strong attachments to their parents and, for example, commonly declare their intention to marry a parent when they grow up. By this age, the child is aware that his or her parents have a relationship from which he or she is excluded. In addition, by this time the child is confronted with the reality that as a boy he will grow up to be a man like his father, or as a girl she will grow up to be a woman like her mother, and that however much the child wants it he or she cannot be biologically like the other parent.

The Oedipus complex has been somewhat revised since Freud’s notoriously phallocentric version, and is regarded by dynamic psychotherapists as centrally important in development. However, most clinicians would not restrict this important maturational hurdle to a period of two years between the ages of three and five, but assume that although it may be important at this stage in childhood, it will remain an issue throughout the child’s development. Learning to negotiate a three-person relationship is a fundamental step for the child, not only in the early years but also throughout life. The presence of an intact family is not essential for these issues to be relevant, although different family structures must modify the child’s experience. The Oedipal stage is significant for the following reasons.
The child realises that he or she is male or female and will grow up to be like one parent but not both. He or she has to resolve any resentment about never being able to have what the other sex has. It may be difficult for a little boy to accept that he cannot grow up to be a woman and have a baby, and for a little girl to accept that she will never have a penis and be a man.

The child loves and desires both parents and is rivalrous with each for the other. Learning to accept that the parents have a special relationship from which he or she is excluded is painful. However, the resolution of this forms the basis of learning to be left out of later situations, and also frees the child to separate from the parents in adolescence and find his or her own intimate relationships.

The parents’ relationship will itself have some mental representation in the child’s mind, and the quality of this will be affected by the actual state of the parents’ affection and care for each other, but also by the fantasies that the child has about what they do together. Some children are alarmed by their own aggressive feelings and fantasies, and may attribute these to the parents and what goes on between them in their sexual relationship.

Fear of parental retaliation for their feelings of rivalry appears to be an issue for some children. A minority of children show signs of anxiety around this age, which in most cases resolves without any therapeutic intervention.

Later difficulties which have been suggested to relate to this stage of development include fear of competition or rivalry, anxiety about sexuality, fear of commitment to a sexual relationship, and excessive anxiety or anger about being left out of relationships.

The present status of Freud’s ideas

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<th>MAIN POINTS</th>
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<td>• Some of Freud’s ideas have been supported by subsequent research.</td>
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<td>• Some of his ideas have been discarded or modified in the light of new evidence.</td>
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A number of Freud’s ideas have been borne out by developmental and neuropsychological research. The notion of unconscious mental process is no longer disputed (Dixon and Henley, 1991), and the idea of conflicting wishes
leading to problems is widely accepted. The term ‘ego’ is still employed, and tends to be used as Freud applied it, to the rational, reasonable part of the personality. The term ‘superego’ is used to refer to both a punitive part of the personality and to conscience, the part that responds with guilt to wrongdoing. The term ‘id’ is now rarely used outside strictly psychoanalytic literature.

Freud’s notion of the infant as a blank slate with instincts cannot now be accepted. There is good evidence from developmental research that the infant has a sense of its separate self from the start, and a strong need to develop relationships (Hobson, 1993). This need, the infant’s ability to seek contact, and the quality of available relationships largely determine how the infant’s innate qualities will be expressed. Freud said little about the importance of the quality of infant care in the early years, and this yawning gap has been filled by others, both psychoanalytic writers and developmentalists. His ideas about specific developmental stages remain plausible, although so much more goes on for the infant that they are no longer considered to be of central importance.

Theories of development are regarded as important in psychotherapy because psychoanalysis and psychodynamic therapy are methods structured on the view that what happened early on is likely to appear later in life and to be accessed through the therapeutic relationship. Some analytic writers (Freud and to some extent Klein) based many of their ideas about very early development on what they observed in the therapeutic relationship with adults. This leap from present to past mental structure may or may not be justified. Others (for example, Donald Winnicott, Margaret Mahler and Anna Freud) observed children and drew conclusions from those observations.

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**The contribution of Melanie Klein**

**MAIN POINTS**

- Klein proposed that the infant is born with innate destructive impulses, and that these will colour his interaction with the environment.
- She believed that the infant has a sense of a separate self from the beginning of life.
- She also thought that the infant has a sense of the parental relationship during the first year of life.
- She proposed two stages or positions in mental development, namely the paranoid schizophrenic position and the depressive position.
Klein formulated several new ideas.

- She emphasised the place of innate destructive impulses in the child from the beginning of life. She proposed that the child’s development is influenced not only by the environment, which the parents provide, but by the infant’s propensity to interpret and colour his environmental experience and his thinking with his own innate aggressive feelings. These are said to be primitive in the sense that they are unmodified by actual experience, and are assumed to be extreme and frightening.
- She suggested that the infant has a sense of self and other from the beginning of life. This is supported by subsequent developmental research.
- She thought that the infant had a sense of the parental relationship from the first year, rather than from the fourth or fifth year as Freud suggested. She derived this idea from her work with young children.
- She described the very young infant as splitting his experience into good and bad. She called this stage of development the paranoid schizoid position. This is consistent with subsequent cognitive developmental research which indicates that the infant categorises experience from the beginning of his life. Klein also thought that the infant split his own mixed sensations into good and bad and projected one or the other into the outside world, so that his perceptions would then become coloured by whatever feelings he had projected. This would affect his relationship with the person who was the unwitting recipient of the projected feelings.
- She further suggested that during the first year the infant gradually learns that he can have good and bad feelings towards the same person. She called this the depressive position. This use of the word ‘depressive’ is not related to either the symptom of depression or the diagnostic category of depression. It was called ‘depressive’ because Klein thought that the baby had some realisation that he could feel destructive feelings towards the mother whom he also loved, and that this would induce a feeling of sadness.

Klein has been criticised for imputing sophisticated thinking to infants at an early age. Whether or not one agrees with this in relation to infants, her ideas have been extremely useful in relation to working with disturbed adult patients suffering from severe personality disorders, who habitually use the
mental mechanisms of splitting and projection that she described (see p. 65 for further discussion of projective mechanisms).

**Attachment theory and attachment behaviour**

**MAIN POINTS**

- Humans need attachment figures throughout their life. Children need attachment figures for protection, and adults need them for contact and comfort.
- John Bowlby was the first to identify attachment as a specific class of behaviour. His important early research with James Robertson in the 1950s involved the observation of children separated from their parents in hospitals and residential care.
- Later research focused on assessing the quality of the security of attachment to the parent(s) and on classification of children’s behaviour into secure and different patterns of insecure.
- Security in children is relationship specific. The child may be secure with one parent and insecure with the other.
- It is suggested that security is related to the parent’s ability to empathise with the child’s state of mind, especially when the child’s attachment needs are aroused.
- An assessment of adult mental representation of attachment was developed in the mid-1980s. Adults, like children, can be classified as secure or insecure, although in adults these classifications are referred to as autonomous and non-autonomous.
- There is a high correlation between a parent’s mental representation of attachment and the security of the child with him or her. The child’s security with that parent at the age of 1 year can be predicted with some confidence by assessing the parent during pregnancy.
- Classifications of the child at 1 year have some predictive value for later psychosocial development.

