DYNAMIC

Therapies for

PSYCHIATRIC

Disorders

(AXIS I)

Edited by
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Dynamic Therapies for Psychiatric Disorders (Axis I)

Jacques P. Barber & Paul Crits-Christoph

To our children Natalie and Adam, and Alexander, Avery, and Nicholas who are going to live in a world that will change even faster than the one we have known

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Acknowledgments

Our interest in collecting treatment guidelines for the dynamic therapy of patients with specific diagnoses grew out of our collaborative work as part of the University of Pennsylvania Center for Psychotherapy Research, a clinical research center for the study of psychotherapy funded by the National Institute of Mental Health. Our center's primary aim is to develop and evaluate the efficacy of psychotherapies tailored to specific populations. In regard to dynamic therapies, we were aware of a variety of other clinicians and clinical researchers who had also begun the process of tailoring some version of dynamic therapy to a specific population; out of this context the present book emerged.

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CHAPTER 1

Introduction: Why We Should Develop Psychodynamic Treatments for Specific Psychiatric Disorders

Jacques P. Barber, Paul Crits-Christoph, and Jennifer Q. Morse

This chapter presents briefly the background and rationale for what the book intends to achieve. Developments in psychotherapy research and practice as well as changes in the patterns of delivery and reimbursement for mental health care have led us to conclude, along with many others, that psychodynamic psychotherapy is in a precarious situation. What follows are the recent developments responsible for our concerns.

SOCIAL AND POLITICAL DEVELOPMENTS

With the emergence of managed health care, such as health maintenance organizations (HMOs), and caps on reimbursement for inpatient and outpatient care, psychotherapists have become more aware of the importance of being recognized by the health alliances as providing a worthwhile, cost-effective service. In general, HMOs and similar managed care organizations provide their patients with a small number of low-fee therapy sessions. The aims of the treatment are mostly targeted at alleviating

symptomatic discomfort. It seems more than likely that the emphasis on specific disorders or on specific symptoms will continue and that therapists will be encouraged to use treatments that have been shown empirically to be effective for those disorders and symptoms.

EMPHASIS ON EMPIRICALLY DEMONSTRATED EFFECTIVE TREATMENT

There is consensus that psychotherapy in general appears to be effective (e.g., Smith & Glass, 1977); thus, the general question of effectiveness is no longer seen as relevant. Instead, the question has become, "What treatments are effective for what types of patients?" Along these lines, researchers on cognitive and behavioral treatments have shown that brief therapies can be effective for specific disorders. As an example, cognitive therapy (CT) (Beck, Rush, Shaw, & Emery, 1979) has been repeatedly shown to be effective for depression (Dobson, 1989), panic disorders (Clark, Salkovskis, Hackmann, Middleton, Anastasiades, & Gelder, 1991), and opiate addiction (Woody et al., 1983). In fact, CT is as effective as pharmacotherapy in treating depression (see, e.g., Beck, 1993, and Dobson, 1989, for reviews) and may be better than medication at preventing relapse (Barber & DeRubeis, 1989). Such efficacy research has already resulted in key organizations recommending that treatments whose effectiveness has been empirically demonstrated be the treatments of choice. However, the interpretation of the research literature by such organizations may be open to question. For

example, despite the demonstrated efficacy of CT for depression (Dobson, 1989), the American Psychiatric Association (1993) recommends the use of CT for mild to moderate depression only. Although empirical evidence may not always be sufficient to convince different policy-making groups of the efficacy of any form of psychotherapy, we cannot envision convincing those groups without such evidence.

PAUCITY OF EVIDENCE FOR THE EFFICACY OF DYNAMIC PSYCHOTHERAPY

If cognitive therapy is barely recommended for depression by the American Psychiatric Association, what would be the recommendations regarding dynamic psychotherapy? Besides being ignored in some circles, dynamic psychotherapy is increasingly believed to be not as effective as other forms of psychosocial treatment. This widespread belief in the field is not necessarily based on facts but rather seems to emerge from the vacuum created by the paucity of adequate studies examining the efficacy of dynamic psychotherapy, especially in comparison with other forms of psychotherapy. For example, no study has ever compared a manualized dynamic therapy with other treatments for anxiety or panic disorders (Barber, 1994a; Crits-Christoph, 1992). Furthermore, the few studies that have compared dynamic psychotherapy with other treatments did not find dynamic therapy to be less effective than other forms of psychotherapy. In particular, Paul Crits-Christoph (1992) has recently shown in a metaanalysis summarizing 11 high-

quality clinical trials that brief dynamic psychotherapy is more effective than waiting list controls and as effective as other psychotherapies. Thompson, Gallagher, and Breckendridge (1987) showed that brief dynamic therapy was as effective as cognitive therapy and behavior therapy in a sample of depressed elders. It is important to note that the studies Crits-Christoph (1992) selected had to follow a treatment manual, include experienced therapists in brief dynamic psychotherapy, and have carefully screened patients.

PSYCHOTHERAPY RESEARCH TRENDS

With the appearance of the third edition of the *Diagnostic and Statistical Manual (DSM-III)* in 1980, research addressing the efficacy of psychotherapy went through a quiet paradigm shift. Before 1980, researchers had looked at groups of neurotic outpatients and administered a "treatment" to them. Neither the patient population nor the treatment was specified in great detail. Since the beginning of the 1980s, researchers have adapted their treatments to groups of patients with specific diagnoses. In addition, researchers have begun using more specific treatment guidelines (Luborsky & DeRubeis, 1984). These guidelines, often called treatment manuals, include an explicit exposition of the strategies and techniques to be used in treatment.

It is quite possible that the use of the term *treatment manual* was a poor

choice. Clinicians often have strong negative reactions when they hear the term for the first time. As our colleague Robert Weinryb has pointed out, the term *manual* is often associated with the operation of programming a VCR; it could be that the term *treatment guidelines* will be more acceptable. Nevertheless, another way of addressing dynamic therapists' reluctance to consider treatment manuals is to explain what dynamic manuals are about. Examples of psychodynamic manuals are Luborsky's *Principles of Psychoanalytic Psychotherapy: A Manual for Supportive-Expressive (SE) Treatment* (1984); Strupp and Binder's *Psychotherapy in a New Key: A Guide to Time-Limited Dynamic Psychotherapy* (1984); and Kernberg et al., *Psychodynamic Psychotherapy of Borderline Patients* (1989). Each of these books presents the reader with a detailed list of things to do and guidelines on how to do them, what to avoid, and so on.

None of the aforementioned authors provides therapists with a list of interventions for each minute of each session. Like many other dynamic therapists, we do not believe that manuals for psychodynamic psychotherapy need to provide a minute-by-minute or hour-by-hour narration of therapists' actions; rather, they should provide a set of specific guidelines or principles about treatment goals and how to achieve them (Barber, 1994b).

We are aware, however, of an increasing trend, among behavior therapists in particular (e.g., Barlow, Craske, Cemy, & Klosko, 1989), to write

very specific and detailed treatment manuals for circumscribed problems (e.g., panic attacks without agoraphobia) and sometimes to disseminate these treatment manuals to paraprofessionals. Although such a "cookbook" approach has been shown to be effective with well-circumscribed psychological problems, it is unclear whether such an approach would be appropriate for patients suffering from more complex co-morbid disorders and concurrent pervasive interpersonal problems. Thus the cookbook approaches used by paraprofessionals are not likely, in our view, to be useful for the treatment of many outpatients.

In addition to treatment manuals, state-of-the-art psychotherapy research includes criteria for specific training requirements and supervision as well as checks on therapists' behavior during actual treatments.

DYNAMIC PSYCHOTHERAPY'S DIMINISHING ROLE IN PSYCHOLOGY AND PSYCHIATRY TRAINING PROGRAMS

In training programs, especially in clinical psychology, we have witnessed a reduction in the number of teaching faculty interested in psychodynamic thinking, along with an increase in interest in cognitive behavioral approaches. In psychiatry residency programs, interest also seems to have decreased in psychotherapy in general and in dynamic psychotherapy in particular. There are various reasons for these trends. Most important, however, is the decreasing interest in treatments that have not been

empirically supported. Thus, in the long term there will be a reduction in the number of therapists actually practicing dynamic psychotherapy unless its effectiveness is demonstrated.

CONCLUSION

The conclusion we draw is that well-designed studies comparing dynamic psychotherapy with other psychotherapies for specific disorders are the best means to provide some of the data required to support the effectiveness of this approach. Studies examining the efficacy of any psychosocial treatment need to include a very specific description of the treatment targeting a specific patient population. Therefore, the obvious first step is to make available treatment manuals that could be used for such clinical trials. In those areas in which treatment manuals are not available, the first step is to encourage experts in the treatment of various disorders to write in detail about the techniques and rationale they use. We narrowed our focus to those psychiatric problems for which we could find treatment experts willing to write a chapter for this book. We also focused on those psychiatric problems that we think respond to dynamic psychotherapy. We have not, therefore, attempted to cover all Axis I disorders. For example, we felt it was not worthwhile developing a treatment manual for *DSM-III* or *IV* obsessive compulsive disorders, although developing treatment manuals for anxiety and mood disorders, for example, should be of the utmost priority.

(We are currently editing a volume similar to this one for personality disorders.)

The emphasis on specific psychiatric disorders is not new in psychodynamic therapy. If we look at the historical development of treatment manuals, we discern a pattern of increased specificity (Barber, 1994b) and increased rejection of metapsychology. Following Freud (1912/1958a, 1912/1958b, 1913/1958, 1914/1958) and Fenichel (1945), books describing psychodynamic psychotherapy in nonanalytic settings began to appear. Langs (1973), for example, described in detail how a treatment manual for dynamic psychotherapy might look. Malan (1963, 1976), Mann (1973, 1991), and Sifneos (1972) came out with books detailing the application of psychodynamic techniques to short-term dynamic psychotherapy. Following their work, Horowitz (1976/1986) developed a 12-session treatment for a group of related disorders. In the late 1970s, Luborsky, Woody, Hole, & Velleco (1977) developed a treatment manual for opiate addicts for the Veterans' Administration-University of Pennsylvania psychotherapy study (Woody et al., 1983). More recently, Kernberg et al. (1989) wrote a manual, intended specifically for patients diagnosed with borderline personality disorder, from a long-term psychoanalytic psychotherapy perspective. Further specification is provided by Yeomans, Selzer, and Clarkin (1992), who address in depth an important aspect of Kernberg's treatment for borderline personality disorders, namely, how to make a safety contract with them in

treatment.

In summary, the goal of this book is to examine the efficacy of dynamic psychotherapy for specific disorders and to provide dynamic therapists with a set of heuristics that they can adopt and modify in their individual practices to treat patients with a specific diagnosis. The chapters in this book, in themselves, should not be taken as final treatment manuals. As a matter of fact, many of them are only the first steps in the much-needed development of complex, sophisticated, and clinically realistic treatment manuals. We hope that one day the chapters will be further developed and turned into more comprehensive treatment manuals that will be used for both clinical and research evaluations of the efficacy of dynamic psychotherapy for different disorders.

The authors of these chapters have accumulated a wealth of clinical experience with the treatment they present, and they believe those treatments have helped their patients. Most of the treatments described in this book have not yet been used in controlled research to examine their efficacy; one exception is the supportive-expressive therapy for opiate addiction (Chapter 5), which was used successfully in the clinical trial comparing cognitive therapy, supportive-expressive dynamic therapy, and individual drug counseling (Woody et al., 1983). At this point, we are interested in stimulating research using those treatments in order to be able

one day to make some statements about their efficacy compared with other forms of treatment. When dynamic therapy proves to be an efficacious treatment, these treatment manuals can then be used to disseminate the treatment methods through training programs and workshops. We want to emphasize, however, that dynamic psychotherapy treatment manuals are simply an aid in the learning process and that there is no substitute for supervision by an experienced expert in the method.

We also want to emphasize that the time is ripe for such an enterprise; it is certainly not too late to "board the plane." Our hope is that it is not too late for such research to get off the ground, because the field seems already to have decided, lacking evidence to the contrary, that dynamic treatments are not effective.

Some of our readers may not sympathize with our pragmatic stance regarding the issue of treatment manuals and our choice of specific disorders; instead, they may argue that such an approach is antithetical to psychodynamic thinking. An often-heard argument is that each patient is different and thus treatment needs to be tailored to each patient's needs; developing treatments for a group of patients defined by an approach as empirical as the *DSM* is not feasible. We agree and disagree with this argument. We certainly agree that each patient is different, and that in principle each patient has her or his specific dynamics that need to be

addressed during treatment; however, we also disagree in that we wonder whether there is a way to generalize across a group of patients. It is certainly worth looking for an underlying organization in many of the existing disorders. Although we were interested in including chapters on *DSM-IV* diagnoses, we instructed contributors that they did not have to follow the *DSM* classification but that they did need to describe the patient group they were addressing.

Another response to the above criticism is that many psychodynamic clinicians—even analysts, including Freud—have written about many forms of symptomatology and their underlying dynamics. That is, not only is it not antithetical to psychodynamic thinking to try to find underlying order in the varied forms of presentation that patients employ to express their problems, but looking for such order is of its essence.

We should also note that, although this volume endorses a pragmatic approach to research on dynamic psychotherapy and emphasizes the public health significance of treatment research through its focus on disorders, at the same time we fully endorse theory-guided research on dynamic psychotherapy (e.g., Luborsky, Barber, & Crits-Christoph, 1990). We believe the two approaches are not mutually exclusive. Researching the process of dynamic psychotherapy, developing measures of key clinical constructs, and studying patient-treatment matching are of equal importance in considering

the public health significance of a treatment. In fact, these different goals can sometimes be combined in the same study.

BRIEF OVERVIEW OF THE CHAPTERS

Many prominent schools of thought coexist under the umbrella of psychoanalytically or psychodynamically oriented psychotherapy, such as the Freudian, interpersonal, object relations, and self-psychology schools. In choosing contributors to this volume, we did not attempt to cover each school. Because we set a limit of one chapter per disorder, the reader will find no comprehensive survey of how different psychodynamic schools tackle patients with specific psychiatric disorders. Furthermore, we recognize that the treatments surveyed in this book are not the only ones.

The chapters differ in many ways. Three of the most important differences are *degree of eclecticism, length of treatment,* and *research background.* Although the general framework of treatment for many of the authors is dynamic psychotherapy, some have moved away from traditional dynamic psychotherapy and include components from other forms of treatment. For example, educational components are included in Katherine Shear, Marylene Cloitre, and Leora Heckelman's chapter presenting a brief, manualized psychodynamic treatment for panic disorder, in Jerome David Levin's chapter on psychodynamic treatment of alcohol abuse, and in Randy

Sansone and Craig Johnson's chapter on psychodynamic therapy for eating disorders. With substance abuse disorders, dynamic therapy is seen as complementary to 12-step programs.

From a research perspective, we would have preferred to include only chapters that describe a form of time-limited psychotherapy because it is still difficult to examine the efficacy of long-term or time-unlimited psychotherapies, both scientifically and pragmatically. We included, however, chapters from contributors who are not committed to time-limited psychotherapy because we recognized that treatment of some disorders (e.g., multiple personality disorders) may be less amenable to a time-limited approach, while other disorders (e.g., panic disorder, generalized anxiety disorder) could be helped in a preset time frame.

Some of the chapters come from a more research-oriented perspective (e.g., the chapters by Crits-Christoph et al.; Eells; Shear, Cloitre, & Heckelman; Luborsky, Woody, Hole, & Velleco; Luborsky, Mark, Hole, Popp, Goldsmith, & Cacciola; and Mark & Faude), while others have little involvement with treatment research (DeRoche). Some of the characteristics of the research-oriented chapters are more stringent and specific inclusion and exclusion criteria and more detailed specification of therapists' training. Some of the authors of these chapters have also paid closer attention to therapists' adherence to the treatment manual. No adherence rating scales, however, are

included in the chapters.

OUTLINE OF THE CHAPTERS

So that we would have a relatively uniform presentation of the treatments, each contributor was asked to address the following topics: (1) history and development of the method; (2) selection criteria used for treatment; (3) specific dynamic issues; (4) treatment goals; (5) theory of change; (6) techniques; (7) case examples; (8) training; and (9) empirical evidence for the approach.

History and Development

A brief review of how analysts and psychodynamically oriented psychotherapists have conceptualized and treated patients with the specific disorder, and how the authors have developed their own approach.

Inclusion/Exclusion Criteria

Description of the phenomenological and dynamic criteria used for defining the specific disorders. Any discrepancy with the *DSM* is discussed and explained. If relevant, a description of the diagnostic process is included.

Dynamic Issues

A detailed psychodynamic description of the specific features of the patients (e.g., etiology, developmental history, major conflicts, identifications, and specific defenses).

Treatment Goals

Description of the therapist's and the patient's goals, including any changes in goals during treatment.

Theory of Change

An account of the changes during treatment and the clinical factors responsible for them.

Techniques

A detailed description of the techniques used and the principles that guide the selection and implementation of interventions. If relevant, this section addresses the issues of time limits and termination.

Case Examples

A detailed and concrete presentation of how the approach is actually applied to a patient.

Training

A description of any experience in training therapists in the above method, and any thoughts on that process.

Empirical Evidence for the Approach

If available, a presentation of empirical data that address the issue of the efficacy of the treatment.

REFERENCES

American Psychiatric Association. (1993). Practice guideline for major depressive disorder in adults. *American Journal of Psychiatry,* 150 (supplement), 1-26.

Barber, J. P. (1994a). Efficacy of short-term dynamic psychotherapy: Past, present and future. *Journal of Psychotherapy, Practice and Research*, 3,108-121.

Barber, J. P. (1994b, February). Developing treatment manuals for dynamic psychotherapy. Presented at the National Institute of Mental Health Methodology Conference on Research on Treatment of Chronic and/or Recurrent Anxiety and Mood Disorders, Bethesda, MD.

Barber, J. P., & DeRubeis, R. J. (1989). On second thought: Where the action is in cognitive therapy for depression. *Cognitive Therapy and Research,* 13, 441-457.

Barlow, D. H., Craske, M. G., Cemy, J. A., & Klosko, J. (1989). Behavioral treatment of panic disorder. *Behavior Therapy,* 20,261-282.

Beck, A. T. (1993). Cognitive therapy: Past, present and future. *Journal of Consulting and Clinical Psychology,* 61,194-198.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression.* New York: Guilford Press.

Clark, D. M., Salkovskis, P. M., Hackmann, A., Middleton, H., Anastasiades, P., & Gelder, M. (1991, November). *A comparison of cognitive therapy, applied relaxation, and imipramine in the treatment of panic disorder.* Paper presented at the meeting of the Association for Advancement of Behavior Therapy, New York.

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

Dobson, K. S. (1989). A meta-analysis of the efficacy of cognitive therapy for depression. *Journal of Consulting and Clinical Psychology,* 57, 414-419.

Fenichel, O. (1945). *The psychoanalytic theory of the neuroses.* New York: Norton.

Freud, S. (1958a). The dynamics of the transference. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 99-108). London: Hogarth Press. (Original work published in 1912)

Freud, S. (1958b). Recommendations to physicians practicing psycho-analysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 111-120). London: Hogarth Press. (Original work published in 1912)

Freud, S. (1958). On beginning the treatment (further recommendations on the technique of psycho-analysis). In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 121-144). London: Hogarth Press. (Original work published in 1913)

Freud, S. (1958). Remembering, repeating and working through. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 145-156). London: Hogarth Press. (Original work published in 1914)

Horowitz, M. J. (1976/1986). *Stress response syndromes.* Northvale, N.J.: Jason Aronson.

Kemberg, O., Selzer, M. A., Koenigsberg, H. W., Carr, A. C., & Appelbaum, A. H. (1989). *Psychodynamic psychotherapy of borderline patients.* New York: Basic Books.

Langs, R. (1973). *The techniques of psychoanalytic psychotherapy* (Vols. 1-2). New York: Jason Aronson.

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

Luborsky, L., Barber, J. P., & Crits-Christoph, P. (1990). Theory-based research for understanding the process of dynamic psychotherapy. *Journal of Consulting and Clinical Psychology*, 58,281-287.

Luborsky, L., & DeRubeis, R. J. (1984). The use of psychotherapy treatment manuals: A small revolution in psychotherapy research style. *Clinical Psychology Review,* 4, 5-14.

Luborsky, L., Woody, G., Hole, A. V., & Velleco, A. (1977). *Special manual for dynamic therapy of drug dependence: Adaptation of the general manual for supportive-expressive psychotherapy.* Unpublished manuscript, Department of Psychiatry, University of Pennsylvania.

Malan, D. H. (1963). *A study of brief psychotherapy.* London: Tavistock.

Malan, D. H. (1976). *Toward the validation of dynamic psychotherapy.* New York: Plenum Press.

Mann, J. (1973). *Time-limited psychotherapy.* Cambridge, Mass.: Harvard University Press.

Mann, J. (1991). Time-limited psychotherapy. In P. Crits-Christoph & J. P. Barber (Eds.), *Handbook of short-term dynamic psychotherapy* (pp. 17-44). New York: Basic Books.

Sifneos, P. E. (1972). *Short-term psychotherapy and emotional crisis.* Cambridge, Mass.: Harvard University Press.

Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist,* 32, 752-760.

Strupp, H. S., & Binder, J. L. (1984). *Psychotherapy in a new key: A guide to time-limited dynamic psychotherapy.* New York: Basic Books.

Thompson, L. W., Gallagher, D., & Breckendridge, J. S. (1987). Comparative effectiveness of psychotherapies for depressed elders. *Journal of Consulting and Clinical Psychology,* 55, 385-390.

Woody, G., Luborsky, L., McLellan, A. T., O'Brien, C., Beck, A. T., Blaine, J., Herman, I., & Hole, A. V. (1983). Psychotherapy for opiate addicts: Does it help? *Archives of General Psychiatry,* 40, 639-645.

Yeomans, F. E., Selzer, M. A., & Clarkin, J. F. (1992). *Treating the borderline patient: A contract-based approach.* New York: Basic Books.

CHAPTER 2

Supportive-Expressive Dynamic Psychotherapy of Depression: A Time-Limited Version

Lester Luborsky, David Mark, Anita V. Hole, Carol Popp, Barbara Goldsmith, and John Cacciola

HISTORY AND DEVELOPMENT[1]

The special form of psychoanalytic psychotherapy that we call supportive-expressive (SE) dynamic psychotherapy was only gradually shaped into its current form. It is an organized compendium of authoritative and representative accounts of psychoanalytic psychotherapy. Its concepts and techniques originated with Freud's recommendations for psychoanalytic psychotherapy (1912/1958, 1913/1958, 1914/1958) and his paper on depression (1917/1957). In the early 1940s these concepts and techniques were shaped to fit the framework of SE psychotherapy by Knight (1949), Gill (1951), and others at the Menninger Foundation, including Ekstein and Wallerstein (1958), who reshaped them into a guide for supervision.

Further organization into a manual was continued by Lester Luborsky after he left the Menninger Foundation in 1959 for the Department of Psychiatry at the University of Pennsylvania. He used the concepts and techniques of SE dynamic psychotherapy in teaching the department's

psychiatric residents and gradually formalized the principles into the general SE dynamic psychotherapy manual (Luborsky, 1976, eventually published in 1984). This progression toward manual making and manual use was at the start of the field's small revolution in practice (Luborsky & DeRubeis, 1984). Today many of the main forms of psychotherapy are developing or have developed their own manuals and measures of adherence to their manuals (Luborsky & Barber, 1993).

The present version of the SE dynamic psychotherapy manual for depression is an adaptation of the general manual (Luborsky, 1984). Some of its concepts and techniques came from experiences in a special form of supervision training in SE dynamic psychotherapy: each trainee gains experience both as a supervisor of his or her peers and as a recipient of supervision from peers (Luborsky, 1993). The first of these yearlong supervision groups was started in September 1987. Shortly thereafter, a similar group was launched at the Department of Psychiatry at the Toronto Women's Hospital (with weekly conference calls that included Drs. Lester Luborsky, Howard Book, Christine Dunbar, Harvey Golombek, Kas Tuters, and Anne Oakley). Further formative experiences came from the application of the manual to the patients in the project on SE dynamic psychotherapy for major depression and chronic depression (Luborsky et al., 1992; Luborsky, Diguer, DeRubeis, Cacciola, Schmidt, & Moras, 1994).

INCLUSION/EXCLUSION CRITERIA

The depressed patients to be treated with the guidance of this manual should be selected by assessments that verify that they fit the *DSM-IV* (APA, 1994) diagnoses of major depression or chronic depression or both. We will therefore use the main points of the *DSM-IV* criteria for these two diagnostic groups because they are the basis for selecting the appropriate patients and because the treatment techniques described in this manual were developed to help therapists deal with these patients' characteristics. The *DSM-IV* diagnostic criteria for major depression include a dysphoric mood or loss of interest or pleasure in the usual activities. The mood includes the symptoms of depression: sadness, hopelessness, and irritability. At least five of the following nine symptoms must be present: depressed mood most of the day; loss of interest or pleasure in most activities; weight or appetite loss; insomnia or hypersomnia; psychomotor agitation or retardation; loss of energy; feelings of worthlessness; slowed thinking; and recurrent thoughts of death. The essential *DSM-IV* diagnostic criteria for chronic depression include a depressed mood for no less than two years and at least two of the following: poor appetite, insomnia or hypersomnia, low energy, low self-esteem, poor concentration, or hopelessness. Details of the diagnostic criteria are given in *DSM-IV* (APA, 1994, pp. 327-344).

DYNAMIC ISSUES IN DEPRESSED PATIENTS

Nine dynamic issues in depressed patients are listed here approximately in order of importance, but they actually work together rather than separately. Some of them will be described more fully later in this chapter.

A sense of helplessness. In Freud's (1926/1959) general theory of symptom formation, it is the expected and remembered state of helplessness that sets off the symptom. Engel and Schmale (1967) further described the complex pre-symptom state as having two parts: (1) "giving-in" (helplessness), followed by (2) "given-in" (hopelessness). Helplessness followed by hopelessness is an especially difficult and central issue in depression; the other dynamic issues listed below feed into this one, as explained later in this chapter.

Vulnerability to disappointment and loss. This vulnerability is described most vividly in *Mourning and Melancholia* (Freud 1917/1957). Freud compares grief with depression. Grief is a response to an actual loss, while depression is a response to an internal loss. A patient's vulnerability is based on difficulty in coping with early childhood experiences of disappointment and loss, and both predispose the patient to later depression.

States of anger turned inward rather than directed outward. The concept of anger turned inward started with Freud (1917/1957) and was elaborated

on by others, including the scoring system for anger turned inward designed by Gottschalk and Gleser (1969). When anger is turned inward, it sets the stage for increased depression; turned outward, it sets the stage for reduced depression.

Vulnerability of the self-esteem. Self-esteem vulnerability is typically based on early injury to self-esteem (Bibring, 1953; Jacobson, 1971). Specific recurrent types of conflicts trigger impairments in self-esteem (as illustrated in the example of Mr. Quinn later in this chapter), which make the patient more vulnerable to depression.

Suicidal ideation and intention. This is a consequence of helplessness—and especially of hopelessness—about being able to deal with one's problems (e.g., Freud, 1926/1959; Beck, Weissman, Lester, & Trexler, 1974; Linehan, Armstrong, Suarez, Allman, & Heard, 1991).

Pessimistic explanatory style. The association of negative (pessimistic) explanatory style with vulnerability to depression has been shown by Seligman (1975). The pessimistic explanatory style for negative events involves three kinds of explanations: (1) it is me (internality); (2) it will always be me (stability); and (3) it is generally me (globality). The core of this style is explaining negative events by blaming oneself rather than external causes. Although the explanatory style concept did not come from the

dynamic tradition, it is compatible with it, and it is an important dynamic factor in setting the stage for depression.

Poor capacity to recognize the state of depression. Patients sometimes lose sight of the fact of being depressed; once they become depressed, the state seems natural and is not recognized as an altered state.

Poor capacity to notice events that trigger depression. For some depressed patients, the depression appears to them to come on of itself; they see little or no causal association with external or associated internal events. As a result, they are deficient in awareness and appreciation of the significance of the external events that trigger their depression.

Inclination to expect negative responses from self and others. Depressed patients often expect negative responses from self or others. But as therapy progresses satisfactorily, patients tend to move toward more positive expectations of self and others (Crits-Christoph & Luborsky, 1990, chap. 9). The shift is partly attributable to a decrease in helplessness and hopelessness and partly to a shift toward a more positive explanatory style for negative events. A similar shift is found in relation to positive outcomes of psychotherapy: More improved patients show a shift toward more positive outcomes and fewer negative outcomes in their relationship narratives.

It is much easier to see the interrelation of these nine dynamic issues in

discussing concrete examples, such as the relationship narrative of Mr. Quinn. That narrative starts with a thought about talking to a woman: he was "just talking to her," and then there was a shift to depression. But in the course of reviewing the thought in the narrative, he was able to fill in what happened before the shift in depression: he thought, "A guy like me could be with her, or [she could be with] a stronger guy. If it's me, then I'm not strong enough. That's what bothered me." Mr. Quinn's readiness to become helpless— dynamic issue number 1—is obvious (although it appears to be out of his awareness): helplessness is his response to a thought that he will fail in comparison with the stronger guy. The thought that he will lose out in competition is part of dynamic issue number 2: vulnerability to disappointment and loss. Dynamic issue number 3, anger, is not evident here. Dynamic issue number 4, vulnerability to self-esteem loss, is very obvious in this example; for this patient, losing out is interpreted as a sign of his failure and lowers his self-esteem. Dynamic issue number 5, suicidal ideation and intention, does not characterize this patient. Dynamic issue number 6, pessimistic explanatory style, is clearly evident: Mr. Quinn explains to himself that he will lose out in a conflict with a stronger guy, that is, his pessimistic explanatory style is based on his deficiency and is therefore an internal explanation. We know from other evidence that this explanation is stable for him and that he thinks it will always be and is generally true. Dynamic issues number 7 and 8 are evident for this patient: at first, he recognizes that the

thought made him "a little tight," but he does not attend to that feeling as related to the shift in depressive tone. Its meaning comes out after he is questioned; the therapist then makes a significant intervention by pointing out the event that triggered the shift toward depression (dynamic issue number 8). Dynamic issue number 9, an inclination to expect negative responds from self and others, is plain in this instance: Mr. Quinn thinks the stronger guy will win out, and he thinks his experience of losing out is based on his own weakness.

TREATMENT GOALS

The general goals for SE dynamic psychotherapy with depressed patients (Luborsky, 1984) include the following three, which amount to a condensed framework for the essential tasks of SE dynamic treatment:

1. To establish a relationship of rapport and trust—the supportive component of SE dynamic treatment. Paying attention to the patient's expressed goals is very important in establishing rapport and trust and leads to a helpful therapeutic alliance.

2. To use rapport and trust to develop an atmosphere in which patients can express what they are thinking and learn to understand what they have expressed—the expressive component of SE dynamic treatment. Understanding can be increased by interpretations that are focused on the central relationship pattern and the conflicts within it.

3. To facilitate maintenance of the gains of the therapy during the treatment period and after its termination.

The process of setting specific goals is especially useful for short-term psychotherapy because of the time limit and because coming to an agreement about goals can rapidly strengthen the alliance, as reviewed by Luborsky (1984). These goals need to be agreed on during the beginning phase of the treatment, especially in the first and second sessions. Goals are to be set in terms of what the patient wants as well as in terms of what can be reasonably accomplished. Usually one of the main goals of these patients is to be relieved of their depression.

THEORY OF CHANGE

The theory of change in SE dynamic psychotherapy explains the onset as well as the overcoming of the patient's symptoms of depression. The theory of how a depressive episode is formed can be derived from Freud's general theory of symptom formation (1926/1959). The symptom forms because the patient evaluates a situation as dangerous; the danger is the recognition of an expected situation of helplessness. The patient then evaluates his or her strength in relation to the magnitude of the danger. The symptom appears as a way to cope with the expected helplessness and the potential anxiety generated by the danger situation. Mr. Quinn's case illustrates this theory: The danger in the situation is that his wish for success

with the girl entails expected competition with a man whom he sees as stronger. The symptom of depression forms when Mr. Quinn expects to fail in that competition and feels helpless to cope with the conflict. For the symptom of depression to form, certain specific vulnerabilities are also involved, as summarized in the listing of the nine dynamic issues.

Four factors are responsible for overcoming the symptoms of depression:

1. The establishment of an alliance, which increases the patient's sense of strength in coping with problems, making symptom formation less likely.

2. The development of self-understanding through (a) more knowledge of the existence of the main relationship patterns and (b) more knowledge of the context of the symptom within the pattern.

3. The development of higher morale about coping and better ways of coping with the conflicts in problem situations.

4. The growth of greater ability to maintain the gains derived from helping relationships. This comes about through the relationship with the therapist by internalization of that relationship and by acquisition of therapy-derived tools for coping with future problems.

TECHNIQUES

Before going into the details of technique, we believe it would be valuable to state the four basic tasks of SE dynamic psychotherapy:

1. Attend to forming an alliance by listening to the patient's goals, coming to an agreement about the main goals, and establishing rapport and trust. These supportive elements begin to take root at the start of the treatment but always go through some ups and downs during the treatment.

2. Formulate the basic relationship pattern by means of the core conflictual relationship theme (CCRT) method. Focus interpretations on aspects of the CCRT so as to nurture the patient's growing awareness of the pattern.

3. Help the patient come to a generally higher morale and acquire ways of coping and mastering the conflicts in the CCRT.

4. Attend to the meanings of separation from the treatment so that they will not interfere with the patient's retention of the gains.

These four specific techniques relate to the general goals of SE dynamic psychotherapy. What distinguishes this adaptation of the general manual for depression is its focus on relieving the depression and on dealing with the associated dynamic issues of depression.

Methods of Introducing the Psychotherapy

This section is partly adapted from Orne and Wender's (1968) preparation interview for psychotherapy. The main points of this introduction can also be presented to the patient as part of the initial evaluation before the psychotherapy.

In the first session, the therapist should ask the patient to describe the main problems and the circumstances surrounding them. This discussion helps to develop an alliance and to focus the work of the psychotherapy, and it also provides the therapist with necessary information about the presenting complaint and its circumstances.

Also in the first session, the therapist should explain the nature of the psychotherapy in these terms: "You are about to start psychotherapy for your depression and other problems. It will help you to know how psychotherapy works. The basic plan is that you will tell what you have to tell about yourself, about events, and about the treatment. I will listen and respond whenever it is likely to be helpful.

"You will gradually get to know your typical pattern of relating to others, to yourself, and to the problems within the pattern connected with your depression.

"You should know that treatment has its ups and downs in terms of the difficulty or ease of making progress. At times it will develop easily, and at

times it will feel stalled. These stalled times may be difficult for you, but they can be the most profitable times of all. One way out of them is to tell me how you feel about the treatment so that we can both problem-solve the difficulty.

"At times you will wish for me to give you advice. Actually, treatment doesn't work that way. Your treatment works best when you, with my help, figure out what's in the way of your moving ahead. Then you will decide how to go. Figuring out how to solve problems will be helpful to you both in the treatment and long thereafter."

Although treatment arrangements will have been discussed in the initial evaluation, the therapist should review them again, including the agreed-upon treatment duration (number of sessions), follow-up sessions, and arrangements for payment of the fee, missed sessions, and so on.

Special Principles of Technique

The techniques listed below are of two kinds: those for learning about each patient's specific thoughts and preconditions for depressive episodes, and those for dealing with the more general dynamic issues that are typical for depressed patients.

Helplessness and Hopelessness

States of helplessness and hopelessness are the most common conditions for depression, as explained by Freud's (1926/1959) theory and by Engel and Schmale's (1965) elaboration of the theory and confirmed by the studies in Luborsky (in press). The therapist can manage these states well by using two methods:

1. The therapist can point to the association of helplessness and hopelessness with the subsequent appearance of depression and say, when appropriate, "Your state of helplessness and hopelessness was followed by the depression as though it was one way for you to try to cope with the helplessness and hopelessness." Such a comment may help the patient to see the depression as a response to the helplessness and hopelessness, not just as an inevitable reaction to the situation.

2. The helplessness and hopelessness can be interpreted in relation to the specific context in which they appear (as described below).

Anger

Recurrent anger in depressed patients is common, according to Freud (1917/1957). His observation is further confirmed in a study of the relationship narratives of patients with major depression by Eckert, Luborsky, Barber, and Crits-Christoph (1990). Sometimes the anger takes indirect forms, such as assuming that the other person does not care,

distancing from the other person, breaking appointments, or chronic lateness.

Anger was recurrent with Ms. Smyth, the patient described later in our case illustration. A patient's anger may in turn ignite anger in the therapist; that potential for contagion is a common countertransference risk and must be dealt with by the therapist. One way a therapist can deal with it, as illustrated in Ms. Smyth's case, is to remain in an empathic position—understanding how the patient becomes angry as a result of the relationship conflicts in his or her central relationship pattern.

Suicidal Ideation and Intention

Hopelessness is sometimes an extreme response to helplessness in situations of danger (reported in Freud's [1926/1959] theory of symptom formation). The basic observation of an association between suicidal intention and hopelessness has been confirmed by the work of Beck and his associates by means of their Hopelessness Scale (1974). The very frequent association of hopelessness with suicidal ideation or intention has an important practical implication—relieving the hopelessness usually relieves the suicidal ideation or intention. The standard way to begin to lessen the hopelessness is to have the patient talk about the situations that led to it. Through this expressive process, the patient often becomes more able to think of ways to cope with hopelessness-inducing situations.

Another time-tested way of handling suicidal intentions is to evaluate their seriousness when the patient first brings up such thoughts and then, if they are serious, to make a pact with the patient in which the patient agrees not do anything self-hurting when the thoughts occur but instead will call the therapist. Patients who make such a pact usually abide by it. The contact, or the availability of contact, with the therapist is usually sufficient to overcome the suicidal intention. If it is not sufficient, it may be necessary to arrange for hospitalization or other protection.

A further source of information in evaluating the potential for suicide is a depression inventory, such as the Beck Depression Inventory (BDI), filled out by the patient before each session. The therapist should check the inventory before and after each session to stay aware of the patient's suicidal risk and level of depression.

A related method of handling suicide intentions or attempts is similar to the method for understanding and dealing with any self-destructive behavior: Find out from the patient whether the behavior was partly intended as a nonverbal message to the therapist. For example, the therapist can ask, "Did you mean for this behavior to give me the message that you were feeling hopeless?" If it was intended as a message, the therapist should try to work out an agreement with the patient to convey these messages in words rather than through self-destructive action. This kind of discussion with the patient

is especially valuable when such behaviors first start to be expressed in the treatment, rather than after the pattern has become habitual. This method was presented in a case discussion at the University of Pennsylvania by John Gunderson on January 15, 1989, on the treatment of suicidal behavior in borderline patients, but his recommendation appears to be generally useful. After such discussion and agreement, some patients are thereafter impressively able to describe their intentions to the therapist rather than show them through actions. The method works by transforming communication through behavior into communication through words.

Negative Explanatory Style

A specific depression-inducing factor has been identified for depressed patients by Seligman, Castellon, Cacciola, and Schulman's research. It is that negative (pessimistic) explanatory styles in response to negative events ("danger situations," in Freud's theory [1926/1959]) help to set off depression. In other words, a person who tends to explain negative events in an internal, stable, and global manner will be more vulnerable to depression than a person who is able to attribute negative events to external, unstable, and local factors. An especially clear illustration of negative explanatory style and its understanding in dynamic terms was provided by the patient Mr. Quinn, who had precipitous depressions during psychotherapy sessions (Luborsky, Singer, Hartke, Crits-Christoph, & Cohen, 1984, pp. 157-193;

Peterson, Luborsky, & Seligman, 1983); these sessions often followed interactions with other people that invoked both his negative explanatory style and his lowered self-esteem. The therapist's interventions reflected an SE dynamic therapist's attempts to make the patient aware of these aspects of the dynamic context for his depressions.

Poor Capacity to Recognize the State of Depression

Some patients find it difficult to recognize when they are depressed. Their depressed state may even feel like a normal state. Such a patient can usually be helped when the therapist simply points out the patient's state and then points to his or her belief that it is a normal state. This kind of feedback from the therapist can be sufficient to improve the recognition of depression. Recognition is sometimes much easier to achieve when it is pointed out at the point of a shift into depression rather than after the depression has continued for a while. Continual feedback to improve recognition of depression may be helpful for some patients.

Poor Capacity to Recognize Depression-Triggering Events

Some depressed patients are not inclined to notice the events that set off their depression, or if they do notice them, they forget them quickly. The events may be external, or they may be a specific kind of thought. For example, Mr. Quinn did not recognize his trigger events, even though they

became obvious to the therapist. These events were thoughts about interactions with others that he interpreted as lowering his self-esteem, as in this very apt example:

> Patient: I dreamt about her ... I don't remember anything remarkable and there was no sex, just talking or something like that (shift to depressed tone), so that made me a little tight.
>
> Therapist: What made you a little tight?
>
> Patient: Just the thought of her, I guess. Oh, I know what it was. You know, I've got it.
>
> Therapist: Uh-huh?
>
> Patient: It was that I said, well, a guy like me could be with her,
>
> or [she could be with] a stronger guy. If it's me, then I'm not strong enough. That's what bothered me.
>
> Therapist: You managed to notice the kind of thought that makes you tight and then discouraged and then depressed: You compare yourself to another man and decide you are not as strong and conclude something is wrong with you.

As in this example, it is often possible to make some patients more aware of their depression-triggering thoughts or events, so that (1) the thoughts or events become less potent at instigating depression, and (2) the thoughts or events become more readily recognized in terms of the core conflictual relationship theme that they show, a recognition that lessens the patient's helplessness in dealing with them.

General Technical Principles of Interpretation: Selecting a Focus and Maintaining It

Use of the Core Conflictual Relationship Theme

Paying attention to the transference-related CCRT is a central technique of SE dynamic psychotherapy for selecting an interpretative focus (Luborsky & Crits-Christoph, 1990). The therapist listens for the redundant components across the narratives patients tell during the course of a session; the CCRT is formulated by recognizing the patient's combination of most redundant wishes, most redundant responses from others, and most redundant responses of self. The CCRT should be a prime candidate for the focus of interpretations because it reliably captures the main relationship conflicts that are evident in the transference, as illustrated in the case illustration of Ms. Smyth, in which a fuller description of the method is given.

Treatment Length and Degree of Focus

As a general principle, the shorter the time limit on the treatment, the more necessary it is to maintain a consistent therapeutic focus. In a 16-20-session treatment, the therapist should keep to the selected focus whenever it is appropriate.

Effects of Consistent Focus

Therapists in the early stages of learning SE dynamic psychotherapy

sometimes raise this question: "When the focus is chosen and the therapist stays focused on it with congruent interpretations throughout the treatment, will the patient and therapist find that it becomes boring?" Our experience is that a consistent focus is not usually a cause for boredom.

What happens instead is that the recurring association between the patient's experiences and the pattern provides more impetus for the patient's growth. Growth is stimulated because patients become more familiar with the shape of their own relationship pattern, and the conflicts within it, and therefore more capable of finding better ways to cope with some aspects of it. Specifically in relation to depression, when the signs of depression appear, patients will be able not only to recognize the state but to control it better by being better able to say to themselves, "I do not need to remain depressed; I can handle in other ways what is pushing me to become depressed."

Deciding Which Part of the CCRT to Interpret and How to Offer It

The CCRT is a complex theme, so it is not appropriate to present routinely the whole CCRT whenever an interpretation is needed. The therapist needs to have principles to guide his or her selection from the CCRT of the facets that are most appropriate for each interpretative occasion. Following are six experience-based principles (all are illustrated by the interpretation for the patient Ms. Simpson, described below):

1. Choose the aspect that fits best with what the patient is able to deal with at the moment and has been able to deal with in the past. A few trial interpretations may help to determine which aspects of the CCRT the patient seems best able to deal with.

2. Choose interpretations that include both the wish and the response from other. This principle is worthy of use because it has evidence to support its efficacy—a correlation has been found between use of such congruent interpretations and the outcome of treatment (Crits-Christoph, Cooper, & Luborsky, 1990).

3. Choose the aspect that fits best with the symptom that is most closely connected with the present suffering.

4. Choose the CCRT aspect that is most intense and most frequent.

5. Concentrate interpretations on the negative components. They are most in need of interpretation, for they tend to impede the treatment the most, as Freud's (1912/1958) principle of technique recommends and as is simply evident in our examples.

6. Choose a manner of offering interpretations that helps the alliance and steers around the resistance, such as "Let's look together at the part of your relationship pattern that might set off your depression" (other presentation modes are in Wachtel, 1993).

Pointing to the Symptom's Context of Relationship Conflict

With any patient who comes to treatment with a prominent symptom, such as depression, it is therapeutically valuable to find the specific context that is related to the manifestation of the symptom. When the symptom emerges directly in the session, the symptom-context method (Luborsky, in press) will help to locate the theme in its antecedents. The expressive techniques of the SE general manual (Luborsky, 1984, chap. 7) will routinely help the therapist to locate the specific context for each patient's symptom, as shown by the CCRT in this example.

Ms. Simpson was selected from a sample of 30 patients (Luborsky, Diguer, DeRubeis, & Schmidt, 1994) with major depression who were treated with time-limited, 16-session SE dynamic psychotherapy (Luborsky & Mark, 1991). She was a 26-year-old, single, white, graduate student who had started psychotherapy in a very depressed state with a *DSM-III-R* diagnosis of major depression. Her CCRT was based on the 10 pretreatment narratives she told as part of a Relationship Anecdotes Paradigm (RAP) interview (Luborsky, 1990b, chap. 7). RAP interviews are specifically designed to elicit relationship narratives. Within the 10 narratives elicited, the CCRT components that appear most frequently constitute the CCRT pattern that is the context for the emergence of the symptom of depression.

In the CCRT given below, the number in parentheses is the number of

narratives out of the 10 (typically half or more of the 10) in which the CCRT components appeared:

Wish 1:1 want to be respected (6)

Wish 2:1 want to be understood (5)

Response from other (RO):

Negative RO1: They are not understanding (5)

Response of self (RS):

Negative RSI: I feel unloved (5)

Negative RS2:1 feel not open (4)

Positive RS3:1 feel I am open (5)

Negative RS4:1 feel depressed (4)

The therapist in the course of treatment continually constructed clinical CCRT formulations as she listened to the patient. In the middle of the fourth session, the therapist responded to the patient's negative interactions with someone the patient depended on with this CCRT-based interpretation: "In these interactions, you clearly felt you couldn't get the respect and understanding you needed, and so you ended up feeling unloved and began to feel depressed."

In very brief treatments of patients with a main outstanding symptom such as depression, the therapist should especially concentrate on interpreting the links between the symptom and the rest of the relationship context in the CCRT, as illustrated in the example above and in the case illustration of Ms. Smyth. That recommendation also applies to longer treatments, but the concentration and correspondence of the interpretations may not need to be as extreme in longer treatments. (See the general SE manual [Luborsky, 1984, pp. 99ff], "Principle 1: understanding the symptoms in the context of relationships").

Eliciting More Concrete Elaborations of Experiences Before Interpreting Them

From time to time the patient refers to certain feeling states or certain events in an obviously incomplete way so that the therapist may have an experience of "looking through a looking-glass darkly." The therapist should try to see into these states or events more clearly and more fully. A good technique is to ask the patient to describe the experience again or tell more about it. Once a state or event has been pointed to by the therapist and the patient has had a chance to attend to it and re-present it, the therapist may find that it is time to interpret the meaning of the patient's experience. This technique will be familiar to experienced dynamic therapists, particularly the advice to give special attention to reexamining the experience of the patient before inferring its meaning. (The technique is more fully explained in Mark &

Faude [chapter 10].)

For example, a patient named Ms. Stanton described an experience of "feeling little, almost fainting, and having an adrenaline rush." The therapist asked her to repeat her description of the experience and to communicate more fully and concretely its content. The therapist subsequently understood it better and said, "So I hear you, you're feeling very little and helpless in relation to me, and that scares and depresses you."

At a later point, the therapist can interpret this same sequence of meanings in relation to other people in Ms. Stanton's life. With some patients, the concrete experiences can be easily reviewed, both in relation to others and in relation to the therapist. As with Ms. Stanton, the experiences that are most likely to be valuable to interpret for depressed patients are those connected with the dynamic theme of an association of helplessness and depression.

Dealing with the Meaning of the Time Limit

Beyond the general meanings of the time limit, patients need to come to terms with the meaning the time limit on the treatment period holds for them. The degree of concern about the limited time for the treatment has a time course. Concern is greatest in the first phase of treatment. As the treatment goes on, both the therapist and the patient accommodate to the

limit. Then apprehensions reemerge as the last phase approaches.

It helps the patient to come to terms with the time limit to be reminded of the length of the treatment. The reminders should be given (a) by the initial evaluator before treatment, (b) by the therapist in the first session when arrangements are discussed, and (c) again by the therapist during later sessions when the termination is anticipated. Even with all of this informing, some patients tend to forget the time-limit arrangements.

Typical questions that patients ask in the process of coming to terms with the time limit include: "What if I'm not ready at the end of 20 weeks?"[2] and, "What if I need a few more sessions at the end?" Reassuring comments by the therapist and the initial evaluator often help to explain to the patient the 20-session treatment length: "We have found that this length of treatment generally provides enough benefit so that the gains can be maintained thereafter. We will also have a meeting with you six months after termination to see how you are doing."

Therapists also need to accommodate to the brief time limit. The therapist's concerns are reflected in such questions in the supervision as, "How can I treat such a severely ill person in such a short time?" and, "How can I make a strong enough bond in such a short time?"

Therapists' concerns usually decrease as they gain experience with the

short-term format, and their confidence increases as they perceive several assets of the short-term format:

1. The pretreatment agreed-upon time limit tends to limit the degree of the patient's regression. It may be that the containment of regression is mediated by the patient taking the attitude: "I need not worry so much about getting overinvolved in the treatment because there are clear limits to my contact with the therapist." In fact, as Mann (1973) has observed, few patients appear to be hurt by the short-term time-limited experience, and its counter-regressive effect may contribute to the benefit.

2. Therapists and patients soon see that worthwhile benefits are being derived from the treatment, and that realization limits their concern about the treatment's agreed-upon brevity.

3. The time limit itself may accelerate the patient's growth by a greenhouse effect—the growth-inducing atmosphere is stimulated by an urgency to move toward the goals in the allotted time. This greenhouse effect may also be fostered when the therapist consistently keeps the interpretative focus on the relationship conflicts that impede the patient's growth. It is as if the amount of needed change remains constant but must be fitted into the shorter time period. Thus, what is seen in time-limited therapy is not a truncated treatment but a complete treatment condensed into the shorter time. The therapist and patient appear to sense what needs to be accomplished, and their attempts to accomplish it are shaped by the time period.

Scheduling Sessions and Payment of Fees

The therapist (and the initial evaluator, if there is one) provides the patient with an orientation about fees and attendance. Both the evaluator and the therapist can tell the patient: "Try to settle on an appointment time that you can keep regularly. Try not to miss any of the 20 sessions that are scheduled." The patient may also be told: "If a problem comes up and you can't make a session, please let me know at least 24 hours in advance. I hold your session open for you. It is your session. In this kind of work, it is not possible for me to fill unplanned missed sessions, so I may charge you for such sessions. But with enough notice, it *may* be possible to change the time of a session, if the schedule permits." The fee becomes less of a potential problem when the arrangement with the patient is for payment at the beginning or end of each session rather than for a monthly bill.

The time duration of the treatment should be adhered to. If the patient wants to extend the spacing of the sessions, for example, to every other week, the therapist may say, "We might lose some of the continuity of the treatment. The treatment works best when a weekly schedule is maintained."

Dealing with Termination: The Interactive Collision of Attachment and Separation

The idea of termination generates concerns in all patients, especially those in short-term treatment (Luborsky, 1984, chap. 9). Their concerns

revolve around attachment and separation. The first part of the treatment shows the fears and satisfactions of making an attachment; the second part shows the fears and satisfactions of the impending separation.

In the middle or late-middle stage of the treatment, the patient increasingly senses the approach of separation; its approach often arouses the irrational fear that the termination will be a catastrophic loss. Typically accompanying this fear is a pre-termination loss of the therapy's gains. But then there is a usually successful method for dealing with such pre-termination loss. The therapist needs to help the patient examine the meanings of the upcoming termination. Often it is discovered that the patient not only fears the loss of the therapist but with it the loss of ability to use the tools acquired during the treatment. The patient then realizes that the tools are part of the patient and can be used when the therapist is not present. Then the gains tend to become reinstated.

This method is part of a broader principle for dealing with termination —the therapist should attend to what is needed to ensure the lasting quality of the patient's gains. The three sections below discuss some specific guides for dealing with special types of termination issues.

Continuation of Therapy Beyond the Time Limit

As part of the initial orientation, the evaluator and later the therapist

present this position about continuing the sessions beyond the agreed-upon limit: "Our intention is to provide 20 sessions. This amount of therapy is likely to help you. After that you will probably be able to manage without our regularly scheduled sessions. Your progress will be evaluated at the end of therapy, and your needs then reconsidered."

Not surprisingly, a few patients near the end of the 20 weeks express the wish to continue. It can be helpful to have the patient explain more about this wish. If there is no emergency or danger to the patient and the patient appears to have made gains, the therapist may respond by asking the patient to wait for about six months and then return to reevaluate the need for further therapy. The exact interval of waiting is to be decided by the therapist and patient. The therapist may explain this response to the patient in these terms: "Sometimes the benefits of the treatment require more time to become integrated and effective, and therefore you should wait before coming back" (as in Mann's [1973] procedure).

During the therapist's discussion of how the patient will manage after treatment, it can be useful to make the point that the agreed-upon 20-week period is a time to become familiar with the everyday use of the tools of self-management. During and after this period, the patient has an opportunity to apply them and so will be able to make further improvements even after the treatment.

If there really is not enough time to review the meaning of the patient's concerns about termination, the therapist may sometimes set up an extra session or two for this purpose. In our experience, this option is taken for only those few patients who the therapist believes need the extra time to work through the meaning of termination.

Patients may raise further questions and need clarification about the finite nature of the time limit. For example, "What does it mean that I can't see you after the 20 sessions are over?" The therapist can explain that termination of sessions is part of the mode of the short-term time-limited treatment that the therapist and patient planned at the onset. But if an additional session or two to work through the meaning of the termination is likely to be insufficient and the patient needs treatment immediately, the therapist can suggest a referral. Another alternative is for the therapist, after the six months, to continue with the patient for an additional period.

"Booster" Sessions

Another way to deal with additional sessions is to use a few "booster" sessions: planned, widely spaced sessions convened between the termination and the follow-up. Booster sessions have been used routinely at the Center for Cognitive Therapy and the Center for Dynamic Therapy at the University of Pennsylvania. If the follow-up period is six months, one session would be one

month later, and another would be scheduled for three months after termination. If the follow-up period is one year, the first booster session would be one month later, the second three months after that, and the third three months after that.

Booster sessions offer another important advantage to the treatment (Whisman, 1990): They can foster the sense of maintaining contact with the therapist and the therapy and therefore further the consolidation of the gains. Booster sessions appear to be generally valuable, especially for patients who have difficulty with internalizing the benefits of helpful relationships.

The plan for these booster sessions is best presented during the orientation before the start of treatment and again in the initial sessions. It is better to inform the patient at these times rather than at the end of treatment so that the plan for boosters will be understood as a part of the planned arrangements. If the patient is told only at the end, the booster sessions could be misconstrued as having other meanings, such as the therapist's need to hold on to the patient or the therapist's uncertainty about the durability of the benefits of the treatment.

The patient can be told, "These review sessions are part of the routine arrangement," and, "They will give us an opportunity to review the treatment during the follow-up period after it is completed." It is useful to distinguish

between "the treatment period" and "the follow-up period." By keeping that distinction clear, the patient will go through much of the process of termination by the end of the treatment period.

Referral After Therapy

If the patient remains in a precarious state and the therapy has not altered his or her depression, the therapist should reevaluate the patient for referral to other treatments for depression, particularly pharmacological ones, either in combination with psychotherapy or alone.

For patients who are still very depressed by the beginning of the last month of treatment, some planning for referral might be begun at that time. Before communicating this intention to the patient, the therapist should keep in mind the possibility that the approach of termination may have an integrating effect and produce unexpected improvement, not just a plateau or a disintegrative effect. But when the therapist concludes that the patient is not likely to pull out of the depressed state during the remaining allotted sessions, the referral possibilities need to be discussed, whether for continuation of the same kind of treatment or for alternative treatments. (The choices for referral may be limited by the patient's finances; for example, because the patient sample in the study of major depression was mostly a low-income group, paying approximately $30 per session, the choices for

referral were limited.)

When a Patient Is Concerned About Not Receiving Medication

Sometimes an arrangement is made between the initial evaluator and the patient before the beginning of treatment to refrain from taking medications for depression, anxiety, or sleep disturbance, as in the major and chronic depression study (Luborsky et al., 1994). Despite the initial agreement, some patients remain concerned about this arrangement, especially in the current climate of controversy about which kinds of depression require antidepressant medications. The Elkin et al. (1989) study reinforces such concerns: although the patients in all treatments compared showed benefits, imipramine plus clinical management was generally best, but not by much, as compared with the two psychotherapies. The slight advantage for imipramine plus clinical management was for the most severe of the patients in this group.

The patient's question about medication needs to be discussed to be better understood. Such discussion tends to be helpful to the patient. Usually the patient is concerned that the psychological treatment by itself may not alleviate the depression. Such a concern should also be addressed directly by both the initial evaluator and the therapist. For example, "Our intention is to have the treatment progress without medications for depression, anxiety, or

sleep disturbance because we expect that these difficulties will be helped by the psychotherapy."

Deciding to Use Antidepressant Medication

If it becomes necessary, nevertheless, to use antidepressant, antianxiety, or sleep medication during the course of the treatment (as it was for 3 of the 30 patients in our major depression study), it is a good practice to use a highly experienced outside consultant for a separate opinion. The patient can then have an evaluative interview with the outside consultant before the medication is decided upon and begun.

The Initial Evaluator's Adjunctive Role

The functions assigned to the evaluator were useful to the treatment in our study of time-limited psychotherapy for major depression (Luborsky et al., 1994). Those functions include more than the selection of the patients; the evaluator also orients the patients to the nature of the treatment. It is worth noting that formal preparation for the treatment generally increases the benefits of psychotherapy—four of six studies have shown a significant added benefit from formal preparation (Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988).

The evaluator's role also goes beyond selection and initial orientation of

the patients. The five hours of contact with the evaluator during the initial assessment and the evaluator's part in the evaluations at termination and at follow-up mean to some patients that the evaluator is a resource person who can help with certain kinds of issues that appear even after the patient is launched in the therapy. For example, Mr. Johnson, a patient who was about halfway through a 16-session time-limited therapy for major depression, called the evaluator to say that he would not be able to continue coming to treatment because he no longer could afford it. The evaluator was able to help him by providing information about the fees and by encouraging him to review the issue with his therapist.

CASE EXAMPLE

The example of Ms. Smyth (SE17 in the major depression study) illustrates (1) how a helping alliance is formed, (2) how to use the relationship episodes in a session to derive the CCRT (Luborsky, 1990a, chap. 2), and (3) how to use the CCRT to focus the interpretations (Luborsky, 1990a).

Ms. Smyth was a 32-year-old single woman and recovering alcoholic who came for treatment for depression. Besides her long-term dysthymia (chronic depression), she had become severely depressed (major depression) when she flunked out of a training course. Her *DSM-III-R* diagnosis, based on

the initial evaluation, was major depression with dysthymia.

The therapy began inauspiciously when she showed up half an hour late and then said she was unable to schedule the next appointment. The therapist felt angry but contained her anger, using her awareness of it to understand and empathize with what Ms. Smyth was doing in the interaction with her. When Ms. Smyth said she was afraid of "sabotaging herself," the therapist replied that she thought she was correct to be afraid. Although Ms. Smyth continued to have difficulty keeping appointments, she nevertheless responded to the treatment remarkably well, much to the surprise of the therapist, who noted in her final report that she "had not expected that someone with such severe depression and who already was making full use of self-help via therapeutic groups, such as AA, could have resolved her depression without the use of psychopharmacology."

In the termination interview, Ms. Smyth said that she was feeling good and that "everything is a lot better." She was less pessimistic and more confident and hopeful. She felt she could take care of herself and no longer seemed as disorganized as she had been during the initial evaluation. She was working regularly in a clerical job, and she had set up a stable living arrangement with a female roommate.

At six months post-termination, she had remained free of depression.

Her BDI was 9. She had continued working full-time at the same job. She found she was pregnant by the man she had been seeing for the last five months of the treatment. She plans to be married, but her boyfriend is uncertain. She is angry and anxious but feels that she can handle whatever happens and knows that she will have the baby. She and her boyfriend have started weekly couples therapy and will continue it.

The helping relationship appeared to have been formed largely when the therapist communicated her intention to be helpful and caring about Ms. Smyth's best interests and concerns. This caring message was also conveyed to Ms. Smyth, however, in the therapist's interpretative focus on her maintenance of self-hurting relationships with a boyfriend and others who were painfully the opposite of caring and helpful. The therapist was surprised at Ms. Smyth's good response to the therapy, but it is not uncommon that a good alliance forms as a consequence of a therapist's correct interpretative focus.

An example is given in Table 2.1, which outlines Ms. Smyth's third session: (1) the four relationship episodes scored according to CCRT components; (2) the CCRT frequency, a summary of the scored relationship episodes, and (3) samples of accurate interpretations based on the CCRT. The therapist examined the relationship episodes with each of the four people who were the subject of Ms. Smyth's narratives. (The four relationship

episodes are listed but not given in full here.) Also listed are the wishes (W), responses from other (RO), and responses of self (RS). The overall CCRT is evident in all four relationship episodes.

The use of the CCRT to help show the relationship context in which depression appears is illustrated by two sample interpretations given at the bottom of Table 2.1. In each interpretation, special prominence is given to the symptom by including the associated relationship conflicts involved in its appearance. For example, the therapist said, "I see you get depressed after you deal with people who won't give you what you need." This is an "accurate" interpretation in the sense that it fits with the CCRT.

TABLE 2.1 Using the CCRT to Interpret Four Relationship Episodes in Session 3 of the Therapy of Ms. Smyth

CCRT Components in Each Episode			
The Other Person in the Relationship Episode (RE)	Wish(W)	Response from Other (RO)	Response of Self (RS)
RE1: Therapist	I want treatment (but have no money) (Wl)	Will not give treatment without money (ROl)	Unhappy and depressed (RSI)
RE2: Ex-employer	I want job and help (Wl)	replaces (fires) me (ROl)	Get helpless (RS2); discouragement and depression (RSI)
RE3: Brother	I want care (Wl)	Treats me badly	Get angry (RS3);

		(ROl)	discouragement and depression (RSI)
RE4: Boyfriend	I want him to care (WI)	Gives no support (ROl)	Crying, sad (RSI); anger (RS3)

Number of Episodes with Each Component

W1 (Getting Care and Support): 4	ROl (Rejects): 4	RS1 (Discouragement and Depression): 4	RS3 (Anger): 2	RS2 (Helplessness):1

Sample of "Accurate" Interpretations Based on the CCRT

"I see you get depressed after you deal with people who won't give you what you need."

"You could see me as one of those people."

TRAINING

A good background for learning SE dynamic psychotherapy, as specified in this manual and in the general manual (Luborsky, 1984), is sufficient training and clinical experience in psychoanalysis or psychodynamic psychotherapy. Beyond clinical experience in dynamic therapies, supervision is needed for specific training in SE dynamic psychotherapy. The mainstay for this experience is the treatment of patients under supervision, along with reading and rereading this manual to learn the specific ways to maximize the curative factors in SE dynamic psychotherapy (Luborsky, 1993). It is not possible, of course, to learn to conduct this therapy just by reading the manual.

The supervision methods come in two formats: individual and group. The individual format consists of regular meetings with the supervisor to discuss the supervisee's tapes, which will have already been listened to by the supervisor. The group format is a newer method of training based on learning how to supervise and be supervised by other therapists who are part of a peer group of therapists (Luborsky, 1993). This training includes practice in CCRT scoring of sample cases as well as in using the CCRT in psychotherapy.

A major part of the supervision consists of evaluations of the therapist's adherence to the principles and techniques of the manual, in both clinical and clinical research applications. Several forms of training have been shown to improve adherence to the manual (Butler & Strupp, 1993; Luborsky & Barber, 1993). In one clinical research training system, independent judges experienced with the manual listen to the sessions and evaluate them on the degree of adherence to the recommendations of the manual (for two sessions early in training and two later in training). The adherence/competence scale is a 45-item scale developed by Barber and Crits-Christoph (1994). An earlier 4-item scale was used in Luborsky, McLellan, Woody, O'Brien, and Auerbach (1985). Experience with this adherence scale will allow trainers to set cutoffs for acceptable adherence.

EMPIRICAL EVIDENCE FOR THE APPROACH

Several kinds of empirical evidence for the efficacy of SE dynamic psychotherapy are available. Some of the evidence is from reviews of studies of outcomes of dynamic psychotherapy. This evidence probably applies to SE dynamic therapy, although most of the studies cover dynamic psychotherapy more generally. The earliest review is Luborsky (1987), which examines studies of dynamic psychotherapy versus other psychotherapies. Its conclusion is the usual one: There is no significant difference in outcome measures between dynamic psychotherapy and other psychotherapies. The same conclusion had been reported by a meta-analytic review of studies of all types of therapies (Smith, Glass, & Miller, 1980). An even more systematic meta-analytic review by Crits-Christoph (1992) also shows evidence for the efficacy of dynamic psychotherapy versus other psychotherapies. A larger meta-analysis of 13 comparative treatment studies of dynamic and other psychotherapies (Luborsky, Diguer, Luborsky, Singer, & Dickter, 1993) showed benefits from each treatment, as well as the usual nonsignificant difference between treatments.

Some of the evidence comes from studies specifically of SE dynamic psychotherapy, approximately as delineated in this manual. Two of the 13 dynamic psychotherapy studies reviewed in Luborsky et al. (1993) evaluated SE dynamic psychotherapy for the treatment of addiction; in both studies, significant and sizable treatment effects were shown (Woody et al., 1983; Woody, McLellan, Luborsky, & O'Brien, 1994). In the most recent study

(Luborsky, Diguer, DeRubeis, & Schmidt, 1994), SE dynamic psychotherapy was used to treat patients diagnosed with major depression or chronic depression. Results were significant, although the benefits were probably limited by the number of very seriously ill patients in the sample. Termination scores were very significantly better than intake scores on the BDI, the Hamilton Depression Scale, and the Global Assessment Scale. The benefits shown at termination were maintained at follow-up.

REFERENCES

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.

Barber, J. P., & Crits-Christoph, P. (1994, June). *Development of an adherence/competence rating scale for supportive-expressive dynamic psychotherapy.* Paper presented at the international meeting of the Society for Psychotherapy Research, York, England.

Beck, A. T., Weissman, H., Lester, D., & Trexler, L. (1974). The measurement of pessimism: The Hopelessness Scale. *Journal of Consulting and Clinical Psychology,* 42, 861-865.

Bibring, E. (1953). The mechanism of depression in affective disorders. In P. Greenacre (Ed.), *Affective disorders* (pp. 13-48). New York: International Universities Press.

Butler, S., & Strupp, H. (1993). Effects of training experienced dynamic therapists to use a psychotherapy manual. In N. Miller, L. Luborsky, J. P. Barber, & J. Docherty (Eds.), *Dynamic psychotherapy research: A handbook for clinical practice* (pp. 191-210). New York: Basic Books.

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

Crits-Christoph, P., Cooper, A., & Luborsky, L. (1990). The measurement of accuracy of interpretations. In L. Luborsky & P. Crits-Christoph, *Understanding transference: The CCRT method* (pp. 173-188). New York: Basic Books.

Crits-Christoph, P., & Luborsky, L. (1990). Changes in CCRT pervasiveness during psychotherapy. In L. Luborsky & P. Crits-Christoph, *Understanding transference: The CCRT method* (pp. 133-146). New York: Basic Books.

Eckert, R., Luborsky, L., Barber, J. P., & Crits-Christoph, P. (1990). The CCRT in patients with major depression. In L. Luborsky & P. Crits-Christoph, *Understanding transference: The CCRT method* (pp. 222-234). New York: Basic Books.

Ekstein, R., & Wallerstein, R. (1958). *The teaching and learning of psychotherapy.* New York: Basic Books.

Elkin, I., Shen, T., Watkins, J., Imber, S., Sotsky, S., Collins, J., Glass, D., Pilkonis, P., Leber, W., Docherty, J., Fiester, S., & Parloff, M. (1989). National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program: General effectiveness of treatments. *Archives of General Psychiatry,* 46, 971-983.

Engel, G., & Schmale, A. (1967). Psychoanalytic theory of somatic disorder: Conversion, specificity and the disease onset situation. *Journal of the American Psychoanalytic Association,* 15, 344-365.

Freud, S. (1958). Recommendations to physicians practicing psychoanalysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 111-120). London: Hogarth Press. (Original work published 1912)

Freud, S. (1958). On beginning the treatment (further recommendations on the technique of psycho-analysis). In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 121-144). London: Hogarth Press. (Original work published 1913)

Freud, S. (1958). Remembering, repeating and working through. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 145-156). London: Hogarth Press. (Original work published 1914)

Freud, S. (1957). *Mourning and melancholia.* In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 243-258). London: Hogarth Press. (Original work published 1917)

Freud, S. (1959). *Inhibitions, symptoms and anxiety.* In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 20, pp. 87-174). London: Hogarth Press. (Original work published 1926)

Gill, M. (1951). Ego psychology and psychotherapy. *Psychoanalytic Quarterly*, 20, 60-71.

Gottschalk, L., & Gleser, G. (1969). *The measurement of psychological states through the content analysis of verbal behavior.* Berkeley: University of California Press.

Jacobson, E. (1971). *Depression.* New York: International Universities Press.

Karasu, B. (1990). Toward a clinical model of psychotherapy for depression I: Systematic comparison of three psychotherapies. *American Journal of Psychiatry, 147,*133-147.

Knight, R. P. (1949). A critique of the present status of the psychotherapies. *Bulletin of the New York Academy of Medicine,* 25,100-114.

Linehan, M., Armstrong, H., Suarez, A., Allman, D., & Heard, H. (1991). Cognitive-behavioral treatment of chronically para-suicidal borderline patients. *Archives of General Psychiatry,* 48,1060-1064.

Luborsky, L. (1976). *A treatment manual for supportive-expressive (SE) psychoanalytically oriented psychotherapy.* Unpublished manuscript version of Luborsky (1984).

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

Luborsky, L. (1987). *A review of comparative treatment studies of dynamic psychotherapies versus other psychotherapies.* Unpublished manuscript, University of Pennsylvania.

Luborsky, L. (1990a). A guide to the CCRT method. In L. Luborsky and P. Crits-Christoph, *Understanding transference: The CCRT method* (pp. 15-36). New York: Basic Books.

Luborsky, L. (1990b). The Relationship Anecdotes Paradigm (RAP) interview as a versatile source of narratives. In L. Luborsky & P. Crits-Christoph, *Understanding transference: The CCRT method* (pp. 102-113). New York: Basic Books.

Luborsky, L. (1993). How to maximize the curative factors in dynamic psychotherapy research. In N. Miller, L. Luborsky, J. P. Barber, & J. Docherty (Eds.), *Dynamic psychotherapy research: A handbook for clinical practice* (pp. 519-535). New York: Basic Books.

Luborsky, L. (in press). *The symptom-context method: Solving and resolving symptoms in psychotherapy.* Washington, DC: APA Books.

Luborsky L., & Barber, J. P. (1993). Benefits of adherence to psychotherapy manuals, and where to get them. In N. Miller, L. Luborsky, J. P. Barber, & J. Docherty (Eds.), *Dynamic psychotherapy research: A handbook for clinical practice* (pp. 211-226). New York: Basic Books.

Luborsky, L., Barber, J. P., Schmidt, K., Redei, E., Prystowsky, M., Levinson, A., Cacciola, J., Crivaro, A., & Schretzenmair, R. (1992, June). *Depression and immune-competence: Do they inversely interact during psychotherapy?* Paper presented at the meeting of the Society for Psychotherapy Research, Berkeley, CA.

Luborsky, L., & Crits-Christoph, P. (1990). *Understanding transference: The CCRT method.* New York: Basic Books.

Luborsky, L., Crits-Christoph, P., Mintz, J., & Auerbach, A. (1988). *Who will benefit from psychotherapy? Predicting therapeutic outcomes.* New York: Basic Books.

Luborsky, L., & DeRubeis, R. (1984). The use of psychotherapy treatment manuals: A small revolution in psychotherapy research style. *Clinical Psychology Review,* 4, 5-14.

Luborsky, L., Diguer, L., DeRubeis, R., Cacciola, J. Schmidt, K., & Moras, K. (1994, February). *The efficacy of dynamic psychotherapy for major depression versus for chronic depression.* Paper presented at the NIMH methodology conference on research on treatment of chronic and recurrent anxiety and mood disorders, Bethesda, MD.

Luborsky, L., Diguer, L., Luborsky, E., Singer, B., & Dickter, D. (1993). The efficacy of dynamic psychotherapies: Is it true that everyone has won so all shall have prizes? In N.

Miller, L. Luborsky, J. P. Barber, & J. Docherty (Eds.) *Psychodynamic treatment research: A guide for clinical practice* (pp. 497-518). New York: Basic Books.

Luborsky, L., & Mark, D. (1991). Short-term supportive-expressive psychoanalytic psychotherapy. In P. Crits-Christoph & J. P. Barber (Eds.), *Handbook of short-term dynamic psychotherapy* (pp. 110-136). New York: Basic Books.

Luborsky, L., McLellan, A. T., Woody, G. E., O'Brien, C. P., & Auerbach, A. (1985). Therapist success and its determinants. *Archives of General Psychiatry,* 42, 602-611.

Luborsky, L., Singer, B., Hartke, J., Crits-Christoph, P., & Cohen, M. (1984). Shifts in depressive state during psychotherapy: Which concepts of depression fit the context of Mr. Q's shifts? In L. N. Rice & L. S. Greenberg (Eds.), *Patterns of change* (pp. 157-193). New York: Guilford Press.

Mann, J. (1973). *Time-limited psychotherapy.* Cambridge, MA: Harvard University Press.

Mark, D., & Faude, J. (1995). Supportive-expressive therapy of cocaine abuse. In J. P. Barber & P. Crits-Christoph (Eds.), *Dynamic therapies for psychiatric disorders (axis I)* (pp. 294-331). New York: Basic Books.

Orne, M., & Wender, P. (1968). Anticipatory socialization of psychotherapy: Method and rationale. *American Journal of Psychiatry,* 124, 88-98.

Peterson, C., Luborsky, L., & Seligman, M. E. P. (1983). Attributions and depressive mood shifts: A case study using the symptom-context method. *Journal of Abnormal Psychology,* 92, 96-103.

Seligman, M. (1975). *Helplessness: On depression, development and death.* San Francisco: Freedman.

Seligman, M., Castellon, C., Cacciola, J., & Schulman, P. (1988). Explanatory style change during cognitive therapy for unipolar depression. *Journal of Abnormal Psychology,* 97,13-18.

Smith, M., Glass, E., & Miller, T. (1980). *The benefits of psychotherapy.* Baltimore: Johns Hopkins

University Press.

Wachtel, P. (1993). *Therapeutic communication: Principles and effective Practice.* New York: Guilford Press.

Whisman, M. A. (1990). The efficacy of booster maintenance sessions in behavior therapy: Review and methodological critique. *Clinical Psychology Review,* 10,155-170.

Woody, G., Luborsky, L., McLellan, A. T., O'Brien, C., Beck, A. T., Blaine, J., Herman, I., & Hole, A. V. (1983). Psychotherapy for opiate addicts: Does it help? *Archives of General Psychiatry,* 40, 639-645.

Woody, G., McLellan, A. T., Luborsky, L., & O'Brien, C. (1994, February). Psychotherapy for opiate addiction in three community programs. Paper presented at the meeting of the North American Society for Psychotherapy Research, Santa Fe, NM.

Notes

1 With thanks for the editors' shaping and for suggestions by the 1993-94 Psychotherapy Practicum participants: Dr. Brian Esch, Dr. Rajni Lad, and Ms. Suzanne Johnson.

2 Most of our experience with this manual was with a 16-session limit for major depression and a 20-session limit for most of the patients with chronic depression (Luborsky et al., 1994). We use these numbers in the text, although the short-term limit in other samples may be anywhere from 12 to 40 sessions.

CHAPTER 3

Brief Supportive-Expressive Psychodynamic Therapy for Generalized Anxiety Disorder

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HISTORY AND DEVELOPMENT

The treatment approach described in this chapter represents an application of Luborsky's (1984) supportive-expressive (SE) dynamic therapy manual to generalized anxiety disorder (GAD). The treatment is brief (16 sessions) and focal in nature. While a diagnosis of GAD does not warrant a radically different treatment approach from standard brief SE, there are important treatment issues and emphases that are relevant to GAD patients, requiring this addendum to the generic SE manual. The specific elements of SE treatment as delivered to GAD patients become even more important in a research context where the mission is to standardize treatment so that studies can be replicated and efficacious treatments disseminated. Thus, on the one hand, we are not attempting to present a "new" dynamic therapy, but on the other hand, we are attempting to provide a further level of specificity of SE treatment for GAD patients that we hypothesize will lead to better outcomes. We believe the combination of the generic manual plus this more

specific guide for applying SE to GAD can meet the goals of standardization for research yet retain the essence of the general SE approach.

The Development of Supportive-Expressive Psychotherapy

As an extension of the generic SE manual, the current GAD treatment approach is influenced by the historical developments in psychodynamic psychotherapy as described by Luborsky (1984). He traces the roots of SE treatment back to Freud's papers on technique (1911/1958, 1912/1958a, 1912/1958b, 1913/1958, 1914/1958, and 1915/1958). Luborsky (1984) also points to the contributions of Ferenczi (1920/1950) and Rank (1936), and later Alexander and French (1946), all of whom proposed shortening the length of psychoanalysis and differentiating psychoanalytically oriented psychotherapy from psychoanalysis per se. The explicit introduction of supportive techniques made the treatment adaptable to a broader range of patients. Luborsky (1984) describes the history of the application of SE treatment at the Menninger Foundation (Wallerstein, Robbins, Sargent, & Luborsky, 1956) beginning about 1940. He also cites the writings of Bergmann and Hartman (1977), Gill (1951, 1954), Greenson (1967), and Stone (1951) as sources of the techniques described in the generic SE manual.

The Development of SE for GAD

Influences on the Development of SE for GAD

The senior author's experiences with SE treatment since 1984 at the University of Pennsylvania Center for Psychotherapy Research have been primarily in a research context, with the goal of developing and testing specific psychosocial treatments for specific patient problems and disorders. This research orientation has led to an interest in further codifying the treatment in more explicit terms so that the training of therapists can be accomplished more efficiently and effectively and a standardized treatment can be evaluated in efficacy studies. The research orientation has also led to an interest in adapting and modifying the treatment approach, based on research evidence suggesting which aspects of treatment are of greater therapeutic importance. Many of the modifications discussed in this chapter, however, reflect the clinical orientation of the writers. In developing SE treatments at the Center for Psychotherapy Research, we have been most influenced by our discussions with, and the writings of, David Mark, a senior SE supervisor at Penn who has authored a treatment manual on the application of SE treatment to cocaine abuse. The SE approach for GAD described here continues in these directions. We have also been influenced by the writings of Horowitz (1986) on the nature and treatment of stress-response syndromes.

Why Develop a Psychodynamic Therapy Specifically for GAD?

GAD is a relatively prevalent disorder that carries significant degrees of

impairment. Lifetime prevalence of GAD using a one-month duration criterion has been reported as ranging from 4.1% to 6.6% in the Epidemiological Catchment Area (ECA) survey (Robins & Regier, 1991). Since more than 60% of the cases in this study reported a duration of illness greater than one year, we can extrapolate a tentative *DSM-III-R* prevalence estimate of approximately 2.5% to 3.5% using a more conservative six-month duration criterion. The community ECA survey found that about one-third of subjects with GAD had an onset of the disorder in their teens or early twenties (Robins & Regier, 1991). The ECA survey found that almost half of the subjects who had ever experienced GAD continued to be ill at the time of interview, and the mean duration of illness was found to be 6-10 years. Data on psychosocial impairment from the ECA survey indicate that 38% of GAD subjects characterize their emotional health as only fair to poor; 27% were receiving disability payments, and only about one-half worked full-time.

In summary, the clinical picture that emerges from recent research suggests that GAD is an early onset condition that tends to be chronic and leads to a fair degree of disability and impairment of quality of life. Thus, public health concerns provide a strong rationale for developing treatments for GAD. Behavioral and cognitive treatments for anxiety, and GAD in particular, have been shown to be helpful (see Chambless & Gillis, 1993). In addition, medication treatments for GAD have also been shown to be efficacious. Despite these advances, there are a number of reasons to develop

a dynamic therapy for GAD.

First, dynamic therapy continues to be a widely practiced form of treatment in the community (see Jensen, Bergin, & Greaves, 1990), suggesting that many patients with GAD are commonly being treated with dynamic therapy. Developing and standardizing a particular dynamic therapy for GAD accomplishes the important first step of making it possible to evaluate the efficacy of dynamic therapy with this disorder.

Second, there are a number of limitations to medication treatments for GAD, particularly benzodiazepine, including (1) inadequate improvement in a subset of patients (about 30%) (Greenblatt, Shader, & Abernethy, 1983a); (2) negligible effect on the core symptom of worry (Rickels et al., 1982); (3) side effects, including attentional, psychomotor, cognitive, and memory-impairing effects as well as possible teratogenic risk in female patients of childbearing age (who constitute a majority of the GAD population); (4) abuse liability, physical dependence and withdrawal, and negative effects on coping and stress response capabilities (Greenblatt, Shader, & Abernethy, 1983b; Rickels, Schweizer, & Lucki, 1987; Woods, Katz, & Winger, 1992); and (5) high relapse rates—for example, Rickels et al. (1987) reported an 81% anxiety recurrence rate at one year for patients who had received four weeks of diazepam therapy.

Although behavioral and cognitive treatments have had some success in the treatment of GAD, missing from these approaches is a treatment focus on the interpersonal factors involved in GAD. (See the discussion of psychodynamic factors in GAD later in this chapter.) A psychodynamic approach could lead to broader life improvements, which might increase the general quality of life and also lower relapse rates.

Psychodynamic Theories of Anxiety

The rationale for the development of a manualized psychodynamic therapy for GAD comes not only from the limitations of other approaches and public health concerns about the disorder but also from the longtime interest in the psychodynamic camp in the theory and treatment of anxiety from a psychodynamic perspective. Psychodynamic writers from Freud through Sullivan, Fairbairn, Klein, and Kohut have all proposed ideas about the etiology and treatment of anxiety. (See Zerbe, 1990, for a review.) Whether the chronic anxiety problems ("anxiety neurosis") described by these theorists are the same problem known as GAD is unclear. However, our assumption is that some part of the chronic anxiety in at least a subset of GAD patients has a psychodynamic component.

Freud actually proposed two theories of anxiety. In his earlier writings (before 1926), he suggested that anxiety is the consequence of repressed or

nondischarged libido. Zerbe (1990) summarizes Freud's theory: "Repressed libido is transformed or converted into anxiety, which then reappears as free-floating anxiety or as an anxiety equivalent (i.e., symptom)" (p. 173). Psychoanalysis, or dynamic psychotherapy, encourages disclosure of warded-off, unacceptable sexual feelings, which in turn brings the anxiety out in the open to be channeled in a more productive direction, including appropriate expression of sexuality. Freud's later theory of anxiety was the "signal" theory (see Compton, 1972): a small amount of anxiety from a perceived danger "signals" the ego to be alert to the threat. Defenses, including symptoms and inhibitions, are then activated in order to keep the threat out of consciousness so that it does not become overly traumatic. If the defenses fail, a full anxiety attack occurs. Treatment is oriented toward insight about the perceived danger so that the patient can see that the danger is not as great as what he or she imagines.

Later psychodynamic writers extended the theories of anxiety in different ways. Karen Homey (1950) proposed that hostile impulses outside of consciousness lead to neurotic anxiety. The therapist's task is to bring these hostile impulses into awareness and help make them more acceptable. Sullivan (1953), on the other hand, focused more on anxiety as a function of anticipated disapproval from the primary caregiver earlier in life. He emphasized the importance of the therapist providing a climate of security that provides the context for patients to gradually develop their own security

operations over time. This context of therapeutic security is similar to the later notion of the "therapeutic alliance" (Greenson, 1967), which is also a major component of SE treatment. Fromm-Reichmann (1955) added to the Sullivanian perspective by emphasizing the anxiety-producing role of distorted views of other people, such views having originated in prior relationship experiences. These distorted interpersonal patterns not only are a function of anxiety but produce further anxiety. Therapists need to have patients develop better ways of relating to others by first helping them understand when they are perceiving others in a distorted way based on earlier relationship experiences. The SE model incorporates these concepts in terms of the core conflictual relationship theme (CCRT), which is one way of defining the patient's distorted relationship experiences.

The object relations theorists also contributed to the psychodynamic literature on the etiology and treatment of anxiety. Fairbairn (1952) emphasized the separation conflict originating in infancy. Although the child has deep feelings of dependency on the primary caregiver, too much closeness generates a fear of being engulfed and of loss of identity. As the natural desire to separate develops, greater distance from the caregiver leads to feelings of isolation and loneliness. Both sides of the conflict generate anxiety. This conflict needs to be mastered in order to achieve mature relationships and reduce anxiety. Klein (1975a, 1975b), on the other hand, linked anxiety to fear of death in the infant if the primary caregiver cannot be

evoked on demand. This anxiety is connected to a sense of being persecuted by other people and a lack of confidence in one's ability to sustain or repair relationships. When these internalized representations of self and others are carried over and activated later in life, relationships can be undermined. The emphasis in brief SE treatment of GAD on the meaning of separation from the therapist (termination) as a process that activates relationship conflicts involving attachment and loss of others is borrowed from the object relations view of separation conflict.

Although psychodynamic theorists have speculated on the origins and treatment of chronic anxiety from a variety of theoretical perspectives ranging from classic psychoanalytic to object relational to self-psychology, the treatment approach described here is more closely aligned with the interpersonal view. This orientation not only reflects the biases and experiences of the authors but is also influenced by the emerging research evidence for the importance of attachment and interpersonal issues in GAD. This literature is reviewed in the discussion of dynamic issues with GAD patients later in the chapter. Most notable in the emerging evidence is the high prevalence of past traumatic events in the history of GAD patients and the suggestive evidence for insecure attachment patterns. This research raises the possibility of the usefulness of brief dynamic therapies with GAD patients, particularly those that treat stress or trauma response syndromes and their maladaptive coping/defensive styles (Horowitz, 1986), as well as

those that examine core conflictual interpersonal patterns (Luborsky, 1984). Our approach, then, attempts to integrate the emerging research information on GAD with the clinical psychodynamic writing of Horowitz (1986) and Luborsky (1984) on brief dynamic therapy.

INCLUSION/EXCLUSION CRITERIA

We have recently crafted inclusion/exclusion criteria for the evaluation of our treatment as part of a planned comparative study including SE, cognitive therapy, medication, and pill placebo treatment conditions. Ultimately, the inclusion/exclusion criteria that would be employed in deciding whether to administer this treatment in a clinical context might differ from our research criteria. Until further data document the usefulness of the treatment with other inclusion/exclusion criteria, however, we prefer to advocate the use of this treatment only when these narrow criteria apply.

Inclusion criteria are (1) the patient meets *DSM-IV* criteria for a primary diagnosis of generalized anxiety disorder, and (2) the patient is age 18-69.

Exclusion criteria are (1) the presence of any acute, unstable, or severe Axis III medical disorder that might interfere with the successful completion of the 16 weeks of treatment; (2) any *current or past* history of schizophrenic disorder, bipolar disorder, or Cluster "A" Axis II personality disorder (schizoid, schizotypal, or paranoid); (3) any history *in the past 12 months* of

panic disorder with or without agoraphobia, alcohol or substance dependence or abuse, eating disorder, borderline personality disorder, or obsessive-compulsive disorder.

DYNAMIC ISSUES IN GAD

As previously mentioned, our application of an interpersonally oriented dynamic treatment to the diagnosis of GAD is partially based on emerging empirical evidence on the nature of GAD. This includes the data reported by Borkovec, Robinson, Pruzinsky, & DePree (1983) showing that worry (the central feature of GAD) is associated with high levels of interpersonal concerns. This link is also apparent in the high level of co-morbidity between GAD and social phobia (Brown & Barlow, 1992).

Research has also begun to shed light on the possible origins of the interpersonal issues in GAD. Lichtenstein and Cassidy (1991) performed a study in which GAD subjects were asked to recall memories of the nature of their attachment to primary caregivers in childhood. GAD subjects were found to be significantly more insecurely attached than non-GAD subjects. This was manifested in terms of more enmeshment/role reversal (i.e., the need to protect, but fear of losing, the primary caregiver) and greater preoccupying anger and oscillating feelings toward the caregiver. GAD subjects also felt significantly more rejected as children by the primary

caregiver than did non-GAD subjects.

In addition to interpersonal issues, GAD has also been linked to a history of past traumatic events. Borkovec (1994) reports on the results of three questionnaire studies involving over 1,000 subjects. In these studies, subjects meeting GAD criteria were found to have had significantly more past traumatic events compared with non-GAD subjects. Subjects meeting the full criteria for GAD also reported more frequent traumatic events than subjects meeting only some of the criteria. Similar results were found for a measure of the frequency of intrusive thoughts (one of the symptoms found in reaction to traumatic events) about traumatic events over the past week. Further analysis of the types of past traumas (Molina, Roemer, Borkovec, & Posa, 1992) has revealed interesting differences between GAD and non-GAD subjects. The vast majority of the traumas (80%) of non-GAD subjects were related to the death of a significant other and/or illness or injury involving self or others. The traumas of non-GAD subjects were rarely physical or sexual assault, emotional events involving friends or family, or miscellaneous traumas. (The percentage of traumas were distributed relatively evenly [6-8%] across these latter categories.) In contrast, GAD subjects characterized only 50% of their traumas as death, injury, or illness, but 21% were physical or sexual assault, 17% involved emotional events, and 11% fell in the miscellaneous category. These percentages describe the distribution of types of traumas in the experience of non-GAD subjects and GAD subjects

separately. Comparing the actual frequency of each type of trauma in the two groups is more revealing: GAD subjects report trauma involving death, illness, or injury at a rate one and a half times greater than that of non-GAD subjects, and traumas related to assault, emotional events, and miscellaneous traumas at rates four to six times greater.

Borkovec (1994) has further compared the data on past traumas with data obtained from interview studies on the content of current worries of treatment-seeking GAD patients and nontreatment-seeking GAD subjects. Although GAD subjects have higher rates of trauma related to death, illness, or injury than do non-GAD subjects, GAD patients and subjects rarely worry about these events (3% for patients and 0% for subjects). Non-GAD subjects, however, worry about these concerns at a much higher rate (25%). Borkovec speculates that these data suggest that GAD subjects/patients avoid thinking about those past events they consider traumatic. A study by Roemer, Borkovec, Posa, and Lyonfields (1991) that examines the function of worry is consistent with this hypothesis. The authors report that worrying appears to distract GAD subjects from more disturbing emotional contents ("Worrying about most of the things I worry about is a way to distract myself from worrying about even more emotional things, things that I don't want to think about"). In psychodynamic terms, worrying appears to serve a defensive function.

To summarize: The emerging research literature on GAD and worry suggests that GAD is linked to both an insecure/conflicted attachment in childhood and to a history of past traumas. It is not clear at this point whether these are two independent paths to GAD or whether they interact (i.e., specific traumas occurring to a person with insecure/conflicted attachment patterns produces the symptoms of GAD). GAD patients and subjects also display a characteristic defensive pattern of avoiding thinking about difficult emotional issues and events by worrying about other issues. It should also be acknowledged that the data are tentative and do not demonstrate causality. Nevertheless, the emerging data are consistent with a psychodynamic/interpersonal perspective on GAD that emphasizes attachment patterns and cognitive/emotional processing of past traumatic events.

In brief, our model of GAD follows from the above research finding and hypothesizes that a set of dangerous or traumatic experiences, which can occur at any phase of life, leads to a set of basic assumptions about oneself and other people, especially about one's ability to successfully obtain what one needs in life and in relationships. With GAD, these beliefs might center on the certainty of obtaining love, security, stability, or protection from others. These concerns at times are connected with feelings of fear so strong and troubling that the patient is actively motivated to not think about his or her concerns. That is to say, coping or defensive processes kick in that lead GAD

patients to become overly cognitively concerned ("worried") with certain current events in their lives as a way to avoid thinking about the more difficult emotional issues. The more difficult emotional issues, however, continue to be "alive," both consciously and unconsciously, and are manifested in repetitive, maladaptive relationship patterns. These self-defeating patterns are cyclical, meaning that they end up re-creating the same sort of perceived circumstances that originally generated the fear (e.g., expectation of losing a loved one).

The anxiety in GAD, then, is hypothesized to consist of multiple components. At its most basic level, the anxiety stems from the fear of not obtaining what one needs in relationships and in life. This anxiety in GAD patients would be reflected in the response of self-component of the CCRT. This basic fear in itself can generate ongoing worry. As described above, however, much of the worry component of GAD is hypothesized to be an additional defensive response. Other symptoms of GAD—for example, somatic symptoms—can also be a defensive response as well as simply a part of the physiology of the fear response. Lastly, it is acknowledged that life presents difficult or traumatic experiences that may add very real anxiety to the mix of fears and defenses that are being brought by patients to their current relationships from past experiences.

Despite the evidence that GAD patients may share common elements of

exposure to traumatic events and/or insecure attachments in childhood, we do not hypothesize one specific CCRT to be evident in all GAD patients. One reason for this is that "trauma" and "insecure attachment" are broad concepts that leave room for various types and severities of specific experiences that shape the exact nature of the interpersonal themes manifested later. In addition, aspects of each patient's past and current social world modify the expression of the effects of the traumas and childhood experiences. For example, one person with a history of an insecure attachment in childhood, if currently in a stable relationship, might display the following CCRT:

Wish: to be taken care of

Response from other (RO): does not protect or nurture

Response of self (RS): fear of losing the relationship; anxiety

A patient who also has a history of insecure attachment in childhood, if not currently in a stable relationship, might display this CCRT:

Wish: to have someone to trust and rely on

RO: not trustworthy

RS: anxious and depressed

Thus, early development events and circumstances are modified by later sets of experiences and current circumstances. The fact that beliefs

about oneself and others may be modified in the context of new or current relationships provides the opportunity for psychotherapy—a relationship with a caring and insightful therapist—to change such beliefs.

It should be clear that our model does not restrict the development of GAD to early childhood events. Trauma and conflicted relationships can occur at any phase of life. A sustained period of insecure attachment during childhood is likely to set up rather powerful expectations about others as one moves into early adulthood. If one has experienced successful, positive relationships early in life, it is less likely that new traumas or conflicted relationships will generate a severe or lasting impact.

TREATMENT GOALS

One of the first tasks in our 16-session treatment for GAD is setting goals. The therapist, however, does not arrive at final goals at the beginning of the first session. Instead, the therapist begins treatment, after introductions, by asking a general question such as, "Tell me what's going on." The intent is to elicit relevant material before formulating goals. Ideally, preliminary goals would be set at the end of the first session, but in some cases a second session is needed to obtain more information or to establish more of a therapeutic alliance before setting goals.

Typically, patients' goals relate to symptom reduction and sometimes to

self-esteem or interpersonal changes. GAD patients in particular are prone to focus on symptoms, especially somatic anxiety symptoms. If a patient is staying only at the level of symptoms, the therapist needs to directly inquire about the rest of the patient's life: "O.K., now that you've given me an idea about the symptoms that you've been having, it would help me to know more about you." The therapist follows up by asking questions about family, work, love relationships, and so on. In addition, the therapist elicits information about relationship themes by asking the patient to describe his or her interactions with other people.

After obtaining relevant information, the therapist attempts to weave symptom reduction goals with goals related to increased self-esteem or interpersonal confidence. Goals are specified using the patient's own language as much as possible. In addition, the goals have to be appropriate for a short-term treatment. This means that they should not extend to major, comprehensive personality change but rather need to be focal in nature. For example, the therapist says, "It's clear that we both agree that an important goal of this treatment would be to help you with your anxiety symptoms. You've also talked about the uncertainty and confusion you feel in regard to where to go with your relationship with your girlfriend. That's clearly an ongoing stress in your life and something you would like to work on, as it may be playing a role in raising your general nervousness. As a first step, it sounds as if you are saying that it would be useful to sort out all the different feelings

that you are having about her. Once you are clearer on all the feelings, and what those feelings are about, it might be easier to figure out where you want to go with the relationship. So why don't we set as the first goal, trying to understand more about your different feelings and how they might relate to your anxiety?"

As treatment develops, goals are referred to periodically to monitor progress, as described by Luborsky (1984, pp. 62-63). In addition, goals may change over time. For example, goals can change if treatment has succeeded in lowering the patient's defenses either by greater comfort in the relationship with the therapist over time through the provision of a secure environment or by direct interpretation of defenses. Once defenses are lower, the patient is likely to have greater access to more troubling conflicts and fears. Additional goals can be added to treatment, but they have to be appropriate for the amount of treatment time remaining.

Whereas the patient's and therapist's goals may not be the same at the beginning of the first session, the task of these sessions is to develop a collaborative relationship so that the final goals are mutually arrived at. In addition, over treatment the therapist will, if possible, attempt to add a goal (if it is not one of the original agreed-upon goals) relating to greater mastery over the patient's CCRT. For example, the therapist says, "We have been seeing over and over again how you are caught in this cycle of wanting to be

close to others but not trusting them and then feeling you must distance yourself from the relationship; I wonder if we can add as a goal of our therapy to help you understand this pattern better and perhaps begin to look at new ways you could handle these situations."

THEORY OF CHANGE

Our theory of change is one that hypothesizes a number of factors that can be responsible for positive outcome. The complexity of dynamic therapy is that the relative salience of each of these factors to a given patient varies as a function of the nature of the patient's interpersonal patterns and characterological style. We also acknowledge that the division of these factors into categories is somewhat arbitrary; in fact, the factors often interact and overlap.

In Luborsky's (1984, chap. 2) description of the theory of change for generic SE treatment, he specifies the three main psychological changes that occur in the patient: (1) an increased understanding of the CCRT and the relation of the symptoms to the CCRT, leading to a greater mastery over negative expressions of the CCRT; (2) an increased sense of having an ally in the struggle to break out of the self-defeating CCRT pattern; and (3) an internalization of the therapist as a helpful person together with acquisition of the tools of therapy (i.e., self-exploration) so that the gains of treatment

persist after termination. Luborsky (1984) describes each of these changes in detail and also articulates the patient's and therapist's roles in bringing them about. Below we expand on Luborsky's discussion of these changes in terms of their relative importance in the treatment of GAD patients and in terms of empirical support for them. We also discuss additional concepts based on our work with GAD patients.

Change in the CCRT

Changes in the patient's CCRT are hypothesized to be the primary determinant of a successful treatment. Crits-Christoph and Luborsky (1990) showed that pre- to post-treatment changes in CCRT wish, response from other, and response of self-components correlated significantly with changes in symptomatology and general functioning. Significantly, the mean changes in the pervasiveness of the CCRT components were relatively small across patients in this study. However, apparently even small changes in the CCRT pattern can be associated with symptom reduction. This study did not provide information on the causal sequence of CCRT and symptomatic changes, and therefore we must provide the caveat that symptom change may cause CCRT change, or that another variable may cause change in both. Nevertheless, the empirical evidence thus far is consistent with the importance of CCRT changes.

From our empirical-psychodynamic point of view, relief of presenting symptoms is very important but not generally the sole definition of a successful treatment. Some degree of change in the CCRT is also necessary for a successful treatment. Symptom relief should not, of course, be devalued; it is likely to have extraordinary importance to the patient and is the first level marker of a successful treatment. However, our theory is that symptom change without change in the CCRT is likely to be associated with a higher rate of relapse and recurrence of the symptoms after treatment has terminated.

The fact that even small changes in the CCRT can be important justifies engaging in brief 16-session therapy, in which major changes in relationship patterns can rarely occur. Thus, our model does not subscribe to the theory that interpersonal conflicts are "rooted out" in a brief course of therapy. Rather, the theory is that conflictual interpersonal themes are activated in the context of relationships and events occurring during a particular developmental phase of the patient's life (e.g., graduating from college, getting married, starting a career, etc.). A brief course of treatment serves to identify underlying CCRT patterns, their current developmental or relationship manifestations, and the maladaptive coping responses that hinder successful life adjustment. Additionally, the course of treatment helps the patient work through new expectations of self and others—thus starting the process of changing the CCRT. After termination, if the patient has successfully learned

the self-exploration tools of therapy, he or she continues to engage in self-exploration, make efforts to master the CCRT, and exhibit new behaviors. The extent to which the patient continues the process of therapy after termination is hypothesized to be associated with the maintenance of the treatment gains and the prevention of symptomatic relapses and recurrences.

A variety of types of changes in the CCRT would be expected in a successful treatment. Of central importance is movement toward less self-defeating responses of self and more new coping responses. We would also hope to see less rigid projection of assumed responses from others into new or evolving interpersonal relationships. Although it is not expected that wishes will change much in a brief treatment, with some patients a modification of wishes that are inappropriate to certain interpersonal contexts would be expected. Alternatively, change might be marked by successfully choosing new relationships that allow for appropriate expression of the CCRT wish(es).

Changes in the CCRT are thought to happen as a result of increasing self-understanding of the CCRT and, as described below, through the forging of a positive therapeutic alliance. Insight, or self-understanding, is actually a complex phenomenon consisting of multiple elements or meanings. At the first level, self-understanding refers to an uncovering of feelings or patterns that have been largely out of awareness (i.e., a de-repression). Although it is

probably rare for a patient to have no memory of a traumatic event and then suddenly during psychotherapy to have a complete lifting of repression with full access to the event, it is more common for a patient in treatment to gain access to difficult memories and feelings that may in fact have occasionally intruded into consciousness and to begin breaking down the variety of defenses (e.g., the distracting worrying of GAD patients) constructed over time to avoid thinking about them. By interpreting the patient's defenses and resistances, the therapist hopes to help the patient confront the deeper fears, conflicts, and feelings directly rather than continue to avoid thinking about them.

In addition to uncovering warded-off feelings, insight can be discussed at the level of cognitive understanding about one's self. At the cognitive level, insight is equivalent to a learning or educational process. Although this level of insight is often criticized as superficial, our position is that cognitive learning is a necessary aspect of treatment. However, the context in which such learning takes place is of central importance. As with any type of learning, cognitive learning is facilitated when the patient is sufficiently motivated and adequate groundwork has been accomplished (i.e., learning basic information before learning more complex information). If statements about the patient's dynamic conflicts are presented before his or her defenses and/or resistances have been lowered, the likely consequence is an increase in the patient's anxiety and further activation of defenses. Learning one's

dynamics after defenses have been lowered and the emotions connected with the conflictual themes have been tapped is often referred to as "emotional insight." With GAD patients, the danger of staying too much at the cognitive level is great, since these patients suffer from excessive thought activity (i.e., worry) and may pick up on a piece of cognitive information presented in therapy and simply incorporate it into their worry system.