**Attachment theory**

John Bowlby construed child development rather differently from Freud or Klein. Bowlby was interested in Darwin’s ideas about evolution and, like Freud, thought that the primary motivational force for human behaviour was
evolutionary and biological. However, whereas Freud thought that survival of
the species was determined by behaviour that maximised sexual contact,
Bowlby considered that behaviours which maximised the survival of the infant
were important and were determined by evolution. Bowlby proposed that
infant attachment to a caregiver was the optimal way to ensure safety and
thus survival of the human infant. The need for attachment was therefore
central not only to the survival of the individual but also to survival of
the species. The theory posits both innate characteristics, determined by
evolution, and a continuing effect of the experienced environment on the
developing child. According to attachment theory, much infant behaviour
with the caregiver and much adult behaviour in intimate relationships relates
to the human need for attachment. The work begun by Bowlby has been
influential both in psychotherapy and in developmental research. One of
the strengths of this theory is that it allows for systematic behavioural
observations as well as theoretical ideas about psychological development.

The attachment figure

Animals who are threatened or frightened seek a place of safety, a hole or a
burrow, and young animals often run to a parent. Children who are frightened
or anxious use attachment figures as a source of protection and safety. Children
usually have several attachment figures, but the child’s overall sense
of security is mainly determined by the quality of the relationship with the
person who provides most of the care. Adults depend on their attachment
figures for contact (both emotional and physical) and for comfort.

Situations in which a person feels anxious or threatened with pain or loss
are likely to arouse attachment behaviour. This has implications for medical
care and for mental healthcare.

The innate aspect of attachment

Infants are born with innate (genetically determined) characteristics that lead
them to seek contact with other humans. For example, they have an inborn
tendency to visually seek the shape of the human face, although they also
soon learn by association to recognise the familiar features of the face.

Like other young primates, human infants have an innate tendency to cling
and follow their familiar caregiver. In the second half of the first year these
behaviours are organised into specific attachment behaviours towards certain
figures in the infant’s life. These specific behaviours include proximity seeking
and contact maintenance. More variable behaviours are learned in the context
of the quality of the relationship available to the infant. Thus in the optimal
situation the infant will learn to expect that when his attachment needs are aroused, he can seek contact and comfort, and his caregiver will recognise his state of mind and respond appropriately. If, for some reason, the caregiver cannot provide this response reliably, the infant will develop an alternative strategy for coping with his aroused attachment needs.

**Early observation of attachment behaviour**

In the early 1950s, John Bowlby and James and Joyce Robertson studied young children who were separated from their parents for a period of days or weeks. They made a series of video films of children in hospital and residential care (Robertson and Robertson, 1969). Their descriptions and film records of the distressing effect of long separation on young children who are not offered good-quality and consistent alternative care had a considerable impact on the hospital management of children, and to an extent on other institutional childcare. For example, whereas in the 1950s and 1960s parents were discouraged from staying with their child in hospital, it is now considered good practice for parents to remain with a child who has to spend time in hospital.

**Assessment of infant security of attachment**

Systematic research from the late 1960s onwards began to look at attachment in more detail, and to examine the effect of quality of attachment on the child’s development when there had not been long separations and the child had been cared for continuously by one or both parents.

Research has consistently shown that in the USA and the UK about two-thirds of children are securely attached to their mothers and about one-third show some degree of insecurity. Secure children are confident that the mother will be a reliable source of protection and safety, whereas insecure children experience the mother as not entirely reliable as a source of protection, and have to find some strategy to cope with the anxiety aroused by this situation.

Infant security can be assessed at 1 year in a standardised test situation involving two brief separations from the mother and two reunions (the *Strange Situation*). Infant attachment behaviour is categorised in two ways:

1. according to whether it is *secure* or *insecure*
2. by the degree to which *disorganisation* of one of the three secure or insecure categories dominates the picture.

On the basis of the child’s behaviour during the procedure he is allocated a classification of secure, insecure avoidant, insecure ambivalent or disorganised
with regard to his attachment to that caregiver. The Strange Situation assesses the quality of a relationship – for example, a child may be secure with one parent/caregiver and insecure with the other, disorganised with one and organised with the other.

Secure infants welcome the mother after the short separation, even if they have been distressed by the mother’s absence. They do not show anger when she returns, they seek proximity and comfort, and soon return to play.

Insecure infants find their anxiety heightened by the uncertainty of the maternal response to their distress, and they deal with this in one of two ways.

1. One group ignores the mother’s going away and ignores her return. If the mother makes an approach to the child it is avoided or treated with indifference. The child often shows more interest in the toys in the playroom than in the mother. This behaviour is called avoidant insecure behaviour.

2. The other group of insecure infants deal with their anxiety by showing an angry clinging to the mother. They may get very upset by the mother leaving them even for a minute, and on her return they angrily demand contact, but show resistance when they get it, are slow to settle, with repeated outbursts of crying, and are reluctant to return to play. This is called ambivalent insecure behaviour.

Infant insecurity has been linked to maternal insensitivity to the child’s cues and signals. As a result, the child can never be sure that he will get the response he needs when he is upset. He may, for example, have a mother who simply does not notice or realise what her child needs, or who needs the child to respond to her rather than the other way round. In using either avoidant or ambivalent behaviour, the child has learned a way to reduce his anxiety. It should be noted that both of these groups show a coherent strategy for dealing with a stressful situation. Note also that these observations are valid only in the standardised research test situation. All children will show upset, anger or resistance when they are tired or excessively stressed, and they should not be considered insecure on this basis.

Children whose behaviour in the presence of the mother is disorganised show disruption of one of the secure–insecure patterns. The child may show an underlying pattern that is either secure or insecure, but in either case there is breakdown of that pattern. There is evidence of behaviour that is not coherent, with episodes that appear to lack an observable goal, intention or explanation.

There is evidence that disorganisation of attachment behaviour is related to the presence of fear in the relationship between child and mother. This places the child in the impossible position where his source of safety is also a source of fear. Disorganisation of attachment is usual among maltreated children,
which is unsurprising, but is also observed in some children where maltreatment is not suspected. Disorganised behaviour in non-maltreated infants has been found to be associated with the caregiver’s failure to resolve an experience of loss or trauma in relation to an attachment figure (see opposite for a discussion of the unresolved–disorganised category of the Adult Attachment Interview).

Correlation between early secure behaviour and later development

Security of attachment is only one factor that shapes the personality of the developing child. Innate abilities, level of environmental stimulation and quality of schooling, for example, are all important factors in development. However, there is evidence that attachment security has a place in shaping later development.

Social relationships

Secure attachment appears to act as a protective factor against the vicissitudes of life. The findings are not entirely consistent, but none of them show an advantage to children who are classified as insecure or disorganised in infancy.

- In the second year, securely attached children show greater enthusiasm and less aggression during shared tasks with their mothers.
- Preschool children who were secure in infancy make fewer bids for a teacher’s attention, but their claims are more likely to be successful than those of insecure children.
- There are inconsistent findings that secure children are better liked and able to socialise more competently.
- Children with secure histories show greater social competence from the age of 10 years into their teens.
- Secure children aged 10 years were rated by camp counsellors as having greater self-esteem and self-confidence.

Conduct problems

Children classified as disorganised in infancy from all socio-economic groups, whether disorganised–secure or disorganised–insecure, experience a degree of vulnerability in later development. The predictive validity of disorganised behaviour is established with regard to problematic stress management, an
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elevated risk of externalising problem behaviours at 6 years, and a tendency for disorganised infants to show dissociative behaviour later in life (van Ijzendoorn, 1995).

Adult attachment

The assessment of adult attachment for research or clinical purposes is not made by observation of behaviour, but by evaluating the mental representation of attachment in the adult. The assessment is made using an analysis of the transcript of a semi-structured interview (the Adult Attachment Interview, or AAI) in which the subject is asked a number of questions relating to their early experience of attachment relationships. The evaluation depends not on a rating of actual or remembered experience, but on the degree to which the subject has been able to form a coherent narrative with regard to his own attachment, to recognise states of mind and motive in both self and attachment figures, and to value attachment to others, even if his own experience was unsatisfactory.