At another level, self-understanding can be thought of as a skill or tactic rather than only as an outcome. Learning the process of self-exploration is then one goal of our brief dynamic therapy. As mentioned, the acquisition of this skill is seen as important for carrying on the work of therapy after termination in order to reduce relapse and recurrence of symptoms.

The main way self-understanding is increased and self-exploration is encouraged, leading to subsequent changes in the CCRT, is through the therapist's interpretations of the CCRT pattern. Our research has shown that the therapist's accurate interpretation of the CCRT is correlated significantly with treatment outcome (Crits-Christoph, Cooper, & Luborsky, 1988). Based on this research finding, our SE for GAD treatment model places even more emphasis on the importance of accurate formulation of the CCRT and centering interpretive work on the CCRT throughout treatment. Accuracy of CCRT interpretation has also been found to be associated with the development of the therapeutic alliance over treatment (Crits-Christoph,

Barber, & Kurcias, 1993). Thus, accurate interpretations may have a direct effect on self-understanding as well as an indirect effect on outcome through the role that the alliance plays in facilitating positive outcome.

Therapeutic Alliance

Luborsky's (1984) second curative factor for SE treatment is an increased sense of having an ally in the struggle to overcome symptoms and problems. We stress the importance of a positive therapeutic alliance as a factor in the change process for two reasons. First, a positive therapeutic alliance has consistently been found to be associated with better treatment outcome across a large number of studies. (See the review by Horvath & Symonds, 1991.) Our view is that this impressive research evidence needs to be taken seriously in the development of new treatment methods.

The second reason the therapeutic alliance is important in the change process relates to our formulation of the dynamic issues with GAD patients. As discussed earlier, GAD patients are hypothesized to have insecure or conflicted attachment patterns. Thus, a secure, positive relationship provides a "corrective emotional experience" and is fundamental to effective treatment with GAD patients. With some GAD patients, anxiety is fueled by guilt (i.e., fear that you have done something wrong to someone else). A safe, positive relationship with the therapist can often help ease the feelings of guilt and

lessen anxiety.

Another way a positive alliance is theorized to affect the patient is that a secure, positive relationship with the therapist allows the patient to feel safe enough to approach his or her fears. By "approach" we mean several things, including both psychologically approaching fears and behaviorally approaching feared situations. For some patients, the safe context allows them to lower defenses and gain access to fears not normally thought about because of their troubling nature. Other patients may be more aware of their fears but reluctant to disclose them given the possible negative reaction from others. At the behavioral level, the safe, positive relationship with the therapist encourages patients to actually approach feared situations, particularly interpersonal situations. Thus, a patient who is afraid of discussing some difficult issues in a relationship for fear of losing the relationship might be more likely to do so once he or she has had a positive experience in disclosing and discussing such fears with the therapist. From a psychodynamic point of view, this process is not simply one of desensitization but a cognitive process of changing internal representations of others and their expected responses.

The safety provided by a positive therapeutic alliance not only allows the patient to approach fears but subsequently also supports the patient's growth in trying new behaviors. The separation-individuation concept of the

object relations theorists is particularly relevant here. We assume that everyone experiences a basic desire to become independent and try new things, but that in order to do so a secure, positive attachment must be present first. The therapist also has to be aware of the danger of becoming overly involved with the patient so that fears of engulfment and losing one's identity are not activated and treatment consequently undermined.

A positive therapeutic alliance is also hypothesized to provide a context in which interpretive or expressive interventions are more likely to be heard, understood, and productively pursued by patients. The positive alliance conveys the sense that patient and therapist are working collaboratively, rather than a sense that the therapist comes up with explanations of the patient's behavior that the patient may hear as critical or condescending. In this way, the alliance sets the stage for the operation of other change mechanisms.

New Behaviors

Although the psychodynamic perspective emphasizes the steps necessary to gain understanding of the maladaptive problematic relationship patterns in order to provide the opportunity for the patient to grow in new positive directions, we also acknowledge the role of successfully engaging in new behaviors for encouraging further change and solidifying existing

change. Taking steps to adopt new, positive behaviors is particularly important for patients suffering from GAD or any other disorder that involves anxiety and/or avoidance. The therapist, therefore, should encourage such new behaviors, particularly if progress has been made on the preliminary steps of lowering defenses and understanding the CCRT patterns.

TECHNIQUES

The major techniques for our SE treatment of GAD are the same as those described in Luborsky (1984, chaps. 5-9), and the reader is referred to the generic manual for a discussion of them. Our discussion here will focus on those techniques that are most applicable to brief SE and those that we emphasize in the treatment of GAD in particular.

Brief SE Techniques

Although Luborsky (1984) has a short section on time-limited SE, our experience with the 16-session format in the treatment of GAD patients has helped us map out the application of brief SE in more detail. We can now characterize the therapist's predominant tasks during four phases of treatment.

Early Phase

In the early phase of treatment, the therapist and patient set goals, as described earlier in this chapter. The early phase can be generally specified as Sessions 1 to 5. The therapist's most important task during the early phase is to build a positive therapeutic alliance, using the supportive interventions described by Luborsky (1984, chap. 6) with the aim of building trust.

The therapist's second major task during the early phase is to formulate and interpret a preliminary CCRT. To obtain the material for formulating the CCRT, the therapist encourages the patient to talk about his or her interactions with other people. Specific incidents with other people, "relationship episodes," are the most useful way of obtaining relevant CCRT information. The therapist needs to learn to help develop the patient's narratives, as advocated by Mark and Faude (chapter 10). In a brief therapy, we do not have the luxury of assuming that after the lifting of resistances, relevant material will naturally flow. According to Mark and Faude, the process of learning to develop narratives is best learned through reviewing tapes of sessions with the supervisor.

If negative transferential issues emerge during the early phase, the therapist should empathize with the patient's feelings as much as possible in order to continue to build the alliance. Patients with an additional Axis II diagnosis are especially likely to display negative transference reactions in the early phase of treatment. The therapist's goal is to manage the Axis II

issues so as to keep the patient engaged in treatment but as much as possible to return to working on the anxiety and worry problems. The therapist should address Axis II defenses in an empathetic way, always maintaining, however, the goal of being in touch with the CCRT feelings and issues. As mentioned, severe Axis II patients (e.g., borderline) are not accepted in this treatment.

Middle Phase

The middle phase of treatment can be generally defined as Sessions 6 to 11. During this phase, the therapist refines the CCRT formulation using information from further relationship episodes told by the patient. It is usually during the middle phase that the patient feels safer in treatment, defenses have lowered somewhat, and more memories and experiences are recalled and discussed. Thus, the therapist now has the opportunity to relate the CCRT pattern to earlier relationships and to illustrate to the patient the extent to which the same patterns are appearing in a variety of relationships in the patient's life, including potentially the relationship with the therapist. This is the process of "working through."

Sometimes a therapist feels caught if a patient brings up new and very serious issues in the middle of the 16-session treatment. For example, given the high level of past traumas found in GAD patients, it is not uncommon for a GAD patient to disclose an incident of abuse or other trauma halfway through

the treatment. We have found that in most cases the incident can be talked about in therapy and used for understanding the patient's symptoms, defenses, and interpersonal conflicts. Thus, our view differs from that of some in the psychoanalytic camp who believe it is inherently counter-therapeutic to explore such material in a brief treatment. If necessary, of course, the patient can be referred for additional treatment if he or she begins to deteriorate once very traumatic experiences are brought up.

Termination Phase

The termination phase, approximately Sessions 12 to 16, is of central importance in our brief SE treatment for GAD. Although our treatment does not go quite as far as Mann's (1973) brief therapy— which makes the termination issues of overriding importance for almost the entire length of treatment—we nonetheless believe that the termination phase is critical. As Luborsky (1984) indicates, the termination phase is often characterized by a resurgence of symptoms as the patient's CCRT is activated in anticipation of the loss of the therapist. The loss of the therapist is meaningful not only in terms of the real loss of an important person in the patient's life but also, more specifically, in terms of anticipation of not obtaining the CCRT wish in relationships (e.g., wishes for support, nurturance, love, closeness, acceptance, etc.). The therapist must interpret the upcoming termination in terms of the link to the CCRT pattern and begin work on termination issues

no later than Session 14, and preferably as early as Session 12, whether or not the patient is making explicit references to termination. Not uncommonly, a therapist will collude with a patient to not discuss the upcoming termination because other topics seem more pressing, when in fact both participants are having difficulty facing the feelings related to termination. If left undiscussed, the termination issues often explode in the last or next-to-last session, with both parties feeling there is not enough time to deal with the feelings and issues that come up. With supervision, however, therapists learn after one or two training cases to address termination issues early enough and to be less apprehensive about the termination feelings that arise. The goal of the therapist in our brief SE treatment is to have patients end treatment with a clear educational understanding of their CCRT. As discussed earlier, this is not to say that an intellectual insight is the only task of therapy or the only requirement for self-understanding to be useful. If the patient is to achieve this educational understanding of the CCRT, the therapist needs to summarize, during the termination phase, what has been learned about the CCRT. Such a summary should be clear and succinct, and the therapist should encourage the patient to express his or her own understanding of the CCRT.

Booster Phase

The final phase of treatment is the booster phase, which was designed on an experimental basis as part of our research project. However, our

experience thus far in using booster sessions has been positive, and we can now recommend their use as part of our clinical treatment package. The booster sessions are scheduled at a rate of one per month over three months. The therapist's task during the booster phase is to monitor and reinforce the improvements the patient has made, encourage and support internalization of the treatment and the therapist (i.e., the patient doing the work of therapy on his or her own), and, if necessary, interpreting relapse in terms of the CCRT and the loss of the therapist. If during the booster phase a serious setback or relapse occurs, the patient is, of course, referred for appropriate treatment.

From a psychodynamic point of view, there is a concern that booster sessions "water down" the termination process, but we have not found this to be the case. The 16th session is still experienced as the final regular session and the cessation of the regular therapy work. Thus, our perception and the sense we have obtained from patients is that the positive aspects of these booster sessions outweigh any potential interference with the termination process. The booster sessions, however, should not be scheduled more often than once a month; more frequent booster sessions would likely cause more disruption in the termination process.

Technical Issues Specific to GAD

Beyond the modification of standard SE for its use in a 16-session format, other technical issues are specifically relevant to the application of SE to GAD patients. One issue has been mentioned already: the emphasis on supportive techniques to facilitate the therapeutic alliance and create a safe context for exploration. Although it is, of course, the larger goal of our treatment to reduce the patient's anxiety symptoms, we should note that some mild amount of anxiety (as an affect) actually contributes to therapeutic progress by providing continued motivation for working actively in treatment. Thus, it is not the therapist's goal to support the patient to the extent that anxiety is removed completely in the sessions.

CCRT Interpretation

In carrying out the main technical agenda for SE therapy, interpretation of the CCRT, several points should be emphasized in the treatment of GAD patients. First, our experience with GAD patients suggests that they not uncommonly display a primitive wish (e.g., "I want to feel safe") that surfaces early in treatment when they are in the most regressed state and overwhelmed by symptoms and feeling helpless. The therapist has to first bring this wish to the surface in the context of the alliance ("You want that in other relationships but are not getting it. How about here?"). Once the primitive wish is conscious and somewhat gratified by the alliance, the patient, after a few sessions, is motivated to move on to more mature wishes

("Well, the world is an unsafe place. I can be safe here, but out there I have to deal with the world as an adult"). The patient then begins to bring his or her more adult CCRT wishes to relationships, and the therapist focuses the interpretive work in that direction.

The therapist also needs to consistently link the CCRT wishes to the response of self. This link is important in first establishing the relation of the wishes to the anxiety feelings and symptoms. In addition, certain RSs are self-defeating and perpetuate a cyclical maladaptive pattern. For example, if the patient's wish is to be close to others but the RS is to distance from others after anticipating rejection, the therapist should not only interpret the CCRT wishes and responses from other and of self but should also point out the self-defeating nature of the RS. The focus on the RSs, whether the affect (anxiety) or the self-defeating behavior, also lays the groundwork for developing new RSs and new behaviors as therapy progresses.

Resistances and Defenses

Little is said in the generic SE manual (Luborsky, 1984) about dealing with resistances and defenses. Mark (in press) elaborates on the handling of resistances and defenses in an SE treatment in some detail, and we borrow from his approach here. Although we have highlighted the nature of worry as a defense in GAD patients, it is not the approach of our treatment to elevate

the interpretation of or confrontation with this or other defenses to the level of the primary intervention strategy of the treatment. Thus, our treatment does not attempt to analyze defenses routinely or to confront defenses head-on along the lines of Davanloo (1980). Rather, our approach is to deal with defenses and resistances to the extent that they present obstacles to understanding of the CCRT.

Mark (in press) also offers a variety of techniques for dealing with defenses in SE treatment; the therapist should (1) attempt to have the patient tangle with realities, rather than arguing with the patient, (2) use questions rather than state truths, and (3) simply sidestep defenses when it is more important to respect the patient's assets.

We have also found that the therapist needs to be aware of resistances and defenses in formulating and interpreting the CCRT. At times a manifest response of self may disguise the underlying wish, i.e., the response of self is defensive to the underlying wish. If interpretation of the defense does not help, the therapist should move toward work on the wish to the extent that it provides a less threatening context in which the patient is less defensive.

Past Traumas

As noted previously, GAD patients have a high frequency of past traumas. It is not the focus of this treatment, however, to specifically search

for past traumas. We have found that patients tend to bring up such experiences if they appear relevant to the therapeutic issues being discussed and the CCRT. The therapist's task is to be empathic to the patient's experience of the traumatic event(s). If relevant, the therapist should also examine with the patient how the CCRT was exacerbated by the trauma. For example, if a patient with a wish to be nurtured and protected also experienced a trauma such as sexual abuse, the therapist needs to help the patient understand how the wish was frustrated and exacerbated by the trauma when the parents or other people were unable to help. The therapist can then proceed to explore what the patient would have wanted in response to the trauma (e.g., to have expressed anger; to have been able to elicit help instead of withdrawing; for others to have taken him or her seriously).

CASE EXAMPLE

The patient, a married male in his late thirties, responded to an ad offering psychotherapy treatment for sufferers of anxiety. David (not his real name) was a college graduate, the oldest of four siblings, and worked with his mother and sister in managing the family business.

He had been in psychotherapy treatment at three points in his life and was now seeking treatment for emotional distress that had been consuming him since his return to work after a recent vacation. Before the first session,

he was evaluated by the research team and found to qualify for a diagnosis of GAD as determined by a structured interview. In the first session, David wept frequently and uncontrollably but was able to link his distress to feeling out of control at work owing to conflict with a longtime employee. He complained of unceasing obsessive worry, difficulty concentrating and sleeping, and feelings of isolation and withdrawal from family and friends.

David related a family history that was marred by the tragic accidental death of his youngest sister. At the time of the tragedy, David was in his early twenties and trying to formulate his career goals and separate from his family of origin. He had decided he did not want to work in the family business and had begun working in another company. He had first experienced symptoms of anxiety and perfectionism as a teenager, around the time his father was stricken and somewhat disabled by a chronic illness. Despite the added responsibilities, David managed his symptoms, entered and completed college, and got married. After his sister died, however, his father's emotional health deteriorated, and it fell to David and his mother to run the family business. David reluctantly accepted the responsibility, hoping that it would be temporary. He ended up staying on, however, without ever feeling he had made a fully conscious decision to do so.

David described his current distress as having been precipitated by increasing difficulties with the problematic employee. He felt that this man

was incompetent, unmotivated, and manipulative and defied supervision. David felt trapped in feelings of powerlessness, inadequacy, and personal failure. He also felt panic and paralysis linked to constant dread of an impending catastrophe. These feelings intensified when he considered taking any action that might result in losing this employee. As the situation worsened, David withdrew emotionally from other people at work and from his family, convinced that any request for help would further prove his failure and/or also lead to "something bad happening." Later in therapy, he revealed an associated dread that his parents would die precipitously and admitted the need to check on them each Sunday to see if they were still alive. The treatment goals he and the therapist agreed on were to regain a sense of control, feel able to manage the work conflict, and experience a reduction in symptoms of anxiety and depression.

In the next section, we present portions of the transcript of an individual session to illustrate the therapist's techniques and the process of David's understanding and working through his CCRT wishes, including important changes in his responses of self. The therapist considered this session, number 11 out of 16, to be a pivotal point in the course of treatment, as David was increasingly integrating his understanding of the CCRT and his past with the present and was recognizing his ability to change rather than remain at the mercy of events outside of his control. The previous sessions had laid the groundwork for this session by exploring and encouraging

David's expression of affect and his feelings about the past. In addition, the therapist had made many interpretations linking his wishes as well as responses of self and responses from others to the feelings he was describing in his relationship episodes with others. Session 11 witnessed a dramatic change: David decided to give up his initial wish (as revealed in earlier sessions) to be taken care of. He also connected his symptoms and personality style of expressing the negative to the gratification of this more regressed wish through the role of victim. David further progressed in this session by expressing his desire to replace the regressive wish with one of taking responsibility for his life, making changes, and tackling the obstacles that had previously led to a perfectionistic, sometimes self-defeating or overly fearful need for control.

We begin with an exchange that occurred at the start of the session.

> Patient: I started to interview for a new employee, what have you. You know, that kind of freaks me out from the standpoint of, what's going to happen? How am I going to deal with a conflict and all that? But I am not going to let that stand in the way of finding someone. Finding somebody will sort of pull, push me through the pipeline that I have to deal with.

> Therapist: So you have some anxiety, but it's not an anxiety that stops you from doing what you have to do?

> Patient: Trying not to. Trying to refocus, get focused, do something, stop sitting around. Not focus on being depressed, woe is me, because that's really not going to change anything. I mean, coming here and trying to figure out where it stems from might change it, but sitting at home lying in bed,

reading, or whatever, and not going to work doesn't change anything. So.

Therapist: That sounds like somewhat of a change in your feelings. What do you think may have precipitated that change?

Patient: Um, I don't know. Deciding that I better do something about this. I can't keep telling myself: I'm depressed, I'm getting more depressed, I'm not getting any better. Only I'm going to get better. Either I am or I'm not going to get better. Only I'm going to correct the situation at work. Nobody is going to step in. My employee is not going to come to me tomorrow and say, "You know, I decided this conflict that we've had is really all my fault, and I'm going to work more hours now, and I really see your point of view and what happened, and let's go forward."

Therapist: Right.

Patient: You know, the chances of that are the same chances that you'll pay me—

Therapist: (laughs)

Patient: —to meet with me every month.

Therapist: Uh-huh.

Patient: Today was a bad day, all kinds of, you know, problems. You know, the poison that's going on. You know, it's kind of hard to take this, and where they're not really doing what they're supposed to do anymore. We're sort of all going through the pretense that everything is sort of okay, but it's really not. They know it's not, we know it's not. They'll say, you know, we're a bunch of assholes, and it's spreading. It's not just the one employee's war anymore. It's like the whole department. You know, they've all commiserated, so it's even gotten uglier than it once was. You know, it might have been a brush fire, now it's a seven-alarmer. You know, the brother's now involved. Because, of course, it's his sister. So whose side is he going to take? He's not going to take the benevolent, caring employer's. He's going to take the asshole sister's who stopped talking to him because he did something wrong six months ago, a year ago.

Therapist: Well, it sounds like what makes a difference is when you think that it's got to be perfect, everything has got to be perfect, or it's a real blow to you.

Patient: Well, things are out of control. The problems freak me out still. And the answer isn't doing what we've been doing.

So I have to realize it's time to make changes.

Therapist: Mm-hm.

In the above exchange, David is directly revealing a desire to change his responses of self and implicitly revealing a change in his wish to be taken care of. He points out that focusing on his anxiety and depression and passively "lying in bed" or escaping by reading is not going to change anything. He adds, "Nobody is going to step in" (i.e., to take care of him). The therapist does not pursue his joking reference to her wish to pay him (and, by implication, take care of him completely) because David is focusing on more adaptive responses and the more mature wish to take care of things himself. When he describes how difficult and more complicated the situation has become ("now it's a seven-alarmer,") the therapist attempts to interpret the increasingly difficult and emotionally defeating effects ("it's a real blow to you") of trying to maintain perfect control. Even though David responds somewhat defensively, stating that there are real problems he can't ignore, he continues with the positive RS, "I'm going to have to find an answer to that."

Immediately following this exchange, David continues to discuss his

need to take care of the stresses and demands of his life and business.

Patient: I've got to change my way of dealing with people, my way of thinking about things. So, you know, the biggest thing is the realization that if I want my life to change, if I want to be more positive, if I want to have a personal life, I've got to do something about it. And not sort of go through being depressed and victimized. Because that's not really going to get me anything. On the other hand, you know, these problems still exist, so I still get depressed and anxious. I still get anxious about money and people hounding me to pay them and, you know, "Why if you're doing all the business can't you be current?" There's a $10 million question. They should spend a day in my business and see how well we run it, and then they can understand.

Therapist: So there is a lot of stress even if you were not going to be overwhelmed by the fear of—

Patient: Dying. You die anyway.

Therapist: You die?

Patient: You get hit by lightning, and all of a sudden you're dead anyway.

Therapist: Mm-hm.

Patient: You've got to look at things to see a positive outcome of them. It's like building a house, right? If you don't see, if you don't plan in your mind how to build it, you can't physically build it. You die anyway. It's all how you want your life to be.

But I can't say that I'm still not dreadfully fearful of someone dying or something like that. But I didn't call my parents immediately to see if they're still alive and breathing, you know, to check their breathing. Because I guess on one level I realize what it is that I was doing, or am doing, and you know, I guess if you realize that, you can sort of stop doing it if you decide that you don't buy into it anymore.

Therapist: Mm-hm. It gives you more choices.

Patient: Right. Or become more responsible for your own outcome of things.

Therapist: It must be a relief to know that it's not really about what other people are doing to you, that it's something that you can change.

Patient: And stop buying into that, you know, these outside forces are what's causing it.

Therapist: Mm-hm. Exactly.

This is a good illustration of both the therapist and the patient combining expressive and supportive techniques and direction; they are clearly working together as a team. The therapist first highlights the effects of David's underlying unconscious fear, and he completes her sentence about what that fear is about. He then elaborates on his attempts to control death, noting that he can consciously decide to stop if he understands what underlying fear is motivating his behavior. Here the therapist has both helped to make the unconscious conscious—by leading David toward identifying the RS as fear of dying—and identified the RO—that they (his parents) will die. She also supportively empathizes with David when he expresses relief that outside stressors from other people are not causing him to have these feelings, that they are coming from within himself, and that he can therefore change his responses to these fears. Her statement is not only empathetic but also effectively supports David's ability to achieve his goals of feeling more in control, taking constructive action, and decreasing his anxiety.

This session is remarkable in that David is able to achieve his wish to take care of himself, as manifested in his leading the focus and content of the session. Because of his focus on having more adaptive responses and working through difficult feelings and fears from the past, the therapist takes a supportive and clarifying approach in her interventions, rather than pushing David toward deeper expressive exploration and encouraging his regression. In a sense, she gratifies— perhaps unconsciously, since there is no mention of this transference in the material—his wish to take care of himself and elicit help and support from others for his efforts. Unlike those who take more conservative and open-ended analytic approaches, proponents of SE treatment do not view this facilitation of the alliance as detrimental so long as it is reviewed as an example of the CCRT wish within the relationship with the therapist before termination occurs.

The following exchange is a further example of the therapist and patient working through the more primitive wish and RSs associated with it by making a transition to a more modified adult-level wish.

> Patient: Well, one of the things is a lot of stress. And (sigh) it's ... I think that there's part of me that wants someone else to take care of me.

> Therapist: Mm-hm. Take care of you.

> Patient: Well, wouldn't we all? I mean—

> Therapist: Sure.

Patient: I think for part of me there's a warm comfortable feeling about being a victim and things not working out. And all of us being huddled in like a life raft and floating out in that storm after the ship sinks. Uh, you know, I don't know where that comes from or what that's about. But there's a certain part of me that—

Therapist: Yeah.

Patient: —that buys into that. That that's a warm comfortable feeling. That [feeling] fights changing myself, reaching out, becoming competitive. Breaking out of that shell or whatever.

Therapist: I think the other side of this is that as a person who's taking over some of the responsibility for keeping that raft aloft, so to speak, it's almost as if part of you needs to succeed so that you could create that secure, childlike sort of haven. And when something feels like it's getting screwed up with that, it just messes up the feeling you have that you can create the security for yourself and the others. You know, that's the fear that you would have if you failed someone.

Patient: Yeah, and that things will get out of control.

Therapist: That's right.

Patient: And you die.

The therapist's intervention highlights for David that part of his perfectionism stems from wanting to take care of things so well that he will be able to re-create the security of his regressive avoidance, and that when he encounters realistic obstacles he feels like he has failed. David confirms and elaborates on this idea by identifying additional RSs—that he is out of control and anxious about dying. Later in the session, to facilitate further affective

working through, the therapist comments on David's verbally unexpressed sadness, which she perceives in his eyes. She also attempts to explore its roots.

Therapist: Mm-hm. What's making you sad?

Patient: Actually, I'm not sad. I don't know, am I sad?

Therapist: Well, you look sort of like you're filling up.

Patient: Um, talking about death, you know, that scares me. I get freaked out about it.

Therapist: Um-hm.

Patient: I really do.

Therapist: Can you stay with that?

Patient: Mm-hm. Just dying, saying "dying," makes me cry.

Therapist: Mm-hm.

Patient: It scares me. I don't know why.

Therapist: Mm. Hm. Does it help at all to be able to at least, you know, feel the feeling?

Patient: No. Because it doesn't seem to go anywhere, you know. It's just painful for a little bit, and I cry, then it stops, then I come back a week later and talk about it, and I'll cry again.

Therapist: It may be hard to let go.

Patient: Of the fear of dying?

Therapist: It's a real step forward that you're not completely running away from those feelings of grief. Even though they may be painful.

Patient: Probably.

Therapist: If you could feel less worried about feeling depressed, maybe there's a good reason for your sadness. Maybe it's something you need to feel. Maybe there's not anything wrong with that. You know, it's accepting the depression.

Patient: Yeah, but you know, it gets old after a while.

Therapist: Nah. I think that the problem is, you keep pushing the feeling down.

Patient: Well, that could be true too.

Therapist: And that's why it feels frustrating, because it keeps coming back and you keep pushing it down.

Patient: Yeah, yeah, yeah. But you know, I've been sad and morose for so long I can't remember just having an out-offhand good time and laughing.

Therapist: Well, you're probably going to lose the battle of pushing that sadness and grief away, because it's taking up so much energy. I don't think it's just the sadness that you've been feeling for a long time. I think that the battle over the sadness is so frustrating.

Patient: Mm-hm. It's a battle. I don't know what the battle is.

Therapist: Well, you want to keep it away.

Patient: (sigh).

Therapist: For instance, your sister's death. That, plus something else.

Patient: Yeah. I don't know. I don't know. (26-second pause). But you think I just push it back and then it resurfaces again and I get depressed again?

Therapist: Mm-hm. You're fighting something. I don't know whether it's the mourning and grief.

Patient: I don't know either (55-second pause).

Therapist: What would happen if you let yourself feel it?

Patient: If I just let myself feel sad?

Therapist: Mm-hm.

Patient: No, I feel like I fall deeper and deeper. I just get consumed by it. Uh, it's like a whole self-destructive kind of path.

Therapist: Why do you feel so bad about feeling that way?

Patient: Pardon?

Therapist: Why do you feel so bad about grief, grieving?

Patient: Uh, not normally. I mean, you know, I've lost people, and I've grieved for them. You know, I lost my grandmother. It hurts, and I feel that sense of loss, but it isn't the same. I mean, I don't have an emotional triggering. When we talk about my sister dying, and dying and all that, I start to cry. I don't know what that's about, to be honest with you. I mean, the closest I have to figuring some kind of sense of it is that my sister died and all of a sudden, if I could have jumped back into my mother's womb, I would have. The closest thing to that, I guess, was going to work for them.

Therapist: What made you want to jump back into the womb? What were you feeling?

Patient: I don't know. What was I feeling? I don't know. I didn't want to go into my

father's business. So for the life of me, I'm sitting here like six years later trying to figure out why I did what I did. And why I continued to be frustrated by it. Even if you make the wrong decision, after a while you say to yourself, It was the wrong decision but this is what I did. And I have two alternatives. I could quit, or I could work it out.

Therapist: Mm-hm.

Patient: But you've got to let the past be the past.

Although the roots of the patient's difficulty accepting his sister's death and accepting his grief are not clear, he understands that his reaction of wanting to be taken care of, "to jump back into his mother's womb," certainly intensified after the death. He also perceives that, however this reaction affected his decision to work for his family, he must now try to take responsibility for his decision in the present. Unlike the goals of open-ended therapy, which would seek to completely understand the roots of David's anxious reaction to his sister's death, short-term SE treatment focuses on the process of understanding and on the beneficial effects of working through and making conscious the defenses, feelings, and wishes associated with the trauma that surface in the safe context of the therapeutic alliance.

The session ends with David directly confronting his fear of catastrophe should he meet head-on the challenge of taking care of himself and other people.

Therapist: Well, it's hard for you to take care of yourself and other people because you're afraid. Do you know why it is hard for you to—

Patient: Take care of other people?

Therapist: To take care of yourself?

Patient: I don't know.

Therapist: What are you afraid of would happen if you got things to be going well?

Patient: Well?

Therapist: Mm-hm.

Patient: I'd be afraid something would happen.

Therapist: Okay, some catastrophe.

Patient: Yeah, right.

Therapist: You raise your hopes, and then catastrophe—

Patient: Right. Like all of a sudden, things will be going well, and then I'll die. You know, it's like the person who ... they're on top of the world and, you know, something happens. But that's life. I mean, I understand, but you can't. You know, even the person that has cancer still goes out, still goes out dancing—well, hopefully. You know, they should still be able to go out and enjoy life. You know, my problem is, I'm so worried about that, you know, if something good were to happen, that it can only mean bad or disaster. That, you know, or looking for the next crisis, you know. I'm always visualizing a negative outcome.

Therapist: Mm-hm.

Patient: You know. And then Thursday they're going to be much better because this is the goal. This is where we're going to go. And yeah, we might have setbacks or something, you know, but that's not the end. You know, you're not going to die from a setback.

Therapist: Setbacks won't kill you.

Patient: The setbacks are what, like, create those anxiety trends.

Therapist: The setbacks are also part of life, they're not part of death.

The therapist's final comment is supportive. By implication, it reinforces all that David has said and provides hope that he can view obstacles with positive coping responses and thus fulfill his goal of enjoying life more and being less symptomatic.

In the next section, the rest of the treatment, in Sessions 12 through 16, is summarized with respect to the development and consolidation of treatment gains and the issue of termination. The therapist felt that Session 11 was pivotal because, in the remaining sessions, David continued taking action to deal with the work conflict. He interviewed applicants to replace the problematic employee and began to consider whether he would fire that employee or demote him to another less responsible position. He was also able to set limits on continued insubordination from the employee, who refused to cooperate in training his replacement. As suggested by the manual, the therapist had predicted that a setback would occur prior to termination. Prior to Session 15, David experienced a temporary regression when he felt that he had taken out his anger about the work situation on his parents and family. He felt "out of control" and worried whether this feeling indicated that he would fall apart after termination. The therapist reminded him of the

expected setback and reframed it as an understandable anticipation of ending.

Although David still felt stressed and anxious in the remaining treatment sessions, the anxiety lessened considerably and he was able to experience a much fuller range of affect and emotions. In Session 14, he mentioned how much better he was and that he was pleased that his sense of humor had returned. David continued to learn about his CCRT, recognizing that one of the ways he had avoided taking responsibility was to inappropriately ask those under his authority for advice. This RS was not only unhelpful to him, but it also undermined his ability to be an effective and credible authority figure.

The process of beginning to give up the more regressed wish to be taken care of was facilitated by David's deepening recognition that he longed for parental figures to depend on and give him advice. He explored his feeling that both his parents had been limited in their ability to take care of him this way, especially since the death of his sister. The therapist suggested that he was enacting his CCRT wishes with her as well. David thought that perhaps he was in some ways, but he had some difficulty accepting that the therapist was serving as a transitional parental figure. He agreed that he had needed her to take care of him, but he denied seeing her as "the father" who would support and encourage him to take care of himself and others. His denial of her in the

fatherly role may have been influenced by his more conscious appreciation of her feminine qualities.

In Session 12, David first mentioned that he was anxious about the upcoming termination, stating that he still feared that his depression and anxiety would come back. He spoke of his anticipated loss of the therapist and of her special role several times in the remaining sessions, sometimes while considering how he might be able to receive more support from other relationships, including that with his wife. He seemed to be accepting his loss of the therapist with good humor even as he admitted to anxiety about "what might happen" afterward. When the therapist asked in the final session whether he had started to feel that he could become his own parent, he said that although he knew he could do it, he would be very lonely. David also began to cry and appeared able to grieve the anticipated loss freely without pushing down the sadness. At the end of the session, he reported feeling very good about the therapy and his progress and was looking forward to the first scheduled monthly booster session.

TRAINING

We have been engaged in the training of therapists in our treatment model in order to have a group of skilled therapists available for efficacy studies on the treatment. We should note that not all of the rather elaborate

steps we employ in the training of therapists in a research context may be necessary for the training of therapists in a clinical context. However, until we have established the efficacy of the treatment under the high-quality conditions we attempt to achieve in research, it is not appropriate for us to speculate on the steps needed to train clinicians outside of a research context. If efficacy is established under high-quality, standardized conditions, further research will be needed on the training process per se in order to understand which ingredients are essential, how many training cases are indicated, what level of previous experience and background is necessary, what cutoff level of adherence/competence is required to certify a therapist as adequate, and what level and format of supervision is necessary to train therapists adequately.

The rather rigorous criteria we have currently established in the research context evolved through our experience in training dynamic therapists for five separate pilot studies or clinical trials conducted at the Center for Psychotherapy Research at Penn. The training program consists of the following steps:

Careful Selection of Therapists

The selection process consists of obtaining a C. V. (or, in some studies, a formal application form), letters of recommendation (or verbal

recommendations from other supervisors or therapists who may know the applicant's work well), and two audiotaped sessions of the applicant's therapeutic work with patients. Ideally, these sessions would be with two different anxious patients.

Therapists selected have generally been at least several years post-terminal degree (PH.D., Psy.D., M.S.W., post-residency M.D.). In addition, most therapists chosen have had some post-degree supervised training in some form of dynamic therapy. They must also have a strong interest in learning brief dynamic therapy, as we have found that many if not most dynamically oriented therapists have negative attitudes about brief treatment. This interest in brief dynamic therapy would include having read some of the main clinical contributions to brief dynamic therapy (e.g., Mann, Sifneos).

The audiotapes are then rated by our senior supervisors using the Penn Adherence/Competence Scale for SE (PAS-SE) Therapy (Barber, Crits-Christoph, Luborsky, Crits-Christoph, & Smailis, 1992). Although this scale relates to SE therapy and the applicant's own approach to dynamic therapy may be somewhat different, one of the subscales of the PAS-SE measures general dynamic therapy skills, and the other scales (the Supportive and Expressive subscales) give us a general sense of whether the therapist's approach is compatible with our SE approach. We have found that the audiotape rating step is crucial for selecting dynamic therapists, since there

are wide variations in technique and style among therapists who label themselves "dynamically oriented." We commonly screen out therapists who (1) rely exclusively on supportive interventions and show no skill at expressive interventions, (2) have a poor ability to formulate patients' interpersonal-dynamic issues, and (3) use a highly idiosyncratic personal approach that, while perhaps dynamic in flavor, would need to be changed substantially to meet our criteria for implementation of SE for GAD.

Preliminary Orientation

The preliminary orientation of a therapist consists of first reading the generic SE manual and then reading our SE for GAD addendum. The therapist then meets with our senior supervisor to discuss questions and reactions to this material. An important part of this orientation is to discuss the therapist's preconceived notions about brief therapy. Most therapists express reservations about the degree of sustainable improvement that can be accomplished in brief therapy and also express concerns about "abandoning" patients. These concerns are addressed by indicating that many, but perhaps not all, patients do appear to benefit considerably from brief therapy. It is also explained that the goals of brief therapy differ from many of the goals of long-term therapy. The therapist is told that, in our experience and the experience of others, most patients actually appear to prefer a time-limited brief therapy format to an open-ended format. While feelings related to termination (both

patients' and therapists') are difficult, working through such feelings is a major part of the treatment model and successfully doing so can provide a unique and important experience for the patient. In addition, the therapist is told that if, upon clinical evaluation by our interviewers, a patient is found to be not in recovery, or to be in significant distress, an appropriate referral for additional alternative treatment is made at termination.

Training Cases

Our current standard is to have therapists learn the method on at least four training cases. Although this number may seem high by standards in the research literature, our experience is that dynamic therapy is difficult to learn to do well. The learning process with dynamic therapy comes not from the manual per se—the manual is a description of general principles rather than the sort of step-by-step session guide that might be found with some cognitive-behavioral treatments—but from the supervision process.

Supervision

Supervision is conducted on an individual basis with one hour of supervision for every two hours of therapy delivered. The supervisor listens to portions of audiotaped treatment sessions as much as possible. The supervision process is explicitly a teaching relationship. The treatment model

and manual are referred to frequently in supervisor-supervisee discussion. Concrete aids for learning are encouraged. For example, during supervision we make use of the CCRT Session Form. After selected sessions, the therapists are asked to complete a brief form that asks for their formulation of the patient's CCRT from the material presented in the session. This form then is discussed during supervision to teach the CCRT concept and to track the development of the therapist's understanding of the patient's CCRT over treatment. This method also helps to accomplish one of the main aims of the treatment model: to focus the therapist's interventions on the CCRT.

The explicit nature of the teaching of the model during supervision makes the training somewhat different from the not-uncommon mode of dynamic therapy supervision in which the therapist simply presents case material and the supervisor gives comments. We have found that when trained well, therapists have a clear understanding of the treatment model and recite principles learned in supervision frequently. Since many experienced dynamic therapists consider themselves expert clinicians already, it is important to select therapists who are open to a new learning experience. The supervisor, of course, while oriented to teaching trainees, is also aware of the clinical competencies that the therapist brings to the training program and is respectful of the stylistic and personality differences among therapists, as long as such differences do not hinder the effective implementation of the model.

In addition to ongoing individual supervision, we have found that group meetings of therapists and supervisors are useful. Such meetings provide another forum for discussion of the treatment model and of different therapists' experiences with patients and with learning the model. By providing another arena for intellectual exchange with colleagues, group meetings also often help to maintain therapists' morale and commitment to the model.

Adherence and Competence Monitoring, and Certification

Ongoing adherence/competence rating should be performed during the training period. Using the PAS-SE adapted for GAD, the supervisor should rate at least two sessions for each training case. In addition, it is useful to have an independent judge (an experienced SE therapist, supervisor, or tape rater) also rate each training case. These ratings serve several functions: provide structured feedback on the strengths and weaknesses of each trainee; show progress over the training period; and serve as the criterion for "certifying" each therapist as competent to perform SE therapy for GAD. We have not obtained enough research experience with the instrument to propose a cutoff score that meaningfully delineates "competent" from "non-competent" therapists. However, we have used a tentative criterion of an average item rating of 4 on the 1-7 scale that is used for rating the items of the PAS-SE.

EMPIRICAL EVIDENCE FOR THE APPROACH

An open trial of SE for GAD has been performed at the Center for Psychotherapy Research. The goals of this study were several-fold. The first goal was to develop and refine the treatment approach for GAD patients. Aspects of the treatment described in this chapter have emerged from our early experience working with GAD patients. A second goal was to gain several trained SE therapists for future comparative efficacy studies by evaluating their performance in treating GAD patients. Therapists therefore had audiotapes of their sessions rated for adherence to and competence in the SE approach. A third goal of the pilot study was to obtain preliminary efficacy data for the treatment approach. This preliminary data would help justify continuing with further research efforts to establish the efficacy of the treatment.

Three of the five trainees have consistently displayed high ratings of adherence and competence, as rated by their supervisor and an independent judge who rated tapes of their sessions. Using the PASSE (Barber et al., 1992) modified for use with GAD patients, all three of these therapists received an average item rating of 5.0 or greater on the 45-item instrument, indicating excellent application of the techniques. These three therapists each have a minimum of 10 years of post-degree experience. (Two are psychologists, and one is an M.S.W. who also had advanced psychoanalytic training.) Each of the

three therapists has treated (or have in treatment) a minimum of five GAD patients and continues to treat GAD patients on an ongoing basis, under supervision, in an extension of the GAD pilot study. Supervision is provided on an individual basis.

For the 11 patients completing treatment, scores on the Hamilton Anxiety Rating Scale decreased from 16 (SD = 6) to 5.8 (SD = 7) (p < .005). Scores on the Beck Anxiety Inventory also decreased considerably (intake mean = 26.2; termination mean = 6.5; p < .001). Those patients with initial Hamilton scores greater than 18 also showed marked improvement (mean initial scores = 20.8; termination mean = 8.4). Thus, there is good preliminary evidence that our SE treatment helps patients with GAD, and that we have a group of therapists who have been trained in the treatment manual and are certified as competent. These promising pilot results suggest that our SE treatment for GAD is ready to be tested in a full clinical trial in comparison with other treatments (e.g., medication, cognitive-behavioral therapy). Such a study is the next step in our research program.

REFERENCES

Alexander, F., & French, T. (1946). *Psychoanalytic therapy: Principles and applications.* New York: Ronald Press.

Barber, J. P., Crits-Christoph, P., Luborsky, L., Crits-Christoph, K., & Smailis, J. (1992). *Initial data on the development of an Adherence/Competence Measure for supportive-expressive psychotherapy.* Paper presented at the meeting of the Society for Psychotherapy

Research, Berkeley, CA.

Bergmann, M., & Hartman, F. (Eds.). (1977). *The evolution of psychoanalytic technique.* New York: Basic Books.

Borkovec, T. D. (1994). The nature, function, and origins of worry. In G. C. L. Davey & F. Tallis (Eds.), *Worrying: Perspectives on theory, assessment, and treatment* (pp. 5-34). Sussex, Eng.: Wiley.

Borkovec, T. D., Robinson, E., Pruzinsky T., & DePree, J. A. (1983). Preliminary exploration of worry: Some 39 characteristics and processes. *Behavior Research and Therapy,* 21, 9-16.

Brown, T. A., & Barlow, D. H. (1992). Co-morbidity among anxiety disorders: Implications for treatment and DSM-IV. *Journal of Consulting Clinical Psychology,* 60, 835-844.

Chambless, D. L., & Gillis, M. M. (1993). Cognitive therapy of anxiety disorders. *Journal of Consulting Clinical Psychology,* 61, 248-260.

Compton, A. (1972). A study of the psychoanalytic theory of anxiety: I. The development of Freud's theory of anxiety. *Journal of the American Psychoanalytic Association,* 20, 3-44.

Crits-Christoph, P., Barber, J. P., & Kurcias, J. (1993). The accuracy of therapists' interpretations and the development of the therapeutic alliance. *Psychotherapy Research,* 3,25-35.

Crits-Christoph, P., Cooper, A., & Luborsky, L. (1988). The accuracy of therapists' interpretations and the outcome of psychotherapy. *Journal of Consulting and Clinical Psychology,* 56,490-495.

Crits-Christoph, P., & Luborsky, L. (1990). Changes in CCRT pervasiveness during psychotherapy. In L. Luborsky & P. Crits-Christoph, *Understanding transference: The CCRT method* (pp. 133-146). New York: Basic Books.

Davanloo, H. (Ed.). (1980). *Short-term dynamic psychotherapy.* New York: Jason Aronson.

Fairbairn, W. R. D. (1952). *An object-relations theory of the personality.* New York: Basic Books.

Ferenczi, S. (1950). *Further contribution to the theory and technique of psychoanalysis.* London: Hogarth Press. (Original work published 1920)

Freud, S. (1958). The handling of dream-interpretation in psychoanalysis. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 89-96). London: Hogarth Press. (Original work published 1911)

Freud, S. (1958a). The dynamics of transference. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 97-108). London: Hogarth Press. (Original work published 1912)

Freud, S. (1958b). Recommendations to physicians practicing psychoanalysis. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 109-120). London: Hogarth Press. (Original work published 1912)

Freud, S. (1958). On beginning the treatment. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 121-144). London: Hogarth Press. (Original work published 1913)

Freud, S. (1958). Remembering, repeating and working-through: Further recommendations on the technique of psychoanalysis II. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 147-156). London: Hogarth Press. (Original work published 1914)

Freud, S. (1958). Observations on transference-love: Further recommendations on the technique of psychoanalysis. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 157-171). London: Hogarth Press. (Original work published 1915)

Fromm-Reichmann, F. (1955). Psychiatric aspects of anxiety. In C. M. Thompson, M. Mazer, & E. Witenberg (Eds.), *An outline of psychoanalysis* (pp. 113-133). New York: Modern Library.

Gill, M. M. (1951). Ego psychology and psychotherapy. *Psychoanalytic Quarterly,* 20, 60-71.

Gill, M. M. (1954). Psychoanalysis and exploratory psychotherapy. *Journal of the Atnerican Psychoanalytic Association,* 2, 771-797.

Greenblatt, D. J., Shader, R. I., & Abernethy, D. R. (1983a). Current status of benzodiazepines: I. *New England Journal of Medicine,* 309, 354-358.

Greenblatt D. J., Shader R. I., & Abernethy, D. R. (1983b). Current status of benzodiazepines: II. *New England Journal of Medicine,* 309, 410-416.

Greenson, R. (1967). The working alliance and transference neurosis. *Psychoanalytic Quarterly,* 34,158-181.

Horney, K. (1950). *Neurosis and human growth: The struggle toward self-realization.* New York: Norton.

Horowitz, M. J. (1986). *Stress response syndromes* (2nd ed.). Northvale, N.J.: Jason Aronson.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology,* 38,139-149.

Jensen, J. P., Bergin, A. E., & Greaves, D. W. (1990). The meaning of eclecticism: New survey and analysis of components. *Professional Psychology: Research and Practice,* 21,124-130.

Klein, M. (1975a). *Envy and gratitude and other works 1946-1963.* New York: Delacorte Press/Seymour Lawrence.

Klein, M. (1975b). *Love, guilt, and reparation and other works 1921-1945.* New York: Delacorte Press/Seymour Lawrence.

Lichtenstein, J., & Cassidy, J. (1991, April). *The Inventory of Adult Attachment (INVAA): Validation of a new measure.* Paper presented at the meeting of the Society for Research in Child Development, Seattle.

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

Mann, J. (1973). *Time-limited psychotherapy.* Cambridge, MA: Harvard University Press.

Mark, D. (in press). *Dynamic therapy of cocaine abuse.* Northvale, NJ: Jason Aronson.

Molina, S., Roemer, L., Borkovec, M., & Posa, S. (1992, November). *Generalized anxiety disorder in an analogue population: Types of past trauma.* Paper presented at the meeting of the Association for the Advancement of Behavior Therapy, Boston.

Rank, O. (1936). *Will therapy?* New York: Knopf.

Rickels, K., Schweizer, E., & Lucki, I. (1987). Benzodiazepine side effects. In R. E. Hales & A. J. Frances (Eds.), *American Psychiatric Association Annual Review* (Vol. 6, pp. 781-801). Washington, DC: American Psychiatric Press.

Rickels, K., Wiseman, K., Norstad, N., Singer, M., Stoltz, D., Brown, A., & Danton, J. (1982). Buspirone and diazepam in anxiety: A controlled study. *Journal of Clinical Psychiatry,* 43, 81-86.

Robins, L. N., & Regier, D. A. (1991). *Psychiatric disorders in America: The epidemiologic catchment area study.* New York: Free Press; London: Collier Macmillan.

Roemer, L., Borkovec, M., Posa, S., & Lyonfields, J. (1991, November). *Generalized anxiety disorder in an analogue population: The role of past trauma.* Paper presented at the meeting of the Association for the Advancement of Behavior Therapy, New York.

Stone, L. (1951). Psychoanalysis and brief psychotherapy. *Psychoanalytic Quarterly,* 20, 215-236.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry.* New York: Norton.

Wallerstein, R., Robbins, L., Sargent, H., & Luborsky, L. (1956). The psychotherapy research project of the Menninger Foundation. Rationale, method, and sample use. *Bulletin of the Menninger Clinic,* 20, 221-280.

Woods, J. H., Katz, J. L., & Winger, G. (1992). Benzodiazepines: Use, abuse, and consequences. *Pharmacological Review,* 44,151-347.

Zerbe, K. J. (1990). Through the storm: Psychoanalytic theory in the psychotherapy of the anxiety disorders. *Bulletin of the Menninger Clinic,* 54,171-183.

CHAPTER 4

Psychoanalytic Therapy of Schizophrenia

Bertram P. Karon and Michael A. Teixeira

HISTORY AND DEVELOPMENT

As early as the paper "On Psychotherapy," Sigmund Freud (1905/ 1953) expressed the hope that psychoanalytic technique would be modified so as to make possible a psychoanalytic psychotherapy for the psychoses. Freud maintained this guarded hopefulness for the psychoanalytic therapy of the functional psychoses to the end of his life (Freud, 1940/1964). In Switzerland, at the Zurich University Clinic Burgholzli, Jung (1907/1960a) attempted individual psychotherapy with schizophrenic patients based on Freud's psychoanalytic method and Bleuler's (1911/1950) investigations into the psychology of schizophrenia. Bleuler observed that discharges at Burgholzli had tripled since the introduction of Freudian understanding (Federn, 1943a). Fifty years later, in a paper read at the Second International Congress for Psychiatry, Jung (1960b) reiterated that schizophrenia can be completely treated and cured by psychotherapeutic means.

Among the significant contributors to early psychoanalytic approaches to the psychotherapy of schizophrenia, Abraham (1916/ 1927) described the oral dynamics in a case of simple schizophrenia treated by psychoanalysis.

Waelder (1925) emphasized the *"narcissistic* transference" in schizophrenia. Bychowski (1930) described the oral dynamics and maternal transference in a case of schizophrenia with delusions of persecution. Bychowski (1954) discussed analytic working-through and systematic correction of the schizophrenic ego regression, including transference, thinking, defense mechanisms, and other formal peculiarities, utilizing interpretation, confrontation addressed to the more adult ego sector, and supportive reassurance against overwhelming affective reactions. Ego fragmentation in schizophrenia was related to alternating and contradictory structural identifications.

In 1933 Federn (1934) gave a technical paper on the analysis of psychoses to the Training Institute of the Vienna Psychoanalytical Society. Federn cautioned against adverse environmental influences, increasing of regression, premature uncovering, and negative transference, as well as against "withholding the [positive] counter-transference" (p. 210) (in order to *establish* positive transference). Federn reported that often a recumbent position in treatment would increase schizophrenic symptoms. Psychotic regression was understood as a defense against unbearable conflicts. Federn later (1943b) suggested that "one wins the normal transference of the psychotic by sincerity, kindness, and understanding" (p. 251), and he emphasized that in psychosis ambivalence is replaced by split ego states. Federn (1943a) reported good results for modified psychoanalytic therapy

with a follow-up period of at least five years.

In the United States, Kempf (1919) at St. Elizabeth's Hospital in Washington, D.C., had reported a case of dementia praecox treated by a psychoanalytic approach. He observed that maintaining an altruistic transference against negative transference taxed the therapist's patience and endurance. The psychoanalytic treatment involved the gradual analysis over two years of the patient's hallucinations, delusions, and physical symptoms in relation to specific environmental influences. At Shepard and Enoch Pratt Hospital in Baltimore, Harry Stack Sullivan (1931/1953a) reported the first large-scale study of 100 male schizophrenic admissions treated by what would today be described as modified psychoanalytic psychotherapy. Sullivan began developing his psychodynamic interpersonal relations theory as early as 1925. Of the 100 schizophrenics, 22 had insidious onset and 78 had acute onset. Sullivan reported that less than 32% (7 patients) of those with insidious onset showed improvement. Approximately 61% (48 patients) of those with acute onset showed a marked improvement, including some who recovered entirely. Sullivan suggested that acute onset had a much better prognosis than insidious-onset schizophrenia.

In 1935 Fromm-Reichmann (1950; Bullard, 1959) came to Chestnut Lodge in Maryland, where she worked closely with Sullivan. Fromm-Reichmann developed a psychoanalytic psychotherapy of schizophrenia that

she revised over a period of more than 20 years. Prominent schizophrenia researchers from the "Chestnut Lodge School" include Arieti (1974), Burnham (Burnham, Gladstone, & Gibson, 1969), Feinsilver (1986), Lidz (1973), McGlashan (McGlashan, 1983; McGlashan & Keats, 1989), Pao (1979), Schulz (1975), Searles (1965), Stanton (Stanton & Schwartz, 1954; Stanton et al., 1984), Stierlin (Stierlin, Weber, Schmidt, & Simon, 1985), and Will (1961). It was Searles who called attention to the importance of transference-countertransference attunement at a time when such a position was heatedly disputed.

In England, Melanie Klein, a student of Abraham and Ferenczi, further developed her psychoanalytic theory of internalized object relations and early oral dynamics, including work with psychotics (1930, 1948, 1975). Kleinian analysts such as Bion (1954, 1957/1967), Rosenfeld (1965, 1969), and Segal (1973) routinely treated borderline and psychotic individuals in psychoanalysis utilizing interpretations of positive and negative transference phenomena, free association on the couch, and most important, interpretations focused on the manifest and latent anxieties and the transference psychosis. Kleinian analysts understand schizophrenic phenomenology as a defense against overwhelming annihilation and persecutory anxieties. Unconscious material is interpreted at the level of the greatest anxiety, to develop awareness of the links between fantasy and reality. Winnicott (1965), an early Kleinian, would later come to emphasize

maturational processes in infancy and early childhood, as well as environmental deficiencies and abnormalities related to the development of schizophrenic disorders. In Scotland, Fairbairn (1954) and Guntrip (1969) contributed to the development of psychoanalytic object relations theory, including its applications to schizophrenics.

Benedetti trained with Bleuler at Burgholzli and later studied with Bally, Boss, Sechehaye, and Mueller, and Rosen in the United States. The Swiss psychologist Sechehaye (1956) had developed her method of "symbolic realization" to enter into the delusional world of the schizophrenic, at first using the symbols as if she and the patient understood their meaning, permitting gratifications not available in current reality as part of the process. Benedetti (1987) has had a profound influence on European psychotherapy of schizophrenia over the last 30 years, particularly in Switzerland and Italy.

In the United States, Bak (1954), following Hartmann, suggested that the inability of the ego to neutralize aggression was instrumental in bringing about a defensive ego regression in schizophrenia. Eissler (1952) developed his concept of parameters in terms of the need to intentionally deviate from standard technique to meet the needs of schizophrenic as well as other difficult patients. Boyer and Giovacchini (1967,1990), Grotstein (1990), Kernberg (1975,1977), and Volkan (1976) have become mainstream proponents for integrating the ego psychological and object relational

psychoanalytic theories and treatment, with important implications for borderline conditions and schizophrenia.

Karon studied with Tomkins and edited the first two volumes of the latter's *Affect, Imagery, and Consciousness* (1962, 1963, 1991a, 1991b), whose emphasis on the neglected central role of affects in the human condition led to a conceptualization of schizophrenia as terror plus humiliation, the latter being a component of most psychopathology, according to Tomkins. Tomkins had required of his students a basic knowledge of Freud, Sullivan, and Fromm-Reichmann, among others. Karon interned with Rosen in 1955-1956. Rosen (1953, 1962) developed what would be described (at the suggestion of Federn) as the "method of direct psychoanalysis" for the treatment of psychotic states. Rosen's approach, as described in his papers, attempted to enter into the schizophrenic's delusional world and to speak directly to the schizophrenic's ego states of infancy and childhood. During that year, it became clear that Rosen himself was not that adequate a therapist—except for occasional impressive single sessions, in front of an audience, that may or may not have been of long-lasting benefit to the patient—but his early ideas were helpful when used and modified by three psychologists in training, Firestone (1957, 1984, 1988), Rosberg (Rosberg & Stunden, 1989, 1990), and Karon. Since the patients were all chronic and had previously been treated at the most prestigious and expensive hospitals in the United States without significant improvement, anything that worked was taken seriously. Frequent

intensive discussions of the meaning and technique and collaborative work led to a series of early papers (Karon, 1958; Karon & Rosberg, 1958a, 1958b; Rosberg & Karon, 1958,1959).

Tomkins recommended the work of Fairbairn (1954), which was obviously relevant, and that theorist influenced the subsequent development of this approach. Bettelheim's views (1955, 1956) were also helpful. Analysts and non-analysts alike usually describe schizophrenics as people who do not sound like anyone on the ward. But Bettelheim described them as ordinary people (children), albeit in deep trouble, and they seemed just like the people one saw on the ward. He was the first to say that every psychotic break is preceded or accompanied by a conscious and overwhelming fear of dying, adding that he had never seen anything in a schizophrenic adult or child that he had not seen normal people do in a concentration camp—that is, normal people subjected to continuous massive terror.

Karon first saw acute schizophrenic reactions as senior clinical psychologist at a reformatory for male adolescents in the late 1950s, and he was startled by how readily the inmates responded to this approach. After continuing to work with schizophrenics during a postdoctoral fellowship at a well-known psychiatric hospital (where he became disillusioned with the kinds of treatments that so-called psychoanalysts provided psychotic patients) and in private practice, Karon felt that systematic research was

clearly needed to demonstrate how powerful psychotherapy can be with this population.

After moving to Michigan State University, Karon undertook a research project (funded by the National Institute of Mental Health) at Detroit Psychiatric Institute and Michigan State University, working with center-city Detroit schizophrenics who were predominantly of lower socioeconomic class and poorly educated; 85% of them were black. Psychoanalytic psychotherapy was found to be more helpful than medication (as described below), an outcome that contrasts with many of the stereotypes about the kinds of patients who can benefit from psychodynamic therapy. The truth is that no patient is capable of benefiting from psychoanalytic psychotherapy if it is never made available.

During and after the Michigan State Psychotherapy Research Project, Karon continued his psychoanalytic training with Richard and Editha Sterba and psychoanalysts in Detroit trained by or influenced by the Sterbas.

Teixeira (1984) studied with Karon at Michigan State University, worked with in-patient and out-patient psychotics at a community mental health center, and then, applying this approach, developed and evaluated a psychoanalytic day treatment program for another community mental health center. Despite clear evidence of its effectiveness (Teixeira, 1982a), the

program was terminated after 18 months, supposedly because "psychoanalytic treatment makes psychotic patients worse"—that is, for political reasons that ignored the empirical findings—as unfortunately is so often the case (Gunderson & Mosher, 1975).

INCLUSION/EXCLUSION CRITERIA

Schizophrenics are a widely varied group of human beings. What they have in common are their drastic adjustment techniques. Insofar as they have anything else in common, they can be characterized by Bleuler's (1911/1950) primary symptoms: autism (withdrawal from people), the thought disorder (an inability to think logically when they want to), and an apparent absence of affect, or inappropriate affect. Bleuler's description of the affect as absent or inappropriate was mistaken. Massive chronic terror blanches out lesser affects and gives the impression of affective flatness. Some patients are not willing to communicate honestly, or even capable of thinking of the affect as fear, since fear is present for them all the time. Further, inappropriate affect may be inappropriate only in the eyes of an external observer.

Schizophrenic individuals may also hallucinate, have delusions or catatonic stupor, and show a wide variety of other symptoms that, although Bleuler called them secondary, are notable for the severity with which they impair the schizophrenic's life. All of these may be understood as attempts to

deal with chronic terror. (Anxiety seems too mild a term.) Human beings do not tolerate chronic terror well.

A therapist can use *DSM-IV* (APA, 1994) criteria to make sure his or her patients are similar to those other researchers and clinicians refer to as schizophrenic, but *DSM-IV* criteria are arbitrary and make distinctions that are not clinically relevant and statements about these patients that are not true. For example, almost all psychoanalytic psychotherapists of any theoretical school emphasize the role of anxiety, terror, panic, or specific anxieties, and all the so-called antipsychotic medications are known to greatly blunt the affect system and anxiety. (This is why they were originally termed major tranquilizers.) But anxiety in schizophrenic patients is not mentioned at all in *DSM-IV.*

At the reformatory for male adolescents, Karon instituted five daily sessions of psychotherapy followed by once-a-week psychotherapy without medication for all apparently schizophrenic inmates. During a six-month period, no patients functioned on a psychotic level after the first week of treatment. (Patients were seen usually within 24 hours of their psychotic break.) Before psychotherapy was available and after it was no longer available, one or two schizophrenic patients were transferred each month to the state hospital and treated with medication; at this time, before the politics underlying deinstitutionalization had been set in motion, the typical hospital

stay was two years. All these patients came from the same reformatory population, but *DSM-IV* makes it seem an irrelevant comparison contrasting those with access to psychotherapy and those with no such access. The adequately treated (psychotherapeutically) acute patients would be diagnosed with brief psychotic disorder, and the inadequately treated (medication) acute patients would be diagnosed with schizophrenia, when the only real difference between them was the adequacy of treatment, not the severity of the disorder. Irrespective of treatment, patients with the same symptoms are classified by *DSM-IV* as suffering from brief psychotic disorder, schizophreniform disorder, or schizophrenia solely on the basis of how long they stay sick, obscuring the fact that inadequate treatments may lead to avoidable chronicity.

The existence in *DSM-III-R* of the category "schizophrenia in remission," to be used "when a person with a history of Schizophrenia is free of all signs of the disturbance," implied that no schizophrenic ever truly recovered (and pessimistically biased statistical compilations of outcome data by researchers who used records but did not directly examine the patients). Fortunately, this category was eliminated for *DSM-IV,* but added was the statement that "complete remission (i.e., a return to full premorbid functioning) is probably not common in this disorder" (APA, 1994, p. 282). Every existing long-term follow-up study, however, shows that approximately 30% of schizophrenics eventually fully recover, that this recovery rate is not a function of modern

treatment (Ciompi, 1980), and that using *DSM-III* diagnoses (which are very similar to DSM-IV for schizophrenics), as opposed to *DSM-1I* (which is similar to earlier diagnostic categories), makes no difference in long-term (25-year) prognosis (Harding, 1988; Harding, Zubin, & Strauss, 1987).

Since we see a continuity between schizophrenics and other human beings, and since the psychoanalytic therapy of every patient is uniquely related to his or her current needs and conflicts, it is not at all troubling, except for research purposes, if psychotherapists treat paranoid, schizo-affective, manic-depressive, borderline, or severe neurotics. On the other hand, we would like to exclude true brain-damage syndromes, such as are produced by lead poisoning, bacterial and viral infections, chronic alcohol or drug use (particularly if liver damage has occurred), cerebral embolisms, tumors, or brain damage resulting from previous psychiatric treatment, including not only psychosurgery but electroconvulsive therapy (ECT).

Unfortunately, the evidence that antipsychotic medication produces brain damage is becoming more and more alarming; not only does tardive dyskinesia occur in 30% of patients on chronic medication for 5 years or more, and more than 50% of patients after 15 years (Glazer, Morgenstern, & Doucette, 1993), but recent studies of monozygotic twins discordant for schizophrenia reveal diffuse brain damage apparently accounted for by lifetime medication exposure (Suddath, Christison, Torrey, Casanova, &

Weinberger, 1990). This is denied in Suddath et al.'s article summary (since the obtained correlation coefficients as high as .50 reach only the .06 level of statistical significance, owing to the small number of cases) but is clearly revealed in their data. The Michigan psychotherapy study (Karon & VandenBos, 1981), which required examinations of all patients by neurologists and internists, nonetheless found that approximately 10% of those schizophrenics suffered from brain damage that was not discovered until after psychotherapy was initiated.

In the Michigan project (Karon & VandenBos, 1981), the clinical staff of the hospital had to diagnose the patient as clearly schizophrenic on the basis of intake interviews, social history, and ward functioning, supplemented if necessary by psychological testing; the ward chief had to diagnose the patient as clearly schizophrenic on review; and hospital internists and neurologists had to examine and clear the patient of organic pathology that might account for symptoms. A research psychologist reviewed all the materials and had to agree that the patient was clearly schizophrenic before the patient was randomly assigned to treatment. We took the simplest way to get clearly schizophrenic patients for the project: we selected the most severely ill in the hospital. However, we do not see a sharp line between schizophrenics and the rest of the human race.

DYNAMIC ISSUES IN SCHIZOPHRENIA

Schizophrenics are, as we said, a widely varying group of human beings who use drastic adaptation techniques to cope with massive terror. All of their symptoms may be understood as manifestations of the terror or as defenses against it. Schizophrenics must be treated as individually as any other patient, and everything the therapist knows about the human condition in all its variety is relevant.

Psychoanalytic writers have talked about conflict and deficit theories as if they were alternatives, but both are involved in the treatment of schizophrenia. Anything that makes life tougher is going to increase the probability of schizophrenia. The book *Psychotherapy of Schizophrenia: The Treatment of Choice* (Karon & VandenBos, 1981) has a chapter on dealing with economically poor people, suicidal problems, homicidal problems, alcoholism, drugs, racism and sexism, sleep problems, eating problems, and criminal activity. The editor wanted that chapter removed because "it did not deal with schizophrenics." The editor was right in that the book's advice would be equally helpful in treating any patient, schizophrenic or not, who had these problems, but the editor was wrong in that any therapist who is unwilling or unable to deal with these problems will fail with schizophrenics.

Most professionals continue to believe that the genetic basis of schizophrenia has been demonstrated. The Danish adoption studies (Rosenthal & Kety, 1968) are widely cited as the strongest evidence for the

genetic transmission of schizophrenia, despite gross errors and distortions of the data. The scientific flaws in these studies have been well documented (Lidz & Blatt, 1983; Lidz, Blatt, & Cook, 1981; Lewontin, Rose, & Kamin, 1984). Thus, Kety, Rosenthal, Wender, and Schulsinger (1968) reported that biological relatives of adopted schizophrenics have higher rates of schizophrenia than do normals, but adoptive relatives do not. However, in their data the increase in schizophrenia occurs largely in half-siblings, who are more likely to be schizophrenic than full siblings or parents. There is no genetic model consistent with those data.

Remove the half-siblings and the increase in schizophrenia is not statistically significant. In the Wender et al. (1971) study, adoptive parents whose children became schizophrenic were themselves more often hospitalized with psychiatric disorders, but that fact was not reported. Margaret Singer (Wynne, Singer, & Toohey, 1976), using her "communication deviance" measure, blindly differentiated adoptive parents of schizophrenics from adoptive parents whose children did not become schizophrenic, with no errors, from the Rorschachs gathered in that study. But Wender et al. (1977) did not report that finding, instead publishing what their research assistants found when misusing Singer's measure (i.e., when the measure was inaccurately scored, it did not differentiate parents of schizophrenics from parents of normals).

In the best adoption study to date (Tienari, 1992), Tienari and his coworkers in Finland carefully examined adoptive and biological parents and found that the best single predictor of whether an adopted individual would become schizophrenic was communication deviance measured from the interaction of the adoptive parents without the child present (so communication deviance is not a reaction to a disturbed child). Whether the biological parent was schizophrenic was not enough to predict whether the child would become schizophrenic, but parental schizophrenia did interact with parenting problems other than communication deviance, apparently making the child more vulnerable. The second-best predictor of schizophrenia was the interaction between adoptive parent-child conflict and whether the biological parent was schizophrenic (accounting for about half as much variance); the third-best predictor was the interaction between lack of empathy (of the adoptive parents) and whether the biological parent was schizophrenic (accounting for about half as much variance as the previous factor). Even this adoption study has a flaw: adoptions of children as old as four were included (in order to make the study parallel to the Danish studies). The data, however, are certainly far more scientifically accurate than any hitherto available.

These interactions (increased vulnerabilities) may represent genetic factors or very early environmental factors or even in utero maternal stress. Huttunen and Niskanen (1978) report data indicating that maternal stress

(death of husband) during pregnancy leads to a higher rate of schizophrenia than the same stress during the first year of the infant's life. Since circulating catecholamines pass through the placenta, this may be the mechanism of sensitization. Physiologically and clinically, schizophrenics manifest a chronic terror, and maternal stress could possibly lead to a vulnerability in the infant that would seem to be genetic in adoption studies.

In every case of schizophrenia we have ever treated, the patient's life history, from a subjective point of view, was so awful that the symptoms seemed inevitable. It may be true that the same patients were seen for years by professionals who did not want to know and that therefore the traumatic life history did not appear in the professional records. Thus, the voluminous records of 10 years of hospitalization of one patient revealed nothing more traumatic than that his family was poor and his father was an alcoholic. But therapy revealed that his mother would wrap a cloth around his neck and choke him for minor offenses, his father had anally raped him at the age of eight, and his priest had seduced him homosexually when he was an altar boy. This is simply one dramatic example of the fact that the lives of schizophrenics are not ordinary.

There is no single way into schizophrenia. All of us are capable of schizophrenic symptoms; the only differences among us are what kinds of stress, of what severity, would precipitate schizophrenic symptoms, and

which symptoms we would develop. The worse one's early life, the less current stress it takes. Of course, it is the meaning of the stress that determines its severity. Some people can cope with physical pain but not abandonment, some people can cope with abandonment but not physical pain. Women who develop postpartum psychoses have been made vulnerable by their life history and the meanings, unconscious as well as conscious, they attach to the experience of childbirth (Rosberg & Karon, 1958). If they had not borne a child, they might never have become psychotic.

Anything that makes life tougher increases the rate of schizophrenia. Living in poverty increases the rate simply because life is so painful for the poor in our society (Hollingshead & Redlich, 1958). Groups that suffer from discrimination have higher rates (Karon, 1975). Growing up in the city, not "downward drift," accounts for the urban increase in schizophrenia (Lewis, David, Andreasson, & Allebeck, 1992). The course and prognosis of schizophrenia in Western industrialized societies is more severe than in less industrialized societies because of the lack of social and personal support for the troubled person (Sartorius, Jablensky, & Shapiro, 1978).

The schizophrenic is simply the end of a continuum of adjustment—the human being in a great deal of trouble. As Charles Brenner (personal communication, 1994) aptly said, "The difference between neurotic, borderline, and psychotic is sick, sicker, sickest. But the mechanisms are the

same." Everything we learn about the human condition and about psychotherapy is relevant to treating schizophrenics, and everything we learn about schizophrenics sheds light on the human condition in general.

For most people, the most important environmental influence is family. Unfortunately, discussing parental factors makes parents feel guilty; there is even a parents' organization (National Alliance for the Mentally 111) that is dedicated to lobbying politically to have schizophrenia declared a biological disease so that parents can cope better with their guilt feelings.

Guilt, however, is inappropriate. Parents of schizophrenics are not criminals, but victims. No one, including the experts, knows how to be an ideal parent. We do know some ways in which parents can be destructive, and some ways parents can be helpful. If the experts do not agree (see the child-rearing section of any bookstore), parents certainly cannot be expected to. Many instances of hurtful parenting consist of well-intentioned parents carrying out bad advice from professionals, and sometimes from friends or family members. There are always destructive experiences in the lives of schizophrenics, but they do not necessarily involve the parents. In most cases, however, experiences with parents (or the lack of experiences, i.e., deficit) have contributed to the vulnerability.

One frequent way parents are unknowingly hurtful is by discouraging

the pre-schizophrenic from using people outside the immediate family as sources of information and corrective identifications. No one has ever had perfect parents, and normal development involves the use (including corrective identifications) of adults and peers outside the family to correct warps in the family. When this normal corrective process is interfered with, any problem in the family is greatly magnified. Parents have no idea that such interferences are hurtful; in the short run, intrafamilial conflicts are avoided.

A series of studies show that parents of schizophrenics, both natural and adoptive, manifest "communication deviance," which can be measured from observations of interaction, from the Rorschach, or from the Thematic Apperception Test (TAT). It can be roughly described as a tendency to keep communications unclear. It has been reported by clinicians that such important distinctions as those between parent and child and between male and female, and what those distinctions mean, as well as to whom particular thoughts, feelings, or needs belong, are often blurred in the families of schizophrenics. The most important study using communication deviance is, of course, the Tienari adoption study.

"Expressed emotionality" (a misnomer used in family research and clinical observations for intrusive hostility) also has been found to be hurtful to schizophrenic offspring (Leff & Vaughn, 1985).

The most general characterization of hurtful parental pressures, encompassing communication deviance and intrusive hostility, is "pathogenesis" (Karon & Widener, 1994; Meyer & Karon, 1967; Mitchell, 1968, 1969), measurable from the TAT. Pathogenesis refers to a tendency, when our needs conflict with those of someone who depends on us, to act on our own needs without being aware of the conflict. Pathogenesis may be understood as an unconscious defense against anxiety that all of us use but that parents of schizophrenics tend to use more often than others. Although pathogenic parenting, or deficit in parenting, can be observed, it is often subtle or not noticed, and the specific behaviors differ widely from family to family. Nonetheless, pathogenesis is pervasive and damaging psychologically to the emotional, cognitive, and social development of the child. Consciously, however, the mother (or father) seems caring, not only to others but to themselves as well.

Schizophrenic pathology is not the result of isolated traumatic experiences but a pattern of pressures that continues throughout childhood in somewhat changing form (e.g., Karon, 1960). Our psychological lives may be described in terms of the fantasy structures that we form on the basis of experience and of previous fantasy structures. These fantasy structures were originally conscious experiences. We use the term "fantasy structures" rather than "fantasies" because fantasies seem ephemeral. Fantasy structures are organized and maintain their internal structure and their relationship to

other fantasy structures over time. They can be remembered, repressed, or modified, but they play an enduring role in the conscious and unconscious psychological life. In addition to externally observable reality, they contain elements that are not perceptible to an external observer: feelings, internal states, memories, wishes, speculations, and imagination that reflect the maturational stage and limited information of the child (and adult).

We interpret our experiences of the present on the basis of the fantasy structures—conscious and unconscious—we formed in the past. It is in the nature of a schizophrenic's fantasy structures and their relationship to each other that we see the effects of childhood experiences on that person. The basic problems that begin in infancy are strengthened rather than reduced by the continuing interactions between the pre-schizophrenic child and the parents, particularly the mother (the more important parent for most children in our society). It is a branching process, with the fantasy structures formed in early infancy influencing how subsequent events are experienced, leading in turn to the next set of fantasy structures.

The end effect of an unfortunate childhood is that the child feels worthless and unlovable. But to be literally unlovable means that mother will not love you, that she will abandon you, and to the infant, this possibility means pain and death. This is the infantile terror that lurks behind the schizophrenic symptoms. The schizophrenic individual's whole life is

organized around the need to defend psychologically against this danger.

The child attempts to deny the "bad" mother, but this defense is self-defeating. Despite this denial, the child still feels rejected and the more "ideal" the rejecting mother, the more unlovable the child must be. The child tries to find something wrong with himself or herself to explain the feelings of rejection. But, when the child changes whatever he or she thinks is wrong, the rejection remains. The only solution is never to change, or to attempt to change in some way that is unchangeable. Either of these maneuvers allows the child to maintain the reassuring belief that if he or she did change, everything would be all right (and therefore that the mother does love her child, except for this unfortunate circumstance). The child also looks around for a second "mother" who can provide what the original mother did not—father, siblings, others—but the schizophrenic symptoms are evidence that the schizophrenic never succeeds in finding a "good" mother in these other persons. Rather, the schizophrenic usually finds new versions of the old problems. Typically, schizophrenics and pre-schizophrenics try all of these defenses frantically and unsuccessfully.

The problems of the schizophrenic are basically oral in the sense that they were first manifested in the relationship between mother and child in the early oral or infantile period. But the same psychological battles are fought successively on the oral, anal, and genital battlegrounds. When a

patient's life situation, as given meaning by conscious and unconscious fantasy structures, gives rise to a terror against which he or she cannot defend except by gross distortions of reality, hallucinations, paranoid delusions, becoming mute, and so forth, we call that person blatantly psychotic.

Two common misconceptions about schizophrenics are:

1. There are no repressions and hence no unconscious. But the unconscious of schizophrenics is not conscious; as compared with normals, they have a consciousness that is dominated by the unconscious, the way the manifest content of a dream is dominated by the unconscious but is not the raw unconscious itself.

2. There is no transference. In fact, much of the psychopathology of schizophrenia is nothing but transference to the world at large.

Catatonic stupor was first reported by Fromm-Reichmann (1939/ 1947) as including a conscious fear of dying "if I move." Experimental data from animal studies (Ratner, Karon, VandenBos, & Denny, 1981) suggest that the catatonic stupor is an evolutionarily adaptive terror state that occurs in almost all animals as the last stage when faced with death. When they become prey for hungry predators, both individuals and the species increase their survival chances by using this defense mechanism.

Hallucinations, according to our view, are nothing but wide-awake dreams, caused by intense motives, and understandable through using the same psychoanalytic principles that are applied to sleeping dreams, except

that while hallucinations may occur in any sensory modality, auditory hallucinations ("voices") are almost always present, because schizophrenia is an interpersonal disorder.

Withdrawal from others, or autism, one of Bleuler's primary symptoms, is clearly a defense against the anxiety engendered by interpersonal encounters, but isolation has also been shown to be related to increased hallucinations (Lapidus & Schmolling, 1975). And, of course, it prevents the growth processes that depend on our interactions with others, including corrective identifications.

In our experience, four principles account for most delusions (Karon, 1989a):

1. Transference to the world at large.

2. Defenses against pseudo-homosexual anxiety, as described by Freud (1911/1958), among them, projection, reaction formation, and displacement.

3. Being taught by family members peculiar concepts or meanings to words, which the patient then erroneously believes the rest of the world shares.

4. An individual's need to make sense out of his or her world and experiences, even if actual life experiences and symptomatic perceptions are bizarre and therefore require unusual explanations.

TREATMENT GOALS

The goals of treatment with schizophrenics are the goals of

psychoanalytic therapy with anyone, namely, to live a more fully human life. Freud is usually quoted as saying, *"Lieben und arbeiten"* (to be able to love and to work). According to Richard Sterba (personal communication, 1986), Freud usually added, "... and to be able to enjoy." It may require more work to achieve a given level of functioning with a schizophrenic, but the aim is to reach as high a level of functioning as possible in the time available. No course of analytic treatment is complete, just as no life history is complete, and there is no such thing as perfect functioning. Therapy, if successful, continues for the rest of the patient's life, albeit without an external therapist. (The treatment is conceptualized as primarily initiated by the therapist in most cases of psychosis, inasmuch as many patients feel that they could not survive without their symptoms and have no hope that better functioning is possible. This attitude changes as the therapeutic alliance is established to the point where both therapist and patient are equally involved, to where the patient is doing most of the work, and finally, at termination, the patient can continue to grow on his or her own.)

The criteria used by the raters and the interviewer in the Michigan State psychotherapy project may be used to give specificity to these goals:

1. *Ability to take care of one's self.* If we cannot take care of our own needs in fundamental ways—food, clothing, shelter, personal hygiene, personal safety—then we must be cared for. We directly take care of ourselves as far as possible, but all of us depend on others to help satisfy our needs, and we know and are capable of doing what is necessary to get others to help, whether by hiring, by friendship, or by personal relationship. If we cannot, then the only alternative is an institution—mental hospital,

board and care home, nursing home, or jail.

2. *Ability to work.* In our society, almost everyone works. A central part of our identity, work provides independence and enables us to take care of ourselves and, often, our families. In our society, 90% of married women, even with children and a working husband, need to work for economic reasons. Finishing school or getting a better education is an important preparatory goal and a temporary alternative (or supplement) to working. For some mothers with young children and others without support, being able to obtain welfare benefits to provide for their children (or themselves) is an important goal, and learning how to cope with the public agencies that administer the welfare, social security, or VA benefits to which they are entitled becomes an important issue, even if welfare is viewed as a safety net, not a permanent goal.

3. *Social adjustment.* We all need friends of both sexes and social relationships to make life worth living. The quality of our relationships with other human beings is perhaps the central issue in all psychotherapy, and particularly with schizophrenics.

4. *Sexual adjustment.* "Sexual adjustment" includes sexual satisfaction, the ability to love, and the ability to form an enduring relationship. The therapist should be willing to help with any sexual problems that exist and should help the patient deal with guilt over masturbation if he or she is not in a relationship. The therapist should not take a moralistic stance about the issue of heterosexual or homosexual relationships but should deal with fantasies as fantasies (and not actions) and evaluate relationships on the basis of their health for each of the partners. The therapist must not be committed to the patient being either heterosexual or homosexual but must let the patient follow his or her own path. However, most patients choose to be heterosexual unless (rarely) they have had a benign and gratifying homosexual relationship. Of course, all patients need to be instructed about birth control, avoiding unwanted pregnancies, and the realistic prevention of sexually transmitted diseases. They need both realistic advice and psychotherapeutic exploration of the fantasies and defenses that prevent them from making use of realistic information.

5. *Absence of hallucinations and delusions.* Obviously, these psychotic symptoms need to be resolved. Typically, the patient believes the hallucinations are reality and then, in therapy, begins to doubt them, to see them as possibly not real. Eventually, the patient understands them as waking dreams. The voices start as external reality, move to being an intermediate experience the patient uses for personal insight, and eventually become simply part of his or her thoughts.

6. *Becoming freer from anxiety and depression.* These unpleasant affects underlie most psychopathology, and improvement means living with less anxiety, less depression, and fewer incapacitating defenses against anxiety and depression.

7. *Amount of affect.* A person who cannot feel is only half alive. One defense against anger, terror, shame, and depression may be simply not to feel, but that is a very high price to pay. (Lobotomy, shock treatments, and even medications all lead to a diminution of the ability to feel.)

8. *Variety and spontaneity of affect.* The healthy affective life is varied and spontaneous. Affective reactions are a necessary part of logical and rational thinking, part of the evaluation of our own ongoing experience, as well as what makes life worth living.

9. *Satisfaction with life and self.* Patients need to like the kind of person they are and are becoming, and the life they are leading, with the bad parts in the past and the present making sense as, at worst, unavoidable evils and, at best, as learning experiences.

10. *Achievement of capabilities.* This treatment does not aim toward improvement by encapsulation or by giving up potentialities. Realistic goals are substituted for unrealistic fantasies. Therapists can sometimes help patients find realistic paths to what patients want but may falsely believe to be unrealistic. The therapist makes possible the patient's discovery even of what the therapist does not know. As patients get healthier, they frequently surprise us with their achievements.

11. *Benign versus malignant effect on others.* Psychopathic, exploitative, and hurtful, sometimes criminal relations with others do not represent health and are subjects for therapeutic exploration. Often these behaviors result from environments or families in which exploiter and victim are the only two roles available. The patient must be helped to develop healthier relationships. In particular the patient's destructive relationships with children, spouses and lovers, and other vulnerable people need to be worked on therapeutically, and the patient needs help in creating an interpersonal world of nonhurtful relationships.

To these criteria might be added:

12. *The ability to think realistically when one wants to*—in other words, the absence of the thought disorder. The Michigan project found that the thought disorder was the aspect of functioning in which psychoanalytic therapy most clearly produced earlier (Karon & O'Grady, 1969) and greater improvement than medication (Karon & VandenBos, 1981). Indeed, other investigators have reported with concern the limited effectiveness of neuroleptic medication in changing the thought disorder (e.g., Spohn, Coyne, Larson, Mittleman, Spray, & Hayes, 1986). The thought disorder is best

measured by tests like the Feldman-Drasgow Visual-Verbal Test, the Whitaker Index of Schizophrenic Thinking, the Porteus Mazes, the Thought Disorder Index, and a full Wechsler Intelligence Scale. In the Michigan project, the Feldman-Drasgow Visual-Verbal Test (which is not correlated with IQ within the normal range [Feldman & Drasgow, 1951]) best predicted long-term functioning and the ability to avoid hospitalization (Karon & O'Grady, 1970; Karon & VandenBos, 1974; Karon & VandenBos, 1981). The ability to think realistically seems to have an increasingly important effect on one's life as time goes by.

Of course, the change in the thought disorder with psychoanalytic therapy is not an isolated specific symptom change but correlates with changes in overall functioning. Both the unique predictive validity of the thought disorder and its correlation with other aspects of functioning are consistent with traditional views of schizophrenia (Bleuler, 1911/1950), and with other empirical data (e.g., Cancro, 1968,1969a, 1969b; Harrow & Marengo, 1986).

THEORY OF CHANGE

The first task of the therapist is to create a therapeutic alliance, that is, to form an alliance with the healthy part of the patient. With neurotic patients this task is easy; with schizophrenic patients it may be the center of the work for a long time.

One of the great mistakes in the literature is the discussion of insight therapy and relationship therapy as if they were alternatives. In fact, insight is only tolerable and attainable within the security of a warm, strong,

dependable, and safe relationship with the therapist. As Fairbairn (1954) said, people only get sick in relationships and therefore can only get better within a relationship.

Schizophrenics are withdrawn and autistic in their interpersonal relationships, but they are also dependent and very enmeshed psychologically in dyadic relationships.

The first function of the therapeutic relationship is to provide sufficient protection and gratification to overcome the *conscious* resistance of the patient. The patient is threatened by the possibility that the therapist will take away the psychotic symptoms (which are the best psychodynamic solutions the patient is capable of before treatment). This threat stirs up intolerable terror, mitigated only by the protection the therapist also provides. This protection is worth some cooperation, from the patient's standpoint.

Patients' search for a new "mother" continues in their illness; they are therefore susceptible to entering a relationship with the therapist. Of course, since this is a transference relationship, schizophrenics will eventually see in it the malevolent characteristics of their past relationships.

The transference relationship has two further functions in the psychotherapy of schizophrenia. The second function is to permit insight, as

in the analysis of neurotics. The patients relive feelings and experiences from the past, particularly those concerning their parents, with no awareness that they are from the past. The more severely disturbed the patient, the more obvious the transference reactions. Understanding the transference with psychotics is central. Contrary to Freud's mistaken notion that schizophrenic patients do not form a transference (e.g., 1917/1961, 1963, p. 447), much of the psychopathology of schizophrenia can be understood as transference to the world at large (Karon, 1963; Karon & VandenBos, 1981; Karon, 1992).

The third function of the transference is to transform the internalized fantasy structures based on the relationships with the parents by the internalization of the therapist. This process may be conceptualized as (1) internalizing the therapist as a more benign superego than the existing one based on the punitive part of the parents; (2) internalizing the therapist as a part of the ego, as a model of how one can be, much as the adolescent internalizes alternative objects (people) as models, eventually keeping what is useful and getting rid of what is not useful; and (3) internalizing the relationship with the therapist as a model for what a relationship with another human being might be like.

The role of insight in treating the schizophrenic is the same as in any psychoanalytic therapy. In classical terms, insight makes the unconscious conscious, changes the defenses in part by awareness, and makes the

connection between the past and the present. However, the role of insight and understanding as human adaptive functions is generally underappreciated because it is so obvious and ubiquitous in normal functioning. Nonetheless, it plays a central role in delusion formation as well as in healthy concept formation. The strong, benign, acceptant therapist who is willing to look at the world through the patient's eyes discovers with the patient when the delusions are inconsistent or ineffective and can then help the patient with knowledge both of outer reality and of psychodynamics to arrive at healthier and more effective thinking.

Central to the change process is the reduction of anxiety (terror). Every therapeutic interaction is aimed at the reduction of the terror to manageable proportions. Behind the inaccurate thinking (thought disorder), distorted perceptions, hallucinations, withdrawal, and inappropriate reactions to other people always lies the terror. As the terror is diminished, the other symptoms diminish as well. Other affects—rage, dependency, even love—may evoke terror. The patient must be helped to understand that affect is not the enemy, but a necessary part of being alive. There is no such thing as an irrational affect. If the patient is scared, there is something to be scared of. If the patient is angry, there is something hurting him or her. If the cause is not conscious, then something unconscious is the cause, and it needs to be discovered. If the cause is not in the present, then it is in the past and something in the present symbolizes it. There is always an adequate cause for every emotion.

Flat emotion is usually a chronic terror state, blanching out other affects and sometimes, by its chronicity, not being labeled by the patient as terror; more often, the absence of affect is in the eye of the beholder rather than in the awareness of the patient. Some of the physiological mechanisms of anxiety arousal may attenuate in response to chronic high-level activation or to psychotropic medication, but the terror syndrome may nonetheless persist (Teixeira, 1982b).

Sequences of actions are often symptoms. Such symbolic (or symptomatic) actions are attempts to resolve unconscious conflicts or traumas from the past. But symptomatic acts, no matter how often repeated, do not resolve the conflict, undo the trauma, or reduce vulnerability. Only when the relationship between the symbolic act (or symptom) and the original traumatic experience is reconnected in consciousness can the person really overcome it.

TECHNIQUES

The most important thing for a therapist to remember is that every symptom of schizophrenia is meaningful and embedded in the life history of the patient. There is a difference between meaninglessness and obscure meaning. Schizophrenics do not understand their symptoms, and they are often geniuses at not communicating clearly what they do understand. They

do not even tell us that we are helping them, because they are afraid it will be used against them. Therapists who have worked only with neurotics are not prepared for working a long time without direct feedback from the patient. It is very frustrating.

In a hospital where the myth that schizophrenic patients cannot be helped is believed, a therapist can be helpful and not know it, then go away assuming that the work was of no value. Very often, a therapist learns from the family that the work helped the patient, or if the patient is in the hospital, the ward staff may report changes in the patient's behavior. (Sometimes the therapist has to educate family or ward staff as to which changes are healthy, not pathological.) Otherwise, therapists have to rely on past experience or their supervisors to sustain therapeutic effort with little or no feedback from patients. Even though the therapist will frequently be mistaken (because the patient is not communicating clearly), if he or she works long enough, the patient will usually get better.

Sometimes the therapist knows the patient is being helped from the nature of the patient's complaints. One patient complains, "You haven't helped me because I really don't like the guy I'm sleeping with, and I really don't enjoy sex very much." These complaints, which should be taken seriously, nonetheless indicate progress. When the patient started treatment, she felt that no man would want her. She also felt that if she dated a man and

said no to sex, he would kill her, and that if she did go to bed with him, the sex would kill her. Her present problems indicate that she has made enormous progress.

Obviously, the therapist must be able to tolerate being confused. A need for certainty, often masquerading as theoretical sophistication, is a good formula for bad therapy. If the therapist cannot tolerate being confused, he or she will not be able to tolerate the schizophrenic patient or the patient's confusion. Such tolerance does not mean that the therapist lives in an unreal world or is uncertain about reality, but rather that he or she is always willing to ask questions, think through problems, and live with areas of uncertainty. The patients know they have not told you everything and that they do not understand much of what they have told you. Typically, they have been raised to pretend to certainty when there is no basis for it, and they have had parents and other authority figures in their lives who pretended to certainty about matters that were uncertain or even untrue. A therapist who can tolerate uncertainty is a good model for the patient. It is useful to tell patients when they complain that therapy is making them confused, "Good. You are not sick because you are confused. You are sick because you are certain of things which may not be true."

Typically, the distortions of schizophrenic individuals are attempts to deal with their problems symbolically: the contents of the unconscious are

expressed, and yet the individual is preserved from the awareness of what is being expressed. Schizophrenic persons are constantly trying to solve their problems, but they are too frightened to deal with the problems directly; they repress the real problems and deal with the symbols. This affords them a measure of relief, but they cannot solve their problems on a symbolic level. It is only after the specific unconscious problems have been made conscious that the patient is capable of seeing that a healthier resolution is possible.

As we have emphasized, human beings carry their childhood with them in their unconscious, and all neurotic and psychotic symptoms are attempts to solve lifelong problems that began in childhood and carried forward in ever-evolving fantasy structures about the world, the self, and others. A person's symptoms are always the best of a bad bargain, the best coping mechanisms available to him or her at the pretreatment stage.

One of the current misconceptions, even among sophisticated therapists, about the nature of schizophrenia is that the repressions are undone and the schizophrenic is aware of his unconscious. In our understanding, no one is more afraid of the contents of the unconscious than schizophrenic patients. The repressions are strong but brittle. Under stress, the unconscious may break through and then be repressed again. The bizarre language and thoughts often appear as a compromise formation, a partial repression—a displacement and condensation similar to a dream—rather

than total repression. Part of the reason for the notion that the repressions are undone in schizophrenia lies in the fact that certain impulses and ideas that are repressed in normal individuals become conscious in the schizophrenic. This material, which is often treated as "deep" in the analysis of neurotic patients, represents for schizophrenic patients nothing but another set of defenses against awareness of their real problems. Thus, Oedipal fantasies may be conscious, but the classic Oedipus complex does not have the significance for these patients originally ascribed to it by Freud. Instead, it serves as a defense against deeper and more frightening problems (Rosberg & Karon, 1958).

Of course, with all patients unconscious resistances are nothing more than the patient's usual defense mechanisms being used in the therapeutic hour. The resistances of the neurotic are primarily unconscious, but those of schizophrenics are conscious as well. Schizophrenic patients often feel that they will die without their psychotic adaptations. Therefore, they consciously do not cooperate. After all, why should they die for you?

A straightforward statement that "I will not let anyone kill you" is usually surprisingly helpful. Such a reassurance made early in therapy, even in the first session, helps to create a positive transference and is often useful later in the process in resolving impasses. The schizophrenic patient is always struggling with the fear of death and is relieved by such an attuned

interpretation. It may be argued that the reassurance is magical, but the real danger for most patients is from the internalized past or its reenactment in reality, and only a therapist can realistically protect them from such dangers.

The suicide rate among schizophrenics has been found to be 10-13%, which is at least as high as among depressives. Between 20% and 40% of schizophrenics attempt suicide. They are usually in despair. Consciously or unconsciously, suicidal patients are (1) trying to get even with someone else; or (2) projecting their conscience onto a possible rescuer, giving the "rescuer" a chance to decide (by intervening or not) whether they deserve to die, sometimes experienced as the hopeless cry, "Does anyone care if I survive?"; or (3) acting out a combination of compliance with an internalized parent whom they fantasied wanted them dead and escape from the same parent whom they fantasied wanted to hurt them. The therapist must provide hope within the psychotherapeutic relationship and deal with whichever of these factors are involved (or all of them, if the therapist does not know). The schizophrenic needs to know (1) that suicide is a surprisingly ineffective way to hurt parents, spouses, ex-lovers, ex-employers, and therapists; (2) that the therapist does not think he or she deserves to die; and (3) that he or she does not need to comply with a destructive parent, that living with therapy is a more effective escape from their pain than dying (Teixeira, 1984,1994).

With most schizophrenics the therapist can begin therapy by simply

asking, "What seems to be the trouble?" or, "How can I be helpful to you?" Most schizophrenic patients will begin to tell the therapist their problem, even many of those who are supposedly uncommunicative, incoherent, or lacking in insight. The aim is to find a problem that is also a problem from the patient's standpoint, that does not make sense to the patient, and that the therapist can help with. It does not have to be the patient's most important problem, but if the therapist is understanding and helpful about it, the patient is typically surprised, a therapeutic alliance begins to form, and the patient will communicate more central problems. (Of course, the patient may not realize that his or her most serious problems are symptoms, not facts of life, or that they can be helped.) The patient's problem is almost never a diagnosis (in the sense of *DSM-IV*); making a diagnosis solves only the insurance company's problem, the hospital's problem, and the therapist's record-keeping problem. Patients are well aware, whether they say so or not, that when therapists make a diagnosis (as opposed to finding out their problems in full phenomenological detail), they are not trying to solve the patients' problem but their own.

Typically, schizophrenic patients have felt deprived all their lives. It is important that the therapist do everything possible to be perceived as a giver, not a taker, and to be perceived as a nonpunisher and a nonpoisoner. The therapist must talk freely and try to be helpful on the verbal level. Even words may be experienced by the patient as a medium of exchange that can be given

and taken. The therapist must be seen as someone who does not demand but gives. There are many schizophrenic patients, however, to whom the therapist need only say, "All I have to offer you is understanding, but that is really a great deal."

The schizophrenic patient's knowledge of the world is usually more limited than that of the therapist for symptomatic, cultural, or even accidental reasons. The therapist who offers usable information becomes a helpful person in the patient's eyes. Of course, the patient may not be able to make use of the information and must be helped to understand that this incapacity is not a sin but a symptom, and that most of psychotherapy occurs when we know what to do but still cannot do it.

It is important, from the very first session, for the therapist to make clear to the patient that anything can be talked about: any thoughts, any feelings, any actions. Commonly, schizophrenic patients fear talking not merely because the therapist will disapprove of what they say but also because they fear that talking about a feeling, or even thinking it, means acting on it (e.g., getting angry means hitting someone) or that the thought or feeling itself is an action with immediate consequences in the external world. Again and again, the therapist must make the distinction between thoughts and actions: "It is all right to think or feel anything. The only things you have to control are your actions, because they are the only things that have

consequences in the outside world."

The only generally valid rule of interpretation, albeit imprecise, is that the therapist interprets what the patient can make use of at the time. Whether to interpret early or late, deep or shallow, defense or impulse, is always a clinical judgment that may be in error and may require constant revision. Sometimes a deep interpretation, even in the first sessions, will make sense out of experiences that otherwise overwhelm the patient; at other times, the same interpretation would be incomprehensible to the patient.

The second rule (following Freud) is that one interprets from the surface, in the sense of exhausting reality factors and realistic explanations first. Few patients are willing to consider psychodynamic interpretations until commonsense explanations are found wanting.

The third rule is that the therapist never does for a patient what the patient can do for him- or herself. But again, what patients can do for themselves is always a clinical judgment, subject to error. Obviously, this is true for self-care activities and interactions, but it is equally true for interpretations and insights. The patient's own insights are more effective than those derived directly from the therapist's interpretations. Further, a good interpretation is one that calls the patient's attention to something but that the patient can confirm from his or her own observations.

An important point of difference between our approach and many American psychoanalytic approaches (Gunderson & Mosher, 1975) is that we treat hallucinations like dreams; we use and interpret both in the same manner, using the associations of the patients supplemented by symbolic interpretations (which, of course, are not universal meanings but "good clinical guesses").

Schizophrenic hallucinations almost always involve voices, as well as other sensory modalities, because schizophrenia is an interpersonal disorder. One of the motives is often loneliness. It is always helpful for the therapist to attend to what is most important, and that involves understanding that the motives for hallucinating have to be stronger and more urgent than for dreams. Further, the hallucination, like the dream, acquires a second function for the patient in treatment. It is a communication between the patient's unconscious and the therapist: it is time for us to discuss this issue.

A terrifying hallucination or a recurrent nightmare becomes a symptom in its own right, and proper interpretive work relieves that symptom as the meanings are dealt with consciously.

It is important to help the patient discover that hallucinations are not real, that they do not represent real persons but are useful material from the unconscious. The patient at first will not accept such a view. When the patient

does accept it, the therapist has already undercut some of the function of the hallucinations, and the patient is already moving with the therapist toward health.

Patients may not tell therapists about their hallucinations for some time, because they do not trust therapists. Indeed, the hallucinations may even say, "Do not tell him about this," or give (wrong) interpretations in the therapist's voice.

In dealing with hallucinations, we attempt to get across to the patient our general view of psychotherapy, that the difficulties and symptoms are themselves the keys to solutions. It is the difference between learning from one's mistakes that everything is hopeless and one is bad or worthless and learning from the same mistakes something about what causes one to make those mistakes, what difficulties might continually arise and why, and consequently what might be done to change things. Eventually, the patient realizes that this is not merely a view of therapy but rather a general view of life, one that, unfortunately, our culture rarely teaches.

A persistent myth about schizophrenic delusions is that they are unchanging and unchangeable. Delusions are so different from the way most people think that to a superficial observer they seem unchanging. But rarely do delusions entirely fit reality; the patient is constantly repairing them. If an

interested and sympathetic therapist begins to consider them in detail, trying to follow their logic, the repair work can get frantic.

The therapist must be on the patient's side, fostering the therapeutic alliance by considering seriously the probability of what the patient relates, helping the patient to think clearly about the issues, and helping the patient to evaluate the evidence, remembering that just because something is improbable does not mean it is necessarily untrue, and even paranoids may be in actual danger of being killed.

The therapist should always ask for as much detail as possible, but in a kindly manner. Not only will details provide the material necessary for accurate interpretive work, but they will lead the patient to become aware of the inadequacies of his or her delusions as explanations and hence to become amenable to interpretation (i.e., to alternative explanation).

Therapeutically, it is often useful to tell the patient, "That is a brilliant explanation." The patient is usually startled that any professional would take his or her ideas seriously.

"You mean you think it is true."

If, as is usually the case, the therapist believes the patient can tolerate an explanation, the therapist might usefully say, "No, but that is because I

know some things about the human mind that you don't know yet, and I'll tell you if you're interested. But given what you do know, that is a brilliant explanation."

With such a nonhumiliating approach, it is often possible to get the most suspicious paranoid to consider what might be going on and the real meaning of delusions as an attempt to solve the terrifying dilemmas of his or her symptoms or life history.

Delusions based on transference can be interpreted, like all transferences. Delusions based on defenses against pseudo-homosexual anxiety can be dealt with by interpreting the fear that the patient's affectional hunger is homosexuality, dealing openly with and accepting his or her feelings of loneliness (rather than homosexuality), making it clear that we all need friends of both sexes, and, of course, reassuring the patient that all feelings and thoughts, including all sexual ones, are normal, and that if they are disturbing, they need to be understood. Sympathetic comments about the increasing acceptability of homosexual lifestyles are rarely reassuring to schizophrenics unless they have had a benign homosexual relationship.

And finally, delusions based on having been taught strange meanings of concepts in the family of origin can simply be pointed out when either the patient or the therapist becomes aware that the two of them are using the

same words with different meanings.

Most of this discussion has been directed to the specific differences in psychotherapy with schizophrenics. These differences are primarily necessary at the beginning of treatment, which gradually begins to follow the lines of the more familiar procedures of psychoanalytic psychotherapy with character disorders and neuroses, although as dynamic balances shift, some of these procedures may characterize short periods of the therapy even late in the process.

For adequate textbooks on therapeutic technique, we recommend Freud's *Introductory Lectures* (1917/1961,1963), *New Introductory Lectures* (1933/1964), and his papers on technique (*Therapy and Technique,* 1963), followed by Fromm-Reichmann's *Principles of Intensive Psychotherapy*

for basic analytic technique with neurotics and psychotics, Malan's *Individual Psychotherapy and the Science of Psychodynamics* (1979) for psychoanalytic psychotherapy and psychopathology, and Karon and VandenBos (1981) for work specifically with schizophrenics.

CASE EXAMPLES

The centrality of the conscious fear of death, the fear of annihilation, is well illustrated by the teenage female patient, diagnosed as hebephrenic on

intake for her second admission, who lapsed within 24 hours into a catatonic state that persisted for two weeks. She was chosen as the most unresponsive patient, in a biologically oriented hospital, to be interviewed for demonstration purposes; the psychiatric residents were curious (and skeptical) about psychodynamic treatment for schizophrenics. She was brought to her first interview, unmoving and mute.

Inasmuch as catatonics hear and see everything that is going on and are terrified, it is important for the therapist to do the talking and to address the terror directly, so as to begin to create a therapeutic alliance. The first session consisted of only the therapist (BK) speaking: "I won't let anyone kill you. I will protect you from anyone. I am on your side against your mother, your father, your sister, anyone. I will not let anyone kill you. But I will not let you stay crazy. There is no place in your insanity to hide. You can hear my voice, and the voices can't drown me out, or make me go away. But I won't hurt you, and I won't let anyone else hurt you. I can protect you against the voices. I won't let anybody kill you."