About two-thirds of adults are classified as autonomous with regard to attachment, with an ability to be reasonably coherent about their attachment experience, to be aware of other people’s states of mind when discussing attachment experiences, and to value attachment relationships.

About 20% of adults are dismissing of attachment, tending to idealise early relationships while being unable to offer evidence to support their idealisation. Despite the idealisation they are either overtly derogatory about attachment behaviour or apparently unaware of its relevance in relationships. They may be rather grandiose in their insistence that they do not need other people. The narrative is generally somewhat incoherent when attachment relationships are being described.

About 15% of people are preoccupied with regard to attachment. Although they value attachment, they have a sense of still being actively involved in early attachments, with little indication that they have resolved their feelings about these relationships, and they often show continuing anger towards early attachment figures. Like dismissing individuals, they are not very coherent in their account of attachment relationships.

A person can be very coherent when discussing other matters, but incoherent when talking about attachment. It appears that the continuing anxiety about attachment is associated with a degree of inability to think and speak clearly about attachment relationships.

The unresolved–disorganised (U/d) category of the AAI

It has been found that mothers of infants who show disorganised attachment are likely to show momentary lapses in language and reasoning when
discussing loss or trauma relating to an attachment figure. This has been considered to be evidence of ‘unresolved–disorganised’ mourning, and is postulated to represent brief episodes of dissociation when thinking of the experience. This is compatible with the psychodynamic explanation that the lapses represent an unconscious defensive strategy to avoid fully giving up the presence of the lost person.

The concept of self-reflection

The capacity of the caregiver (generally the parent) to reflect on her own and other people’s state of mind when attachment needs are aroused is highly correlated with infant security. Adults who are relatively non-anxious about their own attachment relationships can attribute intentions and meanings to their own and other people’s behaviour in situations where they need or seek attachment. Adults who remain anxious about attachment become relatively incoherent when describing their close relationships, and in particular have difficulty in conceptualising why the people concerned behave as they do.

Intergenerational transmission of attachment

There is a high correlation between the parental representation of attachment and the child’s attachment behaviour at 1 year. By assessing a parent in pregnancy, it is possible to predict with 70–80% certainty what the attachment pattern of the child with the parent will be at 1 year. An autonomous parent is likely to have a child who is secure with her or him, a dismissing parent is likely to have a child who is avoidantly insecure with her or him, and a preoccupied parent is likely to have a child who is ambivalently insecure with her or him (Fonagy et al., 1991).

The measure of infant security is relationship specific. The child may be secure with one parent and insecure with the other, depending on the quality of the parent’s representation of attachment. The effect on the child’s subsequent development is additive, in that the child does best if he has a secure relationship with both parents, and worst if he has an insecure relationship with both parents. The primary caregiver (usually the mother) has the greater effect on the child’s development in this respect.

Although innate temperament plays a small part in attachment patterns, the relationship specificity and prenatal predictability demonstrate that relationship experience is more important in determining the child’s attachment behaviour. It seems that either confidence about a reliably responsive relationship, or defensive and coping strategies, are learned from parents by children by as early as the end of the first year.
Psychological defence mechanisms

**MAIN POINTS**

- We all have experiences in life that cause us painful emotion. We also have wishes that conflict with our rational or moral standards.
- People adopt various mental defence mechanisms in order to avoid mental pain or conflict.
- Defence mechanisms protect us from anxiety and other painful emotions – they are a way of reducing painful emotion. Everyone uses psychological defences.
- Defence mechanisms can be anywhere on a spectrum from fully conscious to unconscious.
- Psychological defences may be adaptive (healthy) or maladaptive (pathological).
- The end product of the mechanisms may be a form of maladaptive behaviour or a neurotic symptom. If there is an underlying wish, the symptom may express the original wish in disguised form.

We are all subject to feelings and thoughts that cause us distress. This sense of distress includes feelings of fear or anxiety, shame, guilt and perhaps an acute sense of loss. These may be caused by something in the external world. For example, a person may be distressed by the thought of having a serious illness and the underlying fear that he may not survive or may be seriously disabled.

They may be because of something internal, something which is already on the person’s mind. This may be a thought or wish that conflicts with his self-image or with the moral standards he wants to adhere to. A thought or memory that lowers his self-esteem may make him feel ashamed or guilty. Or he may be distressed because he has thoughts and feelings which he finds abhorrent. For example, he may have violent or sexual wishes which conflict with his moral standards.

Most though not all of these experiences of mental discomfort have a component of anxiety. Anxiety is a useful signal to us that we are in some way endangered and that we should take avoiding action. This is clearly not always possible, so we must either tolerate the uncomfortable feeling or find some way of reducing it.

We find ways of reducing unwanted feelings either consciously or unconsciously. Conscious ways of reducing unwanted feelings may be adaptive or maladaptive. For example, if a student is anxious about an exam he is sitting
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in two weeks’ time and for which he has done no work, he can avoid anxiety by suppressing any thoughts of the exam and diverting himself with an active social life, or he can reduce his anxiety by studying for the exam. Arguably one solution is more adaptive than the other.

Unconscious ways of reducing anxiety or other painful feelings may also be adaptive or maladaptive. For example, a person may function well at least for a time, by being able to unconsciously deny some of his own needs and throw himself into work. On the other hand, at another time this approach may become maladaptive if it leads to overwork and breakdown.

Definition

Defence mechanisms are mental or behavioural strategies that reduce anxiety or other painful affects.

Characteristics of mental defence mechanisms

- Defence mechanisms reduce anxiety or other painful affect.
- They can be conscious or unconscious.
- Everyone uses them in everyday life.
- They can be adaptive or maladaptive, pathological or helpful.
- Sometimes symptoms are the result of defensive mechanisms to avoid unwanted feelings.
- The underlying wish that leads to anxiety may be expressed in the defensive solution.

Case study

A senior nurse was devoted to her work and to her patients. She worked long hours, often staying well beyond her shift to be with a distressed person. She had a reputation for being the kind of nurse who could never do too much for her patients. She led a quiet, rather lonely life outside work, but gained such satisfaction from nursing that she felt her life was comfortable. Her health was good until she contracted glandular fever, which was followed by a prolonged depression that required hospital admission. During the admission she was a most demanding patient, often exhausting and exasperating staff with her demands for attention and support.

She had dealt with her own unconscious wish for attention and care by denying it in herself, splitting it off from her own self-image and projecting it on to her sick and vulnerable patients. She was able to
satisfy her own need vicariously by caring for her patients with great devotion. However, when she was ill herself, and feeling helpless and unable to look after other people, her usual defence mechanism was not available to her and her own need was more directly expressed.

She had in fact found quite an adaptive way of dealing with a side of herself that could perhaps never be satisfied in personal relationships. The problem with such an adaptation (or defence) is its tendency to break down when external circumstances change, as it did in this case.

When she was admitted to hospital her own strong wish to be looked after, which had previously been repressed and unconscious, became conscious. She might have dealt with this new awareness by talking about how unhappy she felt and working out what this might have to do with her early life experiences. This would have been very painful and she would have had to acknowledge to herself her acute sense of deprivation and her sadness that she could never have the kind of childhood care that she longed for. She would also have had to accept that she would need to find some other solution to this need which could never be met as she longed for it to be.