This motionless young woman got up and tried to leave. The therapist stopped her and continued his monologue. When the therapist was tired, after 30 minutes, the session was ended: "That's all for today." Of 12 psychiatrists who viewed the session through a one-way mirror, 10 delivered separate strong opinions that no patient should ever be interviewed in such a

manner and that the treatment was worthless. The next day, six of them apologized, because the catatonic young woman spontaneously approached the ward chief on rounds the next morning and asked, "May I please speak to the same doctor I saw yesterday?" After two weeks of daily therapy, the patient was discharged and continued on weekly outpatient therapy.

A 19-year-old was arrested and, in the local jail awaiting transfer, attempted suicide. He had been arrested five times previously. It later came to light that he was hallucinating, overtly (albeit uncomfortably) homosexual, alcoholic, and "experimenting" with codeine.

In the first session, he told the therapist (BK) that he had thought a psychologist might be able to help him, but that he had changed his mind.

> Patient: There's nothing you can do for me. I'm praying to God 15 times a day, and I don't need your help. I don't see why I need to talk to anyone else. So there's no point in talking to you.

> Therapist: As long as you're here, you might just as well talk to me anyway. It can't do any harm.

> Patient: What am I in for?

> Therapist: Don't you know?

> Patient: No.

The therapist checked his record and found that the patient had broken

parole by failing to report and by changing his address without notifying his parole officer. He denied it. "That's a lie. I didn't move. I was just walking. For five days I just kept walking. I didn't sleep. I didn't stop or stay anywhere. I was just walking."

When the therapist accepted his statement, he went on. He had been in jail several times. He talked about his previous crimes, mainly thievery. He said he was an alcoholic and had tried Alcoholics Anonymous on his last sentence, but it had not helped. He did not know why he had tried to commit suicide, but "it had just seemed right." The session continued a little longer. The therapist mentioned that it was all right for the patient to have any kind of thoughts, to think anything. After this was discussed for a while, the therapist suggested that the young man come back the next day.

On the second day, he told a little more about himself. He said that he had never felt safe without a gun in his pocket since he was 10 years old, and that he had a gun in his pocket when he was walking the streets before he was arrested this time. He was waiting for the "voices to tell him when to start shooting." He did not know when it would be, but he thought it would likely occur in a bus station. Anyway, the voices would know and would tell him.

He told about his girl. He met her while he was on parole. She had been going out with another parolee, a friend of his. The friend had "slapped her

around," and the patient had intervened. Then he began to go out with her. She induced him to "get a bunch of my friends together, all of us parolees, and beat up the other guy. Now he's got his friends, and the word is out to get me."

The patient was afraid to set foot in the city where his erstwhile friend lived. "They'll kill me. I know those guys, and they don't play games."

Meanwhile, he was having sexual relations with the girl regularly, but he heard that she was seeing the first boy again. When he heard this, he decided that "all my troubles were her fault. I could have gone back to jail, and all my friends too, if they [the police] found out about the fight. All on account of her. So I decided to kill her."

> Patient: I went to a drugstore to get some poison, but they wouldn't sell it to me. So I got an icepick, and I put it in my pocket, and I was going to go to her house and ring the doorbell. And when she answered it, put it right here. [He points to his Adam's apple.] When I got to her house, I rang the doorbell. She opened the door and instead of killing her, I was disgusting.
>
> Therapist: What do you mean?
>
> Patient: I was disgusting. I just did that same dirty old thing.
>
> Therapist: What do you mean?
>
> Patient: You know. I went to bed with her. If I was a man, I would have killed her. I was disgusting.
>
> He was told that he was not disgusting, that the therapist was glad he had not killed her (or anyone else) since, if he had, society would not let the therapist help

him. "But I don't think it was her you really wanted to kill. Wasn't there somebody else you wanted to kill?"

Patient: Who do you mean?

Therapist: Well, it was probably somebody female.

Patient: The other girl.

Therapist: What other girl?

Patient: The last time. The first girl I ever got into bed with. I took her out all the time, and we were going to be married, and then I got arrested. And when I got out of jail, she was married to someone else. I asked one of her friends if she loved him, and she said she'd learn to love him. That seems funny to me.

Therapist: And maybe you were angry at her for leaving you for another man, and when your new girl did the same thing, it was like living it over.

He agreed and said that it might have been the first girl whom he wanted to kill. The therapist then asked him to go back even further.

Therapist: But I think that's still not the whole story. I think there's somebody earlier. Somebody who also left you for another man. And it was easier to kill your girl than to face the idea that you want to kill her.

Patient: That's all there was. There ain't any girl before the first one. Just two of them, that's all.

Therapist: But the girl you really want to kill is your mother. Didn't you ever feel that she left you?

Patient: When the old man came back.

Therapist: Came back?

Patient: He used to take off and just leave her and the kids. He'd take up with some woman or just go off and leave her. And when he was gone, she'd tell me I was the man in the house.

Therapist: And you'd feel like you were married to her.

Patient: Yeah. And then he'd come back. And she'd always take him back.

Therapist: And you were a kid again.

Patient: Yeah. I was nothing when he was around.

Therapist: Then you must have wanted to kill her for that. That's reasonable enough. When first one girl and then the other left you, it was like your mother all over again. And it was your mother you wanted to kill.

The therapist and patient went on to discuss the idea that it was all right for him to want to kill somebody, how all of us want to kill someone when they hurt us, that, in the unconscious, anger is always the wish to kill someone, and that the thought and the feeling are all right.

It was in the third session that he asked about the dream.

Patient: What do you do to get rid of a nightmare?

Therapist: You tell it to me so that we can analyze it.

Patient: Well, I get this dream about once a week, since I was eight. I trip and fall, and then it's like nothing human. I fall, and I don't feel nothing and it's dark, and I get smaller and smaller until there's nothing.

His associations to "trip" and "fall" were the same: falling in the gutter like a drunk, taking codeine, falling down, doing something bad sexually (i.e., heterosexually), getting into trouble with the law, being a homosexual. To

"It's like nothing human," and, "I don't feel nothing," he associated insanity and death. To getting "smaller," he had no associations.

Guessing at the symbolism of getting smaller, the therapist interpreted the dream by pointing out that the patient's associations to tripping and falling were, in fact, all the ways he got into trouble—by getting drunk, taking codeine, getting into trouble with the law, doing something bad sexually, being a homosexual—all of these were his problems. Each was a way of "falling down." Similarly, he had tried to commit suicide and he was going insane, but the dream was a wish and therefore he wanted to fall down. Each of these ways of falling down had a purpose—getting smaller represented a wish to become a child again so he could get the love he wanted but never got from his mother. All of these ways of falling down were ways of proving to himself that he was bad, that his mother was right in not loving him, and that therefore, if he were good, she would have loved him and still might. "But you can't ever stop falling down, or you'll find out she doesn't love you at all, no matter what you do. When you were an infant, you might die if she didn't love you, and therefore you will do anything rather than face that fact."

Not only did the nightmare never recur, but a marked change in pathology occurred at that point. The next day's session began as follows: "Doc, this is crazy. Here I am in jail. I don't know how long I'm in for, at least a year. I'm in with a crew of gorillas. [He had been assigned to the cottage

reserved for the toughest inmates.] Yet I feel freer than I ever felt in my whole life. I'm happier and freer than I've ever been. It's crazy."

He was continued in psychotherapy on a weekly basis after the first week. After the first interval of a week, he said: "You know, it's funny, it's like all my life I've been scared shitless, there was a door closed, and it was bulging at the seams, and I was afraid it would break open. Now the door is wide open. Occasionally something comes out that scares the hell out of me, but I can deal with it. And I'm free. It was worth going to jail for this."

Eventually he was released and found a job. When last heard from, he was looking for a therapist with whom to continue psychotherapy.

Here the connections between symptoms, fantasies, and life events clearly emerge if the therapist does not prevent the patient from talking about his feelings, responds as if everything makes sense although it may be puzzling, accepts murderous thoughts and feelings as normal and meaningful, differentiates thoughts and feelings (which must be understood) from actions (which are the only things that must be controlled), and is aware of the importance of relations with others, of the life history and childhood, and of the unconscious.

In the next example, exploring the meaning of hallucinatory material led to an understanding of significant preverbal traumatic determinants of

schizophrenic illness.

A young woman, diagnosed paranoid schizophrenic, chronic type, with 14 hospitalizations over 10 years, reported the emergence of a persistent visual hallucination of a circle receding away from her. She felt persecuted by the recurrence of the hallucination and by not being able to comprehend it. When the patient and therapist (MT) focused their attention on the image, the patient became aware that it was "a circle within a circle, the inside circle is smaller and darker," receding into the distance. The circle was interpreted as a breast, a breast leaving her. The patient, who did not know the details of her feeding in infancy, asked her mother. Her mother was upset by the question but told her daughter that she had decided to stop breastfeeding because she was uncomfortable with it. She stopped abruptly, but her baby refused to bottle-feed, became increasingly distressed, and was only comforted two days later when, at the urging of her pediatrician (who had been called to deal with the child's "sickness"), the mother resumed breast-feeding. The patient then remembered other situations in which her parents had been unhelpful or unavailable: She was taken to the hospital for a tonsillectomy without prior discussion, and when discharged from the hospital, she was put in her room, where she could hear her parents having a dinner party downstairs, apparently oblivious to her discomfort.

TRAINING

It is essential, first, that the therapist be someone who consciously wants to be helpful to schizophrenic patients, is willing to make a commitment, and is working in a setting that supports such treatment. Therapists who do not want to work in therapy do not keep patients (Karon & VandenBos, 1972; Malan, 1963; May, 1968). In two of the controlled studies in which psychotherapy was reported not to be helpful to schizophrenics, the therapists were told they would not finish their psychiatric residencies unless they "volunteered" (May, 1968; A. Hussain Tuma, personal communication, 1965), or that they would lose their affiliation with a prestigious training hospital if they did not volunteer to treat schizophrenic patients without pay (Grinspoon, Ewalt, & Shader, 1972).

In the Michigan State psychotherapy project (Karon & VandenBos, 1981), the student therapists had the real option of not participating, were paid for their time, and were not required to work with a particular supervisor unless they thought it would be a useful experience.

The second essential quality in a therapist is unconscious motivation. If possible, therapists should be selected on the basis of unconscious motivation. Therapists who were high on unconscious pathogenesis (measured from the TAT)—that is, who tended to meet their own needs when they conflicted with those of dependent others— were not helpful therapists (VandenBos & Karon, 1971).

A third element in therapist training is didactic material. The most important source is the clinical and theoretical section of Karon and VandenBos (1981, pp. 1-369), possibly supplemented by Karon (1984, 1989a, 1992). Useful background readings are Freud's *Introductory Lectures* (1917/1961, 1963; 1933/1964) and his papers on technique (1963), Sullivan (1953a, 1953b), Fairbairn (1954), Guntrip (1969), Fromm-Reichmann (1950), and Malan (1979). This material should be supplemented by any of the many insightful psychodynamic writers who may interest the student. (Every good student will have his or her own interests.)

A fourth element is the observation of tapes or live therapy sessions by an experienced therapist. This is not an absolute necessity, but it provides a model, makes it obvious that patients do respond to intervention, and demystifies the process. Tape review is helpful for showing not only appropriate and useful technique but also the obvious fact that even experienced therapists make mistakes—they don't understand, make wrong interpretations, feel sleepy, have countertransference reactions, and so forth —and still patients get better if most of what is going on is helpful. Thus, psychotherapy with schizophrenics is not magic requiring superhuman therapists, but something any reasonably intelligent, reliably strong, kindly, and well-motivated therapist can learn.

A fifth element of training is supervision. In the Michigan project, early

sessions were observed on videotape or live by other trainees as well as by the supervisor. Live observation can be reassuring to a novice therapist worried about a possibly violent patient. In general, however, supervision is most helpful in the traditional mode of discussing the sessions from the memory and notes of the trainee. When a trainee raises an issue, the comments of the supervisor lead to rapid learning because they solve a problem for the trainee; when something is commented on from a videotape or audiotape, it does not solve a problem for the trainee and does not lead to rapid learning. A videotape may reveal something obvious going on in the patient that the student had not noticed, but most of the subtleties of the interrelationship are far more evident in the awareness of the two participants (and their unconscious reactions) than in the observations of an outside observer. Further, videotaping or audiotaping may make the student therapist anxious or artificial. Notes, as Freud recommended, should be made after and not during the session, because they distract from the therapy. Of course, a trainee may be so out of touch that gross aspects of the session are not noticed, or the trainee may lie about what went on, but such students are probably hopeless in any event. Luckily, such students are rare.

EMPIRICAL EVIDENCE FOR THE APPROACH

The most important study is the Michigan State Psychotherapy Research Project (Karon & VandenBos, 1981) carried out at Detroit

Psychiatric Institute. Twelve sets of three clearly schizophrenic hospitalized patients were selected. Within each set, one patient was randomly assigned to each of three treatments: (1) psychoanalytic psychotherapy without medication, (2) psychotherapy with adjunctive medication, or (3) medication alone as primary treatment. Psychotherapy patients received an average of 70 sessions over a 20-month period.

The medications used were phenothiazines, which were considered the treatment of choice by the majority of the staff of the hospital. For the subset receiving medication as the sole treatment, the patient-physician ratio was held to eight to one for the first weeks of medication (as was usual in that hospital) and then allowed to increase. Specific medication and dosage levels were adjusted for each patient according to the clinical judgment of the treating psychiatrist and his or her supervisor as to the optimal dosage for that patient at that time, varying in accordance with good and routine practice in that hospital. Dosage levels for patients for whom medication was the primary treatment typically were 400 mg of chlorpromazine daily (or its equivalent), varying from a high of 1,400 mg to a low of 100 mg, with most patients receiving between 300 and 600 mg. The dose was decreased somewhat at discharge but was recommended for indefinite use. Interviews were used primarily to adjust medication levels, assess whether discharge or transfer to another hospital was appropriate, and provide minimal support.

For the patients receiving both psychotherapy and medication, the dosage levels tended to be lower, between 100 and 600 mg of chlorpromazine daily (or its equivalent).

Patients in all three treatment groups were blindly evaluated in a series of tests and a thorough clinical status interview (recorded on tape, with possible clues to treatment deleted) before treatment, after 6 months, after 12 months, and after 20 months (end-of-project treatment), whether or not they continued in therapy. All living patients (there were no dropouts) were evaluated at 20 months. The lengths of hospitalizations and rehospitalizations were also recorded. There was a two-year follow-up on hospitalization at all probable hospitals.

Patients were economically poor, of lower socioeconomic status, from the inner city, and predominantly black. While we intended to select acute patients with no prior hospitalizations, repeated evaluations revealed that all the selected patients were chronic and that one-third had been previously hospitalized. Patients and their families routinely lied initially about anything they believed might lead to mistreatment of the patient. (Unfortunately, such lying is *not* irrational.)

Psychoanalytic therapy, compared with medication alone, produced a dramatic improvement in the thought disorder, as well as a more human way

of life in a variety of ways, earlier discharge, and fewer rehospitalizations. The lower rehospitalization rate counterbalanced the initially greater cost of psychoanalytic therapy, which in the end was considerably less expensive over the four-year period. Two-thirds of the patients who received only medication had to be rehospitalized in the follow-up period, whereas only one-third of those who had received psychotherapy, with or without medication, had to be rehospitalized. Three-fourths of the medication-only patients received welfare in the follow-up, compared with only one-third of the psychotherapy patients.

Most effective was psychotherapy without medication, or with medication that was reduced as rapidly as the patient could tolerate it. Psychotherapy with medication that was maintained was not as effective, but more effective than medication alone. Future ability to avoid hospitalization was best predicted by improvement in the thought disorder, not by length of initial hospitalization.

Experienced therapists were more effective, as were more emotionally mature and responsible therapists and those who had low pathogenesis (TAT) scores.

Three frequently cited American studies seemed to find that psychotherapy has little to offer schizophrenic patients, but the Philadelphia

study (Bookhammer, Myers, Schober, & Piotorowski, 1966) used a psychotherapy that bore no relationship (Brody, 1959) to the therapy described in the theoretical and clinical papers on which it was supposedly based (Rosen, 1953); the California study (May 1968) used therapists with no relevant training or experience supervised by supervisors with no relevant training and experience (Wexler, 1975); and most of the "experienced" therapists in the Boston study were unfamiliar with working with these kinds of patients, and half resented "volunteering" to work without pay (Grinspoon, Ewalt, & Shader, 1972).

A survey of all available empirical studies with control groups (Karon, 1989b) showed considerable evidence that a variety of psychosocial treatments are effective. Thus, a modified Rogerian approach (Rogers, Gendlin, Kiesler, & Truax, 1967), particularly if the therapists are warm, genuine, and empathic, and a behavioral approach (Paul & Lentz, 1977) were demonstrated to be helpful. Soteria House, a therapeutic milieu, was demonstrated to be more helpful to nonmedicated first-break young schizophrenics than treatment with medication (Matthews, Roper, Mosher, & Menn, 1979). Deikman and Whitaker (1979) found that a ward using psychological treatment without medication (for 11 months) resulted in fewer rehospitalizations and no suicides, suicide attempts, or elopements. (The comparison medication ward had three suicides.) In Austria, Schindler (1980) found that patients treated with "bifocal family therapy" fared far

better than those treated with medication in a 10-year follow-up. In Sweden, Sjostrom and Sandin (1981) found that patients treated with psychodynamic therapy and lowered medication did better than controls treated with medication.

Revere, Rodeffer, Dawson, & Bigelow (1981) found that "warm intrusive therapy" (their form of psychodynamic group therapy, based on ideas similar to those of this chapter) was more helpful to chronically institutionalized (average of 15 years) schizophrenics than medication alone. Five out of seven psychotherapy patients obtained employment or were discharged or both and also improved on clinical measures. No such improvement occurred in the medicated controls.

Teixeira (1982a) found that a psychodynamic day treatment program was helpful on a number of measures, but he had appropriate comparison group data only on some outcome variables on patients treated in other kinds of day treatment programs. In Finland's community mental health system, Alanen (1991; Alanen, Rakkolainen, Laakso, Rasimus, & Kaljonen, 1986) demonstrated empirically that increasing the availability of individual and family therapy greatly improved the outcomes, especially long-term outcomes, as compared with earlier (medication) results.

Of course, a wealth of case studies and clinical experience exists, as well

as studies without control groups, but they are less scientifically convincing. For example, Benedetti and Furlan (1987) reported from Italy and Switzerland a series of 50 severe cases treated with intensive psychoanalytic therapy (two to five sessions per week) for three to ten years by supervisees, with very good outcomes in 80% of the cases.

REFERENCES

Abraham, K. (1927). The first pregenital stage of the libido. In *Selected papers on psycho-analysis.* New York: Brunner/Mazel. (Original work published 1916)

Alanen, Y. O. (1991). *Psychotherapy of schizophrenia in community psychiatry.* Paper presented at the Tenth International Symposium for Psychotherapy of Schizophrenia, Stockholm, Sweden.

Alanen, Y. O., Rakkolainen, V., Laakso, J., Rasimus, R., & Kaljonen, A. (1986). *Towards need-specific treatment of schizophrenic psychoses.* New York: Springer-Verlag.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd. ed., rev.). Washington, DC: APA.

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: APA.

Arieti, S. (1974). *Interpretation of schizophrenia* (2nd ed.). New York: Basic Books.

Bak, R. C. (1954). The schizophrenic defense against aggression. *International Journal of Psychoanalysis,* 35,129-134.

Benedetti, G. (1987). *Psychotherapy of schizophrenia.* New York: New York University Press.

Benedetti, G., & Furlan, P. M. (1987). Individual psychoanalytic psychotherapy of schizophrenia.

In G. Benedetti (Ed.), *Psychotherapy of schizophrenia* (pp. 198-212). New York: New York University Press.

Bettelheim, B. (1955). *Psychology of schizophrenia.* Paper delivered at Princeton University.

Bettelheim, B. (1956). Schizophrenia as a reaction to extreme situations. *American Journal of Orthopsychiatry,* 26,507-518.

Bion, W. R. (1954). Notes on the theory of schizophrenia. *International Journal of Psychoanalysis,* 35,113-118.

Bion, W. R. (1967). Differentiation of the psychotic from the nonpsychotic personalities. In *Second Thoughts* (pp. 43-64). New York: Jason Aronson. (Original work published 1957)

Bleuler, E. (1950). *Dementia praecox, or the group of the schizophrenias.* New York: International Universities Press. (Original work published 1911)

Bookhammer, R. S., Myers, R. W., Schober, C. C., & Piotorowski, A. Z. (1966). A 15-year clinical follow-up study of schizophrenics treated by Rosen's "direct analysis" compared with controls. *American Journal of Psychiatry,* 123, 602-604.

Boyer, L. B., & Giovacchini, P. L. (1967). *Psychoanalytic treatment of schizophrenic and characterological disorders.* New York: Science House.

Boyer, L. B., & Giovacchini, P. L. (Eds.). (1990). *Master clinicians on treating the regressed patient.* Northvale, NJ: Jason Aronson.

Brody, M. W. (1959). *Observations on "direct analysis."* New York: Vantage Press.

Bullard, D. M. (Ed). (1959). *Psychoanalysis and psychotherapy: Selected papers of Frieda Fromm-Reichmann.* Chicago: University of Chicago Press.

Burnham, D. L., Gladstone, A. I., & Gibson, R. W. (1969). *Schizophrenia and the need-fear dilemma.* New York: International Universities Press.

Bychowski, G. (1930). A case of oral delusions of persecution. *International Journal of*

Psychoanalysis, 11, 332-337.

Bychowski, G. (1954). On the handling of some schizophrenic defense mechanisms and reaction patterns. *International Journal of Psychoanalysis,* 35,147-153.

Cancro, R. (1968). Thought disorder and schizophrenia. *Diseases of the Nervous System,* 29, 846-849.

Cancro, R. (1969a). Clinical prediction of outcome in schizophrenia. *Comprehensive Psychiatry,* 10, 349-354.

Cancro, R. (1969b). Prospective prediction of hospital stay in schizophrenia. *Archives of General Psychiatry,* 20, 541-546.

Ciompi, L. (1980). Catamnesic long-term study on the course of life and aging of schizophrenics. *Schizophrenia Bulletin,* 6, 606-617.

Deikman, A. J., & Whitaker, L. C. (1979). Humanizing a psychiatric ward: *Changing from drugs to psychotherapy. Psychotherapy: Theory, Research, & Practice,* 16, 204-214.

Eissler, K. R. (1952). Remarks on the psychoanalysis of schizophrenia. *International Journal of Psychoanalysis,* 32,139-156.

Fairbairn, W. R. D. (1954). *An object-relations theory of personality: Psychoanalytic studies of the personality.* New York: Basic Books.

Federn, P. (1934). The analysis of psychotics. *International Journal of Psychoanalysis,* 15, 209-214.

Federn, P. (1943a). Psychoanalysis of psychoses: I. *Psychiatric Quarterly,* 17, 3-19.

Federn, P. (1943b). Psychoanalysis of psychoses: II. *Psychiatric Quarterly,* 17, 246-257.

Feinsilver, D. B. (1986). Continuing towards a comprehensive model for schizophrenic disorders: Conclusions and implications. In *Towards a comprehensive model for schizophrenic disorders* (pp. 347-349). Hillsdale, NJ: Analytic Press.

Feldman, M. J., & Drasgow, J. (1951). A visual-verbal test for schizophrenia. *Psychiatric Quarterly Supplement,* 25, 55-64.

Freud, S. (1953). On psychotherapy. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 7, 255-268). London: Hogarth Press. (Original work published 1905)

Freud, S. (1958). Psycho-analytic notes on an autobiographical account of a case of paranoia (dementia paranoides). In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 1-84). London: Hogarth Press. (Original work published 1911)

Freud, S. (1961, 1963). Introductory lectures on psychoanalysis. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vols. 15 & 16). London: Hogarth Press. (Original work published 1917)

Freud, S. (1964). New introductory lectures on psychoanalysis. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 22, pp. 1-182). London: Hogarth Press. (Original work published 1933)

Freud, S. (1964). Outline of psychoanalysis. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 23, pp. 139-301). London: Hogarth Press. (Original work published 1940)

Freud, S. (1950). *Collected Papers.* London: Hogarth Press and the Institute for Psychoanalysis.

Freud, S. (1963). *Therapy and technique.* New York: Macmillan.

Firestone, R. W. (1957). *A concept of the schizophrenic process.* Unpublished doctoral dissertation, University of Denver.

Firestone, R. W. (1984). A concept of the primary fantasy bond: A developmental perspective. *Psychotherapy,* 22(2), 218-225.

Firestone, R. W. (1988). *Voice therapy: A psychotherapeutic approach to self-destructive behavior.* New York: Human Sciences Press.

Fromm-Reichmann, F. (1947). Transference problems in schizophrenia. In S. S. Tomkins (Ed.), *Contemporary psychopathology* (pp. 371-380). Cambridge, MA: Harvard University Press. (Original work published 1939)

Fromm-Reichmann, F. (1950). *Principles of intensive psychotherapy.* Chicago: University of Chicago Press.

Glazer, W. M., Morgenstern, H., & Doucette, J. T. (1993). Predicting the long-term risk of tardive dyskinesia in outpatients maintained on neuroleptic medications. *Journal of Clinical Psychiatry,* 54,133-139.

Grinspoon, L., Ewalt, J. R., & Shader, R. I. (1972). *Schizophrenia, pharmacology, and psychotherapy.* Baltimore: Williams & Wilkins.

Grotstein, J. S. (1990). Invariants in primitive emotional disorders. In L. B. Boyer and P. Giovacchini (Eds.), *Master clinicians on treating the regressed patient* (pp. 139-163). Northvale, NJ: Jason Aronson.

Gunderson, J. G., & Mosher, L. R. (Eds). (1975). *Psychotherapy of schizophrenia.* New York: Jason Aronson.

Guntrip, H. (1969). *Schizoid phenomena, object relations, and the self.* New York: International Universities Press.

Harding, C. M. (1988, July). *Chronicity in schizophrenia.* Paper delivered at the International Association of Psychosocial Rehabilitation Services conference, Philadelphia.

Harding, C. M., Zubin, J., & Strauss, J. S. (1987). Chronicity in schizophrenia: Fact, partial fact, or artifact? *Hospital and Community Psychiatry,* 38, 477-486.

Harrow, M., & Marengo, J. T. (1986). Schizophrenic thought disorder at follow-up: Its persistence and prognostic significance. *Schizophrenia Bulletin,* 12, 373-393.

Hollingshead, A. B., & Redlich, F. C. (1958). *Social class and mental illness.* New York: Wiley.

Huttunen, M. O., & Niskanen, P. (1978). Prenatal loss of father and psychiatric disorders. *Archives*

of General Psychiatry, 35,429-431.

Jung, C. G. (1960a). *The psychology of dementia praecox.* Princeton, NJ: Princeton University Press. (Original work published 1907)

Jung, C. G. (1960b). Schizophrenia. In *The psychology of dementia praecox* (pp. 178-193). Princeton, NJ: Princeton University Press (chapter added 1960).

Karon, B. P. (1958). Some clinical notes on the significance of the number four. *Psychiatric Quarterly,* 32, 281-288.

Karon, B. P. (1960). A clinical note on the specific nature of an "oral" trauma. *Journal of Abnormal and Social Psychology,* 61,480-481.

Karon, B. P. (1963). The resolution of acute schizophrenic reactions: A contribution to the development of non-classical psychotherapeutic techniques. *Psychotherapy: Theory, Research, and Practice,* 1,27-43.

Karon, B. P. (1975). *Black scars: A rigorous investigation of the effects of discrimination, with an appendix on the southern white.* New York: Springer.

Karon, B. P. (1984). A type of transference based on identification with an abusing parent. *Psychoanalytic Psychology,* 1, 345-348.

Karon, B. P. (1989a). On the formation of delusions. *Psychoanalytic Psychology,* 6(2), 169-185.

Karon, B. P. (1989b). Psychotherapy versus medication for schizophrenia: Empirical comparisons. In S. Fisher & R. P. Greenberg (Eds.), *The limits of biological treatments for psychological distress: Comparisons with psychotherapy and placebo* (pp. 105-150). Hillsdale, NJ: Lawrence Erlbaum Associates.

Karon, B. P. (1992). The fear of understanding schizophrenia. *Psychoanalytic Psychology*, 9,191-211.

Karon, B. P., & O' Grady, P. (1969). Intellectual test changes in schizophrenic patients in the first six months of treatment. *Psychotherapy: Theory, Research, and Practice,* 6, 88-96.

Karon, B. P., & O' Grady, P. (1970). Quantified judgements of mental health from the Rorschach, TAT, and clinical status interview by means of a scaling technique. *Journal of Consulting and Clinical Psychology,* 34, 229-235.

Karon, B. P., & Rosberg, J. (1958a). The homosexual urges in schizophrenia. *Psychoanalysis and the Psychoanalytic Review,* 45, 50-56.

Karon, B. P., & Rosberg, J. (1958b). Study of the mother-child relationship in a case of paranoid schizophrenia. *American Journal of Psychotherapy,* 12, 522-533.

Karon, B. P., & VandenBos, G. R. (1972). The consequences of psychotherapy for schizophrenic patients. *Psychotherapy: Theory, Research, and Practice,* 9,111-120.

Karon, B. P., & VandenBos, G. R. (1974). Thought disorder in schizophrenia, length of hospitalization, and clinical status ratings: Validity for the Feldman-Drasgow Visual-Verbal Test. *Journal of Clinical Psychology,* 30, 264-266.

Karon, B. P., & VandenBos, G. R. (1981). *Psychotherapy of schizophrenia: The treatment of choice.* New York: Jason Aronson.

Karon, B. P., & Widener, A. J. (1994). Is there really a schizophrenogenic parent? *Psychoanalytic Psychology,* 11,47-61.

Kempf, E. (1919). The psychoanalytic treatment of dementia praecox: Report of a case. *Psychoanalytic Review,* 6,15-58.

Kernberg, O. F. (1975). *Borderline conditions and pathological narcissism.* New York: Jason Aronson.

Kernberg, O. F. (1977). Clinical observations regarding the diagnosis, prognosis, and intensive treatment of chronic schizophrenic patients. In C. Chiland (Ed.), *Long-term treatments of psychotic states* (pp. 332-360). New York: Human Sciences Press.

Kety, S. S., Rosenthal, D., Wender, P. H., & Schulsinger, F. (1968). The types and prevalence of mental illness in the biological and adoptive families of adopted individuals who have become schizophrenic. In D. Rosenthal & S. S. Kety (Eds.), *The transmission of*

schizophrenia (pp. 345-362). Oxford, Eng.: Pergamon.

Klein, M. (1930). The psychotherapy of the psychoses. *British Journal of Medical Psychology,* 10,242-244.

Klein, M. (1948). *Contributions to psychoanalysis, 1931-1945.* London: Hogarth Press.

Klein, M. (1975). *Envy and gratitude.* New York: Free Press.

Lapidus, L. B., & Schmolling, P. (1975). Anxiety, arousal, and schizophrenia: A theoretical integration. *Psychological Bulletin*, 82,689-710.

Leff, J., & Vaughn, C. E. (1985). *Expressed emotion in families: Its significance for mental illness.* New York: Guilford Press.

Lewis, G., David, A., Andreasson, S., & Allebeck, P. (1992). Schizophrenia and city life. *Lancet,* 340,137-140.

Lewontin, R. C., Rose, S., & Kamin, L. J. (1984). Schizophrenia: The clash of determinisms. In *Not in our genes* (pp. 197-232). New York: Pantheon.

Lidz, T. (1973). *The origin and treatment of schizophrenic disorders.* New York: Basic Books.

Lidz, T., & Blatt, S. (1983). Critique of the Danish-American studies of the biological and adoptive relatives of adoptees who became schizophrenic. *American Journal of Psychiatry,* 140,426-435.

Lidz, T., Blatt, S., & Cook, B. (1981). Critique of the Danish-American studies of the biological and adoptive relatives of adoptees who became schizophrenic patients. *American Journal of Psychiatry,* 138, 1063-1068.

Malan, D. H. (1963). *A study of brief psychotherapy.* London: Tavistock.

Malan, D. H. (1979). *Individual psychotherapy and the science of psychodynamics.* Cambridge, Eng.: Butterworth-Heinemann.

Matthews, S. M., Roper, M. T., Mosher, L. R., & Menn, A. Z. (1979). A non-neuroleptic treatment for schizophrenia: Analysis of the two-year post-discharge risk of relapse. *Schizophrenia Bulletin*, 5, 322-333.

May, P. R. A. (1968). *Treatment of schizophrenia: A comparative study of five treatment methods.* New York: Science House.

McGlashan, T. (1983). Intensive individual psychotherapy of schizophrenia. *Archives of General Psychiatry,* 40, 909-920.

McGlashan, T., & Keats, C. J. (1989). *Schizophrenia: Treatment process and outcome.* Washington DC: American Psychiatric Press.

Meyer, R. G., & Karon, B. P. (1967). The schizophrenogenic mother concept and the TAT. *Psychiatry,* 30,173-179.

Mitchell, K. M. (1968). An analysis of the schizophrenogenic mother concept by means of the TAT. *Journal of Abnormal Psychology,* 73, 571-574.

Mitchell, K. M. (1969). Concept of "pathogenesis" in parents of schizophrenic and normal children. *Journal of Abnormal Psychology,* 74, 423-424.

Pao, P. N. (1979). *Schizophrenic disorders.* New York: International Universities Press.

Paul, G. L., & Lentz, R. J. (1977). *Psychosocial treatment of chronic mental patients: Milieu versus social learning programs.* Cambridge, MA: Harvard University Press.

Ratner, S. G., Karon, B. P., VandenBos, G. R., & Denny, M. R. (1981). The adaptive significance of the catatonic stupor in humans and animals from an evolutionary perspective. *Academic Psychology Bulletin,* 3,273-279.

Revere, V. L., Rodeffer, C. J., Dawson, S. D., & Bigelow, L. B. (1981). Modifying psychotherapeutic techniques to meet the needs of chronic schizophrenics. *Hospital and Community Psychiatry,* 34, 361-362.

Rogers, C. R., Gendlin, E. T., Kiesler, D. J., & Truax, C. B. (1967). *The therapeutic relationship and its*

impact: A study of psychotherapy with schizophrenics. Madison: University of Wisconsin Press.

Rosberg, J., & Karon, B. P. (1958). The Oedipus complex in an apparently deteriorated case of schizophrenia. *Journal of Abnormal and Social Psychology,* 57, 221-225.

Rosberg, J., & Karon, B. P. (1959). A direct analytic contribution to the understanding of post-partum psychoses. *Psychiatric Quarterly*, 33, 296-304.

Rosberg, J., & Stunden, A. A. (1989). The principles of direct confrontation: Psychotherapy with the schizophrenic patient. *Nordisk Psykiatrisk Tidsskrift,* 43,491-498.

Rosberg, J., & Stunden, A. A. (1990). The use of direct confrontation: The treatment-resistant schizophrenic patient. *Acta Psychiatrica Scandinavica,* 81, 352-358.

Rosen, J. N. (1953). *Direct analysis.* New York: Grune & Stratton.

Rosen, J. N. (1962). *Direct psychoanalytic psychiatry.* New York: Grime & Stratton.

Rosenfeld, H. A. (1965). *Psychotic states: A psychoanalytic approach.* New York: International Universities Press.

Rosenfeld, H. A. (1969). On the treatment of psychotic states by psychoanalysis: An historical approach. *International Journal of Psychoanalysis*, 50, 615-631.

Rosenthal, D., & Kety, S. (1968). *The transmission of schizophrenia.* London: Pergamon.

Sartorius, N., Jablensky, A., & Shapiro, R. (1978). Cross-cultural differences in the short-term prognosis of schizophrenic psychoses. *Schizophrenia Bulletin,* 4,102-113.

Schindler, R. (1980). The change of long-term progress of psychotics after psychotherapy. *Psychiatria Clinica,* 13, 206-216.

Schulz, C. G. (1975). An individualized psychotherapeutic approach with the schizophrenic patient. *Schizophrenia Bulletin,* 13,46-69.

Searles, H. F. (1965). *Collected papers on schizophrenia and related subjects.* New York: International Universities Press.

Sechehaye, M. A. (1956). *A new psychotherapy of schizophrenia.* New York: Grune & Stratton.

Segal, H. (1973). *Introduction to the work of Melanie Klein.* New York: Basic Books.

Sjostrom, R., & Sandin, B. (1981). *Effects of psychotherapy in schizophrenia: A retrospective study.* Paper presented at the First European Conference of Psychotherapy Research, Trier, Federal Republic of Germany.

Spohn, H. E., Coyne, L. C., Larson, J., Mittleman, F., Spray, J., & Hayes, K. (1986). Episodic and residual thought pathology in chronic schizophrenics: Effect of neuroleptics. *Schizophrenia Bulletin,* 12, 394-407.

Stanton, A. H., Gunderson, J. G., Knapp, P. H., Frank, A. F., Vannicelli, M. L., Schnitzer, R., & Rosenthal, R. (1984). Effects of psychotherapy in schizophrenia: I. Design and implementation of a controlled study. *Schizophrenia Bulletin*, 10,520-563.

Stanton, A. H., & Schwartz, M. S. (1954). *The mental hospital.* New York: Basic Books.

Stierlin, H., Weber, G., Schmidt, G., & Simon, F. (1985). Why some patients prefer to become manic-depressive rather than schizophrenic. *Yale Journal of Biology and Medicine,* 58, 255-263.

Suddath, R. L., Christison, G. W., Torrey, E. F., Casanova, M. F., & Weinberger, D. R. (1990). Anatomical abnormalities in the brains of monozygotic twins discordant for schizophrenia. *New England Journal of Medicine,* 322, 789-794.

Sullivan, H. S. (1953a). The relation of onset to outcome in schizophrenia. In *Schizophrenia as a human process* (pp. 233-255). New York: Norton. (Original work published 1931)

Sullivan, H. S. (1953a). *Schizophrenia as a human process.* New York: Norton.

Sullivan, H. S. (1953b). *The interpersonal theory of psychiatry.* New York: Norton.

Teixeira, M. A. (1982a). *The development and evaluation of a psychoanalytically oriented day treatment program.* Unpublished doctoral dissertation, Michigan State University.

Teixeira, M. A. (1982b). Theoretical integration: Psychodynamic and neurophysiological corollary mechanisms in schizophrenia. In *The development and evaluation of a psychoanalytically oriented day treatment program* (pp. 189-224). Unpublished doctoral dissertation, Michigan State University.

Teixeira, M. A. (1984). Annihilation anxiety in schizophrenia: Metaphor or dynamic? *Psychotherapy,* 21(3), 377-381.

Teixeira, M. A. (1994, June). *Psychodynamic and risk factors for suicidality in schizophrenia.* Paper presented at the 11th International Symposium for the Psychotherapy of Schizophrenia, Washington, DC.

Tienari, P. (1992). Interaction between genetic vulnerability and rearing environment. In A. Werbart & J. Cullberg (Eds.), *Psychotherapy of schizophrenia: Facilitating and obstructive factors* (pp. 154-172). Oslo: Scandinavian University Press.

Tomkins, S. S. (1962). *Affect, imagery, and consciousness* (Vol. 1). Edited by B. P. Karon. New York: Springer.

Tomkins, S. S. (1963). *Affect, imagery, and consciousness* (Vol. 2). Edited by B. P. Karon. New York: Springer.

Tomkins, S. S. (1991a). *Affect, imagery, and consciousness* (Vol. 3). New York: Springer.

Tomkins, S. S. (1991b). *Affect, imagery, and consciousness* (Vol. 4). New York: Springer.

VandenBos, G. R., & Karon, B. P. (1971). Pathogenesis: A new therapist dimension related to therapeutic effectiveness. *Journal of Personality Assessment,* 35, 252-260.

Volkan, V. D. (1976). *Primitive internalized object relations: A clinical study of schizophrenic, borderline, and narcissistic patients.* New York: International Universities Press.

Waelder, R. (1925). The psychoses: Their mechanisms and accessibility to influence.

International Journal of Psychoanalysis, 6, 254-281.

Wender, P. H., Rosenthal, D., Zahn, T., & Kety, S. (1971). The psychiatric adjustment of the adopting parents of schizophrenics. *Archives of General Psychiatry,* 30,121-128.

Wender, P. H., Rosenthal, D., Rainer, J. D., Greenhill, L., & Sarlin, M. B. (1977). Schizophrenics' adopting parents. *Archives of General Psychiatry,* 34, 777-784.

Wexler, M. (1975). Comment on the five-treatment comparative study. In J. G. Gunderson & S. R. Mosher (Eds.), *Psychotherapy of schizophrenia* (pp. 431-433). New York: Jason Aronson.

Will, O. A. (1961). Process, psychotherapy, and schizophrenia. In A.

Burton (Ed.), *Psychotherapy of the psychoses* (pp. 10-42). New York: Basic Books.

Winnicott, D. W. (1965). *The maturational process and the facilitating environment.* New York: International Universities Press.

Wynne, L. C., Singer, M. T., & Toohey, M. L. (1976). Communication of the adoptive parents of schizophrenics. In J. Jorstad and E. Ugelstad (Eds.), *Schizophrenia 75: Psychotherapy, family studies and research* (pp. 413^51). Oslo: Universitet-forlaget.

CHAPTER 5

Supportive-Expressive Dynamic Psychotherapy for Treatment of Opiate Drug Dependence

Lester Luborsky, George E. Woody, Anita V. Hole, and Anthony Velleco

HISTORY AND DEVELOPMENT

This manual is a guide for psychotherapists engaged in supportive-expressive (SE) dynamic psychotherapy with people who suffer from heroin dependence and are simultaneously being treated with methadone. The manual is an adaptation of a general manual (Luborsky, 1984) that was first formally used early in 1976 in the training of therapists at the Department of Psychiatry of the University of Pennsylvania. It has been gradually shaped to meet the needs of drug-dependent patients by adaptations based on both clinical and research experiences.

The backing to do studies using this manual first came from the National Institute on Drug Abuse (NIDA) to determine the contribution of psychotherapy to the benefits from the usual treatments for heroin-dependent patients. The initial group of researchers included A. Thomas McLellan, George Woody, Lester Luborsky, and Charles O'Brien.

From the beginning of the training in the use of this manual, a special training format was developed (Luborsky, 1993a; 1993b). Groups of therapists worked for yearly periods with Lester Luborsky, who has served as the group orchestrator (since 1992 Lynne Siqueland has been co-orchestrator).[1] The first studies of the method were part of the Veterans Administration (VA) Drug Dependence Treatment Program at the Philadelphia VA Medical Center, directed first by Charles O'Brien and later by George Woody. From 1987 to 1990, the patient groups also included clients from three community clinics in Philadelphia, including the Parkside Clinic, the Jefferson Clinic, and the Alcohol and Mental Health Association (Woody, McLellan, Luborsky, & O'Brien, 1994).

The principles in this manual have a long background in clinical practice. Starting about 1940, Freud's recommendations for psychoanalysis (1912, 1913) were adapted into the SE psychoanalytic psychotherapy used at the Menninger Foundation by Knight (1949), Gill (1951), and others, including Ekstein and Wallerstein (1958) in their system for training psychotherapists. Our manualization of the SE dynamic psychotherapy system is not intended as a new method but only as a formalization of the widely used existing methods of dynamic psychotherapy. As its name implies, the essence of the method is the use of techniques for establishing a supportive relationship and for encouraging patients to express and understand their relationship patterns and the conflicts within them as they

appear in interaction with the therapist and others.

INCLUSION/EXCLUSION CRITERIA

The primary inclusion criterion is the presence of a *DSM-III-R* substance abuse disorder primarily for opioid dependence (APA, 1987, 304.00). Other diagnoses involving other substance abuse disorders can be evident, but the opioid diagnosis should be primary. The method of diagnosis used in the original study was a structured interview and application of the Schedule for Affective Disorders and Schizophrenia (SADS), leading to a *DSM* diagnosis as well as a Research Diagnostic Criteria (RDC) diagnosis. Patients were screened to exclude those with serious medical, legal, or personal problems that would prevent them from continuing to take part in or profit from the treatment. Patients with signs of organic impairment or inability to read were excluded. Patients assessed with antisocial personality were nevertheless included in the studies, although experience suggests that many of those with antisocial personality do poorly (Woody, McLellan, Luborsky, & O'Brien, 1985). Currently, the *DSM-IV* (APA, 1994, pp. 249-250) diagnosis of opioid substance abuse disorder and the Structural Clinical Interview for DSM (SCID) interview are used.

DYNAMIC ISSUES IN PATIENTS WITH OPIOID DEPENDENCE

Psychoanalysts and psychodynamically oriented psychotherapists have a long history of concern with conceptualizing the nature of addiction, as shown, for example, by Fenichel (1945). The outstanding dynamic issue is the involvement in taking the drug. Following are a few of Fenichel's (1945) conclusions: The addict is thought to come to use the effect of the drug for satisfaction of other needs. The need is so strong as to overwhelm other interests. It is therefore not just the chemical effect of the drug but the nature of the personality that is significant. Interests other than those having to do with getting the drug diminish or disappear. Addicts are amenable to psychoanalytic treatment, but they offer special technical problems. It is best to treat the patient after withdrawal of the drug, but it is not to be expected that withdrawal will be consistent; drug taking will increase with increased resistance. In general, the more recent the addiction, the better the prognosis.

Some of Fenichel's conclusions about addiction are still part of the explanatory framework used today, and some of that framework is further specified in the present manual. Still applicable is the concept of the attachment to the substance and its rewarding properties at the expense of other interests, especially in relation to people and also often in relation to work. Personality patterns vary considerably, but addicts have a strong tendency to concentrate their interests on the satisfactions from the drug itself rather than from people. This observation, in fact, has become part of the definition of addiction.

TREATMENT GOALS

Goal setting takes place primarily in the early sessions but extends throughout the treatment as the patient comes to settle on the goals. For all of these patients, one common treatment goal will be to control the opiate use without increasing their use of other substances. Another more general goal for most patients will be to improve psychological and occupational functioning. Some patients will have the goals of decreasing certain symptoms or getting along better with others. The selection of the main goals should also take into account what seems achievable.

One of the functions of setting goals early in treatment in SE dynamic psychotherapy is to keep the treatment focused on the main goals and to make it clear to both patient and therapist toward what ends the treatment efforts will be directed and the time span allotted for achieving the goals. In this type of treatment, taking a relaxed attitude toward time is an unaffordable luxury. Goals are not only important at the beginning and end but also throughout the treatment. They provide markers of progress, or the lack of it. Goals achieved during the course of treatment are likely to be correlated with "internal markers" that, as observed by Schlesinger (1977), signal the change, thus making it possible to recognize treatment phases. These phases and subphases allow the patient and therapist to have a sense of completion and accomplishment along the way. In addition, setting

reasonable goals is especially important for those patients for whom the treatment may be seen as an opportunity for goal-less dependence. Reasonable goal setting acts as a modulating brake on such regressive developments.

THEORY OF CHANGE

What is unique about SE dynamic psychotherapy as compared with other psychotherapies is how it fosters expressiveness as a vehicle for acquiring self-understanding and its ability to vary the proportions of supportiveness and expressiveness as needed for each patient.

SE dynamic psychotherapy has two main therapeutic components: support via the relationship (the supportive component), and information and insight via clarifications and interpretations (the expressive component). Of the two components, the support via the relationship appears to be the more therapeutically potent. That a relationship with another person who is seen as potentially helpful can be curative has been known through the centuries. The loss of such a relationship has also been known for its power to set off psychic and somatic illness (e.g., Schmale, 1958; Luborsky, in press). It should be no surprise, then, that the power of the relationship is recognized as a potent curative factor.

This recognition of the power of the relationship is not intended to

diminish the value of the interpretations provided by the therapist and by the patient. Interpretations have a value in their own right in providing understanding, and the search for understanding provides a meaningful agenda for the joint work in the sessions, but interpretations as a vehicle for achieving a good relationship probably have even greater value.

The therapist's tasks are: (1) to listen to what the patient is trying to say; (2) to attend during this listening to the understandings that will occur of the central relationship patterns and their connections with the patient's drug dependence and relationships; (3) to impart this information to the patient in the most readily assimilable ways; and (4) to accomplish these tasks knowing that the information imparted cannot be of much use without attending to the special needs of drug-dependent patients, especially the supportive conditions and good therapeutic alliance. In fact, the good relationship and alliance are furthered by the focus on understanding.

Personality change appears to be more difficult for many addicted patients than for nonaddicted patients. It is their attachment to the drug that makes for the greater difficulty. The consequences of using drugs impede attachments to people and involvement in work, as noted earlier.

TECHNIQUES

The methods in this manual derive from dynamic concepts. The main

concept is the importance of understanding the patient's wishes and their consequences (Klein, 1970). These wish-consequence sequences, although partly outside of the patient's awareness, can be understood by listening to the flow of what the patient says. After forming a helping relationship with the patient, the therapist, as well as the patient, can then use some of the understanding gained to help the patient both to deal with the drug dependence and to improve his or her general functioning.

Our experience with psychotherapy for heroin-dependent patients has been with treatments that also provide methadone. The methadone makes it possible for most patients to give up the search for illegal heroin and to concentrate on the psychotherapy.

Two main classes of psychotherapeutic techniques, supportiveness and expressiveness, are essential in SE dynamic therapy. The designation "supportive-expressive" or "expressive-supportive" has been used for many years at the Menninger Foundation for a similar form of treatment and was the subject of a long-term study in the Menninger Foundation Psychotherapy Research Project (Wallerstein, Robbins, Sargent, & Luborsky, 1956; Kernberg, Burstein, Coyne, Appelbaum, Horwitz, & Voth, 1972; Wallerstein, 1986).

The expressive component of the treatment refers to the techniques aimed at permitting patients to express themselves so as to facilitate

understanding. The focus is on two main goals: (1) finding the meanings of the drug dependence, particularly by understanding the stresses that precipitate and continue the drug taking, as well as the other symptoms; and (2) discerning the core relationship conflicts as expressed both inside and outside of treatment, especially in relation to the drug dependence. The expressive component, therefore, is much like what has been called in recent years a "focal psychotherapy," as described in Sifneos (1972), Malan (1976), and Mann (1973): the therapy focuses on one main problem. Each patient is provided with as much of the expressive component of the treatment as he or she can profitably use. This component will be greater for those persons who possess the requisite ego strength and anxiety tolerance, along with a capacity for reflection about their interpersonal relationships.

Psychoanalytically oriented psychotherapies are widely used by psychiatrists, psychologists, and social workers. For example, a recent survey of clinical psychologists (Norcross, Prochaska, & Farber, 1993) found that of the 481 practitioners listed in the American Psychological Association Division of Psychotherapy, taking primary and secondary orientation topics, fully 70% endorsed a form of psychoanalytic or psychodynamic orientation (Henry, Sims, & Spray, 1973, p. 272).

Representative overviews of techniques are Menninger and Holzman (1973), Bergmann and Hartman (1977), Mann (1973), Luborsky, Fabian, Hall,

Ticho, and Ticho (1958), Luborsky, (1984), and Miller, Luborsky, Barber, and Docherty (1993). The aims of our manual are to further specify the treatment's operations and to adapt the treatment to the needs of opiate drug-dependent patients. Specifying its operations requires surveying what has been written, selecting what is most central, and presenting it in a form that makes it immediately obvious what a therapist must do. We hope that such specification will make the therapist's learning task easier and ensure that therapists carry out the treatment in a uniform manner.

Summary of Special Adaptations for Drug-Dependent Patients

The form of psychotherapy described here, because of its application to opiate-dependent patients, has special emphases as compared with the general manual (Luborsky, 1984). The therapist attends to working out the conditions that reduce the drug taking and is aware of the dynamic issue of the patient's readiness to retreat into involvement with drugs rather than relationships. The therapist must spend extra time and energy introducing these patients to this psychotherapy and engaging them in it. In addition, goals must be formulated early and kept in sight.

The therapist must also be attentive to developing a therapeutic relationship and supporting the patient. With most drug-dependent patients, it is usually not possible to provide a mainly expressive psychotherapy because a strong supportive component is necessary for them to be able to

tolerate the expressive aspects. A supportive component is especially suitable for patients with character disorders and disruptive symptoms who have low anxiety tolerance and difficulties with being reflective. Supportive psychotherapy is designed to strengthen defenses as compared with its polar opposite, the analysis of defenses (Gill, 1951). The support is aimed at preventing regression, stabilizing the patient, and thus increasing his or her chances of benefiting from the expressive aspects of the treatment.

The therapist must also keep abreast of the patient's compliance in not taking nonprescribed drugs and staying on methadone (Woody, Stockdale, & Harris, 1993). Regular compliance information should come from the patient and from the drug counselor. Information about compliance will allow the therapist to explore the meaning of relapses into illicit drug taking or infractions of rules. A team approach with its division of duties allows the SE dynamic therapist to keep out of the administration of rules—a valuable asset for maintaining a psychotherapeutic relationship.

Another difference in SE therapy with opiate-dependent patients concerns the methadone dose: it should be temporally separate from the sessions. Therapy can occur before or after the methadone dose is administered. However, therapists may want to have the session *before* because methadone usually is such a central part of the patient's life that the patient may temporarily lose interest in therapy immediately after the dose

has been received—especially those patients who are just starting the program and have not yet established a close relationship with the therapist. Yet preventing the patient from receiving methadone until the session has been completed may create negative feelings and hinder the development of a positive relationship.

Presentation of the Opportunity for Psychotherapy

Without special assistance, some of these patients are not likely to seek psychotherapy and, if given the opportunity, often would not take advantage of it. One reason is their inexperience with psychotherapy; many come from a low socioeconomic group. Strupp and Bloxom (1973) suggested that a role induction film may be helpful for these patients. Burstein's (1976) study concluded that it is not necessarily true that poor people lack the capacity for insight. The same view was expressed by Lorion (1974), who also provided suggestions for treatment. One of his main suggestions was to modify the therapists' attitudes in this regard in the course of training. Chappel (1973) and others have discussed how the negative attitudes of physicians can serve as barriers to effective treatment for substance abusers. It has taken many years to show that even some of those referred to as "intractable" addicts grow out of the addiction because of the help of peers and significant others (Valliant, 1973, 1983). SE dynamic psychotherapy is aimed at providing such "significant others."

Preliminary Socialization

In the VA-Penn project (Woody et al., 1983), which first utilized this SE manual in research, patients are launched into the treatment after two introductory phases: (1) a formal introductory orientation, sometimes called "preliminary socialization," and (2) completion of a required initial three sessions of psychotherapy. The introduction to psychotherapy is accomplished by an adaptation of the Orne and Wender (1968) interview, which showed the significant advantage of preliminary socialization interviews conducted just before the patient is assigned to the psychotherapist. The interviewer explains to the patient how psychotherapy works, what the patient is to do, and what the therapist does.

The interviewer also explains that the initial three sessions of psychotherapy, over a three-week period, are to be used for getting acquainted with psychotherapy, and that completing the three sessions will give the patient the opportunity to continue the treatment for six months. This agreement constitutes an engagement criterion for acceptance into the treatment.

The Use of Unauthorized Drugs and Medications

The patient should be told at the outset to avoid unauthorized medications: "We hope that you will be able to stay on the methadone, perhaps even gradually reduce it, and not take unauthorized drugs or medications. If it happens that you do take anything unauthorized, it is to

your advantage to tell your therapist and your counselor. We find that telling your therapist makes it easier for you and the therapist to figure out the conditions under which that happens. And if you have just taken something, it is very important that it not be done close to the time of a therapy session. Therapy sessions work best when you are able to think clearly, both before and after therapy, and the taking of substances prevents thinking clearly."

The Role of the Clinic Director

The role of the clinic director can be vital for the effectiveness of the psychotherapy for addicted patients, as it was in the VA-Penn study. Effective management and encouragement of the staff doing the treatment serves as a morale builder. The director also sees that patients keep appointments (or that therapists and counselors see that their patients keep appointments) and reminds therapists and counselors to stay current about patients' abstinence from unauthorized medications and drugs. The director can be the person who asks the patients to participate in the project, and he or she can also be the person who carries out the preliminary socialization interview.

Techniques for Beginning Treatment

Freud (1913), in his famous analogy between psychotherapy and a chess game, considered that, as with a chess player, the therapist's opening and closing moves are clear but the intervening ones are based largely on skill and intuition. The opening moves, in the first session especially, should

include (1) listening to what the patient wants and using those desires to help set goals, and (2) explaining to the patient what the therapist does.

Explaining the Treatment

Besides reviewing the patient's goals, the therapist should also explain the process to the patient—what the patient will be doing and what the therapist will be doing. This explanation may take several sessions, and it may repeat some of what was in the preliminary socialization interview. From time to time the therapist should emphasize that what the patient and therapist do is actively find ways of coping with and mastering problems that will lead to making progress toward the goals.

Techniques for Fostering a Supportive Relationship

Developing a Helping Relationship

Usually the patient's experience of a helping relationship will develop as the therapist simply does the job (Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988). The patient will ordinarily recognize that the therapist is trying to do his or her job of helping, the patient will then feel helped, and a good working relationship will develop. One main requirement for the development of a therapeutic alliance—which is, of course, a large component of a good relationship—is that the therapist *feel* an alliance. Sometimes its presence is reflected in the use by patient and therapist of the word *we. A* supportive relationship leading to the development of an alliance can produce

significant benefits for the patient, as was shown in the Menninger Foundation Psychotherapy Research Project (Wallerstein, 1986) and in the Penn Psychotherapy Research Project (Luborsky et al., 1988).

One possible impediment for the therapist is a dislike of the patient, especially patients with character disorders. A suggestion for therapists by Dr. Jan Frank (personal communication, 1952) is sometimes very helpful: If you search, you can always find some aspect of a patient that you approve of and like; it is useful to make such a search and find that part. Understanding the psychological problems, especially those related to the addictive behavior, is also useful, as well as being aware of the common countertransference responses (Singer & Luborsky, 1977).

The therapist may also at times need to foster the development of a helping relationship by using these specific techniques (also described in Luborsky, 1984):

> 1. The therapist conveys a sense of wanting the patient to achieve his or her goals. ("When you started treatment, you picked as your goal [cutting down on drugs] [going back to school]. In the next weeks you and I are going to try to see to it that you get what you are aiming for.")

> 2. The therapist is alert to any improvement in the patient and lets the patient know that he or she is aware of such improvement. ("You mentioned that you're feeling less depressed since you

started treatment. We are making some progress.")

3. The therapist conveys that he or she understands, accepts, and respects the patient, as in this session with Mr. Lennon.

Therapist: So you've started to feel depressed in the last couple of weeks?

Patient: Yeah. The last two weeks now. It's really been a drag. I've just got to break out of it.

Therapist: Yeah. Well, I guess it started when you started working nights, for one thing.

Patient: Yeah. It throws my whole routine off.

Therapist: Uh-huh. And you haven't had much time for yourself, and your girlfriend.

Patient: Nobody. No time for nobody—I just want to take a couple days off [from work]. It's just too much, I'm telling you.

Therapist: Yeah, it is. It seems that everyone should have off some time.

4. The therapist makes comments that show that he or she feels a "we" bond with the patient, a sense of alliance with the patient in the joint struggle against what is impeding the patient.

5. The therapist conveys (when appropriate) that he or she accepts the patient's growing sense of being able to do what the therapist does in terms of using the basic tools of the treatment.

6. The therapist refers (as appropriate) to experiences that he or she and the patient have been through together, building up, as it were, a joint backlog of common experience.

7. It may be necessary to encourage some patients to express themselves, especially to speak about the areas in which they wish to be helped.

Bolstering Areas of Competence

A second technique for providing support is to find the patient's strengths, including his or her areas of competence and effective defenses, and then to support them (Gill, 1951). For example, if the patient is trying to get a job or to complete school, the therapist should recognize the patient's efforts and explore with the patient anything that might interfere with these endeavors.

In this further example from Mr. Lennon's therapy, the therapist is clearly supportive of the patient's goal of having a job.

> Patient: So I got a job in this pizza pie place starting next week.
>
> Therapist: Oh, you do?
>
> Patient: Yeah.
>
> Therapist: Oh, good! That starts on Monday?
>
> Patient: Tuesday.

Therapist: So—what do you think? Are you happy about getting it?

Patient: Yeah! It's something to keep me occupied.

Therapist: Congratulations! That's good. You've been looking around for work.

Patient: Yeah. It's something to keep me busy.

Here the therapist is recognizing and supporting the same patient's continued reliance on self-control.

Patient: It [methadone] wears off in the early part of the morning. I'd start to feel not myself. I'd say, "You're going to get it this afternoon. Don't worry about it. You know it's there."

Therapist: How did you do on the weekend [with methadone take-homes]? Did you wait until afternoon to take them?

Patient: Yeah, every day. I'd take my medicine every day at three o'clock in the afternoon. I got up in the morning and didn't think about it.

Therapist: A lot of self-control to do that.

Patient: That's what I'm basing my thing on: a lot of self-control.

And it seems to be working. But like I said, it isn't easy.

Therapist: No, not at all.

Patient: You know it worked every day.

Therapist: So you really kept to your schedule.

Patient: Yeah. I kept to it well, very well. If I can do that, you know—

Expressive Techniques for Achieving Understanding

For a large part of the time that the therapist is engaged with the patient in a session, the therapist's attention should be on the task of listening to what the patient is communicating, evaluating it, and then deciding how to communicate his or her understanding. The process from the point of view of the therapist is an alternation of three phases: listening, understanding, and responding.

Phase 1: Listening

In this phase, attention is unreflective, or as Freud (1912/1958) named it, "evenly suspended attention," or sometimes "free-floating attention." It is just listening and not trying to fit the material to any particular conceptual model.

Phase 2: Understanding

The type of listening in Phase 1 is the best preliminary for the next phase, which is understanding. After listening, the therapist shifts to a more reflective, evaluative, understanding attitude as hunches and hypotheses develop (as shown by Spence, 1973).

In this phase, the therapist's primary goal is to find the main theme of the patient's most important symptoms (usually related to drug taking and vocational problems) and their interpersonal context.

Some patients are aware when they first come for treatment that

psychological conditions contribute to their drug taking. Mintz, O'Brien, Woody, and Beck (1979) reported that 43% of addicts studied at the start of the methadone maintenance program said they used narcotics for relief of inner tensions and worries. Similar results were found in other studies (Fejer & Smart, 1972; Hart, 1976). Two kinds of observations assist in understanding the meaning of the symptom: (1) noticing the immediate circumstances leading to the symptom, which might be the taking of the drug or just the temptation to take the drug, and (2) finding the core conflictual relationship theme (CCRT), whose conflicts might serve as preconditions for the recurrence of the symptoms.

Noticing the immediate circumstances leading to the symptom: When the drug taking or even the urge to take drugs is reported in the session, the therapist and the patient have a special opportunity to notice important conditions that led to the drug taking, as would be true for any symptom that appeared during the session, such as a momentary forgetting or a sudden increase in depression (as is described in Luborsky, 1970; in press). The appearance of a symptom when the therapist can observe the verbal and nonverbal context in which it is reported can be revealing. The report of a symptom that occurred in the past is a bit harder to understand than one that arises at the moment, but it is still likely to be enlightening. Two examples are given from the same patient, Mr. Lennon, in the same session.

1. The session starts with the patient coming in, smoking, and remarking, "Everybody in the waiting room was smoking, so I got the urge." This information should be used by the therapist to review with the patient one of the conditions that might be related to his drug taking, that is, a kind of contagion effect based on the environmental stimulation of others who are smoking (or taking drugs).

2. Another aspect of the context for drug taking is very clear in this session when the patient says, "I feel I'm so bad when I eat. I therefore try to control the impulse by not eating. Then it's like a dam bursting, and I overeat." The same sequence apparently occurs in taking drugs. An interesting confirmation of this formulation is provided when the patient says that after seeing the therapist, he feels better and he can go and have a sandwich—after he sees the therapist, he feels better about himself and therefore does not feel the urge to overeat, and he can comfortably accept the idea of modest eating.

Finding the core conflictual relationship theme associated with the symptom: The therapist gains understanding of the intra- and interpersonal context for the patient's symptoms by figuring out the core conflictual relationship theme. The CCRT contains within it the patient's central relationship problems (Luborsky, 1977; Luborsky & Crits-Christoph, 1990). The biggest tip-off to this theme is its prevalence in many different narratives of relationship episodes, about relationships both in the present and in the past. Because it also appears in the relationship with the therapist, the CCRT

can be referred to as a measure of the transference relationship.

One of the best ways for the therapist to gain experience in identifying the CCRT is to review some sessions in terms of the patient's accounts of interactions with people. Each time the patient describes an interaction with another person, the therapist should attend to three components of the account: (1) the patient's wishes, needs, or intentions ("I wish [or want] something from the person"), (2) responses from others ("I will be rejected"), and (3) responses of self ("I get upset"). This kind of analysis for a series of narratives about interactions with people provides the therapist with a sense of the most frequent wish-consequence combination, i.e., the core conflictual relationship theme.

Viewing the symptoms as attempts at problem solution: The drug taking and other symptoms can partly be understood as faulty and costly attempts at problem solution. Seeing the symptoms as problem-solution attempts and using such language with the patient is useful to both therapist and patient. One of the virtues of formulating the CCRT in terms of wish-consequence sequences is that it leads the patient and therapist to think in terms of faulty problem solutions. After grasping the wish-consequence theme and thinking of the consequence as a trial solution, further listening will then allow both therapist and patient to hear alternative solutions. It is usually best for the patient to come up with alternative solutions, but if they are not clearly

labeled as such by the patient, the therapist should do so. Theoretically, there are always many possible ways of coping; practically, it may be difficult to tell which solution is one the patient can and will try.

The triad of temporal spheres: As the therapist obtains a rounded picture of the main theme, it is valuable to understand how it appears in three spheres: (1) current relationships inside the treatment ("current-in"), (2) current relationships outside the treatment ("current-out"), and (3) past relationships. The therapist should stay alert to when the pattern of relationships with people includes the relationship with the therapist ("current-in"). Understanding the relationship with the therapist, both its transference and real components, is a valuable guide to the therapist, especially at times of special stress in the relationship. In fact, it is a good rule for this kind of therapy that when the patient is unusually upset, especially if that state began during one of the sessions, that the causes of the upset might be found in the relationship with the therapist.

It will help in evaluating and understanding the patient's problems to keep a sense of the past process of the treatment. As Holzman (1965) points out so well, the therapist tends to comprehend the process on the basis of three segments: (1) relationships within the present session, (2) relationships of the present session and the immediately prior one, and (3) relationships of these two and the longer course of a series of sessions. As a practical guide, it

is often helpful for the therapist to refresh his or her memory just before seeing the patient by looking over the themes of the last session or the series of sessions immediately prior (without letting this review distort proper listening to the session about to convene). Staying in tune with what has happened between patient and therapist in the immediate past is often useful. This attention to what has just gone before as well as what follows immediately thereafter offers a solid psychological basis for understanding the main theme or any recurrent behavior in psychotherapy. As Freud (1895/1955,1926/1959) pointed out, temporal continuity is a good basis for suspecting causal association. It is also an underlying premise in exploring the basis for symptom formation (i.e., Luborsky, 1970; Luborsky, Sackeim, & Christoph, 1979).

Phase 3: Responding

The following principles can guide the therapist's technical responses to the patient.

Response Principle Number 1. Congruence between the therapist's responses (i.e., interpretations) and the patient's main theme: The main principle is that the therapist's responses should be chosen for their congruence with some aspect of (1) the theme of the drug taking or other main symptoms, or (2) the core conflictual relationship theme. This wish-consequence theme characterizes the following example from Mr. Lennon:

The wish, need or intention: I want my efforts to be approved and recognized, not criticized for being deficient.

The consequences (responses from self): I grow up, I get upset, I get angry, I take drugs, I keep trying in hopes of getting the recognition.

The therapist selected responses that fit this wish-consequence theme.

Patient: You don't get your true recognition because they think, once a junkie, always a junkie. And they always think you're trying to connive and trying to do something, you know. It's not what some person does, like, it's just what goes along with the whole character. They generalize that you are the same as them [other addicts], but you know, it's hard to generalize everyone in one category. Everybody isn't the same. But they do, you know. They give you the runaround a lot of times. "We'll see about this," "We'll see," "We'll see." I think, "Ah, man, the hell with it. Why should I even bother anymore?" But then I say to myself, "If I didn't bother—but there's always the chance that I'll get it [a take-home]." There's always that little chance, a hope, you know.

Therapist: Yeah.

Patient: It makes me strive. But it seems like I'm never getting it, you know. I get upset. I get very ... I start to get hostile. Therapist: Then you need to calm down, and then you feel like you want to take some drugs to calm down. So I guess the pattern, if we try to make it more general, is you feel that people don't give you what you deserve. They don't recognize your accomplishments. You meet them halfway, and they don't meet you halfway.

Patient: Right.

Therapist: And then what happens is that you start getting angry about it, and it makes you feel anxious, you said. And then you end up really craving drugs

even more, feeling like you really need something to calm down.

Patient: Yeah, right. And that turns into doing something.

Therapist: And then you get angry with yourself for having done something. And it gets into a real circular thing.

Patient: Really, yeah, really. And it ain't worth it, you know. 'Cause there's always that hope I'll get the other take-home (of methadone). One of these days it's gotta happen. But I feel like, what else do I gotta do for you [counselor]? You bring in your pay slips to show him you're working and so on, keep your urines clean. I've been doing all that. I don't know what else I have to do.

Therapist: So I guess when you start getting angry with one person, you end up angry with a lot of people.

Patient: Yeah, right.

Therapist: And you feel like, "I'm just going to go out and do something. I'm not going to come to therapy. I'm going to take drugs." You end up sort of hurting yourself....

Response Principle Number 2. Presenting the therapist's responses in a tactful style that encourages the patient to feel understood (as in the previous example with Mr. Lennon).

Response Principle Number 3. Noting signs of progress in understanding: The therapist should recognize signs of progress. Since many of the therapist's responses are guided by attention to the CCRT, even after a few sessions the CCRT will become clearer to both therapist and patient and the way toward achieving goals of self-understanding will be clear. The therapist

may then say to the patient at an appropriate time, "We begin to see the problem in your relationships, which you are trying to solve. It is ." Such a formulation provides a renewed focus; "We now see ..." also increases the sense of progress, and the use of "we" adds to the sense of alliance. Such a focus is especially important in short-term psychotherapies.

Response Principle Number 4. Limiting the extensiveness and complexity of the interpretations: In general, it is better not to make too long or too complex a statement all at once. It may be hard for the patient to take it all in, if the therapist presents too much. Furthermore, it is better to give the response piece by piece and be guided by the patient's response to each piece.

Response Principle Number 5. Timing the responses: It is usually good to listen for five or ten minutes at the beginning of the session before responding to get a sense of the patient's main message. Most of the therapist's responding should be given in the first 40 minutes of a 50-minute session, leaving the rest of the time for the patient to work over what has been said. Ordinarily, new material should not be introduced at the end since there may not be enough time for the patient and therapist to go over it sufficiently.

Response Principle Number 6. Patiently waiting to respond until understanding comes: From time to time the therapist should remember to

avoid the temptation to respond before knowing what he or she is responding to. The best way for the therapist to heed this self-counsel is to also remember that it is natural not to understand consistently. Understanding comes saltatorially and unpredictably, not consistently and gradually. There is no point, then, to the therapist responding just for the sake of responding, or to the therapist appearing to be understanding before he or she really is. After working together for a while, a parallel process in the patient will develop. The patient, too, will become more tolerant of delays in self-understanding.

Response Principle Number 7. *Overcoming countertransference:* It is very easy to get caught up in certain types of negative or counter-therapeutic responses to the patient. Such responses can be especially problematic in patients with impaired ego function, such as is often the case with opiate addicts.

The first such response could be called responding without sufficient reflection and understanding. This usually happens when the therapist becomes overly involved in the exchange with the patient and finds it difficult to get the necessary distance for reviewing, reflecting, and understanding.

The second kind could be called the contagion of mood—if the patient is depressed, the therapist becomes depressed; if the patient is happy, the

therapist becomes happy; and so on. The term "contagion" has been applied by Redl (1966) as a partial explanation for the transmission of affects.

The third form of counter-therapeutic response may be more common than has been supposed: The therapist responds in ways that fit into the patient's negative expectations and fears (described in Singer & Luborsky, 1977, as "negative fit"). For example, if the patient is communicating his great fear that people in his life dominate him and tell him what to do, the therapist may unwittingly begin to do just that. Of course, the therapist is more protected from falling into these counter-therapeutic responses if he or she observes a reasonable balance between listening involvement and reflective uninvolvement. Maintaining this balance, the therapist would become aware of the main theme of the patient's fears and expectations and therefore have greater protection against fitting into them.

Response Principle Number 8. Testing the "goodness" of a session: One test of a good session that has stood up well in practical applications can be called the "matching-of-messages test." In reviewing a session, the therapist reflects on the patient's main message, which often is the same as the main relationship theme. Then the therapist should review the session again and ask a similar question: What was my main response to the patient? A good session is one in which there is a reasonable match between the two messages—when the therapist let the patient know that he or she was aware

of the patient's message, or the therapist's response took into account a realization of what the patient's message was. The matching-of-messages test was first applied under the label "therapist responds effectively to the patient's main communication" in Auerbach and Luborsky (1968). Three judges working independently were able to estimate this quality with moderately good agreement (.65, *p* < .01). In that study, the judge was instructed first to specify the patient's main communications, then to specify the therapist's responses, and finally to compare them so as to determine whether the therapist had dealt with the patient's main communication in a reasonable and effective way.

Phase 1: Returning to Listening

The therapist returns again to an attentional mode that is essentially unreflective listening. It may be difficult to shift back to this mode, not just because it involves a shift from reflectiveness to involvement. It is hard at times to keep the balance between openness to what the patient is saying at the moment and reflective recall of the main themes the patient has expressed before. The optimal state entails a combination of knowing how to proceed with the treatment and keeping calm enough to do the task. Knowing how to proceed means knowing the principles outlined earlier. And knowing these certainly lowers the therapist's anxiety about the task and therefore allows him or her to listen and understand more accurately (cf. Spence & Lugo, 1972). The therapist being able to hold his or her anxiety in check has

much to do not only with experience—with having treated many patients—but also with patience. Understanding will come in time; if it is not here at the moment, it will come in a while.

Techniques for Dealing with the Anticipation of the Ending of Treatment

Terminating Time-Limited Treatment

The supportive-expressive psychotherapy we have presented can be carried out in either of two main time structures: time-limited or open-ended. The VA-Penn project used time-limited psychotherapy. When the treatment is structured at the outset as time-limited and the patient is kept adequately informed and aware of this constraint, the patient will go through all the phases of a longer treatment in a more condensed fashion and will not experience the ending of treatment as an abrupt cutoff. In time-limited psychotherapy, because the patient and therapist know the time frame, much of what would be present in a longer treatment is present as well in the shorter treatment, that is, the treatment is still shaped by a clearly marked beginning, middle, and end. Furthermore, it is reassuring, although surprising, to realize that so far the research evidence does not show time-limited treatment to be less effective than time-unlimited treatment (e.g., Luborsky, Singer, & Luborsky, 1975).

Maintaining Awareness of Treatment Length

To minimize the special problems of dealing with termination for drug-

dependent and generally dependent patients, it is important to have the patient clearly aware from the start that the treatment is intended to last six months. Such a clear statement at the outset, referred to repeatedly thereafter, will make it easier for the patient to complete the treatment at the end of six months, to minimize the sense of rejection, and to maintain the gains. As in the VA-Penn project, the patient can also be reminded that not all treatment stops; only this psychotherapy stops, but he or she will continue with the drug counselor (Woody et al., 1983). When signs of the patient's reactions to impending termination are not evident spontaneously, the therapist should remind the patient of termination or find out whether the patient is responding to termination but not expressing it.

Dealing with Resurgence of Symptoms in Anticipation of Termination

Dealing adequately with the meaning of termination will usually have a good effect on solidifying the gains of the treatment. For example, the initial problems usually revive as termination approaches. If the therapist deals with this reappearance of the initial problems by considering it with the patient in terms of an anticipation of the meaning of ending, usually the problems subside and the patient is better able to reinstate the gains made earlier.

For example, Mr. Fergeson was a little difficult to engage during the first and second sessions but then was very pleased to participate and come to the sessions. He was always on time until about a month before termination,

when he found it very difficult to come. Then he stopped coming altogether, because, he said, he was so frustrated that he didn't get the money to start his vocational training. His absence may also have been based on disappointment about having to stop the treatment, or other kinds of disappointments. He had seemed during the treatment to be headed toward being able to accomplish things that he needed to do, but none of them came to pass. His dose of methadone was down to 10; two months before termination, he was expecting to soon be off the methadone. He was expecting to start school. He spoke about it being time to leave his mother's home. As termination approached, however, he became discouraged and spoke of falling back into his mother's care and back into drugs. Discussion of the meaning of the return of his symptoms just as the ending came helped reinstate his improvements.

This is an example of a not uncommon inclination to get discouraged about achieving the initial goals as termination looms. In this case, discussing the issue with the patient restored much of his motivation.

Recognizing Treatment Phases

All through the treatment, the therapist should be alert to the appearance of phases of the treatment as a function of the achievement of the goals, as Schlesinger (1977) has pointed out. Completing or even partially completing goals and starting new ones is of special value for the therapist and patient since, as we discussed earlier, doing so provides a sense of

completion and progress to the patient at a readily understandable level. Attention to completion of phases can also provide a brake on too much transference involvement or too much regression.

Continuing the Relationship After Termination

Many patients naturally are interested in knowing whether the therapist wants to be kept up to date on their progress after termination. The therapist may say, when this issue comes up, that he or she would welcome news of how things are going. To those patients who were part of the VA-Penn project, therapists said that news would also come to them from the patient's routine follow-ups. Such an exchange at the time of termination can understandably contribute to maintenance of the treatment gains.

Dealing with the Need for Further Treatment

If at termination new goals are raised, or if the old goals are not achievable in the time remaining and the patient wishes to continue treatment, the therapist should help with a referral to another therapist.

CASE EXAMPLE

At the start of therapy, Mr. Lennon was heavily addicted to heroin. He functioned poorly in work, in relationships, and in self-care. His grooming was almost absent. By the end of therapy, his heroin usage had almost

vanished and he had a regular job in an automotive store. He had his old girlfriend back, he took better care of himself, and his grooming and self-esteem were much improved.

This patient's psychotherapy showed a strong supportive component. The following discussion, however, focuses on the central relationship problems that were the object of the therapist's interpretations. The therapist used the following examples of his relationship episodes (REs), told in the session of July 8, 1981, to formulate the core conflictual relationship theme, which was the recurrent focus of the therapist's interpretations.

RE1: Friends. For many years I helped my "friends" by giving them food, shelter, drugs, and money. But when I asked for help from them, they disappeared. It's difficult now to find friends who aren't using some kind of drug or alcohol. Everyone wants to get high. I do not want to get involved in that scene.

RE2: Therapist. I'm trying to figure out how to get out of this rut. It feels like there's no way out of this bind. I'm tempted to drive to New York City to buy some heroin. I just wanted to escape reality somehow. I thought about buying dope while I was driving here [to see you]. If I wasn't coming here today for our appointment, I would have driven to New York City. *[At this point, the regular 60-minute session would have ended.]* However, I want to

talk for an additional time about anything else but drugs. I can't leave here feeling this way, or I'll go straight to New York. Please, let's talk until I feel more calm.

RE3: Girlfriend. I want to tell you about my relationship with my girlfriend and our planned marriage. We have dated since we were 15 years old, although she refused to continue dating after I returned from Vietnam [at age 23] addicted to heroin, but we kept in contact with each other and remained friends. Four months ago, we decided to continue the relationship we had 12 years ago. Very recently, we decided to marry. Using drugs would jeopardize these plans. *[After 30 minutes, Mr. Lennon said he felt much calmer and ready to return to work.]*

These three relationship episodes reveal the following CCRT:

Wish: I want to work hard to do something that would please someone else. I wish for a return in terms of approval, respect, and affection.

Response from other: I expect the other person will not give me what I wish for.

Response of self: I feel deprived and angry. (*Taking drugs lessens these feelings of deprivation and anger.*)

During the course of the session, the buildup of this conflictual theme was apparent, and Mr. Lennon's request for additional time was a test of the theme in relation to the therapist. By the end of the session, he did not feel deprived to such a degree that he had to use drugs. The threat to the relationship if he did use drugs also served as a deterrent. In his relationship with his girlfriend, he usually had a sense of security, an expectation that he would receive approval and affection. The same feelings were illustrated in his relationship with the therapist. Fie was able to risk asking for the extra time and was able to feel satisfied after receiving it. At the time, his craving for heroin was sufficiently reduced that he did not feel compelled to use the drug that day.

An even briefer excerpt from an earlier session shows that the therapist had repeatedly focused interpretatively on parts of this CCRT. This example is from the first third of the session of June 17,1981.

> Patient: I'm using a lot of things for motivation—diet and relaxation. You know, coming here motivates me every Wednesday.
>
> Therapist: Yes.
>
> Patient: You know, going to see Melody [relaxation trainer], going to see Nina [nurse-practitioner], going to see Lou [counselor]. You know, four days a week I see people. . . . And everything is going good.
>
> Therapist: So, the main thing is, you're using motivation and challenges from all different areas.

Patient: Right, right.

Therapist: And I guess you're saying, no matter how hard you work, sometimes you feel that you're supposed to be doing more, or never feel that people are saying, "Good work."

Patient: Yeah. I never see people accept me for what I do. It always seems like a downhill struggle.

Therapist: You always feel like you're fighting this image [of a drug user].

Patient: Yeah. And I've got to struggle better all the time.

More detailed instructions for scoring the CCRT and its use in clinical work can be found in Luborsky and Crits-Christoph (1990), and Luborsky (1993a) adds more on how to use the CCRT to maximize the benefits of psychotherapy.

TRAINING

Trainees should already have had several years of experience as dynamic psychotherapists. For this group, the special training in SE dynamic can usually be accomplished in a matter of a year or two. Supervision aided by this manual is a necessary combination. Learning to follow the manual's recommendations can be facilitated by applying the manual to patients and then rereading the parts of the manual that are relevant to the treatment. The concurrent supervision can be either individual or in a group led by an expert in SE dynamic psychotherapy. Also helpful is a special form of group

supervision in which each therapist has a chance to present and also a chance to help supervise the other presenters (as described in Luborsky, 1993a).

Whether the supervision is individual or group, it is absolutely essential that samples of the therapist's audio- or videotape recordings be scored for adherence. Assessing adherence ensures that the therapist is actually using the essential principles in the manual.

Dynamic Psychotherapy for Treatment of Opiate Drug Dependence

Our first study of psychosocial treatments with opiate addicts was started in 1977 at the Drug Dependence Treatment Unit of the Philadelphia VA Medical Center (Woody et al., 1983). Patients who were interested in the treatments and fit the criteria were offered random assignment to drug counseling alone or to drug counseling plus six months of either SE dynamic psychotherapy or cognitive-behavioral psychotherapy. Of the patients who met the criteria, 60% expressed interest, and 60% of these, or 110, actually completed the intake procedures and became engaged in the therapy. Engagement was defined as keeping three or more appointments within the first six weeks of treatment. All three treatment groups significantly improved, but patients receiving the two psychotherapies showed greater improvement and improvement in more areas than those receiving drug counseling alone; they also used less medication. In summary, opiate addicts were both interested in the professional psychotherapies and benefited from

them.

In the same study, there were no significant differences in the number of areas of benefit between SE dynamic psychotherapy and cognitive-behavioral psychotherapy. The gains evident at the 7-month follow-ups (one month after termination) were also evident at the 12-month follow-ups. The psychiatric severity at the start of treatment (measured either through the Addiction Severity Index [McLellan, Luborsky, Cacciola, Griffith, McGahan, & O'Brien, 1985] or through composites of standard psychological tests) was a significant predictor of outcome for all three treatments. Finally, the advantage of the two professional psychotherapies over counseling alone was best seen among the most psychiatrically ill patients.

The National Institute of Drug Abuse was interested in the cross-validation of these results in community clinics. We therefore did a cross-validation in three Philadelphia community clinics from about 1986 to 1990 (Woody, McLellan, Luborsky, & O'Brien, 1994). Because the two psychotherapies had shown mostly nonsignificant differences, we chose only the SE dynamic psychotherapy for this study, and because less time had been given in the original study to the drug counseling than to the psychotherapies, we used two separate drug counselors. The results still showed the advantages for the professional psychotherapy, but the advantages were reduced as compared with the original study. While at seven months the

advantage was slight, at 12 months the advantage had become larger. The finding of reduced differences between drug counseling and SE therapy at seven months was almost certainly attributable to it being harder to show advantages when the comparison was between SE psychotherapy versus *two* drug counseling treatments simultaneously.

REFERENCES

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: APA.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: APA.

Auerbach, A. H., & Luborsky, L. (1968). Accuracy of judgments of psychotherapy and the nature of the "good hour." In J. Shlien, H. F. Hunt, J. P. Matarazzo, & C. Savage (Eds.), *Research in psychotherapy* (Vol. 3, pp. 155-168). Washington, DC: American Psychological Association.

Bergmann, M., & Hartman, F. (Eds.). (1977). *The evolution of psychoanalytic technique.* New York: Basic Books.

Burstein, A. (1976). Psychotherapy for the poor. In J. L. Claghorn (Ed.), *Successful psychotherapy* (pp. 189-196). New York: Brunner/Mazel.

Chappel, J. N. (1973). Attitudinal barriers to involvement with drug abusers. *Journal of the American Medical Association,* 224,1011-1013.

Ekstein, R., & Wallerstein, R. (1958). *The teaching and learning of psychotherapy.* New York: Basic Books.

Fejer, D., & Smart, R. (1972). Drug use, anxiety and psychological problems among adolescents.

Ontario Psychologist, 4,10-21.

Fenichel, O. (1945). *The psychoanalytic theory of neurosis.* New York: Norton.

Freud, S. (1955). Studies on hysteria. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 2, pp. 3-305). London: Hogarth Press and the Institute of Psychoanalysis. (Original work published in 1895)

Freud, S. (1958). Recommendations to physicians practicing psychoanalysis. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 111-120). London: Hogarth Press and the Institute of Psychoanalysis. (Original work published 1912)

Freud, S. (1958). On beginning the treatment (further recommendations on the technique of psychoanalysis). In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 123-144). London: Hogarth Press and the Institute of Psychoanalysis. (Original work published 1913)

Freud, S. (1959). Inhibitions, symptoms and anxiety. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 20, pp. 87-174). London: Hogarth Press. (Original work published 1926)

Gill, M. M. (1951). Ego psychology and psychotherapy. *Psychoanalytic Quarterly,* 20, 60-71.

Hart, L. (1976). Attitudes toward drug use, therapeutic community (concept) resident versus methadone patients. *British Journal of Addictions,* 69, 375-379.

Henry, W., Sims, J., & Spray, S. (1973). *Public and private lives of psychotherapists.* San Francisco: Jossey-Bass.

Holzman, P. (1965). Process in the supervision of psychotherapy. *Bulletin of the Menninger Clinic,* 29,125-130.

Kernberg, O., Burstein, E., Coyne, L., Appelbaum, A., Horwitz, L., & Voth, H. (1972). Psychotherapy and psychoanalysis: Final report of the Menninger Foundation's Psychotherapy Research Project. *Bulletin of the Menninger Clinic,* 36,1-275.

Klein, G. (1970). *Perception, motives and personality.* New York: Knopf.

Knight, R. (1949). A critique of the present status of the psychotherapies. *Bulletin of the New York Academy of Medicine,* 25,100-114.

Lorion, R. P. (1974). Patient and therapist variables in the treatment of low-income patients. *Psychological Bulletin,* 81, 344-354.

Luborsky, L. (1970). New directions in research on neurotic and psychosomatic symptoms. *American Scientist,* 58, 661-668.

Luborsky, L. (1977). Measuring a pervasive psychic structure in psychotherapy: The core conflictual relationship theme. In N. Freedman (Ed.), *Communicative structures and psychic structures* (pp. 367-395). New York: Plenum Press.

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

Luborsky, L. (1993a). How to maximize the curative factors in dynamic psychotherapy research. In N. Miller, L. Luborsky, J. P. Barber, & J. Docherty (Eds.), *Dynamic psychotherapy research: A handbook for clinical practice* (pp. 519-535). New York: Basic Books.

Luborsky, L. (1993b). Recommendations for training therapists based on manuals for psychotherapy research. *Psychotherapy,* 30, 578-580.

Luborsky, L. (1994). Therapeutic alliances as predictors of psychotherapy outcomes: Factors explaining the predictive success. In A. Horvath & L. Greenberg (Eds.), *The working alliance: Therapy, research and practice* (pp. 38-50). New York: Wiley.

Luborsky, L. (in press). *The symptom-context method: Solving and resolving symptoms in psychotherapy.* Washington, DC: APA Books.

Luborsky, L., & Crits-Christoph, P. (1990). *Understanding transference: The CCRT method.* New York: Basic Books.

Luborsky, L., Crits-Christoph, P., Mintz, J., & Auerbach, A. (1988). *Who will benefit from*

psychotherapy? Predicting therapeutic outcomes. New York: Basic Books.

Luborsky, L. B., Fabian, M., Hall, B. H., Ticho, E., & Ticho, G. (1958). Treatment variables. *Bulletin of the Menninger Clinic,* 22, 126-147. (Part of the *Menninger Bulletin* issue entitled *The Psychotherapy Research Project of the Menninger Foundation*)

Luborsky, L., Sackeim, H., & Christoph, P. (1979). The state conducive to momentary forgetting. In J. Kihlstrom & E. Evans (Eds.), *Functional disorders of memory* (pp. 325-353). Hillsdale, NJ: Lawrence Erlbaum Associates.

Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that "everybody has won and all must have prizes?" *Archives of General Psychiatry,* 32,995-1008.

Malan, D. (1976). *Towards the validation of a dynamic psychotherapy.* New York: Plenum Press.

Mann, J. (1973). *Time-limited psychotherapy.* Cambridge, MA: Harvard University Press.

McLellan, A. T., Luborsky, L., Cacciola, J., Griffith, J., McGahan, P., & O'Brien, C. (1985). *Guide to the Addiction Severity Index: Background, administration and field testing results* (Department of Health and Human Services Monograph Vol. 30). National Institute on Drug Abuse Treatment Research Report. Publication No. (ADM) 85-1419. Washington, DC: U.S. Government Printing Office.

Menninger, K., & Holzman, P. S. (1973). *The theory of psychoanalytic technique* (2nd ed.). New York: Basic Books.

Miller, N., Luborsky, L., Barber, J. P., & Docherty, J. (Eds.). (1993). *Psychodynamic treatment research: A handbook of clinical practice.* New York: Basic Books.

Mintz, J., O'Brien, C. P., Woody, G., & Beck, A. T. (1979). Depression in treated narcotic addicts, ex-addicts, non-addicts, and suicide attempters: Validation of a very brief depression scale. *American Journal of Drug and Alcohol Abuse,* 6(4), 385-396.

Norcross, J., Prochaska, J., & Farber, J. (1993). Psychologists conducting psychotherapy: New findings and historical comparisons on the psychotherapy division membership.

Psychotherapy, 30, 692-697.

Orne, M., & Wender, P. (1968). Anticipatory socialization for psychotherapy: Method and rationale. *American Journal of Psychiatry,* 124, 88-98.

Redl, F. (1966). *When we deal with children.* New York: Free Press.

Schlesinger, H. (1977). The responsibility of the psychoanalyst for analytic and therapeutic change. *Bulletin of the Menninger Clinic,* 41, 202-206.

Schmale, A. (1958). Relationship of separation and depression to disease. *Psychosomatic Medicine,* 20, 259-277.

Sifneos, P. E. (1972). *Short-term psychotherapy and emotional crisis.* Cambridge, MA: Harvard University Press.

Singer, B., & Luborsky, L. (1977). Countertransference: A comparison of what is known from the clinical versus quantitative research. In A. Gurman & A. Razin (Eds.), *The therapist's contribution to effective psychotherapy: An empirical assessment* (pp. 431-148). New York: Pergamon.

Spence, D. P. (1973). Tracing a thought stream by computer. In B. B. Rubinstein (Ed.), *Psychoanalysis and contemporary science* (Vol. 2, pp. 188-201). New York: Macmillan.

Spence, D. P. & Lugo, M. (1972). The role of verbal cues in clinical listening. In R. Holt & E. Peterfreund (Eds.), *Psychoanalysis and contemporary science* (Vol. 1, pp. 109-131). New York: Macmillan.

Strupp, H., & Bloxom, A. (1973). Preparing lower-class patients for group psychotherapy: Development and evaluation of a role induction film. *Journal of Consulting and Clinical Psychology,* 41, 373-384.

Valliant, G. (1973). A 20-year follow-up of New York narcotic addicts. *Archives of General Psychiatry,* 29,237-241.

Valliant, G. (1983). *The natural history of alcoholism.* Cambridge, MA: Harvard University Press.

Wallerstein, R. (1986). *Forty-two lives in treatment: A study of psychoanalysis and psychotherapy.* New York: Guilford Press.

Wallerstein, R., Robbins, L., Sargent, H., & Luborsky, L. (1956). The psychotherapy research project of the Menninger Foundation: Rationale, method, and sample use. *Bulletin of the Menninger Clinic,* 20, 221-280.

Woody, G., Luborsky, L., McLellan, A. T., O'Brien, C., Beck, A. T., Blaine, J., Herman, I., & Hole, A. V. (1983). Psychotherapy for opiate addicts: Does it help? *Archives of General Psychiatry,* 40, 639-645.

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

Woody, G., McLellan, A. T., Luborsky, L., & O'Brien, C. (1994, June). *The outcomes of psychosocial treatments for opiate addicts in three community clinics.* Paper given at the meeting of the North American Society for Psychotherapy Research, Santa Fe, NM.

Woody, G. E., Stockdale, D., & Harris, W. (1993). *Drug dependence treatment unit manual.* Unpublished manuscript.

Notes

[1] The authors of the present version of the manual were part of the first such training group; those in successive training groups have also contributed ideas to successive editions, including A. Thomas McLellan, Anna Rose Childress, David Mark, Jeff Faude, Mike Montanero, Larry Hart, Sam Okpaku, Barbara Goldsmith, Andrew Cooper, Lorrie Helgie, Pam Bekir, and Morrie Olsen.

CHAPTER 6

Dynamic Therapy for Post-Traumatic Stress Disorder

Louise Gaston

HISTORY AND DEVELOPMENT

In the field of psychoanalysis, the infantile conflict was historically viewed, for the most part, as the principal pathogenic factor in psychic trauma (Fenichel, 1945; Freud, 1939/1953, 1962). The ego of the victim had to reestablish homeostasis by "discharging," "binding," or "abreacting" (Freud, 1962). In reaction against this classic model of symptom formation, Kardiner and Spiegel (1947) postulated that the factors related to the event are decisive in traumatogenesis. More contemporary authors (Hendin & Hass, 1984; Horowitz, 1986; Krystal, 1985) have reconciled the two extreme positions on the etiology of trauma by emphasizing the role played by the meanings attached by the individual to the traumatic event (Brett, 1993). Horowitz (1974, 1986) further introduced the concept of information, as borrowed from information theory. Information can have inner and outer origins, it applies to both ideas and affects, and if salient information is not assimilated within the existing system, the system must accommodate itself to integrate the incongruent information.

In this chapter, I describe a comprehensive dynamic approach for treating post-traumatic stress disorder (PTSD) that is mostly based on Horowitz's model (1974, 1986). The approach I use is brief in its orientation; it is focused on trauma, its associated conflicts, and their resolution. It encompasses various techniques, including hypnosis. Its duration depends on the severity of the trauma, its chronicity, and the patient's ego structure and motivation for therapy. If trauma is severe and renders the patient dysfunctional, therapy sessions are held twice a week to both support the patient's ego in dealing with the traumatic aftermaths and counter the avoidance tendencies associated with PTSD.

Basic dynamic concepts are employed to guide patients toward resolving the trauma. Nonetheless, each therapy is tailored to the needs and capacities of the individual. Therefore, all dimensions involved in a traumatic response are considered. A patient's unbalanced neuronal activity, behavioral patterns, coping skills, cognitive schemas, and self-concepts, as well as the influences of familial and social systems, can also contribute to the etiology and maintenance of a traumatic response. My approach recognizes their impact and attempts to manage them adequately. Consequently, therapeutic adjuncts, such as medication, functional analysis, skill acquisition techniques, encouragement toward interpersonal proximity and assertion, anxiety or anger control techniques, hierarchical exposure to stimuli, and cognitive restructuring, can be added.

Furthermore, I realized that exploration of trauma can only be intellectual rather than experiential or involving emotional components. In a normal state of consciousness, information that could contribute to complete understanding of a traumatic response is often missing. Information can be best retrieved in the same emotional state of consciousness in which it was encoded. Therefore, I specifically include hypnosis as a tool for revising the traumatic experience because it enforces the emotional re-experience of trauma and the full review of the event.

INCLUSION/EXCLUSION CRITERIA

Patients who present with a PTSD (APA, 1994) and are susceptible to benefit from this approach are late adolescents or adults with a relatively good premorbid functioning on the psychological, interpersonal, and vocational levels. Those who are most likely to benefit are psychologically minded, respond minimally to interpretations, have some tolerance for pain, and utilize repression only among other strategies to contain painful affects.

Intense anxiety symptoms, however, can mask those capacities in a patient at intake. The most useful criterion is therefore the patient's history of interpersonal relationships, including the presence of an adequate parental figure (even if physical or sexual abuse has occurred) and no history of psychiatric problems. Suicidal patients are not excluded.

Some patients, however, are not predisposed to change in dynamic therapy. These patients usually display a substance abuse disorder, psychotic features, a history of antisocial behavior, a severe personality disorder, or less than average intelligence. Furthermore, dynamic therapy cannot be instigated until a victim is out of danger. Until the threat is eliminated, only supportive therapy should be provided.

DYNAMIC ISSUES IN PTSD

Etiology

Historically, psychotherapists have tended to focus on one of two possibilities in regard to the etiology of trauma symptoms (Brett, 1993). The first position views the factors related to the individual as decisive in the traumatogenesis. There are three fundamental conceptualizations of this etiology of trauma (Brett, 1993). The first is Fenichel's (1945) model of symptom formation: Symptoms form when current frustrations revive infantile conflicts, and come to reflect ways of feeling and defending that were operative in childhood. The second etiological model was Freud's (1939/1953): Traumatic events lead to excessive incursion of stimuli by exceeding the "stimuli barrier" or "protective shield" of the individual. Consequently, the organism is flooded with impulses, and its functioning is disrupted. The third formulation is Freud's addition of the repetition model

(1939/1953): Following the overwhelming assault on the stimulus barrier, a regression occurs, leading to the use of a primitive defense, repetition compulsion, to repeat the event in an effort to master it.

In reaction against these classic models of symptom formation, the second position postulates that the factors related to the event are decisive in the traumatogenesis (Kardiner & Spiegel, 1947). This position sometimes concedes that a preexisting conflict may be symbolically revived by a traumatic event, but the conflict occurs as an independent accompaniment to the trauma, not as a cause of the event being traumatic. It is only when the individual tries to defend against the damage done to his functioning by the event that meanings symbolic of old conflicts are attached to it.

More contemporary authors have compromised between these models (Hendin & Hass, 1984; Horowitz, 1986; Krystal, 1985). Their positions reconcile the two extreme positions on the etiology of trauma. In these models, the subjective meaning of the event determines whether it becomes traumatic or not, and the meaning is defined through the individual's earlier experiences as they relate to the traumatic event's characteristics. In these interactional models, the primary pathogenic force is nevertheless viewed as coming from the traumatic event itself. There are empirical results supporting this position. It has been shown that, as the intensity of violent events increases, the number of traumatized individuals increases (Green,

Lindy, & Grace, 1985). Furthermore, particular types of events are more likely to create trauma in victims than others (Breslau, Davis, Andreski, & Peterson, 1991). This view has been adopted by the *DSM-IV* committee on PTSD, which softened its previous position by stating that, to be traumatic, an event has to provoke intense fear, horror, or helplessness in the individual, rather than being traumatic for most people as it was defined in the *DSM-III-R* (APA, 1985,1994).

Factors at Play

The phenomenologic description of psychic trauma in the *DSM-IV* (APA, 1994) is consistent with most dynamic principles about psychic trauma. The two basic processes involved in psychic trauma are the repetitive and intrusive re-experiencing of trauma and the avoidance of this re-experiencing. A third cluster of symptoms arises from over-activation of the autonomic nervous system, observed through sleep difficulties, irritability and concentration problems, hypervigilance, and startle reactions, which can be viewed as a consequence of the former two clusters of symptoms.

Horowitz's model (1986) proposes a sequence of phases that, before the installment of those symptoms, may lead to psychic trauma, depending on the individual's reactions. The immediate response to a traumatic event is usually an outcry phase. This alarm reaction is often accompanied by strong

emotions, usually fear and anger. The individual is likely to postpone any other activity. Internally, the individual may say, "I'm going to die," or, "It can't be happening," the latter providing an indication as to what will happen in the denial phase. When the situation no longer calls for an immediate response or an extensive implementation of coping mechanisms, the individual usually begins to relax and to lower defenses. Intrusion and denial phases ensue.

The intrusion phase is characterized by unbidden ideas about the traumatic event, suddenly feeling and acting as if the event were happening again, and psychological distress and/or physiological arousal at the presentation of stimuli associated with the event. During the intrusion phase, the autonomic arousal is usually at its peak. The individual may perceive reality through its inner sensations and therefore distort it. Some images may have a pseudo-hallucinatory or illusory quality. A traumatized individual may also ruminate about the event during these intrusion periods; reenactments of the events can take place involving fantasied responses in which the individual symbolically masters the event, indicating a denial of the reality of the failed enactment. The intrusion phase may manifest itself through distressing nightmares, from which the individual may wake up sweating in fear. The individual may have the impression that these intrusive and repetitive affects and ideas are meaningless and overwhelming and may interpret them as a sign of losing control over his or her internal world.

In an attempt to regain control, the individual enters a denial phase. Repression and avoidance are put in place to reduce the anxiety associated with re-experiencing the event. Actions are taken to avoid talking about the event or being in situations and places that resemble the event. Sometimes parts of the event cannot be remembered, usually the most significant ones, due to a peri-dissociation at the time it occurred. Denial also serves the purpose of pushing away from consciousness unwanted emotions and their associated meanings. The energy required to install repression mechanisms depletes the inner resources of the individual, leaving little to invest in hobbies and daily activities. Often this lack of other interests also indicates the individual's perception of the event: "If such events are part of life, it may not be worth living." Emotional numbing may set in, taking the form of detachment from others, estrangement, and attempts to stop feeling any emotion—at first joy, then anger and sadness. A sense of a foreshortened future follows.

Although the intrusion and denial phases can become pathological, a normal reaction to a traumatic event also involves these phases, which do not necessarily imply the development of a psychic trauma. Re-experiencing and avoidance should be viewed as pathological only if they are enduring and interfere with the individual's functioning. Re-experiencing allows the mind to revise the events in all its facets, and avoidance permits resting periods from this intense psychic work.

Trauma occurs when the intrusion and denial phases are out of the control of the individual, when the oscillation between Re-experiencing and avoidance is involuntary. In this case, the individual's defense mechanisms and coping strategies are likely to interfere with the processing of the information attached to the event.