Her solution in hospital was to regress to a state of childish neediness and to make the unreasonable demands on her carers that a small child might reasonably make on a parent. Not surprisingly, these demands could not be met. A temporary regression may be very helpful in allowing a physically or mentally ill person to receive care and support to recover from the illness. However, a longer-term regression is generally unhelpful because it stops the person from managing their usual ways of coping with life’s difficulties.

Common defence mechanisms

**Repression**

Two businessmen are dining with an important visitor. During the meal the conversation turns to schools and the visitor says that he has just taken his son to school in Borsetshire. ‘Oh, my neighbour has a kid at school in Borsetshire,’ says one of the hosts, ‘but it’s a school for loopy kids – his son has Down’s syndrome.’

‘The same school, no doubt,’ says the visitor coldly, ‘my son has learning disability.’

A year later, over drinks, his colleague reminds him of this appalling faux pas. He has no memory of it.
Dynamic psychotherapy explained

He has repressed this painful moment of acute embarrassment, and need not experience the anxiety which the memory would arouse.

**Reaction formation**

Aggression is something that many people regard as ‘bad’ in themselves. It is also part of normal experience. So how can a person deal with his unacceptable wish to be aggressive? Perhaps by unconsciously repressing it and using it in a disguised form to destroy anything which is tainted with aggression. An aggressive person may become a determined pacifist (although of course not all pacifists repress aggressive feelings). He can then fight for the cause of pacifism and in doing so satisfy his aggressive drives. This mechanism which both gratifies and repudiates an unacceptable drive is called reaction formation.

Sexual wishes and sexual excitement are another aspect of normal experience which makes some individuals feel highly anxious.

Mrs Grey spent much of her time writing to television companies to complain about programmes with unacceptable scenes of explicit sexual behaviour. She also spent hours every day searching newspapers and watching television so that she could spot these threats to public morality.

**Denial**

Denial is the mechanism whereby in the face of all logical evidence a person behaves as though reality is not happening.

A patient was found to have a potentially fatal illness. His diagnosis was explained to him by the consultant, who invited him to bring his wife for further discussion. The patient arrived for the subsequent appointment alone and had no memory that his wife was invited. Treatment was begun immediately. A week later the wife demanded a meeting with the consultant and was horrified to hear the diagnosis, of which she (and later the patient) denied any knowledge. She sent a formal complaint to the hospital.
This patient was so frightened by the diagnosis that he denied to himself that he had heard it. The process was unconscious. Denial is different from repression in that it involves some obliteration of current reality.

**Rationalisation**

Rationalisation occurs when an external agency is held to be responsible for an internal event – for example, ‘I failed my viva because he asked all the wrong questions.’

The woman who says ‘I’m depressed because people don’t like me’ is trying to make sense of or *rationalise* her inexplicable depression. Her observation may be accurate, but she may find it difficult to see that there may be something in her attitude to people which makes them avoid her.

**Projective identification**

This mental mechanism was first described by Melanie Klein (*see* p.53). She proposed that small children tend to see things in black-and-white terms and to assume that a thing or a person is either entirely good or entirely bad. She called this *splitting*. As the child gets older, he begins to realise that this is not how the world is, and he becomes increasingly able to accommodate the idea that people are both good and bad and that he can have good and bad feelings towards the same person. However, we never entirely lose our tendency to split the world into good and bad. Articles in the tabloid press may demonstrate the mechanism of splitting.

In times of stress we are especially prone to *split* within ourselves, to *deny* the part that is unacceptable and to externalise it and attribute it to (or *project* it into) someone or something outside ourselves. This triad of *splitting*, *denial* and *projection* is a universal mental mechanism and it is of central importance in understanding how people relate to each other.

Thus the nurse whose case study was presented earlier denied her own vulnerability, split it off from conscious awareness and projected her unwanted needy feelings on to her patients. It is not unknown for doctors to do this, too. This mechanism in medical practice may lead to the kind of devoted care that was described for the nurse, who did not despise her own vulnerability, but unconsciously wanted it to be caringly responded to.

In contrast to this, some people dislike their own need for care, which they find humiliating. Like the nurse, they project it on to other people, but unlike her they then treat it and the other person patronisingly or even contemptuously. This mechanism probably lies behind the ‘arrogance’ that patients sometimes complain of in their doctors.
Dynamic psychotherapy explained

The therapeutic relationship: working alliance, transference and countertransference

<table>
<thead>
<tr>
<th>MAIN POINTS</th>
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<tr>
<td>We bring our mental representations or working models of self and others to new relationships and new situations.</td>
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<tr>
<td>These lead us to have expectations of how another person will behave and feel in the relationship.</td>
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<tr>
<td>We give verbal and non-verbal cues which invite the behaviours that we expect.</td>
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<tr>
<td>The therapeutic relationship in psychodynamic psychotherapy is actively used so that the patient’s mental representations can be played out and analysed in a safe setting.</td>
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<tr>
<td>The therapeutic relationship has three components: the working alliance, transference and countertransference.</td>
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<tr>
<td>The working alliance is the business contract that allows the work to take place.</td>
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<td>The transference is the unconscious process by which the patient’s mental representations of expected behaviour are attributed to the therapist, who is experienced and treated as a figure in the patient’s inner world.</td>
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<td>The countertransference consists of the feelings that the therapist has towards the patient, some of which will relate to the therapist’s own mental models and experience, and some of which will be elicited by the patient’s projected expectations.</td>
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<tr>
<td>Therapists have personal therapy to enable them to be more aware of their mental models so that these contaminate the therapeutic relationship as little as possible.</td>
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We bring our existing mental representations of the world and ourselves to new relationships. These representations may be thought of as a range of scenarios or stories involving self and another person or people, each with some emotion attached. This is our prototype or working model for approaching new situations, where we will tend to use old information to give us rules about how to deal with it. We project our internal images or expectations into the new relationship and expect to find a familiar response.
In addition, we not only expect a particular response, but unconsciously we may actually try to elicit it by giving verbal and non-verbal messages that invite another person to behave as we expect.

**Example**
Rob grew up feeling that he could never satisfy his parents. He felt that they had high expectations of their children and he believed that he was a disappointment to them. He was shy and uncertain when he went to school, and was bullied by some of the other children. As a rather isolated student, he forced himself to go to a party, hoping that he would make friends and have a better social life. He went into the party stiff with anxiety, did not make eye contact with anyone, and stood alone looking miserable and tense. His body language told people that he was afraid of contact and that he feared being disappointing, and the students at the party responded as he expected and did not approach him. He left feeling that he had been rejected just as he had dreaded, but did not realise how much he had invited the feared response.

Rob has an (unconscious) internal representation of himself with other people in which he is unable to give people what they want and is rejected because he disappoints them. Although he knows rationally that he must try to make friends if his life is to be happier, he unconsciously sabotages his own efforts by giving messages to other people that he expects the relationship to fail.

How can we help a person to access and understand the unconscious mental representations that hold them back from sorting out emotional problems? There are two kinds of psychotherapy which try to gain access to the patient’s representational world. Cognitive psychotherapy explores the conscious and almost conscious thoughts underlying maladaptive behaviour. Psychodynamic psychotherapy also explores these thoughts, but in addition it attempts to help the patient to find the unconscious beliefs and assumptions that underlie his maladaptive behaviours and feelings.

More than any other kind of psychotherapy, psychodynamic psychotherapy makes very active use of the relationship between the patient and the therapist as part of the therapeutic process. It is within this relationship that the patient will be able to enact at least some of what he cannot remember or bring to his conscious thinking. The therapist is constantly alert, and closely observes not only the patient’s overt behaviour, but also the quality of the relationship that he creates in the therapy.