Beyond traumatogenic factors, numerous maintenance factors are at play in psychic trauma. The losses associated with the event may contribute to the maintenance of symptoms; for instance, an individual may have lost a limb after the event, or his job, because symptomatology interfered too much with his performance at work. Chronic pain may also fuel the repeated reviviscence of the trauma and act in a positive feedback loop with the traumatic memories to augment PTSD symptoms. Responses from others are also important in determining whether a psychic trauma will be easily resolved or not, particularly the responses of those providing immediate help, close ones, and the judicial and medical systems. The more chronic a psychic trauma is, the more difficult is its resolution, and the more likely it is to create permanent sequelae. In addition, trauma often becomes complicated by co-morbidity, rendering the picture more complex and depleting the individual's resources.

The constellation of predisposing, precipitating, and maintaining factors potentially at play in a psychic trauma highlights the presence of individual

differences among victims. Consequently, dynamic therapy ought to be tailored to the specific needs and capacities of each individual.

Developmental History

The impact of a traumatic event differs according to the developmental stage of an individual. Preschool children who are abused are limited in their capacity to verbally represent the trauma. With increasing maturity, these experiences may not become readily assimilated into verbal representations (Pynoos & Nader, 1993). Inversely, if no harm has been caused to them or others, preschool children may not be cognitively developed enough to understand the realistic implications of a traumatic event but rather may interpret abusive actions as simple play.

During early adolescence, trauma exposure can interfere with the ongoing tasks of separating from parents, developing moral judgment, developing identity, and so forth. In later adolescence, repetitive trauma can result in severe personality disorders, as seen in young combat veterans (Marmar, 1991).

Models of traumatization have less adequately addressed the impact of adult development on trauma. The meaning of an event may depend on the situation experienced by the adult at a certain time period. For example, witnessing a child being hit by a car is likely to be differently traumatic to a

parent than to a childless adult.

In late adulthood, a traumatic event may occur when the individual is going through a decline in social status, loss of loved ones, and diminishing mental and physical capacities. Older adults' perception of self-efficacy in coping with a traumatic event may be low, and they are often left to themselves (Marmar, Foy, Kagan, & Pynoos, 1993).

Major Conflicts

Preexisting neurotic conflicts can be impediments to processing a traumatic event, but only when they are associatively similar to the information attached to the traumatic event. Other more general conflicts may arise when basic illusions that provide a sense of security in the world have been shattered by the traumatic event, revealing anxiety-provoking realities about oneself and the world.

Most of us entertain, consciously or unconsciously, three basic illusions. Humans tend to view the world as benign, controllable, and predictable, and conversely, they view themselves as immortal, invulnerable, and omnipotent (Epstein, 1991). Trauma experientially enforces on us the notions of helplessness and death, to which we usually react with overwhelming anxiety. A rejection of this reality activates a series of defense mechanisms.

Another dimension of an individual's reality can compensate for those painful realizations and bring a sense of relative security in the world, namely, feeling attached to competent and caring individuals (Bowlby, 1988). The saliency of the need for secure attachments has been empirically demonstrated in traumatized individuals (Epstein, 1991). However, a traumatic event can also shatter an individual's representations of being safe in relation to others. A traumatic event can be either natural/accidental or provoked by another human being. If the event is natural/accidental and involves the real or imagined loss of a loved one, we can be abruptly confronted with the painful realization that love objects are not eternal. One defense employed against this painful realization is seeking isolation from others, either physically or affectively, in an attempt to lower the pain associated with future losses. If a traumatic event is provoked by a human being, such as in criminal acts, the individual is brutally confronted with the evilness of others. Through generalization, the victim's relation to others can become severed, or at least questioned, in an attempt at self-protection. The individual comes to fear others, viewing their physical and verbal actions as hostile, especially if the immediate assistance after the event has been neglectful, minimizing, or aggressive. Another defense against this realization of evil is imagining that pain was deserved because one has been bad.

Surprisingly, traumatized individuals rarely feel anger at the aggressor at the beginning of therapy. Anger is displaced or diffused. Traumatized

individuals are often conflicted about the tremendous anger they experience following a traumatic event. If they feel anger or rage, they may conclude that they are bad, and they may fear losing control over their anger. The self is viewed as dangerous and others as helpless (Catherall, 1991).

Victims can also be conflicted about pain, rejecting the unavoidability of its existence. They become angry at life and end up rejecting it, viewing it as not worth experiencing. Such angry reactions are more forceful as more painful elements are attached to the traumatic event. Such anger is usually associated with a wish for others to repair the damage, especially, if available, the person responsible for the traumatic event, or to simply recognize it fully.

Defenses and Identifications

Any defense mechanism can be observed in traumatized individuals. Because the ego of traumatized individuals is overwhelmed, it resorts to less mature defense mechanisms. Ideally, patients preserve part of their most advanced defense mechanisms, such as humor and distancing, but they sometimes use somatization and projection to express isolated affects. Some patients can even temporarily utilize such immature defenses as splitting and hallucinations. Defenses are usually organized against fear, anger, or helplessness.

While the primary damage is done to the individual's ego, a secondary

damage occurs to the individual's relation to internal objects (Catherall, 1991). The latter effect can be clinically operationalized as a loss of trust. The individual has been confronted with the reality that others cannot be trusted to control their aggressive impulses.

Against fear, many victims employ minimization of both the event and the associated psychic damage. They may even resort to extreme repression or denial at times, leaving the psychological distress unattended and operating in isolation. To somehow regain a sense of control and security, the individual may generalize the dangerous features associated with the event to other aspects of reality, thus preparing for any new danger. The individual may also deny the existence of danger, using a counterphobic mechanism, which leads to potentially dangerous actions such as walking alone at night in violent neighborhoods.

The discovery that others cannot be trusted to control their aggressive impulses can be more or less devastating. In general, traumatized individuals become enraged at the injustice of being a victim and disown aspects of the self, including their own aggression impulses and capacity to victimize. Some individuals already rely on splitting and projection to deal with unacceptable parts of the self; when they are victimized, these individuals may defend through an identification with the aggressor. When this defense mechanism is adopted and well established, it often leads to the characterological use of

violence as a means of interacting with others. Most victims, however, do not resort to an identification with the aggressor, violence being ego dystonic or against their moral values. They usually displace anger toward close ones and project it into strangers. Projecting anger often leads to hypervigilance. Only when some victims can calmly acknowledge that they wish to hurt or kill someone are they capable of walking at ease on the streets. In therapy, a direct viewing of these disowned aspects of the self in the therapist is often accomplished through the mechanism of protective identification. As for children, identifying with the object's capacity to cope with the projected material is part of acquiring a more mature internal structure (Catherall, 1991).

Anger may itself serve as a defense, usually against panic or disintegration (Catherall, 1991). Anger may also function as an attempt to restore one's narcissism through the wish to regain control over the aggressor, as usually observed in male victims. Or anger may be aimed at restoring the feeling of being in relation with others, through the wish to make the aggressor recognize that pain was inflicted on the victim and it should not happen again, as usually seen in female victims.

Victims can feel exaggerated guilt as a defense against anger. But most traumatized individuals also feel guilt as a defense against helplessness. A traumatized individual is likely to be better able to tolerate guilt than to

acknowledge the reality that sometimes we cannot prevent a terrible accident or interfere with another's malicious plans. Rather than recognize their sense of helplessness, traumatized individuals feel guilty over their failed enactment and develop endless scenarios to ultimately master the event (Lipton, 1993).

Finally, dissociation is an extreme attempt to protect oneself or others. It is characterized by a marked loss of control over one's mental state and is often accompanied by intense panic states. According to Spiegel (1988), trauma can be understood as the experience of being made into an object, and dissociation can be conceptualized as a reflection of the profound loss of physical control experienced during the traumatic event. Trauma seems to foster the use of dissociation, especially when severe physical harm occurs in early childhood (Putnam, 1985). Whenever an individual uses dissociation to protect himself or herself against pain, the information associated with the traumatic event cannot be processed. In therapy, it is most often consciously concealed by the individual. To relinquish its pathological use, the consequences of dissociation have to be identified and reappraised, and more mature strategies need to be implemented.

TREATMENT GOALS

There is an overlap between therapist and patient goals in dynamic

therapy for psychic trauma. They both aim at restoring the patient's premorbid functioning and eliminating the PTSD symptoms. To accomplish these tasks, the therapist develops process goals in accordance with dynamic theory. The goals of brief dynamic therapy for psychic trauma are limited to ideational and emotional working-through of the stress response syndrome to a point of relative mastery, a state in which both denial and repetitive Re-experiencing are reduced or absent (Horowitz & Kaltreider, 1979). It is possible to expand on these goals.

Therapist Goals

Acknowledging and Accepting the Traumatized Self

Many traumatized patients come into therapy seeking relief from their loss of control over themselves and their lives, though they deny that they have been wounded psychologically. The first goal of the therapist is to assist the patient in acknowledging the traumatized self, usually by recognizing his or her psychological distress. The ensuing goal is to help the patient accept the traumatized self by viewing psychological distress as non-infantile. These goals are usually achieved through a parallel process of restoring the patient's damaged narcissism.

Regaining Mastery

The second goal is to help the patient regain or develop a sense of mastery over both external and internal worlds, within realistic limits. For example a patient can be assisted in making decisions about his or her participation to the justice system, actively seeking support, and limiting external demands as much as possible. The therapist can help a patient to lower baseline anxiety or depression levels and regain control over transitions between intrusion and avoidance states. Achieving these goals usually counters helplessness and enhances self-esteem; when they are attained, the therapist can work on freeing the patient from PTSD symptoms.

Integrating the Traumatic Information

The third goal is to make the patient's psychological structure accommodate itself to the new traumatic information, to ultimately transcend the traumatized self. To achieve this goal, the patient must revise his or her self-concept to that of someone able to respond, either internally or externally, whenever it is feasible. This goal also involves developing new concepts of others and the world—mainly, becoming able to perceive the outer world as unpredictable but only within certain limits, uncontrollable but only within certain limits, and hostile but only within certain limits (Epstein, 1991). The attainment of this goal usually ensures the remission of PTSD symptomatology and prevents relapse.

If such a goal cannot be achieved, the therapist can lower the therapeutic objective to a partial assimilation of the new information by the patient's psychological structure, through aiding the patient's ego in developing new skills to counter the impact of the traumatic event so as to ultimately constrain the traumatized self within certain limits.

Viewing Trauma as Challenge

Fourth, the therapist assists the patient in learning to view traumatic events as opportunities for growth. This goal aims at reducing the individual's predisposition to become traumatized. Patients come to perceive potentially traumatic events as challenges rather than threats. The achievement of this goal, however, depends on the patient achieving the three previous ones. Ideally, the therapist should also address issues of life and death, which involve the patient harnessing his or her will to fully experience life and recognize its finality.

These four goals can be attained in sequence. However, depending on the individual's capacity to tolerate intense affects or structural deficits, regaining mastery over the inner and outer worlds may need to be achieved before proceeding to a full acknowledgment of the traumatized self. More often, the patient achieves these two goals in parallel, alternatively working on both, since acknowledgment of vulnerability is often more tolerable when

the individual has somehow regained a sense of competency.

Patients have similar but more limited goals. Patients wish to regain control over themselves and their lives by getting rid of their symptoms. They want to go on with life as usual by resuming their past psychosocial functioning. Sometimes patients also wish to discover new aspects of themselves and life, but this goal develops only over the course of therapy.

THEORY OF CHANGE

Changes to Take Place

To resolve a traumatic response, it is essential that the individual process the new information attached to the traumatic event, information that is incongruent with preexisting inner representations. The mind continues to process the new information until reality and inner models are brought into accord, in what Horowitz (1974, 1986) calls a "completion tendency." Until memories of a traumatic event are integrated with preexisting mental representations, they are stored in an active form of coding. When each repeated representation of the event causes the individual to process the information attached to the traumatic event, he or she may ultimately revise inner representations. As new structures are established, they may allow the information attached to the event to be integrated into the

whole. The traumatic information then becomes part of long-term memory, and codifications in active memory decay (Horowitz, 1974, 1986). After the event is fully reappraised, the individual can adopt new behaviors and attitudes, thus reinforcing the inner changes.

As in Piaget's (1954) theory of child intellectual development, there are two options for integrating new information attached to a traumatic event: assimilation of the information by the preexisting structure, or accommodation of that structure to include the incongruent information. By definition, traumatic information cannot be assimilated into preexisting mental representations. Trauma is viewed as overloading the system because no preexisting schemas are available to assimilate this information without creating overwhelming anxiety. Integration thus needs to occur through the accommodation of the preexisting structure by considering the new information associated with the trauma. New concepts of self and the world have to be elaborated, taking into consideration previous ones and the ones associated with the traumatic event. The information associated with the traumatic event can then become part of the individual's inner representations (Horowitz, 1986).

At the same time, factors such as the individual's neuronal activity and the reactions of his or her familial and social systems may also need to be altered if trauma is to be resolved. If the individual's neuronal activity is

augmented to such a degree as to create panic states, this dimension needs to be managed before initiating the process of reviewing the traumatic information. When high anxiety is associated with PTSD, it should be reduced to a tolerable level. Furthermore, the presence of adequate social support has been shown to be associated with the intensity of PTSD (Solomon, 1986) and is likely to assist the individual in counterbalancing the "bad" news associated with the traumatic event by providing "good" news about others. Therefore, obtaining support from others is also part of the recovery process.

Clinical Factors Responsible for Change

An early intervention has distinct advantages. It has been shown to be shorter and more effective than a therapy instigated only after trauma has become chronic (Friedman, Framer, & Shearer, 1988). With early intervention, chronic responses may be prevented and pathological responses to the traumatized self may not become crystallized. Whenever trauma is chronic, however, therapy needs first to focus on undoing the associated pathological responses, mainly defense mechanisms and interpersonal patterns, before it can revise the information attached to the traumatic event.

The therapist's attitude and theories are crucial determinants of success in helping traumatized individuals. Traditional analytic theory has been weak

in dealing with trauma, leaving most clinicians unequipped to handle it. Traditional dynamic therapists are used to dealing most often with unconscious, developmentally based conflicts, an orientation that requires the patient to assume complete responsibility for those conflicts. Most traumatized patients find such an approach demeaning and humiliating, since it relegates to the periphery the importance of the trauma they experienced (Spiegel, 1988). A dynamic therapist should therefore adapt his or her traditional approach by adding to it more contemporary models that recognize the etiological contribution of the traumatic event.

Dynamic therapists also need to keep in mind that an active stance is required on their part. Waiting for the material to emerge usually involves waiting a long time because avoidance mechanisms are in place. Furthermore, the therapist's attitude of restraint is likely to leave the patient alone and disoriented with overloading affects. A dynamic therapist needs to constantly remember that traumatized individuals actively and forcefully employ denial mechanisms and avoidance coping skills, and that the usual attitude of restraint is not productive with such patients. The therapist must repeatedly question the patient to gather as much detailed and concrete information as possible, while always keeping in mind the patient's sensitivity and not becoming overly inquisitive.

It is imperative that the therapist intervene in a manner that gives

control to the individual. Such a strategy counters the helplessness that the individual experienced at the time of the event and that has usually been generalized to many other aspects of his or her life. Giving control to the individual also prevents a regression into dependency, which is often observed in traumatized individuals, although some patients come into therapy presenting themselves as counter-dependent. Giving control to the patient requires, however, a delicate balance, because traumatized individuals avoid dealing with the traumatic information; the therapist needs to firmly guide them into acknowledging their traumatized self and revising the event.

The therapist must also pay constant attention to preserving and restoring the patient's narcissism. Traumatized individuals have usually felt humiliation, even if they were not overtly humiliated. The therapist needs to be aware of the damaged self-esteem and should attempt to repair it whenever possible. While empathic recognition of pain and harm is first required, it is also imperative that therapists treat patients as adults capable of making adequate decisions whenever full information is provided, as well as allies in the recovery process. Although the patient is suffering and temporarily damaged, his or her inner resources can be recognized by the therapist. Important and healthy psychological functions can still be accessed in the patient and employed to work with the therapist on salient issues, thus preparing the patient for future self-efficacy.

The therapeutic work should be conducted at tolerable dosages. The revision of the traumatic representations and affects should always be kept in check by the patient's potential for panic. The unconscious material surfacing should not become overwhelming for the self. When a generalized state of high anxiety or panic is observed, it is imperative to reduce the baseline level of anxiety. A low dosage of benzodiazepines is useful, as is reducing caffeine intake or unnecessary exposure to anxiety-provoking stimuli.

These maneuvers provide conditions to help an alliance develop. To establish a safe relationship with the patient, it is essential that the therapist demonstrate involvement and nonjudgmental acceptance, as well as an expert understanding of trauma. By experiencing these qualities in a caring and competent therapist, the patient can come to feel supported. As a consequence, the patient can dare to explore the traumatic event, with its anxiety-provoking features, while returning regularly to experience the safe relation with the therapist (Bowlby, 1988).

When these conditions are in place, it is essential to foster an experiential revision of the traumatic event. Intense distress and emotions are usually associated with trauma, and they need to be recognized as such. To accept his or her potential for vulnerability and helplessness, an individual needs to experience these feelings as they happened, while firmly attaching their experience to the context of the traumatic event, thus avoiding

generalization to actual situations. A similar reasoning can be applied to other emotions.

Uniqueness of Approach

The approach presented here may be unique in that it incorporates diverse models of traumatization and applies them differentially to each patient depending on the factors at play. Nevertheless, it is mostly based on Horowitz's model (1974, 1986), which already encompasses concepts borrowed from different fields, explaining both normal and pathological responses to traumatic events.

In its application, this approach approximates the technical recommendations of Horowitz (1974, 1986). While the main technique resides in differentiating reality from fantasies, it not only includes interpreting a patient's problematic reactions but emphasizes validating his or her experience of reality in accordance with the characteristics of this reality. Furthermore, hypnosis is added as a specific tool for experientially reviewing the traumatic event.

TECHNIQUES

Phases

This approach is phase-oriented, like the dynamic therapy outlined by Horowitz (1974, 1986). Three major phases are presented below, along with the therapeutic goals to be achieved. In general, these phases are of equal duration.

The first phase consists of establishing the conditions for an alliance to develop; gathering information about the traumatic event, the ensuing psychic trauma, and the patient's history and actual situation (mostly about significant past and present relationships, occurrence of previous traumas, past and present psychiatric illnesses in both the patient and family, occupational attainment, and actual additional stressors); reducing the anxiety baseline experienced by the patient to a tolerable level; encouraging the patient to seek effective social support; and addressing the avoidance mechanisms in order to reduce their use in therapy. In doing so, an alliance is usually created, the traumatized self is partially acknowledged, and some mastery over inner and outer worlds is achieved by the patient. The patient can then proceed to reappraise the traumatic event, which often augments the intrusive and arousal symptoms of PTSD.

The second phase involves a detailed revision of the traumatic event, along with addressing the associated defense mechanisms and conflicts, past or present. By repeatedly revising the traumatic event in detail, in terms of both the inner and outer worlds, the patient gains greater understanding of

the emotions and meanings attached to the event. Working through the defenses and emotions associated with these meanings, the patient often addresses unresolved conflicts in either past or current relationships. In resolving these conflicts, the patient makes the necessary revisions of his or her maladaptive defensive pattern and associated wishes and emotions, and subsequently adopts more mature defense mechanisms and coping skills. As a result, the patient can revise inner models of self and the world, make new decisions, and engage in adaptive actions. At the end of this phase, the PTSD symptomatology is usually eliminated because the traumatized self has been fully acknowledged and accepted, mastery has been regained and often enhanced, and integration of the traumatic information has been achieved through an accommodation of the psychic structure.

In the third and final phase, the patient is encouraged to practice the new defensive, cognitive, and behavioral patterns until they become automatic. New ways of facing stressful or traumatic events are identified and reinforced. For each new stressful event encountered during this period, the patient is encouraged to readily and experientially recognize the provoked emotions, to explore and acknowledge the meanings attached to them, and to revise them in light of the new inner models of self and the world. During this phase, the patient realizes greater self-efficacy in dealing with inner and outer phenomena, thus developing greater confidence in his or her capacity to face life and its associated difficulties. Termination issues are then addressed.

Technical Approach

The traumatized individual may regress from the more mature way of relating to internalized objects via empathic resonance to seeking primitive merger states with them in order to maintain self-cohesion (Kohut, 1984). Acknowledgment of the traumatized self can be achieved through empathy, validation of reality, exploration, and interpretation. Very often, the therapist needs to identify the individual's distress through empathic resonance beyond the discourse of the patient, who fears presenting a vulnerable self. Sometimes it can also be helpful to employ reassurance, such as normalizing the individual's reactions to the traumatic event. The therapist should always acknowledge that the psychological damage caused was beyond the control of the individual and validate that hurt was brought upon the individual by others.

Exploration of the patient's reactions to the presenting symptoms often identifies the obstacles to acknowledgment and acceptance of the psychic distress. For those minimizing their distress, the therapist needs to pay attention to the patient's superego attitude toward PTSD symptoms. Patients often criticize and even punish themselves for being so weak. The therapist should encourage more caring attitudes at this point, especially after demonstrating the negative impact of such judgmental reactions. Inversely, other patients put their traumatized self on display. Their distress should be

acknowledged but put in perspective by showing them that not all their inner resources have been damaged.

Interpretations may be useful if the patient resists acknowledging any psychological distress beyond obvious anxiety symptoms. Such interpretations focus on the defenses employed by the individual to hide the traumatized self from awareness—such as counterphobic behaviors or minimization—and the fears associated with such recognition. Full acceptance of the traumatized self is achieved, however, only through an experiential exploration of the event and its impact.

To help the patient regain mastery over the inner and outer worlds, several techniques can be employed. When a patient experiences relative failures of control, the therapist's activities are geared toward helping the patient to regain a sense of self-regulating control and mastery over his or her environment. First, the therapist can encourage the patient to reduce internal and external demands by reducing the daily tasks to be achieved, seeking appropriate help in accomplishing them, reducing the presentation of anxiety-provoking stimuli associated with trauma, taking medication if sleep difficulties interfere with daily functioning, seeking comfort from significant others, using strategies proposed by the therapist to counter concentration and memory problems, and so on.

Another useful approach in the effort to give control to the individual is to explain the mechanisms involved in trauma and its resolution. Educating the patient about the manifestations and mechanisms involved in PTSD usually encourages him or her to participate in the revision of the traumatic material. In doing so, it may be necessary to bring forth, using the evidence gathered from daily facts reported by the patient, that the alternative strategies employed have not been successful. The patient can then decide whether to embark on the painful revision of the traumatic event.

Then the therapist may proceed to use the techniques of exploration and interpretation. To gently initiate the revision process, the therapist may occasionally question the specific details attached to the event, including the patient's inner reactions, while constantly assessing whether the anxiety or emotions provoked are tolerable to the patient and not damaging to the alliance in progress. It is essential to approach gradually the core meaning of the event, proceeding from peripheral to more central issues. Interpretations should be presented as working hypotheses, along with the information gathered supporting them. When these techniques fail to produce the desired effect, confrontation may be necessary. Transformation of basic schemas usually requires working through the emotions and meanings attached to the traumatic event. Most often, through exploration and interpretations, defensive patterns and warded-off unresolved conflicts are highlighted because they have been reactivated associatively by the traumatic

information. To undo these conflicts, the therapist often needs to explain to the patient the necessity of addressing these more personal issues. Conflicts associated with past events can be undone by working through the repressed affects and wishes associated with them, while contemporary conflicts need the further work of implementing actions that can effect changes in the patient's current reality.

To facilitate the integration of the traumatic information, the therapist usually focuses on differentiating reality from fantasies. Horowitz (1974) refers to differentiating fantasies from reality in terms of reducing the perceived threats of reality by reducing the patient's adherence to fantasy expectations. While an effective differentiation involves interpreting the patient's problematic reactions toward reality, I believe that it should also include, and usually in the first place, acknowledging the problematic aspects of reality that created painful reactions in the patient. It is necessary to validate the full traumatic reality of the event, along with the legitimacy of the patient's fear, anger, sadness, or disgust. Some events are terrifying, aggressors can truly be bastards, victims can legitimately wish to hurt and kill their aggressor, and some scenes or actions can be forcefully disgusting. When a therapist acknowledges those aspects of reality, without dramatization, the patient can address his or her problematic reactions to the traumatic reality without overwhelming shame or guilt.

During this exploration and interpretative work, it is essential that the therapist experientially attach the associated emotions and meanings to the event. While therapist and patient are revising the event, it is extremely helpful for the patient to experience the associated emotions in their full intensity in order to attach them to the event and the appropriate object. Such an experiential revision can also lead the patient to remember previous moments in his or her life during which similar affects were provoked. Exploration and working-through can be greatly facilitated by reviewing the traumatic event under hypnosis.

Hypnosis is a technique that involves the development of an altered state of consciousness in which attention is focused inwardly, with heightened awareness and perceptions. As pointed out by Spiegel (1988), hypnosis has long been associated with fears of losing control, but it can be ironically effective in helping traumatized individuals regain control over their traumatic memories. The therapist can reassure the patient about hypnosis by explaining the procedure and by conducting an initial hypnotic trial aimed at revising a happy moment rather than a traumatic one. During a hypnotic session, the therapist should make the patient feel in control of the progression of the exploration in progress. A hypnotic exercise is divided into three parts: a relaxation procedure (such as autogenic training), a deepening phase, and an exploration phase. The unfolding of the exploration phase of the traumatic event has been previously agreed on by the patient and

therapist, and it should always start in a place where the patient feels secure and end at a moment when the patient feels secure. The revision can be paced according to the patient's capacities, as well as timing constraints. The Re-experiencing of the event can be slowed, stopped, or fast-forwarded, just like a videotape. Again, it is essential to proceed at tolerable dosages, and to ensure that this happens, the patient talks constantly to the therapist about what is being experienced under the hypnotic state. The therapist guides the patient's exploration, stopping the image at crucial moments and asking the patient to explore thoughts, images, emotions, or perceptions happening then. After the exploration is completed, the repetition of the hypnotic technique enables the patient to distance from the event. It should be noted, however, that such a powerful technique should be used only when a strong alliance has been established, and when the exploration has already been undertaken in therapy but has presented some form of stagnation.

In reflecting on the material newly emerged, the therapist should link the trauma with past or present situations and conflicts and differentiate fantasies from reality. This provides the patient with an opportunity to initiate changes under his or her control and to take responsibility for part of his or her reaction to the traumatic situation. Whenever the processing of the information attached to the event is blocked, the therapist needs to envision the possibility of an unresolved conflict stagnating the processing of the related information. Such conflict needs to be addressed and worked through.

Whenever structural deficits are at play, the therapist needs to provide compensatory skills before pursuing the exploration. Without those skills, the patient may be unable to proceed toward symbolically approaching the traumatic event and experiencing its associated affects, because the ego becomes overwhelmed. Teaching certain techniques, such as anxiety management strategies, is often required at this stage. Whenever an insecure attachment pattern is detected within the therapeutic context, a behavioral technique can be employed at the service of a dynamic purpose. A relaxation exercise can be tape-recorded during a session with the therapist. The patient then listens to the voice of the therapist to calm himself or herself at convenient times at home. The therapist is thus present in the form of a transitional object, which helps reduce the patient's anxiety while also restoring his or her sense of autonomy.

Transference and Countertransference

As pointed out by Lindy (1989), most analytic literature fails to underline the unique transference reactions in traumatized patients. He identifies four types of transference. The patient may transfer specific repressed or disavowed memories of the traumatic event onto the treatment situation. The patient may transfer onto the therapist the roles occupied by significant figures during the traumatic event and its aftermath, either the aggressor or other victims. The patient may transfer onto the therapist the

intrapsychic functions that have been distorted as a result of the trauma, in the hope of restoring healthier functions. Finally, the patient may transfer onto the potentially understanding therapist a deeper wisdom about life, in the hope of making sense out of the catastrophe and thereby restoring a sense of personal meaning.

McCann and Pearlman (1990) outlined diverse transference reactions to the therapist. The therapist may be perceived as a potential aggressor, a violator of sacred boundaries, an untrustworthy betrayer, an interrogator or a judge, a controller, an indifferent witness, and a potential victim of the patient's aggressive impulses. Inversely, the therapist may be perceived as a caretaker, a friend, a protector, and a potential loss. In response to the patient's damaged functions, the therapist may be viewed as either a soothing other or a container for intolerable affects.

When dealing with a traumatized individual, a therapist is also at risk of inappropriately reacting to the patient in specific ways. Four basic countertransference issues can be identified: namely, becoming hostile toward the patient, feeling helpless or overwhelmed, becoming indifferent, and attempting to save the patient. According to Wilson (1989), the therapist's anger may become directed at the patient because the therapist fears the intensity of the patient's affects or because the experience of the patient's helplessness during the trauma challenges the therapist's notions of

unalterable control, invulnerability, and safety. Upon hearing the trauma story, the therapist may identify with the patient more than empathically and thus lack the appropriate distance from the patient's affects. In reaction, the therapist may become indifferent by numbing his or her responsiveness or by deliberately avoiding discussions about the patient's traumatic experience. The therapist may develop anxiety over his or her ability to help the patient by becoming overwhelmed by the patient's feeling of helplessness or by guilt over being exempted from such a traumatic experience. Finally, the therapist may become overcommitted, from an excessive belief in his or her responsibility to rescue the patient, whom the therapist sees as helpless and pitiful.

It should be noted that the therapist can feel anger and even rage toward the victimizer, or toward society for failure to help or protect the victim. These reactions are normal, but the therapist should be aware of a potential vicarious traumatization and revise, if necessary, his or her own internal representations of self and the world (McCann & Pearlman, 1991).

Evaluation of Efficacy

The evaluation of therapy efficacy is first achieved through an ongoing examination of the attainment of the therapeutic goals outlined earlier. The therapist first considers whether the patient better acknowledges the

traumatized self. Acceptance of the traumatized self, however, is usually achieved only after the complete revision of the traumatic event. At the same time, the therapist verifies whether the patient has regained some control over his or her inner and outer worlds. This goal is fully attained only when the revision of the patient's inner representation of self and the world is completed. With integration of the traumatic information, the patient has usually regained premorbid functioning, if not at a more adaptive level, and PTSD symptoms have usually disappeared, along with any other comorbidity. These latter achievements are the cornerstone of the evaluation of the efficacy of therapy. Some anxiety or PTSD symptoms are likely to remain, however, if the individual presented with a premorbid disorder, which usually impedes the processing of the traumatic information.

The finalization of the therapy process involves, nonetheless, attaining two other therapeutic goals: the automatization of mature defense mechanisms and coping skills in the eventuality of potentially traumatic events, and a reconceptualization of trauma as a challenge for growth and of life as necessarily entailing painful aspects.

Time Limit and Termination

The duration of therapy may vary from three months to two years. While the length of treatment can usually be predicted at intake by an

experienced therapist, it can be shorter or longer depending on the patient's motivation for change and/or premorbid ego functioning.

Termination is usually first addressed by the therapist when a revision of the patient's inner representations has been completed. At this point, if the patient was absent from work following the traumatization, a progressive re-installment at work is planned and undertaken. When the patient has successfully been reintegrated into the workplace, the frequency of therapy sessions drops from two per week to one. Patient and therapist then discuss the therapy work accomplished and the work left to be accomplished, including terminating the therapeutic relationship. It is important to set the end date with the participation of the patient, again giving control to the patient.

Before terminating, the patient's reactions to losing the therapist are addressed. A regression in the patient can be encountered at this point, with a resurgence of some symptomatology. Besides interpreting the patient's wish for continuity, it is important that the therapist highlights the patient's much lesser need for the therapist, because therapy has led to a remission of symptomatology, regaining past functioning and an increased sense of self-efficacy. At the end of this phase, the patient usually thanks the therapist for providing competent help, and the therapist recognizes the patient's contributions to the recovery process.

CASE EXAMPLE

Mary was a 40-year-old woman married to a retired policeman. She was the mother of a 13-year-old teenager who was successful at school. They were religious and close to their relatives and friends. Mary had worked as a bus driver for the previous two years. When I evaluated Mary's psychological status, she presented with a severe and chronic post-traumatic stress disorder, along with a conversion disorder that made her hands and arms become painfully swollen.

Her PTSD symptoms appeared six months before she consulted me, when a teenager was murdered by another teenager in the back of her city bus. She discovered a 13-year-old boy moaning, with rolling eyes and blood spitting from his chest cavity. She first attended to him but quickly realized that she had to call 911 because no passenger had done it. She left the bus, running to the garage station across the street. She then returned to the bus, evacuated the remaining passengers, and held the hand of the victim. The boy died before emergency personnel arrived. She went to the police station, where she spent most of the night. The next day, the event was highly publicized in the press; some journalists wrote that the bus driver had had to go to the hospital due to a nervous breakdown. To save her honor and that of her women colleagues, Mary went back to work a week later despite her severe PTSD symptomatology.

The murder trial was held three months later. While waiting to give her testimony, she had to sit in a small room for two days with the friends of the murderer. Just before the trial, the prosecutor had called Mary to inform her not to say that she had stopped her bus abruptly before the knife went into the victim (which did not happen) because the defense lawyer might attempt to say that she was responsible for the death. Two days after the trial, Mary developed a conversion disorder and had to be hospitalized for a month. After two scans produced negative results, the medical staff let her go home. She called me for an appointment two months later, at the insistence of a friend, after the swelling had spread throughout her upper body.

Before she could return to work, Mary was treated in dynamic therapy that lasted nine months, at a frequency of two sessions per week. I present below the processes and outcomes of this portion of therapy, dividing it into three phases.

At the beginning of the first three months of therapy, Mary complained mostly about her swelling, which she forcefully wished to be of organic origins. She denied any distress over the occurrence of the murder in her bus. I quickly attended to her swelling because it greatly interfered with her functioning and, therefore, her self-esteem. I recorded a hypnotic session in which I had her imagine that she had regained her manual dexterity (she chose to peel a potato successfully) and gave her suggestions that the swelling

would reduce (but not vanish). She practiced it twice a day and, within a week, she was functional, with only some swelling and pain still present.

In parallel, I gently but repeatedly questioned her about her PTSD symptoms. I educated her about PTSD symptomatology and interpreted her avoidance strategies, while acknowledging that they were helpful in protecting her against psychic pain. I normalized her irritability, stating that she also suffered when her irritability hurt others because she usually hurt loved ones. I invited her to seek comfort from them, especially her husband, rather than isolate herself. As a result, her relationships at home improved and she became less irritable. I repeatedly inquired about the details of what happened during the traumatic event and about how she reacted, and I repeatedly and empathically interpreted her panic and anger, which she denied less and less, at least her anger toward the press. I gradually linked the swelling to her distress, providing some evidence for this hypothesis, but I also encouraged her to get another neurological checkup, which she vehemently insisted was necessary.

To foster the alliance, I offered the hope of a psychotherapeutic solution to her presenting problems, provided her with empathic comments, and protected her damaged self-esteem by rendering her more functional. The alliance gradually strengthened as she grew in commitment and capacity to work in therapy and felt a faint, emerging hope. I did not interpret her

growing idealization of me, and therefore, positive transference developed.

After three months of therapy, the intrusion and avoidance symptoms had decreased in frequency. Emotions like panic, anger, and sadness were emerging, but numbing was still important.

During the fourth month of therapy, we did exploratory hypnosis about the traumatic event. We stopped the review at crucial moments. One of those moments was when she first realized what had happened, when she saw the 13-year-old boy stabbed to death. I asked her what she felt, what were her thoughts or sensations, and pursued by asking if she saw any image. She had immediately seen her son. I kept up my queries: "What if it were your son?" She replied, "It should be me." Then I asked, "What if it should be you?" She replied, "Then I should be stabbed." Mary had intrusive pseudo-hallucinations during which she felt that someone behind her was going to stab her. Besides other meanings that emerged from this hypnotic session, we could identify her survivor guilt at the impression that her son had been killed, and her wish to repair the damage by being killed herself. I went on interpreting her panic, anger, and shame. I suggested that her guilt feelings interfered with the resolution of her trauma and that we had to explore its source. She told me that she felt responsible for the happiness of the passengers on her bus; I pointed out how unrealistic that attitude was and wondered why she felt so responsible. She then went on to talk, for the first time, about her husband's

manic-depressive disorder, which developed following a shooting in which he intervened as a policeman some years before. During the months following this traumatic event, her husband had regularly abused her verbally and deserted her. She had been hurt by his manic comments and behaviors, which led her to become very angry but she repressed her anger. She had to obtain a court order to have him treated against his will and had felt responsible for his emotional stability ever since. In addition, she had to become the pillar of the family, a role she had not expected to have to fill when she married a policeman. This situation also provoked her anger. We could then start working on her anger and on understanding why she kept herself from acknowledging it.

To reduce her sense of responsibility for her husband's well-being, on my encouragement they decided that he would seek psychotherapy for himself. Having to be less vigilant about his mood changes, Mary could better attend to herself and acknowledge her anger. I interpreted her pseudo-independence and encouraged her to reach out for emotional support from her husband and friends as well as to set limits on others' demands. At my invitation, she asserted herself toward the media during an interview with a decent television magazine in which she talked about what she had experienced as an indirect victim of a crime, exposed her mishandling by the press and the prosecutor, and corrected the facts surrounding the event.

With respect to her conversion disorder, we identified situations that provoked the swelling. However, as her psychological defenses toward the traumatic event loosened, the swelling extended to her lower body. Consequently, I had to restrain myself from feeling panicky. 1 kept on exploring, and for the first time, I affirmed that her symptoms were of psychological origin. I discouraged further neurological checkups because there had already been three negative scans. When a neurologist suggested exploratory surgery, she refused it, being capable by then of recognizing that her panic was expressed by her swelling.

After six months of therapy, she approached the various stimuli related to the traumatic event more freely, and her numbing had vanished. Re-experiencing and denial symptoms were reduced. But she had become more depressed and anxious, with emotions emerging in association with relevant meanings. She resumed seeing her friends, including coworkers. She felt that she had regained some mastery over her external world and that her self-esteem had increased, but her gains over her internal world were only partial.

With respect to the alliance and transference issues, 1 kept on providing empathic support but increased my challenges, while remaining hopeful. She had become very committed and worked hard in therapy, providing more significant information and making relevant links. Her initial fear of hurting me with her anger was dissipated. Her positive transference feelings kept on

increasing, but they were not interpreted.

Between the sixth and ninth months, the anniversary of the event occurred. I predicted a surge of symptoms, and as they were re-experienced, I linked the reoccurrence of her pseudo-hallucinatory symptom to her anger at the murderer, who had damaged the lives of so many individuals, including herself. I conducted another hypnotic session, reviewing both her participation in the trial as a witness and the period during which she had waited to testify. It appeared that she had felt terribly guilty and afraid of being accused (as the prosecutor had suggested might happen, unknowingly playing on her heightened sense of responsibility for everybody on her bus). To compensate, she had held her body very straight, like a soldier, during the entire two days of waiting. I linked her guilt feelings to her anger at her husband for having hurt her so badly a few years before, a connection she resisted at first but affirmed later. She had felt tremendous guilt over being angry at her husband, who was sick and had therefore not been responsible for his behavior and illness. At first, she felt like a bad person for being so angry; her negative self-image was confronted, and her anger validated. Turning her anger toward herself and ending up feeling guilty was the usual defense mechanism she employed against her anger. Her guilt feelings were also at play in her response of denial of her realistic helplessness toward what could happen to loved ones: her husband could relapse, and her son could be hurt or killed by others, like the young victim on her bus.

As her PTSD symptoms dissipated and her conversion disorder became barely noticeable, giving her only some occasional pain, we initiated her return to work. To assist her in facing the associated anxiety, I quickly taught her cognitive and behavioral techniques for anxiety management. For the first two weeks, she returned to work part-time during the day, sitting on a bench next to the driver on duty. Then she drove the bus accompanied by the same driver for another two weeks. Then for two more weeks, she drove the bus accompanied by another driver at night. Because these steps were successful, she resumed a full-time work schedule. Coincidentally, she was assigned the same route she had been driving the night of the murder. After her full return to work, everything went well, except for an intrusive image that emerged every time she stopped at the street corner where the murder happened. She saw the same woman on a balcony, and herself crossing the street to call 911 because a murder had just happened on her bus. To erase this flashback memory, I interpreted it as being there because her mind had not put the event into the perspective of time. We did another hypnotic session in which she was on her bus and had the flashback at the same corner, but this time she actually got out of her bus, as if a murder had just happened again. I made her stop across the street, wonder what she was doing, asked herself whether a murder had really just happened, look at the bus to see whether there was turmoil in it, decide that everything was fine, come back to her bus, and resume driving. The flashback never reoccurred. Furthermore, in the first

week after her return to full-time work, two gangs of teenagers started a fight on her bus; she put on her sign for 911 and got out of the bus. She went back only after they had left. She was shaken for a few minutes, realized her state, and calmed herself down. She was able to finish her shift. We had foreseen such an event, and I had taught her how to cope with it effectively. No relapse occurred.

To maintain the alliance during this period of therapy, I fostered her autonomy as well as her needs and organized her step-by-step return to work. To foster her independence, I interpreted her idealization of me as a belief that I was omnipotent. At first she argued, becoming angry at me for two weeks, but she then conceded that I could also make mistakes and might not know everything. She even acknowledged that she had previously noticed me struggling with different hypotheses. We went on interpreting her conception of God as omnipotent and judgmental; she viewed God as punishing sinners by provoking bad events in their lives. Therefore, she thought she had been punished for being bad. We settled on another conception of God, as the creator of the universe, which includes randomness. We concluded that, as humans, we have to face every event and try to learn from it, even if doing so entails pain; we can then pay better attention to the more essential things in life, like our relationships with loved ones.

During the next few months, therapy sessions were reduced to once a

week, then to once every two weeks. I kept on interpreting her exaggerated sense of responsibility on her bus, while providing her with alternative attitudes and behaviors and giving her permission to feel angry at passengers who were nasty toward her but not to act on her anger, because there were inherent dangers in her work. We also addressed her anger at a parental figure who rejected one of her characteristics. This parent had died while they were still in conflict. We worked on recognizing her anger at this parental figure, and then on encouraging her to feel close again to this lost loved object.

She was unhappy when therapy had to terminate, but she thanked me for my help. I recognized both our contributions and stated how much I had enjoyed working with her.

TRAINING

Training in dynamic therapy for PTSD requires that a therapist understand basic dynamic concepts. However, any dynamic therapist who wishes to treat traumatized individuals should become familiar with the features of PTSD, along with the associated conflicts, and should be knowledgeable about the various contemporary analytic models of its etiology. The main difference between a traditional dynamic therapist and a dynamic therapist specializing in treating PTSD is that the latter fully

recognizes that external events can be traumatic in and of themselves and addresses them as such.

Ideally, the educational curriculum of the Society for Traumatic Stress Studies (1989) should be included in the training of any therapist who wishes to specialize in treating PTSD. Pragmatically, I have come to realize that a complete training involves weekly theoretical seminars and clinical supervision for at least one year and bimonthly theoretical seminars and supervision during the second year. A successfully trained therapist should be able to demonstrate a clear understanding of both PTSD and the therapy process, as well as efficacy in the treatments provided. Only already experienced therapists should specialize in treating PTSD.

EMPIRICAL EVIDENCE FOR THE APPROACH

To my knowledge, there exists only one randomized clinical trial that has tested the efficacy of Horowitz's model. Brom, Kleber, and Defares (1989) randomized 112 subjects presenting with PTSD, diagnosed according to *DSM-III*, among three therapy modalities— Horowitz's brief dynamic therapy, trauma desensitization, and hypnotherapy—and a waiting-list control group. The mean length of treatment varied from 15 to 19 sessions. Outcome was assessed, among other measures, on the Impact of Event Scale. The 12 dropouts were evenly distributed among the therapy groups. Results

indicated that, after four months, treated subjects presented significantly fewer symptoms related to trauma than did the control group. There was no overall significant difference between therapy modalities at termination and follow-up. However, trauma desensitization and hypnotherapy had a stronger influence on reducing intrusion symptoms, and brief dynamic therapy had a greater impact on avoidance symptoms. Furthermore, the authors underlined that these therapies did not benefit everyone and the effects were not always substantial; only about 60% of treated patients showed clinical improvements. These findings suggest that, as in the dynamic approach presented here, a combination of dynamic therapy and hypnotherapy may be beneficial to traumatized individuals, each therapy primarily addressing either avoidance or intrusion symptoms, and that a longer duration of therapy might yield greater improvements.

With respect to the process of brief dynamic therapy for trauma, Horowitz, Marmar, Weiss, DeWitt, and Rosenbaum (1984) found that, in a sample of 52 bereaved patients, the alliance was predictive of outcome, and that there was an interaction between patient pretreatment motivation and two types of interventions. Patients with lower motivation did better with more supportive interventions, and patients with higher motivation obtained better results with more work on differentiating reality from fantasies. These findings are in accord with the process outlined in this chapter.

REFERENCES

American Psychiatric Association. (1985). *Diagnostic and statistical manual of mental disorders (DSM-III-R)*. Washington, DC: American Psychiatric Association.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders (DSM-IV).* Washington, DC: American Psychiatric Association.

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory.* London: Routledge.

Breslau, N., Davis, G. C., Andreski, P., & Peterson, E. (1991). Traumatic events and post-traumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry,* 48, 216-222.

Brett, E. A. (1993). Psychoanalytic contributions to a theory of traumatic stress. In J. P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 61-68). New York: Plenum Press.

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

Catherall, D. R. (1991). Aggression and protective identifications in the treatment of victims. *Psychotherapy,* 28,145-149.

Epstein, S. (1991). The self-concept, the traumatic neurosis, and the structure of personality. In D. Ozer, J. M. Healy, Jr., & A. J. Stewart (Eds.), *Perspectives in personality* (Vol. 3, pp. 63-98). London: Jessica Kingsley Publishers.

Fenichel, O. (1945). *The psychoanalytic theory of neurosis.* New York: Norton.

Freud, S. (1953). Moses and monotheism. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 23, pp. 7-53). London: Hogarth Press. (Original work published 1939)

Freud, S. (1962). On the psychical mechanism of hysterical phenomena. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 3, pp.

25-39). London: Hogarth Press.

Friedman, R. J., Framer, M. B., & Shearer, D. R. (1988). Early response to post-traumatic stress. *EAP Digest* (October), 45-49.

Green, B. L., Lindy, J. D., & Grace, M. C. (1985). Post-traumatic stress disorder: Toward *DSM-IV. Journal of Nervous and Mental Disease,* 173, 406-411.

Hendin, H., & Hass, A. P. (1984). *Wounds of war: The psychological after-math of combat in Vietnam.* New York: Basic Books.

Horowitz, M. J. (1974). Stress response syndrome: Character style and dynamic psychotherapy. *Archives of General Psychiatry,* 31, 768-781.

Horowitz, M. J. (1986). *Stress response syndrome* (2nd ed.). New York: Jason Aronson.

Horowitz, M. J., & Kaltreider, N. (1979). Brief therapy of the stress response syndrome. *Psychiatric Clinics of North America,* 2,365-377.

Horowitz, M. J., Marmar, C. R., Weiss, D., DeWitt, K., & Rosenbaum, R. (1984). Brief dynamic psychotherapy of bereavement reactions: The relationship of process to outcome. *Archives of General Psychiatry,* 41, 438-448.

Kardiner, A., & Spiegel, H. (1947). *War stress and neurotic illness.* New York: Paul B. Hoeber.

Kohut, H. (1984). *How does analysis cure?* Chicago: University of Chicago Press.

Krystal, H. (1985). Trauma and the stimulus barrier. *Psychoanalytic Inquiry*, 5,131-161.

Lindy, J. D. (1989). Transference and post-traumatic stress disorder. *Journal of the American Academy of Psychoanalysis,* 17, 397-413.

Lipton, R. J. (1993). From Hiroshima to the Nazi doctors: The evolution of psycho-formative approaches to understanding traumatic stress syndromes. In J. P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 11-23). New York: Plenum Press.

Marmar, C. R. (1991). Brief dynamic psychotherapy of post-traumatic stress disorder. *Psychiatric Annals*, 21, 405-414.

Marmar, C. R., Foy, D., Kagan, B., & Pynoos, R. S. (1993). An integrated approach for treating post-traumatic stress. In J. M. Olham, M. B. Riba, & A. Teaman (Eds.), *American Psychiatry Press Review of Psychiatry,* 12, 239-272.

McCann, I. L., & Pearlman, L. A. (1990). *Psychological trauma and the adult survivor: Theory, therapy, and transformation.* New York: Brunner/Mazel.

McCann, I. L., & Pearlman, L. A. (1991). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress,* 3,131-149.

Piaget, J. (1954). *The construction of reality in children.* New York: Basic Books.

Putnam, F. W. (1985). Dissociation as a response to extreme trauma. In R. P. Kluft (Ed.), *The childhood antecedents of multiple personality.* Washington, DC: American Psychiatric Press.

Pynoos, R. S., & Nader, K. (1993). Issues in the treatment of post-traumatic stress disorder in children and adolescents. In J. P. Wilson & B. Raphael (Eds.), *International handbook of traumatic stress syndromes* (pp. 535-549). New York: Plenum Press.

Society for Traumatic Stress Studies. (1989). *The initial report of the presidential task force on curriculum, education, and training.* Northbrook, IL: International Society for Traumatic Stress Studies.

Solomon, S. (1986). Mobilizing social support networks in times of disaster. In C. Figley (Ed.), *Trauma and its wake* (Vol. 2, pp. 232-263). New York: Brunner/Mazel.

Spiegel, D. (1988). Dissociation and hypnosis in post-traumatic stress disorder. *Journal of Traumatic Stress*, 1,17-33.

Wilson, J. P. (1989). *Trauma: Transformation and healing.* New York: Brunner/Mazel.

CHAPTER 7

Psychodynamic Treatment of Alcohol Abuse

Jerome David Levin

Alcohol abuse cannot be viewed solely in psychodynamic terms. Ethanol, the "active" constituent of all beverage alcohol, is a drug that profoundly affects the nervous system, altering cognition, affect, perception, and motor functioning. Ethanol is toxic, and its small molecule gains ready access to all body tissues, where it can inflict a wide variety of damage. It is an addictive drug in the sense that it induces tolerance and withdrawal symptoms. Abrupt cessation of prolonged, heavy drinking can be life-threatening. The *DSM-III-R* and the *DSM-IV* make a distinction between alcohol abuse and alcohol dependency (alcoholism) that parallels but is not identical to the distinction between problem drinking and alcoholism. Alcohol abuse and problem drinking are usually viewed as more psychodynamically and socioculturally determined, while alcoholism is usually viewed as more biologically determined. There is considerable evidence (Cloninger, 1983; Goodwin, Schulsinger, Hermanson, Gaze, & Winokur, 1973; Propping, Kruger, & Mark, 1981; Schuckit & Gold, 1988) for the existence of a genetically transmitted biological predisposition to alcoholism. Alcoholism typically has a progressive, downward course.

Although the distinction between alcohol abuse and alcoholism is an

important one, theoretically and clinically their psychodynamics, whether antecedent and etiological or consequent and resultant, are essentially similar. Accordingly, the distinction between them will not be emphasized here. I view alcohol abuse as emergent from the interaction of four factors: the pharmacology of alcohol, genetic predisposition, environment, and psychodynamics. The weight of each factor in etiology varies from case to case. There is a continuum from alcoholism that is powerfully, if not uniquely, determined biologically to alcohol abuse that is driven by a futile attempt to ameliorate intrapsychic conflict. Alcohol abuse is best conceptualized as a biopsychosocial disorder. Patients presenting with alcohol problems demonstrate considerable commonality, and even if that commonality is the product of their drinking rather than its cause, the clinician must deal with it. The nature of that commonality has been variously understood over the history of psychoanalysis.