There are three parts to the therapeutic relationship in psychodynamic psychotherapy:
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1. the working alliance (also called the therapeutic alliance)
2. the transference
3. the countertransference.

The working alliance

**Definition:** The *working alliance* is the agreement between the patient and the therapist that they will work together on the patient’s emotional or psychological problems. It is a contractual arrangement and is a rational and adult transaction.

Any contract between a doctor and a patient requires an agreement. In some situations the patient’s cooperation is less important than in others. If a patient is brought in unconscious to the Accident and Emergency department, his immediate cooperation is not relevant to the treatment. If a patient is admitted for an operation, he has to cooperate to agree to have the operation, to come on the agreed day and to fast on the morning that he goes to theatre. In some ways, however, he is a relatively passive recipient of the treatment, as the surgical team will act upon his body to produce the required changes.

A greater degree of cooperation is needed for a patient to have psychotherapy. The treatment requires the patient’s active involvement to work over a period of weeks, months or even years. Some patients are unable or unwilling to enter into such an agreement, which needs a commitment to regular attendance, and a willingness to explore their own behaviour and to tolerate sometimes painful thoughts, feelings and memories.

The transference

**Definition:** *Transference* is the transfer of feelings that belong to a relationship from the past into a present relationship. This process is unconscious. The attributions are inappropriate to the present relationship.

When a patient enters into a regular therapeutic relationship with a therapist, he is likely to develop a degree of attachment to the therapist and to feel some dependency on this person who listens non-judgementally and who is interested in his story and relationships. It is an unusual relationship which is both intimate and professional. Although the therapist learns a great deal about the patient, she does not give personal information in return, and this imbalance allows the patient to imagine and assume what he chooses about the therapist. In doing so the patient has to use his own mental images and expectations.

This is similar to the situation described above when the young man, Rob, went to a party with expectations which were almost inevitably fulfilled. We expect our patients to bring their mental images and internal relationships
into the therapeutic relationship and to project some of them on to the therapist, who unlike Rob’s classmates will not enact them but will try to clarify them for the patient. In this setting, unconscious expectations can be elucidated and understood.

Whereas no one at Rob’s party was likely to explain to him how his mental model was sabotaging his behaviour, this is precisely what we do expect to happen in psychotherapy. The therapist pays close attention to the behavioural and verbal hints about what the patient’s assumptions and unconscious expectations are, and together the therapist and the patient work out what is going on under the surface. This central therapeutic activity of psychodynamic psychotherapy is called the analysis of the transference relationship.

The countertransference

**Definition:** Countertransference is the feeling or feelings elicited in the therapist by the patient’s behaviour and communications.

The setting for the therapy is intended to facilitate the patient recreating his inner world in the therapy and bringing his expectations of relationships to the therapeutic relationship. All doctors and all therapists have feelings about their patients, but in this particular setting the therapist’s feelings are important in helping to understand something of what is going on in the patient’s mind.

One of the therapist’s tasks is to identify the responses that the patient generates in her by the patient projecting something of his mental representations (i.e. in the transference relationship).

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**Example**

Mr Green had a childhood history of rather unavailable parents and inconsistent parental care. He described his father as a rather distant figure who was more interested in his work than in the family. His mother had repeated episodes of severe depression, leaving Mr Green and his older brother to fend for themselves. As an adult he himself had had spells of depression which did not respond well to antidepressant treatment. He reported short-lived and unsatisfactory close relationships with women. In therapy the therapist became aware that although Mr Green talked fluently about himself and his life, she felt rather distant and even a little bored. As there was no obvious reason for this feeling, she surmised that he was creating this sense of distance between them. As the therapy progressed and further work was done, it became clear

*Continued*
that he was afraid to burden the therapist with his emotional state, and in particular his depressed feelings, just as he had been afraid to burden his emotionally fragile mother.

The therapist gained a clue to how Mr Green related to people whom he might want to depend on by being alert to the response that he evoked in her. As Mr Green became aware of this himself, he could see that he held people at a distance in other relationships because of the same fear. He was able to recognise that this fear was no longer appropriate to his life.

It is important that the therapist is as aware as she can be about her own unconscious expectations, so that she is in touch with her personal tendencies to make assumptions. This is one reason why dynamic psychotherapists are expected to have their own personal therapy or analysis before they start to treat patients. If this is not practicable (for example, trainees in psychiatry are required to treat patients in dynamic psychotherapy, but are not always able or willing to have personal therapy), they should have supervision from an experienced psychotherapist.

Other psychoanalytic terms used in psychodynamic psychotherapy

**MAIN POINTS**

- Several terms that are commonly used in psychodynamic psychotherapy are explained.
- Enactment is the playing out within the therapy of mental representations that cannot be expressed verbally.
- Repetition compulsion is the tendency to repeat instead of remembering.
- Acting out is enactment that takes place outside the safer confines of the therapeutic relationship. It is usually damaging for the patient.

**Enactment**

*Enactment* is the term used to describe the non-reflective playing out of a mental scenario, rather than verbally describing the associated thoughts and feelings. To some degree this is an inevitable part of dynamic therapy, where
to an extent old relationships are recreated in therapy. However, in this
case the patient is asked to use his adult mind to step back and think about
what is going on. In some kinds of therapy, regression or dependency is
discouraged. In psychodynamic therapy it is temporarily encouraged so that
it can be re-experienced and understood in the safe setting of the therapeutic
relationship.

Case study
Ms Black began therapy because of depression related to difficulty in
maintaining relationships. She attributed this to her poor choice of
partners. She was in her late twenties and a graduate with a good job
which she did well. After leaving university she had married a man who
had been a fellow student, but the marriage broke down about a year
later. She managed her life very competently in those areas where
relationships were not too intimate, but her history revealed that her
love affairs had been stormy and short-lived.

A few months into therapy she became demanding and emotionally
fragile, oscillating between tearfully wanting understanding from the
therapist and furiously accusing him of neglect and of deliberately
disappointing her. Her conscious wish for a supportive and loving
relationship was swamped by unconscious needs which she neither
recognised nor understood. Consciously she saw and experienced herself
as a highly capable, warm person who had been the victim of un-
reasonable partners.

Ms Black had spent much of her earliest years in hospital suffering
from a chronic condition which improved in mid-childhood. Because of
the distance of the hospital from her home her family visited only rarely,
but she was said to have adapted well to life in hospital and was called
‘the extra little nurse’. When she returned to the family at the age of 9
years her parents had separated and her mother was only too glad to
have a dependable eldest child to help her. Ms Black was responsible for
the care of her younger siblings from mid-childhood, and had been
unfailingly supportive of her mother. Problems only arose in her adult
life when she entered a relationship where she had a chance of being
looked after. Then all her old childhood longings for care and support,
which had been long suppressed, were aroused, and she became
impossibly demanding, angry and tearful when her partner would not or
could not respond to her needs. She herself recognised that she was
‘emotional’ in her relationships, but perceived her partners as cold
and withholding.
Dynamic psychotherapy explained

The therapy became an opportunity for her to reassess both her own behaviour and the needs that lay behind them. The therapist’s ability to be reliably available and not to respond with anger or exasperation made her feel responded to and helped her to think more calmly about herself. Ms Black longed to recreate a relationship with a parental figure who would look after her as she would have liked to have been looked after as a child. In the therapy she was able to see how her strong childhood feelings were actually damaging her adult relationships, and she was able to have more conscious control over her life.

Repetition compulsion

The term ‘repetition compulsion’ derives from Freud’s notion of the compulsion to repeat instead of remembering. Ms Black was demonstrating repetition compulsion in her relationships with partners where she enacted her emotional need and her anger that she had not been responded to without remembering what this need or anger was originally about. When she made sense of her feelings of longing for care, she could remember, or at least realise, that she had wanted that care as a child, but because there was no chance of getting it she had resolved the situation by caring for others. As an adult, the trigger of a close relationship led to her being ‘obliged to repeat’ the child’s insistent demand for affection, unconsciously attempting to get what she had not felt was adequate when she was a child. She could not recover and have less demanding relationships until she could consciously acknowledge her childhood deprivation and give up the hope that she could still get what had been missing from her childhood. Once she could mourn what she had missed, she was freed to form more realistic adult relationships.

Note that repetition compulsion is not the same as the compulsive symptoms, such as hand washing, which are seen in obsessive-compulsive disorder. Hand washing in obsessive-compulsive disorder can be considered as an expression of extreme anxiety about getting rid of the damaging effects of germs. This fear about something damaging or destructive is arguably a projection of anxiety about the subject’s own feared impulses to damage. The most effective treatment is behavioural therapy.

Acting out

Acting out is enactment that takes place outside therapy. A patient may have strong feelings stirred up during his therapy. Instead of containing them until he can explore them by thinking about them and discussing them with the therapist, he acts them out in another setting. This is sometimes destructive
for the patient, and in this case must be urgently addressed in the therapy. If the patient is really unable to contain certain emotional issues within the treatment setting, it may be better for the patient to end the therapy.

Example
Unlike Ms Black, Mr White – who had similar relationship problems to Ms Black – did not allow his need for attention and affection to surface during the therapy. When there was a break in therapy Mr White became furiously angry and abusive towards his wife. He felt that she had lost interest in him and was giving all her time to the children. When he started his therapy again he realised that these were feelings he had towards the therapist who had left him to go on holiday. He had acted out feelings which were stirred up by the therapy in the outside world.

Note that ‘acting out’ has nothing to do with drama therapy. It is not a therapeutic activity, and it is generally unhelpful for the patient.

A dynamic formulation of psychiatric diagnoses

**MAIN POINTS**
- A dynamic formulation suggests a personal meaning for a person’s symptoms or behaviour.
- It is important not to generalise about the meaning of symptoms based on diagnostic classifications.
- However, some dynamics are commonly associated with particular symptoms.
- Some dynamic ideas are outlined for common psychiatric problems.

It is important not to generalise about the meaning of specific symptoms, and it is essential to look at a particular person’s problems and his individual thoughts, feelings and experience. Each person’s illness occurs against the background of his personality and the life experience that has shaped him. It is important to recognise that some patients have a strong genetic predisposition and/or a substantial biological contribution to their illness or condition, and in such cases a dynamic understanding may be of secondary
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importance. For such individuals dynamic psychotherapy may be helpful in some instances, but often will not be the first-line treatment. However, as exam candidates are often asked to comment on the dynamics of a particular condition, these formulations may be relevant.

A psychodynamic approach recognises and emphasises individual differences in the meaning of people’s behaviours, but there are also certain dynamics which are commonly seen in relation to particular diagnostic groups. This section gives an outline of dynamics that are often encountered in people suffering from specific mental disorders.

A dynamic formulation suggests a personal meaning of a person’s symptoms in terms of his or her psychological organisation. Even when the person is unlikely to benefit from a formal psychodynamic treatment, an understanding of the psychological reasons underlying their symptoms and clinical presentation may help a psychiatric team to plan treatment, and may improve cooperation between the patient and the team because the patient feels that his individual feelings and problems are recognised and understood.

The conditions whose dynamics are outlined in this section include:

- depressive disorder
- mania and hypomania
- schizophrenia
- anxiety (anxiety states, post-traumatic stress disorder and phobias)
- obsessive-compulsive disorder and obsessional behaviour
- addictive behaviour
- eating disorders (anorexia nervosa and bulimia nervosa)
- borderline personality disorder
- narcissistic personality disorder.

**Depressive disorder**

It is important to distinguish between depressed mood and sadness. Depression is a much more complex emotion and includes sadness and anger and sometimes also guilt and shame. A person who is suffering from depressive disorder feels helpless and often has strong feelings of self-blame or worthlessness. He feels unloved and unlovable. He may hate himself so much that he feels he would be better off dead. He may also feel angry that those closest to him have not been able to support and help him.

Common dynamics include:

- a denial of sadness, with anger turned against the self
- a sense of helplessness in carrying out normal activities
- anger towards others.
A denial of sadness, with anger turned against the self

Many episodes of depressive disorder are precipitated by an identifiable external event. This is often a loss or disappointment which may be trivial, but which may trigger by association memories of previous loss, or an awareness of the person’s helplessness in controlling loss of people and things that really matter. However, the pain of loss does not lead to acceptance and healthy mourning, but to denial of sadness, and in its place a feeling of anger. According to Freud in his paper ‘Mourning and Melancholia’, the person denies the reality of loss and keeps the lost object (person) alive by identification. Anger that is felt towards the lost object is then turned on the self, which is now identified with the lost person. The depressed person accuses himself of failure and of being a worthless person.

A sense of helplessness

A sense of loss brings with it a feeling of helplessness to prevent the loss of what we need and love. If the true sense of loss is denied and mourning does not take place, the feeling of helplessness may be displaced from its original source to other aspects of the person’s life. Thus he may be unable to carry out activities which are well within his capacity.

Anger towards others

The anger that is felt towards the lost object is displaced on to a person or people in the present life of the depressed person. Hostility may be unconscious, but is expressed in various aspects of behaviour – for example, in making heavy demands on family or professionals, while at the same time apologising for being ‘a nuisance.’

Mania and hypomania

In dynamic terms, mania is usually considered to be a defence against depression. There is a denial of depression or of the sense of helplessness associated with depression. The feeling of omnipotence and the grandiose behaviour that are often found in mania and hypomania are expressions of this denial. This is not to say that there is not a neurochemical change, and most psychiatrists would consider it important to treat hypomania with drug therapy at least during the acute phase of the illness.

A less extreme presentation of manic behaviour is also seen in people who have narcissistic personality disorder. A dynamic understanding of manic behaviour is valuable for understanding these patients, where there is denial.
of depression and helplessness and the expression of grandiose ideas without the appearance of psychotic symptoms.

**Schizophrenia**

Like a person with a neurotic problem, the psychotic individual may see the external world in terms of his own internal world, but to a degree which is outside normal experience. His current perceptions may be interpreted as if they are part of his internal model. He loses the ability to distinguish between internal and external reality, between his own thoughts and events in the outside world.

Aspects of his internal world are *split off* and *projected* into the outside world in a very concrete way. Thus, for example, an auditory hallucination that is a critical commentary on his behaviour may be considered in dynamic terms to be a self-criticism projected into an outside agency. A delusion that his thoughts can be read or that others can put thoughts into his mind may express his feeling that he has no privacy and no control over his own mind. His sense of the boundary of his self is fragmented, and his subjective feeling that others can put things into his mind and take things out at will is expressed as a delusional belief.

**Anxiety**

**Anxiety states**

Anxiety is a normal and healthy response to a perceived threat. Anxiety is considered to be pathological when the anxiety is out of proportion to any identifiable threat, or when the person cannot limit or regulate the anxiety in a manageable way.

People may be habitually anxious because they constantly expect something damaging to happen to them or to another person. This may be linked to an unconscious fantasy of the person’s own destructiveness, which has to be controlled, or to a fear of that same destructiveness projected into the outside world and constantly guarded against.

**Post-traumatic stress disorder**

In post-traumatic stress disorder the excessive anxiety can be traced back to a real experience of overwhelming fear or threat. The person may or may not already have a sense of anxiety about his own destructive capacity or that of something in the world, but this can be augmented by the actual experience
of a severe threat to life in the outside world. The real experience then confirms his pre-existing fears or anxieties about the dangerousness of the world.

**Specific phobias**

It is assumed that there has been *displacement* of anxiety from one feared object to an associated one, possibly from an unconscious fear which cannot be controlled to a conscious and therefore potentially avoidable one.

**Obsessive-compulsive disorder and obsessional behaviour**

**Obsessive-compulsive disorder**

The person with obsessive-compulsive disorder (OCD) has anxiety about unconscious wishes or impulses which are unacceptable to him, and which are felt to be damaging to him or to other people. These are usually to do with either hostile or sexual feelings.

The damaging wish is *projected* into something in the outside world – for example, into dirt – which is experienced as dangerous. The person then experiences intense anxiety about contact with this feared contaminant, and feels the need to control it. This underlies the compulsive rituals whereby the feared contaminant is *magically controlled* by certain rituals such as washing a specific number of times.

**Obsessional behaviour**

As a personality characteristic, the obsessional wish for order and cleanliness may be considered to be a *reaction formation* to the wish to make a mess, perhaps a sexual or aggressive mess. The obsessional person is anxious about things getting out of control, is characteristically rather controlling of himself and others, and may be careful to the point of meanness. As a personality trait it can be positive if it is not too extreme. For example, a degree of obsessionality may be an advantage to a researcher.

**Addictive behaviour**

Common dynamics include:

- control of someone/something the person depends on
- fear that no other person can ever cope with his needs
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- anaesthetising painful feelings
- attacking or punishing another person.

Controlling a needed person or thing

In infancy, the baby is allowed the illusion that the people he needs and cares about are under his control. As the child grows older he gradually learns that love and attention have to be earned, and that his parents and others have their own needs and that they have interests which exclude him.

Coming to terms with the fact that the people we most care about are separate and largely outside our control is part of the process of growing up. We learn that mature relationships involve a degree of independence as well as closeness to another person. People with low self-esteem are particularly vulnerable because they not only fear being disappointed, but also expect that they will disappoint the person they care about.

One way to deny the pain of being separate and not being in control over a needed person is to use a substance as a substitute for a person. The defence mechanisms that are used are denial of dependence and displacement of the need from a person to a substance. Whereas a person cannot be picked up and dropped at will, and is not endlessly available, a bottle of alcohol or a dose of a pleasurable drug can be controlled in terms of both access and quantity. The person has the comfort of putting the pleasurable substance into his body without having to consider another person’s needs and without the fear of the relationship being taken away.

Fear that no one can ever cope with his needs

Some people despair that their needs for attention and care can ever be met. Alcohol or drugs may then be used as a substitute for a loving relationship. The need is displaced from a person to a substance.

Anaesthetising painful feelings

A person who is depressed, fearful, anxious or angry may use alcohol or an addictive drug as a way of cutting off his feelings. In the longer term this is not usually successful, as the same feelings are likely to be still there or even to have intensified when the effects of the alcohol or the drug have worn off. The defence mechanism that is used is avoidance.

Punishing someone else

Sometimes the addiction is obviously a way of punishing a partner or parent who can be hurt by the addictive behaviour. For example, the addicted person
may feel that his partner is not giving him the attention that he needs, so he turns to an addictive substance partly for gratification and partly to ‘show’ his partner that she has failed him. This may be a fully conscious process or there may be unconscious denial of hostility to the other person, but enactment of it in the damaging behaviour.

**Eating disorders**

**Anorexia nervosa**

Common dynamics include:

- control of a body which feels out of control
- denial of anxiety about the dangerous level of starvation and a sense of triumph over bodily needs
- denial of the reality of an adult sexual body.

**Control of a body which feels out of control**

The adolescent suffering from anorexia nervosa often feels conflict about separating from her parents, both longing for the closeness of a small child and her parent, and at the same time fearing that such closeness will lead to a loss of identity.

The onset of puberty with the bodily changes of an adult sexual body signals a process that will lead to separation from the family, and the demands of seeking close relationships elsewhere. At the same time the hormonal changes of puberty lead to states of arousal and a biologically driven impulse for physical intimacy. This is alarming for the adolescent, who feels herself to be out of control and fears that her bodily needs will push her towards either a regressive intimacy with a parent or a relationship outside the family for which she is not ready.

Starvation becomes a solution which allows both suppression of sexual arousal and the recovery of a child-like body that will not signal sexual maturity to other people.

**Denial of anxiety about the dangerous level of starvation and a sense of triumph over bodily needs**

The patient usually shows no anxiety about the danger in which she is putting herself. Instead there is often a denial of the helplessness she feels about her body’s sexual development, and a manic triumph in the way she is able to control her bodily needs. Anxiety and a sense of helplessness are projected on to family and those who are treating her, who find themselves feeling all the frustration and worry relating to the situation.
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Denial of the reality of an adult sexual body
Some women with anorexia nervosa who recover normal weight may then behave as if their bodies were still child-shaped, and may dress or otherwise behave in a socially inappropriate way. The reality of what it means to have a sexually mature body, and how this affects other people, may be denied.

Bulimia nervosa
Some people who suffer from an eating disorder alternate between showing symptoms of anorexia and symptoms of bulimia. Others have either only anorexic or only bulimic symptoms.
People who compulsively binge and vomit may long for intimacy, but at the same time fear it. There is a simultaneous belief that intimacy is intensely desirable but also damaging. Thus when closeness is possible the bulimic person begins to panic that something harmful will happen either to her or to the other person.
There is often a chronic feeling of emotional deprivation and emptiness, which she seeks to fill in her frantic need for large quantities of food. The sense of deprivation is displaced from a person to food—a controllable object. However, as soon as the food is safe inside, she behaves as if it is like a person who has got inside or too close, she becomes anxious that it will damage her and she has to get rid of it quickly. Thus she controls her needed object by being able to take it in very much as the alcoholic does, but unlike the alcoholic she further controls it by expelling it. Vomiting is often followed by a sense of relief and euphoria, which may have components of both a chemical response to changes in blood sugar and a psychological ‘high’ (manic denial of helplessness and a feeling of omnipotent control).

Borderline personality disorder
There is a characteristic constellation of anxieties which include several of those described above for people with anxiety or eating disorder, and those found in people who use addictive substances for self-calming. The person with borderline personality disorder longs for closeness, but is frightened of the damage that can occur when people get close, so she panics when an intimate relationship begins to develop. She may believe that her own needs are so immense that they will overwhelm and damage the other person, and she assumes that the other’s needs are equally excessive and frightening. There is characteristically a pattern of clinging and being demanding in relationships, followed by abrupt withdrawal. There is great difficulty in self-calming, so that distress is not quickly followed by a useful defensive activity, but by escalating arousal and a feeling of disintegration. The panic may
be expressed in an outburst of rage or in some physical activity that re-establishes a sense of contact with the world and a feeling of greater control. This may include self-cutting, bingeing or substance abuse.

There is a rigid view of self and the world, and the individual can become acutely upset if the world does not match the expectations that are projected on to it. For example, self-esteem is precarious, and the person may show apparent self-confidence which quickly disintegrates when feedback from others does not confirm their fragile self-image. The individual will then rapidly descend into acute distress.

**Narcissistic personality disorder**

The narcissistic defences of grandiosity and arrogance are sometimes seen in people who have a borderline personality disorder. The level of social functioning is usually better than it is in those with borderline personality disorder, and someone with a narcissistic personality disorder may function fairly well, especially in non-intimate relationships – for example, at work. However, like people with borderline personality disorder, they are acutely sensitive to slights, and easily feel humiliated and diminished. Their self-esteem is precarious and they are vulnerable to sudden plunges of mood following a disappointment or a real or imagined criticism. Lesser degrees of narcissistic personality traits are common and may be compatible with a high level of competence at work, along with vulnerability in personal relationships, especially where the person has to be emotionally dependent on someone else. Dependence on another person is felt to be humiliating, and ‘intimate’ relationships may only be tolerated by showing aloofness and distancing. The emotional needs of other people may be defensively regarded with contempt, which can be acutely painful for a partner.

**References**


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Further reading

Merits of psychodynamic therapy

The research suggests that benefits of this therapy increase with time.

Cognitive behavioral therapy (CBT) has emerged, both in the research literature and in the media, as a “first among equals” in psychotherapy—most often studied and most frequently cited in news reports. CBT seeks to change conscious thoughts and observable behaviors by making patients more aware of them. But considerable research also supports the efficacy of other types of psychotherapy, in particular psychodynamic therapy. In fact, a recent review in American Psychologist cited evidence that psychodynamic therapy is just as effective as CBT, and that the benefits may increase over time.

Psychodynamic therapy has its roots in psychoanalysis, the long-term “talking cure.” Like psychoanalysis, psychodynamic therapy recognizes that the relationships and circumstances of early life continue to affect people as adults, that human behavior results from unconscious as well as conscious or rational motives, and that the act of talking about problems can help people find ways to solve them or at least to bear them.

Both psychoanalysis and psychodynamic therapy rely on the therapeutic alliance in order to work. The therapeutic alliance is the personal connection between therapist and patient that enables them to work in tandem so that the patient can gain insight into aspects of experience that may be difficult to talk and think about. As the therapeutic alliance deepens, a therapist helps patients to understand themselves in new ways, and to become more mindful of a greater range of their thoughts, feelings, perceptions, and experiences. Dr. Glen Gabbard, professor of psychiatry and psychoanalysis at Baylor College of Medicine, has called the therapeutic alliance the “envelope” within which psychodynamic therapy takes place.

Although modern therapists frequently question the distinction, it is useful to note that psychodynamic therapy and psychoanalysis differ in some ways. During psychoanalysis, patients generally attend meetings three to five days a week, whereas in psychodynamic therapy, a patient typically sees a therapist once or twice a week. Thus the intensity of the therapeutic relationship is greater in psychoanalysis. Both psychoanalysis and the long-term form of psychodynamic therapy may be conducted in an open-ended manner, over many years, with the patient and therapist/analyst taking as much time as they need to decide about the duration of treatment. Short-term treatment with psychodynamic therapy, in contrast, is time-limited and usually lasts less than six months.

Gaining self-knowledge

A recently published paper compared psychodynamic therapy to CBT. It highlighted notable differences between these two forms of therapy.

Acknowledging emotion. Whereas CBT focuses on thoughts and beliefs, psycho-
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Psychodynamic therapy continued

dynamic therapy encourages a patient to explore and talk about emotions as well—including those that are contradictory, threatening, or not immediately apparent. The focus is on using therapy to gain emotional, as well as intellectual, insight. Ideally, insight enables a patient to reconsider life patterns that once seemed inevitable or uncontrollable, and leads to the identification of new choices and options. The insight may lead a patient to feel more ready to make changes.

Understanding avoidance. Psychodynamic therapy helps patients to recognize and overcome ingrained and often automatic ways in which they avoid distressing thoughts and feelings. Therapy may bring avoidance into high relief—such as when patients cancel therapy appointments, arrive late, or tiptoe around emotionally charged topics. Psychodynamic therapists point out that such psychological maneuvers often involve painful compromises between the wish to attend sessions in order to get help, and the fear of what may emerge during therapy. Psychodynamic therapy can help a patient become more aware of these maneuvers, which are likely to manifest outside of therapy as well, with the aim of nurturing more flexible and adaptive ways of coping.

Identifying patterns. Psychodynamic therapy recognizes that in mental life, the past is often prologue. Early-life experiences, especially with parents, caregivers, and other authority figures, shape present-day outlook and relationships. The goal of psychodynamic therapy is not to dwell on the past but to explore how prior relationships and attachments may provide insight into current psychological problems. A psychodynamic therapist may work with a patient to identify recurring patterns in relationships, emotions, or behaviors (such as being drawn to a verbally abusive partner) to help the patient recognize them. At other times the patient may already be painfully aware of self-defeating patterns, but needs help to understand why they keep recurring and how to overcome psychological obstacles to making changes. The aim of this work is to give patients greater freedom to direct their lives.

Focusing on relationships. Interpersonal relationships—with loved ones, friends, and colleagues—are a core focus of psychodynamic therapy. A person’s characteristic responses to other people often emerge in relation to the therapist, a phenomenon known as transference. For example, a patient who experienced hostility or dependency in an early important relationship may find the same feelings arise during a therapy session. Thus the therapeutic relationship provides a window into the dynamics of a patient’s relationships outside the office, and offers an opportunity to recognize and change self-defeating patterns.

Psychodynamic therapy often addresses not just transference, but also the therapist’s responses to the patient, often called “counter-transference.” Such reactions may reflect the therapist’s own formative relationships, but they often signify the “pull” the therapist feels to play out the patient’s relationship patterns. Either way, the psychodynamic therapist tries to help patients understand how they contribute both to beneficial and painful relationship patterns, and how such reactions often originate within the self, yet foster the tendency to see the outside world (including relationships) as the exclusive source of disappointment or other painful emotion.

Encouraging free associations. In CBT and other structured therapies, the clinician tends to lead the discussion. In psychodynamic therapy, the clinician encourages a patient to speak as freely as possible about thoughts, desires, dreams, fears, and fantasies, as they come to mind. Psychodynamic therapists believe this unstructured, uncensored process of reporting provides access to thoughts and feelings that might otherwise remain outside of awareness. These thoughts and feelings might then become the raw material for helpful insight, or be reworked in ways that expand freedom and choice. However, it is not true that psy-
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Challenges and conclusions

One ongoing challenge in the research is that the studies of psychodynamic therapy often involve patients with different diagnoses, making it hard to draw conclusions about how effective this approach will be for individual patients. Moreover, many studies provide inadequate details about treatment methods or use “control” situations (such as a waiting list) that don’t actually control for the benefits of active intervention, no matter what technique is being employed.

Nevertheless, there is now enough research available to support the claim that psychodynamic therapy is an evidence-based treatment with effect sizes similar to or superior to those reported for other psychotherapies. In the current reimbursement environment, however, a significant practical challenge is whether psychodynamic therapy will also prove to be cost-effective—especially in the “real world,” where practitioners vary in terms of skills and experience, and patients vary in commitment to continuing therapy.

Yet it is encouraging that the benefits of psychodynamic therapy not only endure after therapy ends, but increase with time. This suggests that insights gained during psychodynamic therapy may equip patients with psychological skills that grow stronger with use.


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