HISTORY AND DEVELOPMENT

Until recently, analysis has paid little attention to addiction. Yet alcohol abuse and other chemical dependencies have played an important role in the history of analysis. Freud's involvement with cocaine is well known. A lifelong depressive, his attraction to an "up" drug is not surprising. Part of Freud's obsession with cocaine was narcissistically determined by his drive for fame. The extent of his obsession with it comes through in the myriad associations

and references to cocaine in *The Interpretation of Dreams* (1900/1953). His other addiction, to cigars, killed him. Freud's physician, Max Schur, pleaded with him to stop smoking. Sounding like any addict rationalizing his addiction, Freud refused, saying, "I can't be creative without smoking."

The earliest psychoanalytic insight into addiction is contained in a letter from Sigmund Freud to his friend Wilhelm Fleiss: "It has occurred to me that masturbation is the one great habit that is a 'primary addiction,' and that the other addictions, for alcohol, morphine, etc., only enter into life as a substitute and replacement for it" (1897/1985, p. 287). In Freud's view, infantile masturbation is both compelling and guilt-inducing. Often forbidden by parents, children internalize that prohibition, and a struggle ensues between the wish for instinctual gratification and the internalized prohibition. The struggle not to masturbate is almost always lost. However, the return to masturbation is accompanied by guilt, anxiety, and the fall in self-esteem that accompanies failure to carry through a resolution. Masturbation can then be used as a way of assuaging that guilt and anxiety. A vicious cycle ensues. Later addictions are not only displacements and reenactments of the original addiction to masturbation; they are also attempts to master, through repetition, the traumatic loss of self-esteem that follows the failure to live up to the resolution not to masturbate. It is now believed that infantile masturbation plays an important role in the process of separation-individuation, and that it is a vehicle through which the child establishes

autonomy, learns to soothe him- or herself, and establishes a sense of efficacy. If this is the case, and later addictions are symbolic reenactments of the first addiction, then addiction must serve the same purposes.

Freud returned to his theory of addiction in "Dostoyevsky and Parricide" (1928/1961). Playing on the word *play,* Freud traces Dostoyevsky's compulsive gambling back to his addiction to masturbation, emphasizing that addiction serves as a means of self-punishment for the original, forbidden wish. Oedipal wishes are similarly and simultaneously punished. Freud (1926/1959) said that the resistance from the superego—the need for punishment and the patient's feeling that he or she does not deserve to be well—is the most difficult resistance to overcome. This is true in alcohol abuse: the drinker often continues to drink to punish him- or herself for drinking.

Freud's insight has more than a little validity. Alcohol addiction is indeed a dead-end path, as is masturbation as an exclusive form of sexual activity. Freud's theory has the additional merit of highlighting the narcissistic nature of addiction. The love object of the alcohol abuser becomes alcohol itself, which is experienced either as an extension of the self or as an omnipotent substance with which the drinker merges. Freud's theory also highlights another aspect of the narcissistic pathology inherent in alcohol abuse: the loss of self-esteem that alcohol addicts experience when they

drink.

Freud's (1920/1962) theory of the "repetition compulsion" also sheds light on alcoholism. In fact, the addictions were one evidence he gave for the existence of a repetition compulsion. For Freud, such compulsion was a derivative of the death instinct. One need not be an adherent of the death instinct theory to agree that the mobilization and adaptive externalization of aggression are salient in breaking the circle of alcohol abuse.

Karl Abraham (1908/1979) published the first psychoanalytic paper on alcoholism. In it he viewed alcoholism as a nervous and sexual perversion. He was referring to oral-regressive and homoerotic tendencies when he spoke of perversion. Abraham based his theory on analysis of male alcoholics and on his observation that men become openly affectionate in the camaraderie of the beer hall. He inferred that heavy drinking allows expression of forbidden homosexual wishes and postulated that alcohol addicts have especially intense conflicts around repressed homosexuality. Abraham, as one would expect in an era of id psychology, emphasized instinctual regression in alcohol abuse. The capacity for sublimation is lost. Abraham's paper is also prescient in its amalgamation of the sociological and the psychodynamic.

Edward Glover (1928) emphasized the aggression in alcoholism. Writing from the viewpoint of classical analysis, he spoke of "oral rage" and

"anal sadism." He was talking about drinking at someone, using alcoholism as a weapon. Although a primitive, ineffectual, and self-punitive way of expressing rage, this mechanism underlies much abusive drinking. The twin hook of expressing rage and being punished for expressing it is extraordinarily powerful. What Glover did not pick up is the extent to which the rage externalized by drinking is projected self-hatred.

Sandor Rado (1933) was the first to point out the similarity between alcoholism and manic-depressive psychosis, with the alcoholic elation during the high and depression during the hangover paralleling the manic-depressive cycle. Rado related both the mood alterations of manic-depressive illness and the alcoholic pattern of highs and lows to the cycle of infantile hunger and satiation. He saw the key issue in alcohol abuse as a disturbance in the regulation of self-esteem. Abusive drinking is a futile attempt to raise self-esteem.

Robert Knight (1937) distinguished between "essential alcoholics" and "reactive alcoholics." The essentials are patients who never established themselves in life. They are financially and emotionally dependent and have spotty educational and work histories. Their object relations are at the need-gratifying level. Knight described them as oral characters who have not reached the "mastery of the object" characteristic of the anal stage of psychosexual development. Essential alcoholics had trouble with alcohol from

the first drink. Knight pioneered the study of borderline personality disorder, and his essential alcoholics had borderline character structure. He believed that they could never drink safely. Knight's essentials may have suffered from a strong biological vulnerability to alcoholism.

The reactive alcoholics had managed some life successes. They had achieved economic independence and often had considerable educational and vocational attainments. They generally succeeded in marrying and establishing families. The quality of their object relations was once fairly adequate but is now gravely impaired by their drinking. Most had a period of social drinking before crossing what Alcoholics Anonymous (AA) calls the "invisible line." Knight thought that reactives could return to normal drinking once their psychological conflicts had been resolved. This is doubtful.

Knight emphasized the depressive aspects of the alcoholic personality. The fathers of his reactive patients were powerful, unavailable, and erratically punitive. One suspects that many were themselves alcohol abusers. The mothers, dominated by their husbands, were passive and ineffectual. The alcoholic sons were overwhelmed by their fathers and unable to achieve a satisfactory masculine identification. They wanted oral supplies from both father and mother, were enraged at not receiving them, and were afraid to express their rage directly. Their alcoholism, which humiliated their families, was an expression of their rage, but mostly they turned their rage against

themselves—hence their depression. If Knight's essentials are borderline, his reactives are narcissistic personality disorders.

Otto Fenichel (1945) also thought that oral dependence and frustration result in chronic depression in the alcoholic. He saw alcoholism as a maladaptive defense mechanism used to resolve neurotic conflicts, especially conflict between dependence and expression of anger. It is to Fenichel that we owe the observation that "the superego is that part of the mind which is soluble in alcohol" (p. 379). Therefore, forbidden impulses can be indulged and id-superego conflicts resolved by the use of alcohol. Fenichel was the first to explicitly refer to narcissistic regression in alcoholism. He highlighted the deepening self-involvement that accompanies alcoholic regression.

Karl Menninger (1938) put great emphasis on the self-destructiveness of alcoholism. He called alcoholism a form of chronic suicide. It is an aggression against the self as punishment for hostile, aggressive feelings. Alcohol makes the conflict between passive, erotic dependence on the father and resentment of him manageable.

Ernst Simmel (1948) was the first analyst to recognize the usefulness of AA in the treatment of alcoholism. He had founded the first alcohol rehab in the 1920s. In it, he used splitting adaptively; the nursing staff was trained to encourage regression and provide gratification while the analyst represented

the constraints of reality. Simmel emphasized the social pathology created by World War II, which trained men to kill and enjoy it, predicting that this would lead to an increase in all kinds of acting out, including alcohol abuse. On the psychodynamic side, he emphasized the narcissistic disturbance in alcoholism. Seeing the potential of AA for containing primitive aggression, he proposed an alliance between the self-help movement and analysis.

Thomas Szasz (1958) viewed addictions as counterphobic activities. The drinker drinks to confront and master intolerable fears of being addicted, absorbed by symbiotic merger, and annihilated by regressive fragmentation. Experientially, these fears are death. Thus, alcoholics self-inflict death to master fear of death. So seen, alcoholics are mythic heroes who descend to the underworld and emerge intact—at least, that is their hope. Defensive grandiosity is fed by participation in this unconscious drama.

Krystal and Raskin (1970) proposed a theory of affect regression in alcoholism in which discrimination is lost and the predominant affect becomes diffuse dysphoria, a murky muddle of anxiety and depression. This theory has important clinical implications, since the alcoholic patient does not know what he or she is feeling. Recognition of affect is at least partially learned. Affect labeling is a highly affective object-relational experience. If it was missed or has been lost by affect regression in the course of addiction, it becomes vital for the therapist to label affect for the patient.

Carl Jung had an important, albeit indirect, role in the founding of Alcoholics Anonymous. Jung had treated a patient known in the AA literature as Roland H. for his alcoholism. Having undergone a seemingly successful analysis, Roland left Zurich certain he had been cured. In a short time, he returned to Jung drunk and in despair. Jung told him that only a major personality reorganization driven by powerful emotion—in essence, a "conversion experience"—could save him. Jung's words touched something deep inside him, and he did what AA would later call "hitting bottom." In his despair, he did indeed have a conversion experience, joined the Oxford Movement, and became and remained sober. The Oxford Movement had a set of spiritual steps that became the basis of the 12 steps of AA. Roland's experience was communicated to Bill Wilson, the founder of AA, who was still drinking. He too had a "peak" experience and became sober. Many years later, Wilson wrote to Jung to tell him the story, and Jung (1961/1973) replied that Roland's "craving for alcohol was equivalent on a low level of the spiritual thirst . . . for wholeness, expressed in medieval language: the union with God. . . . You see, 'alcohol' in Latin is 'spiritus' and you use the same word for the highest religious experience as well as for the most depraving poison. The hopeful formulae, is *Spiritus contra spiritum"* (p. 623).

More recent psychoanalytic theorists, including Hartocollis (1968), Kohut (1977a), Wurmser (1978), and Levin (1987,1991,1994), emphasize impairments in ego functioning, lack of affect tolerance, and the use of

primitive defense mechanisms, including splitting, projection, and denial. These theorists stress the adaptive function of addiction. Kohut and the present author believe that alcoholism, on its psychological side, is a futile attempt to remediate deficits in the self. Alcohol is experienced as an all-powerful mother with whom the drinker merges in order to raise self-esteem, quell anxiety, feel soothed, feel cohesive and whole, feel full as opposed to empty, feel companioned as opposed to alone, and feel safe. Since alcohol cannot do any of these things for very long and in fact exacerbates the very deficits it is used to ameliorate, an addictive cycle is set up.

INCLUSION/EXCLUSION CRITERIA

Alcohol abuse is a behavioral disorder and is best diagnosed by behavioral criteria. If drinking is causing detriment in the drinker's physical health, emotional well-being, or social or economic functioning, it is abusive. Problem drinking is detrimental but may remit, allowing the problem drinker to return to non-injurious social drinking. Social drinking is not possible for alcoholics. The abstinent alcoholic who returns to drinking will re-experiencing the same or more severe symptoms.

The attempt to define alcoholism has a long and vexed history. The lack of agreement among authorities makes research studies incommensurate and hampers clinical work. The more severe the alcohol abuse, the easier it is to

see. It is the functional alcoholics who are underdiagnosed.

There are two clear behavioral definitions of alcoholism, that of the World Health Organization (WHO) and that of the American Psychiatric Association (APA). In the WHO definition (Keller, 1958), alcoholism is "a chronic behavioral disorder manifested by repeated drinking of alcoholic beverages in excess of the dietary and social uses of the community, and to the extent that it interferes with the drinker's health or his social or economic functioning" (p. 1).

The *DSM-III* and *DSM-III-R* have categories of "substance use disorders," which are classified according to severity as either substance abuse or substance dependence. Pathological use of alcohol is treated this way. "The essential feature of alcohol abuse is a pattern of pathological use of at least a month that causes impairment in social or occupational functioning [evidenced by]: a need for daily use of alcohol for adequate functioning; inability to cut down or stop drinking; repeated efforts to control or reduce excessive drinking by 'going on the wagon' . . .; binges; occasional consumption of a fifth of spirits; amnesiac periods for events occurring while intoxicated; continuation of drinking despite a serious physical disorder; drinking non-beverage alcohol" (*DSM-III*, p. 169) Alcohol dependence is diagnosed by the presence of withdrawal symptoms.

The *DSM-IV* continues to distinguish between abuse and dependence but is clearer on the seriousness of abuse, which is now defined as recurrent use in spite of adverse consequences of various kinds. The *DSM-IV* adds a useful category of alcohol-induced psychiatric disorders.

Many patients who are in fact alcohol abusers come for psychodynamic therapy without presenting excessive drinking as a problem. Most often the complaint is depression, anxiety, or martial conflict. In my experience, if patients feel safe enough, they will tell therapists their secrets. For the most part, patients diagnose themselves. However, denial leads to minimalization, and inquiries upon intake as to drinking behavior miss the problem. This is usually not conscious deception on the part of the patient. There are a number of self-evaluations for alcohol abuse that the therapist can administer to the patient. The two best are the MAST (Michigan Alcoholism Screening Test) (Selzer, 1971) and AA's 12 questions contained in the pamphlet *Is AA for You?* (A.A. World Services, 1974). The following are signs of alcoholism: the drinker does not remember what happened when he or she was drinking; radical personality change when drinking; Monday morning absences from work; fighting and abusive behavior while drinking; health problems related to drinking; depression that does not remit with appropriate treatment; defensiveness about drinking that sounds crazy because what the drinker maintains is so clearly contrary to fact; trouble on the job, especially otherwise unexplained faltering performance; otherwise unexplained

detriment in functioning in any important life sphere; passing out, usually rationalized as "relaxing after dinner"; violence when drinking; restlessness and agitation when alcohol is not available; morning drinking; the shakes and other symptoms of withdrawal; neglect of personal hygiene; daily drinking of more than socially accepted proportions; frequent drunkenness; otherwise unexplained moodiness and emotional withdrawal; increasing suspiciousness and exclusiveness; increasing self-centeredness in a person who was not previously self-centered.

DYNAMIC ISSUES: FIXATION/REGRESSION TO PATHOLOGICAL NARCISSISM AS THE PSYCHODYNAMIC CORRELATIVE OF ALCOHOL ABUSE

I do not wish to say that all alcoholics have narcissistic personality disorders as defined by the *DSM-III-R* and *DSM-IV,* an assertion that would be contrary to fact, or that all pathology is self-pathology, as the more radical self-psychologists maintain. But I do wish to say that alcohol abuse is one possible consequence of fixation to the stage of the archaic nuclear self (see below), and that alcohol abuse that does not flow from such fixation results in a regression to it. I cannot stress too much that a great deal of what we see in active alcoholism and alcohol abuse—depression, anxiety, rage, and self-centeredness—is caused by the drinking. To some extent, that is also true of pathological narcissism, albeit the pathological narcissism remits much more slowly than the depression and anxiety do when the patient ceases drinking.

In cases in which the pathological narcissism is antecedent and etiological, the drinking exacerbates it and makes its remediation impossible.

It is to Kohut's (1971,1977b) conceptualization of pathological narcissism that I appeal. Kohut defines the self as a unit cohesive in space and enduring in time that is a center of initiative, and a recipient of impressions. It can be regarded either as a mental structure superordinate to the agencies of the mind (id, ego, and superego) or as a content of those agencies. According to Kohut, the infant develops a primitive (fragmented) sense of self very early. Each body part, each sensation, each mental content is experienced as belonging to a self, to a me; however, there is no synthesis of these experiences. The infant experiences selves but no unitary self. Nor does the infant experience clear boundaries between self and world. Kohut designates this stage that of the *fragmented self;* it is the stage at which psychotic persons are fixated.

At the next stage of development, an *archaic nuclear self* arises from the infant's experience of being related to as a self rather than as a collection of parts and sensations. This self is cohesive and enduring but not securely established. It is prone to regressive fragmentation, nuclear in the sense of having a center, and archaic in the sense of being a primitive (i.e., grandiose and undifferentiated) precursor of the mature self. The archaic nuclear self is bipolar in that it comprises two structures: the grandiose self and the

idealized parental imago. In this stage, there is a differentiated self, experienced as omnipotent, but no truly differentiated objects.

The internalization of psychic structure (Kohut's term for the capacity to do things once done by parents and now a part of self) is co-determinous with the formation of the nuclear self. Failure to adequately internalize functions originally performed by self-objects results in deficits in the self. A *self-object* is both the internal representation of an object perceived as an extension of the self and a person so experienced. Addiction is a futile attempt to compensate for this failure in internalization. Of crucial importance in creating a securely cohesive self are the internalization of the capacities for tension regulation, self-soothing, self-esteem regulation, and the self-object's function as stimulus barrier.

Pathological narcissism is the regression/fixation to the stage of the archaic nuclear self. It is characterized by the presence of a cohesive but insecure self that is threatened by regressive fragmentation; grandiosity of less than psychotic proportions that manifests itself in the form of arrogance, isolation, and unrealistic goals; low affect tolerance; feelings of entitlement; the need for omnipotent control; poor differentiation of self and object; and deficits in the self-regulating capacities of ego (self). The narcissistically regressed individual is subject to massive anxiety stemming from fear of annihilation (i.e., fear of fragmentation of the self) and to "empty" depression,

reflecting the paucity of psychic structure and good internal objects. These manifestations of the archaic self may be either blatantly apparent or deeply repressed and/or denied, with a resulting facade of pseudoself-sufficiency.

The overtly grandiose self is the result of merger with a parent who used the child to gratify narcissistic needs. It is a "false self" (Winnicott, 1960/1965). Kohut (1971) envisions this false self as insulated from the modifying influence of a reality ego by a "vertical split." The reality ego is in turn impoverished by the repression of unfulfilled, archaic narcissistic needs by a "horizontal split" (repression barrier). The overt grandiosity of the alcohol abuser is a manifestation of a false self that is isolated, both affectively and cognitively, from the more mature reality ego, which is itself enfeebled by its inability to integrate the archaic grandiosity—hence the coexistence of haughty arrogance and near-zero self-esteem in alcoholics.

It is no accident that the phrase "His Majesty, the baby," which comes from Freud's 1914 essay *On Narcissism: An Introduction,* plays such a prominent role in the AA literature. AA sees pathological narcissism as the central problem in alcoholism and, in its didactic way, emphasizes the necessity to outgrow the need for omnipotent control. The narcissistic rage that follows the failure to exercise omnipotent control all too easily leads to "slips."

There is a body of empirical psychological findings on the clinical alcoholic personality (to be distinguished from a pre-alcoholic personality, if there is one), including elevated psychopathic deviancy (Pd) and depression (D) on the Minnesota Multiphasic Personality Inventory (MMPI), field dependence, ego weakness, and stimulus augmentation. The concept of regression/fixation to pathological narcissism makes sense of these empirical findings. Elevation in the Pd scale of the MMPI in both active and recovering alcoholics, probably the most consistent finding in the literature, can be understood as a manifestation of the grandiose self, with its arrogance, isolation, and lack of realistic goals. The elevation of the D scale on the MMPI reflects both the psychopharmacological consequences of active alcoholism and the impoverishment of the self, riddled with structural deficits and impaired in its capacity for self-esteem regulation. Developmentally, the depression reflects the disappointment that results from inadequate phase-appropriate mirroring of the child's grandiose self. Additionally, alcoholism gives the alcoholic much to be realistically depressed about. Empirical findings, using adjective checklists and self-reports, of impoverishment of the self can be understood in the same way. The structurally deficient self of pathological narcissism is experienced as empty depression and is reported as lack of interest in people, activities, and goals. Even the self is uninteresting to the self. The regression to pathological narcissism concomitant with the alcoholic process progressively strips the already enfeebled ego of its

investment in objects and activities, leaving an empty self, an empty world, and an empty bottle.

Another consistent finding in alcoholics is field dependence. Field-dependent persons rely more on environmental clues than on proprioceptive input in construing the environment (Witkin, Karp, & Goodenough, 1959). Field dependence entails a relative inability to utilize internal resources, as well as impairments in the differentiations of body image, of figure and ground, and of self and world. The field-dependent person experiences the environment as a self-*object*— which is precisely how the person fixated/regressed to pathological narcissism experiences the world.

Ego weakness is a construct that integrates several empirically confirmed characteristics of alcoholics: impulsivity, lack of frustration tolerance, lack of differentiation of the self-concept. In terms of pathological narcissism, ego weakness in the alcoholic is understood in terms of structural deficits in the self. Stimulus augmentation (Petrie, 1967/1978), the experiencing of stimuli as impinging, has been found to be characteristic of alcoholics and contributes to their ego weakness. Stimulus augmentation can be understood in terms of pathological narcissism as a failure to internalize the mother's function as an auxiliary to the innate stimulus barrier.

Major theories of the psychodynamics of alcoholism, including the

dependency-conflict theory (drinking is a covert way of meeting unacceptable dependency needs), the need-for-personal-power theory (men drink to feel powerful), and the epistemological error theory (alcoholics drink to remediate a pathological severance of subject and object), are also given coherence and made consistent by the concept of regression/fixation to pathological narcissism. Because they experience others as extensions of themselves, the pathologically narcissistic are, by definition, dependent on those others for their very existence as integral selves. They can be neither independent nor interdependent; there is no one apart from themselves with whom to be interdependent. This is the ultimate basis of alcoholic loneliness. Further, because the very existence of the self is dependent on the object (experienced as a self-object), this dependency is fraught with primitive, massive, panic-level anxiety—hence the need for omnipotent control of the object. Any failure of the self-object to meet the needs of the archaic self is experienced as an injury to the self, which is reacted to with "narcissistic rage."

Although this deep need for fusion may be repressed from consciousness or dealt with by reaction formation, the alcoholic unerringly finds the "perfect" self-object with which to fuse—alcohol. Dependence on people is denied, while the pathological use of alcohol leads to enslavement.

Alcohol readily performs the normal self-functions of affect regulation,

stimulus attenuation, and self-soothing by anesthetizing painful drives, emotions, and sensations. It also raises self-esteem, at least initially. Fusion with the idealized, omnipotent self-object characteristic of the stage of the archaic cohesive self is driven by a wish to participate in the self-object's greatness and *power.* Alcoholics idealize alcohol, to which they attribute omnipotent power. Thus, the need for power as proposed in one theory of the dynamics of alcoholism (McClelland, Davis, Kalin, & Wanner, 1972) is also accounted for by regression/fixation to pathological narcissism.

The epistemological error theory of the dynamics of alcoholism (Bateson, 1971) sees the driving force behind alcoholism as an impossible misperception of reality that sets the alcoholic in opposition to the world and allows no meaningful interaction with that world. Rather than experiencing reality as an infinite set of interrelationships, interactions, and feedback loops, the alcoholic experiences it as a reified subject, acting on a disjunctive world. Since this experience is incongruent with the nature of things, conflict must ensue. This is precisely the phenomenology of the experiential world of the pathologically narcissistic.

Although alcoholics in their pathological narcissism may have selves experienced as separate from the world (grandiose self), they do not have a world experienced as separate from them. The inflated ego has no world with which to establish interdependence. What is seen in structural terms as an

archaic self is seen by Bateson in cybernetic terms as an information system without feedback loops, as cognitive error.

Kohut (1971,1977b) speaks of self-object transferences in which the analysand experiences the analyst as an extension of self, as a self-object, in one of two ways: in the mirror transference, the analyst is an extension of the grandiose self, whose only function is to mirror and confirm the patient's grandiosity; in the idealizing transference, the situation is reversed and the analyst, experienced as omnipotent and perfect, is fused with so that the patient partakes of the analyst's perfection. This is exactly what alcohol abusers do with alcohol: They experience alcohol either as a mirror that confirms their grandiosity or as an all-powerful parent who will provide the goods. The essence of treatment is to transfer the alcohol abuser's need for a self-object relationship from a chemical, alcohol, to a relationship with the therapist, where it can be understood and worked through.

Alcoholics who have achieved sobriety often manifest obsessive-compulsive personality traits. The sober alcoholic's newfound compulsivity is a defense, a reaction formation, against underlying impulsivity. However, there is a more profound reason for this phenomenon: Both the impulsivity of active alcoholism and the compulsivity of arrested alcoholism are manifestations of the alcoholic's pathological narcissism. The bridge between them is the need for omnipotent control characteristic of the grandiose self. In

alcohol addiction, such power and control are sought in fusion with an omnipotent self-object, alcohol; in recovery, power and control are sought in ritual, rigidity, and other character defenses. AA rightly sees the modification, or treatment, of the underlying pathological narcissism as the key issue. Untreated, its outward manifestation quickly reverts from compulsivity to impulsivity, and the alcoholic is once again drinking.

The most important clinical implication of the dynamics of alcoholism is the light it casts on the newly sober alcoholic's needs for mirroring, idealized objects, and omnipotent control and disabilities in managing intense feelings, quieting anxiety, and maintaining self-esteem. This dynamic model understands anxiety in early sobriety as the panic-terror of regression to the stage of the fragmented self (psychic death) and understands depression in early sobriety as both an empty depression consequent upon failures of internalization and an angry depression consequent upon turning narcissistic rage against the self.

TREATMENT GOALS

The treatment goal with alcoholics and most alcohol abusers must be sobriety—sustained, total abstinence from alcohol. Some problem drinkers can return to normal social drinking when the psychological conflicts that drove their abusive drinking have been resolved; however, their initial goal

must still be abstinence. The more severe the alcohol abuse and the more symptomatic the drinker, the less the chance that social drinking is a feasible goal. It rarely is. Therefore, it becomes crucial that the alcohol be replaced with something that does the job better—relationship. Drinking is taking something from the outside in, in a futile attempt to provide what is missing inside. Therefore, the long-term goal must be the internalization of psychic structure, that is, acquiring the abilities to self-soothe, modulate and maintain a reasonably high level of self-esteem, tolerate affects, and feel securely cohesive, enduring, and capable of initiative.

The treatment of alcohol abuse takes place in three stages: diagnosis, confrontation, and education. Once the diagnosis has been made, the next step is confrontation. Since the patient rarely shares the therapist's goal of abstinence from alcohol, conflict is inevitable. Alcoholism counseling has been compared to taking a bone away from a hungry Doberman. This metaphor is not always appropriate: Some patients are extremely disturbed by their alcohol abuse, feel out of control, and are desperately begging for help in their effort to cease drinking. However, such patients are unusual. What we are more commonly confronted with are denial and rationalization. Hence, there is a real discrepancy in treatment goals between the therapist, who wishes the patient to stop drinking and work on psychological and emotional problems, and the patient, who wants to learn to drink without experiencing problems. The first goal must be the establishment of a working alliance,

always a difficult task with alcohol abusers. It is reached by empathic understanding of the drinker's dilemma: At some point he or she feels, consciously or unconsciously, that drinking is now impossible yet life is not possible without drinking. The therapist must always be on the side of reality and do everything possible not to be perceived as the withholding, punitive, introjected parents of the superego. Hence, matter-of-factness in the educative task is crucial. The degree to which the patient's distress is caused by drinking, even though the patient believes the opposite, must be communicated. In the confrontation—which is essentially a matter of saying, "You think you drink because you're crazy, but did it ever occur to you that you might be crazy [or "in pain," "depressed," "anxious," "despairing," "desperate"] because you drink?"—the patient's and the therapist's goals are made congruent.

With the goal of abstinence established, a treatment plan is put in place to bring it about. That treatment plan may include a period of detoxification and/or a period of inpatient treatment in an alcoholic rehabilitation center, but most frequently it is simply a planned progressive decrease to zero in the patient's drinking. Slips are to be expected and must be treated in a nonpunitive way. Slips can be analyzed, as can any other behavioral manifestation. Once sobriety is achieved, the next goal is building affect tolerance. Lack of affect tolerance will lead to relapse. This is the stage in which the therapist interprets what the patient is feeling, labels it, contains it,

and helps the patient process it. Helping the patient deal with anger is crucial. Most slips are infantile expressions of repressed rage. The long-term goal is to make the patient less narcissistically vulnerable so that he or she is not in an almost constant state of rage; however, this takes time, and in the beginning what is needed is to help the patient become conscious of and verbalize in treatment his or her rage so that it is not acted out. Additional goals in early sobriety are making the patient aware of the "places, people, and things" that act as triggers. Affect is an important trigger. After a period of six months to a year of sobriety, treatment goals change and become focused on the transmuting internalization of the therapist so that the therapist's functions as a self-object become part of the patient's resources. AA speaks of providing its members with "tools for living sober." AA's tools are Kohut's psychic structure. The long, slow process of internalizing the self-object functions performed by the therapist and working through disturbances in the therapeutic relationship is of the essence of treatment. No part of this process precludes the resolution of structural (id-ego-superego) conflicts. However, the initial focus is on self-esteem maintenance. In Kohut's terms, the goal is to move from the stage of the archaic nuclear self to the stage of the mature self.

THEORY OF CHANGE

Since alcohol abuse is a pharmacological as well as a psychodynamic disorder, the changes that come about in sobriety are multifaceted. The most

striking change is that which follows cessation of drinking. The neurochemical and neurophysiological effects of ethanol on the nervous system are profound. In effect, it induces a transient organic brain syndrome. On the cognitive side, that means that there are impairments in the ability to abstract, reason, and remember. The patient tends to be confused. On the affective side, the transient organic brain syndrome manifests itself as emotional liability. The patient is up, down, and sideways. This instability only adds to his or her confusion and disorientation. Recovery from the effects of alcohol abuse takes a long time. In working with the alcohol abuser, anywhere from three months to two years must elapse before full neurochemical recovery takes place. This means that in doing therapy with early sobriety patients, we are working with people who are not playing with a full deck. In terms of technique, interventions must be simple, clear, and redundant. They are not well processed, because of both neurochemical impairments in cognition and the dynamic effects of denial. What is needed to change all this is simply abstinence from alcohol. Essentially, we are buying time for nature to take its course.

Cessation of drinking has psychodynamic as well pharmacological consequences. Alcohol abusers, for all their bluster and denial, hate themselves because of their drinking. With the cessation of alcohol abuse, that self-hatred abates, although not quickly or all at once. One might think that since drinking serves a psychodynamic function, patients will do worse sober.

This is never the case. Whatever psychodynamic issues the patient may have are always exacerbated by the alcohol abuse, so that even if they are not ameliorated by sobriety alone, a change in the patient's state of being comes about that makes treatment possible. Since the patient has lost a script, a lifestyle, a way of structuring time, a defense, and an anesthetic, it is vital that all these be replaced by a relationship with a therapist, and preferably a relationship with a self-help group as well. The regressive pull of addiction is overwhelmingly powerful, and forces of equal or greater weight pulling in the opposite direction toward differentiation and integration must be put in place. That is why I believe that the best chance for recovery occurs when the patient is simultaneously in professional treatment and a member of a self-help group. Things can be accomplished in therapy that cannot be accomplished in a self-help group, and no therapist can provide the kind of safety net and support system that AA offers. (There are patients who find AA and its ideology unacceptable. Some do fine without it, others are best referred to other support systems such as an early recovery therapy group or a Rational Recovery [RR] meeting.)

Many patients are in a state of euphoria, which AA refers to as a "pink cloud," in early sobriety. This is a response to escape from a life-threatening, progressive disability. There is certainly denial in the pink cloud, denial of the devastation that alcohol abuse has visited on the patient. However, that denial is adaptive, and although it is wise for the therapist to alert the patient to its

temporary status and to be alert for signs of an impending crash, the patient should basically be allowed to enjoy it. Usually three or four months into sobriety reality penetrates in ways that are often very difficult for the recovering person to cope with.

There are other reasons the patient usually feels better in sobriety. Not only is self-hatred radically reduced, but the environment becomes less retaliatory and punitive. People are no longer scornful of and angry at the alcohol abuser. Now playing with a fuller deck, with augmented resources, the recovering alcoholic is in a much better position to cope with the tasks of life, internal and external. His or her existential position has been radically altered for the better. It is also true that a need for self-punishment or for provoking the environment to inflict that punishment may still be very much in place. Therefore, the therapist must interpret, and if possible anticipate, acts of self-destruction and the motivations for them.

Once the patient settles down, the most powerful vehicle for change is the transference. Alcohol abusers usually form self-object (narcissistic) transferences. It is rare that the patient forms only a mirror or only an idealizing transference. Rather, there is usually alternation between the two. Patients with such fragile self-esteem and such tenuous self-cohesion as those in the early stages of recovery are desperately in need of the affirmation of the mirroring transference. Additionally, their boundaries are none too firm,

and they easily enter into mergers. Inevitably, the therapist fails to be a perfect self-object and a disruption of the relationship takes place. In working through and mending such breaches of the self-object transference, a process Kohut (1971) calls "transmuting internalization," the functions of the therapist as provider of self-object functions are internalized a little bit at a time. If the therapist always perfectly performed these functions, the patient would have no reason to acquire these skills, capacities, and structure for him- or herself, and if the needs are not met or are met too unreliably, then there is no opportunity for internalization. This notion is very similar to the traditional psychoanalytic notion of optimal frustration.

The patient is also desperately in need of an object to idealize. Alcohol had been the ideal object. Now it is gone and must be replaced. Generally, that replacement takes place through idealization of a therapist, an AA sponsor, an AA group, the AA program, or AA's "higher power." Kohut maintains (1977b) that the needs for mirroring and idealization, the needs of the narcissistic segment of the personality, are just as immemorial as the need for instinctual gratification. If they are not met in healthy ways, they will inevitably be met in unhealthy ones. The formation of a self-object transference provides the patient with the stability and security out of which growth from the stage of the archaic nuclear self into the stage of the mature self can take place.

In the latter stages of recovery, psychodynamic therapy tends to move

toward a more traditional psychoanalytic set of tasks. The patient increasingly relates to the therapist as an object rather than as a self-object, and reenactments of early object relations in the transference provide an opportunity for understanding and working through Oedipal conflicts.

Change is thus brought about by a combination of educational (cognitive behavioral) interventions and the acquisition of psychic structure through transmuting internalization. In many ways, such therapy constitutes a corrective emotional experience. The patient has either not had phase-appropriate, growth-promoting self-object relationships or has suffered massive regression, so that psychic structure was lost—so to speak washed out. He or she now has an opportunity to learn (or to relearn) how to manage feelings and conflicts without anesthetizing them.

Another way change takes place is through the labeling and verbalization of affect. Affect tolerance is built through practice in the same way one builds a muscle, by exercising it. Each time the patient is able to express a feeling in the transference and that feeling is accepted by the therapist, the capacity for affect tolerance is increased. Narcissistic rage that was previously either acted out or turned against the self, perhaps simultaneously by drinking, is now verbalized and in the course of time plays a less significant role as increased ego strength and self-cohesion reduce vulnerability. The patient is less easily hurt, therefore less enraged. Anxiety

that had been experienced as panic-dread of dissolution of the self and anesthetized is now tolerated. The therapist has faith that the patient will not disintegrate, and through identification, the patient's terror diminishes. Panic-terror becomes signal anxiety, and the patient learns that he or she can take action to deal with the danger. Self-cohesion is increased with sobriety and treatment, so there is less reason to fear regressive fragmentation.

Winnicott points out that "the capacity to be alone" (1958/1965) is a paradox. It is acquired through the experience of being alone with another person who is not impinging but allows us to be. If we are so fortunate as to have enough such experiences, the non-impinging other becomes internalized and we can be comfortably alone without the physical presence of another— because we are not really alone, there is someone within us. Winnicott's "capacity to be alone" is the diametric opposite of defensive isolation: The first is a sine qua non of all creativity, while the second is driven by fear and terror. Alcohol abuse is often the consequence of the failure to acquire the capacity to be alone. Once again, something outside is being put inside because something inside is missing. People drink to be companioned. In the dyadic relationship of therapy, the conditions necessary to acquire the capacity to be alone are present. The patient "plays" in the presence of an attentive yet non-impinging other, and in the course of time that attentive and non-impinging other becomes a part of self and the patient can be comfortably alone without turning to alcohol for companionship.

Alcohol abusers are often themselves children of alcohol abusers. When that is the case, it is inevitable that traumatic failure to meet narcissistic needs is part of their childhood history. The damage may be far more than that of omission; it often includes that of commission, including physical and sexual abuse. Although not all alcohol abusers were abused children, many were. Very often, the abuse is denied or repressed. The therapeutic task is de-repression, and the key factor in de-repression is providing a safe enough environment in which it can happen. I do not believe that a transferential reenactment of childhood horrors is curative. What is needed is a sufficient feeling of safety so that the patient can remember and feel and eventually work through childhood trauma.

The disease concept of alcoholism, if the patient comes to believe in it, is also an agent of change and should be taught. "You're not a bad person trying to be good; you're a sick person trying to be well." Alcoholism was viewed as a disease as early as the American Revolution by Surgeon General Benjamin Rush. In the 19th century, Thomas Trotter, an English naval physician, proposed that alcoholism is a disease caused by premature weaning and heredity, not a bad intuitive guess. More recently, the disease concept of alcoholism has been promoted by AA and given scientific support by Jellinek (1960). All of our official bodies, the AMA, both the APAs, and the courts, now regard alcoholism as an illness. It is a notion with extraordinary healing power. The disease concept reduces guilt (and what alcohol abusers do with

guilt is drink). One might think that teaching that alcoholism is a disease would lessen the chances of recovery by providing a rationalization for drinking. Although this is true of some patients, they are unusual. What happens for most alcohol abusers is that the disease concept reduces anxiety by providing a way of understanding what has been a hellish experience. Cognitive structure reduces anxiety, and patients come to believe that they are responsible for their recovery but need not feel guilty about being alcoholic. Alcohol abusers, contrary to the stereotype, often have severe superegos. What appears to be sociopathic behavior flows from the desperation of the need to attain supplies to maintain the addiction. The exception is a type of severe early-onset alcoholism called "male-limited alcoholism," which Cloninger (1983) believes to be biologically mediated. For the vast majority of alcohol abusers, however, the disease concept is mutative and enables a sustained recovery.

AA speaks of the necessity for surrender, or what Tiebout (1957) called "ego deflation." What both terms refer to is the relinquishing of reactive grandiosity. Alcoholic grandiosity, which Kohut (1977a, 1977b) would understand as unintegrated archaic grandiosity separated from the reality ego by the vertical split, serves no purpose but to keep the patient drinking. The patient holds onto the notion that he has power over alcohol, when in fact alcohol has power over him. Recognizing this reality and relinquishing the myth of omnipotent power is extraordinarily liberating. What had been

anticipated as a dreadful, even life-threatening deprivation is now experienced as freedom. The AA literature has many accounts of such ego deflations. I too believe that a radical reorganization of psychic forces, which takes place if the proper environment is provided and information is conveyed in a way that the patient can hear it, is curative. The notion of surrender sounds as if it would be narcissistically injurious to those who are already narcissistically injured. This is simply not the case. The experience, although defended against with the energy of desperation, is in fact narcissistically sustaining because what is given up is pure illusion. The patient who has had the surrender experience no longer needs to fight an impossible battle and can use his or her energy in the service of growth and integration.

To sum up, change takes place through the cessation of drinking, with its neurochemical, psychic, and interpersonal consequences; through didactic intervention, which reduces anxiety by providing cognitive structure for chaotic experience; through providing tools for living, the psychic structure needed to deal with feelings and conflicts; through the reversal of affect regression; through internalization, transmuting and otherwise; through de-repression; and through the breakdown of defensive isolation through integration into a community of recovering persons.

TECHNIQUES

The therapist's first task with the alcohol abuser is *building a relationship.* Because treatment will end unless the therapist succeeds in establishing a meaningful relationship with the alcoholic, the building and preserving of bonds takes precedence in the therapeutic interaction. Bonds are built by empathic listening, supplemented by the clearing of resistances. Confrontation of addiction is an empathic response. We tend to think of confrontation as unempathic, but that is not the case.

It is the *attitude* of the therapist that is crucial. What is required is active listening, the projection of interest and concern, and nonjudgmental positive regard. However, the situation with the active or newly sober alcoholic requires modifications of Freud's (1913/1958) excellent advice on beginning the treatment. Freud advised the analyst to remain silent so that the transference could develop until resistance manifested itself and then to interpret the resistance. That procedure will not work with alcohol abusers. The required modification consists of greater overt activity on the part of the therapist. Although empathic listening and the clearing of resistances remain paramount, the therapist must also serve as an expert on the disease of alcoholism; he or she has an educative function to perform.

The therapist is dealing with an impulse disorder that may be acted out at any time, ending treatment. Insofar as possible, this acting out must be anticipated and circumvented. Intolerable affects result in drinking.

Unconscious, disavowed affects are particularly dangerous, but any intense feelings, "positive" or "negative," conscious or unconscious, that remain unverbalized are a threat to sobriety. The therapist must actively encourage the expression of feelings and must appropriately interpret some of the emotional discomfort in early recovery as a symptom of that recovery. The therapist tells the patient, "When you are feeling upset, we'll try and understand it together, in terms of what's going on in your life or your relationships with people, or things that have happened to you in your past, including your childhood, but we're going to find that very often, when you're feeling badly, we will not be able to find any reason for it. The reason that is so is that your discomfort will be a symptom of the healing of your nervous system after the assault that alcohol has made on it. If you don't drink, the discomfort will disappear." The foregoing is an example of an educative intervention, albeit one with dynamic import.

The acting out of resistance by drinking must be anticipated and dealt with before it occurs. Of course, this is not always possible; it is a goal, not a demand on the therapist. Therapy in early recovery is difficult because the therapist has little time in which to deal with the patient's conflicts, since those conflicts may be acted out through drinking. We do not have the luxury of waiting the patient out. What is required is a bob and weave on the part of the therapist. Empathic listening, imparting of information, and the elicitation of feelings must be integrated into a coherent style. It requires a great deal of

"therapeutic tact" for the therapist to sense when to do what in order to maintain the relationship. However, the growing attachment of the patient to the therapist provides the cement that holds both the patient and the therapeutic relationship together. Some form of self-object transference is being elicited, be that a mirror transference, an idealizing transference, or an oscillation between the two.

Virtually no chronic alcohol abuser wants to get sober. The fear and pain are too great. The regressive pull is too great. That is why external events—such as loss of a job or loss of a mate—are so often the precipitant of an emotional crisis that results in sobriety. These external events furnish the apparent motive for sobriety. At this point, the alcoholic is "doing it for them." Such motivation is often not sufficient, and external controls such as those provided by hospitalization may be necessary to achieve sobriety of any duration.

Whether or not the patient has had some sort of inpatient experience, it is my belief that referral to Alcoholics Anonymous is a crucial part of the therapeutic process. (As noted previously, there are patients for whom AA is the wrong treatment. These include severe borderlines and schizoids as well as those who find AA's approach repugnant.) Patients often have a great fear of A A and many misunderstandings of it. Therefore, the therapist needs to be thoroughly familiar with and comfortable with 12-step programs. Many

therapists are uncomfortable with the language of the 12-step movement and with its spirituality. So are many patients. It is important that the therapist be able to present the program in a way that will be palatable to the particular patient. AA's "higher power" can be interpreted as the group, and such AA slogans as "Let go and let God" can be interpreted as "Get out of your own way." They are essentially injunctions to relinquish omnipotent control. The therapist needs to work through his or her own power and control issues in order to be comfortable with the AA approach to recovery. This does not entail ideological commitment to the beliefs of AA; the therapist needs to be objective. Not all of the patient's complaints about AA are resistances or symptoms of denial, and it is important to understand that. I tell patients that AA is a support network that will enable them to remain sober and to share their experience and deliquesce their guilt. I also tell them that they need not believe everything they hear there, and that they can regard it is a smorgasbord from which they should take what they can use most profitably.

In one way or another, omnipotent control as expressed in the belief, "I can drink as much as I want without it damaging me or controlling me," must be relinquished. The paradox of recovery is that the patient must relinquish control in order to gain control. Alcohol abusers, at the end of their drinking, have tenuous control of their sobriety at best. That is why some form of external control is often needed, whether that control is coming from the AA group, from the therapist, from a hospital, or from Anabuse, a drug that does

not permit you to drink. Eventually, such controls become internalized. It is not known exactly how this happens. Identification helps; in fact, it may be the key. This is one reason AA is so effective in establishing stable sobriety. AA provides the alcoholic with figures with whom to identify. They too are alcoholic, but they no longer drink; they are recovering. It is not with Bob or Jane or John or Sally that the alcoholic must identify, but with their sobriety. The alcoholic may also identify with his or her nonalcoholic therapist's sobriety, although here the identification is less direct.

With time, sobriety becomes more rewarding. The pain of early sobriety recedes, the residual pain is endurable, and the alcoholic wants to remain sober. Sobriety becomes part of the recovering alcohol abuser's ego-ideal. Living up to one's ego-ideal increases self-esteem, and that feels good; hence, it becomes a behavior the patient tries to maintain. Remaining sober is then no longer a struggle; it is an increasingly comfortable decision.

Self-psychology, as I have modified it for the treatment of alcohol abusers, suggests a number of powerful interventions for use in working with those abusers. Each addresses what theory understands as narcissistic deficit and narcissistic injury and their attempted self-cure through alcohol abuse; the attempt to fill inner emptiness due to failures in transmuting internalization by drinking; the acting out of narcissistic rage and turning it against the self; idealizing and mirror transferences to alcohol; attempts at

omnipotent control through alcohol abuse; attempts to boost abysmally low self-esteem through abuse of alcohol; and shame experiences, both antecedent to and consequent upon alcohol abuse. The following ways to translate theory into concrete interventions need to be modified so a particular patient can hear them.

1. *Not being able to drink "like other people" inflicts a narcissistic wound.* The admission that one is powerless over alcohol is extremely painful. It is experienced as a defect in the self, which is intolerable for those who are as perfectionistic as most alcohol abusers. The self must not be so damaged. Additionally, to be able to "drink like a man" or "drink like a lady" may be a central component of the alcoholic's self-image, of his or her identity. This self-image is particularly compelling for "macho" men but is by no means restricted to them. The therapist must recognize and articulate the conflict between the patient's wish to stop drinking and the patient's feeling that to do so entails admitting that he or she is flawed in a fundamental way. The therapist does this by saying, "You don't so much want to drink, as not want not to be able to drink." This makes the patient conscious of the conflict in an empathic way, allows him or her to struggle with the issue, and often opens the way for the patient to achieve stable sobriety.

2. *Alcoholism is one long experience of narcissistic injury.* Failure stalks the alcoholic like a shadow. As one of my patients put it, "When I drink, everything turns to shit." Career setbacks, job losses, rejection by loved ones, humiliations of various sorts,

ill health, economic decline, accidental injury, and enduring "bad luck" are all too frequent concomitants of alcoholism. Each is a narcissistic insult. Cumulatively, they constitute a massive narcissistic wound. Even if outward blows have not yet come, the inner blows—self-hatred and low self-regard—are always there. The alcoholic has all too often heard, "It's all your fault," in one guise or another. The therapist must empathize with the alcoholic's suffering. "Your disease has cost you so much," "You have lost so much," and, "Your self-respect is gone," are some ways the therapist can make contact with the alcohol abuser's pain and facilitate his or her ability to experience this pain instead of denying, acting out, and/or anesthetizing it.

3. *Alcoholics feel empty.* Either they have never had much good stuff inside or they have long since flushed it out with alcohol. "You drink so much because you feel empty" not only makes the connection but brings into awareness the horrible experience of an inner void. After sobriety has been achieved, the genetic determinants of the paucity of psychic structure experienced as emptiness can also be interpreted.

4. *Alcoholics frequently lack a firm sense of identity.* How can you know who you are if your experience of self is tenuous and its inner representation lacks cohesion? The therapist can comment on this and point out that being an alcoholic is at least something definite—an identity of sorts. When an AA member says, "My name is ___, and I am an alcoholic," he or she is affirming that he or she exists and has at least one attribute. With sobriety, many more attributes will accrue—

the self will enrich and cohere. One way of conveying this prospect to the patient is by saying, "You are confused and not quite sure who you are. That is partly because of your drinking. Acknowledging your alcoholism will lessen your confusion as to who you are and give you a base on which to build a firm and positive identity."

5. *Many people drink because they cannot stand to be alone.* This should be interpreted: "You drink so much because you can't bear to be alone, and alcohol gives you the illusion of having company, of being with a friend. After you stop drinking, it will be important for us to discover why it is so painful for you to be alone."

6. *Alcoholics form self-object (idealizing and mirror) transferences to alcohol.* The imago of the archaic, idealized parent is projected onto alcohol, which is experienced as an all-powerful, all-good object with which the drinker merges in order to participate in its omnipotence. "Alcohol will deliver the goods and give me love, power, and whatever else I desire" is the drinker's unconscious fantasy. The therapist should interpret this: "Alcohol protected you and made you feel wonderful, and that is why you have loved it so much. Now drinking isn't working for you anymore, and you are disillusioned and afraid."

7. *One reason alcoholics are devoted to the consumption of alcohol is that it confirms their grandiosity.* In other words, alcoholics form a mirror transference to alcohol. I once had an alcoholic patient who told me that he felt thrilled when he read that a

sixth Nobel prize was to be added to the original five. His not-so-unconscious fantasy was winning all six.

The therapist should make the mirror transference to alcohol conscious by interpreting it: "When you drink, you feel that you can do anything, be anything, achieve anything, and that feels wonderful. No wonder you don't want to give it up."

8. *Alcoholics, without exception, have abysmally low self-esteem.* Self-psychology understands this as an impoverishment of the reality ego consequent upon failure to integrate archaic grandiosity. The therapist needs to say, "You feel like shit, and that you are shit, and all your claims to greatness are ways of avoiding knowing that you feel that way. You don't know it, but way down somewhere inside, you feel genuinely special. We need to put you in touch with the real stuff so you don't need alcohol to help you believe that the phony stuff is real." The particular reasons, antecedent to and consequent upon the alcohol abuse, that the patient values him- or herself so little need to be elucidated and worked through.

9. *Sometimes the patient's crazy grandiosity is simultaneously a defense against and an acting out of the narcissistic cathexis of the patient by a parent.* That is, the patient is attempting to fulfill the parent's dreams in fantasy while making sure not to fulfill them in reality. This is especially likely to be the case with ACOAs (adult children of alcoholics). Heavy drinking makes such a defense/acting-out easy. If the alcoholic patient's grandiosity seems to be a response to being treated

as an extension of themselves by either parent, the therapist can say, "One reason you feel so rotten about yourself is that you're always doing it for Mom or Dad, and not for yourself. You resent this and spite them by undermining yourself by drinking."

10. *Alcoholics have a pathological need for omnipotent control.* Alcohol is simultaneously experienced as an object they can totally control and coerce into doing their will and an object that gives them total control of their subjective states. Alcoholics frequently treat people, including the therapist, as extensions of themselves. The AA slogans "Get out of the driver's seat" and "Let go and let God" are cognitive behavioral ways of loosening the need to control. Therapists should interpret the need to control in the patient's relationship with alcohol, other people, and the therapist. For example: "You think that when you drink you can feel any way you wish," "You go into a rage and drink whenever your wife doesn't do as you wish," or, "You thought of drinking because you were upset with me when I didn't respond as you thought I would."

11. *Alcoholics and their children suffer greatly from shame experiences.* Alcoholic patients are ashamed of having been ashamed and often drink to alleviate feelings of shame. Therapists need to help alcoholic patients experience rather than anesthetize their feelings of shame. One way to do this is to identify feelings of shame that are not recognized as such. For example: "You felt so much shame when you realized that you were alcoholic that you kept on drinking so you

wouldn't feel your shame."

12. *Alcoholics who achieve sobriety need to mourn their lost "friend."* Therapists should encourage them to speak about the loss of script, companion, soother, and lifestyle.

All of the above interventions and techniques are specific to active alcoholism and early recovery. Once stable sobriety is achieved, the attenuated withdrawal syndrome over, the pink cloud lived through, and the patient stably sober, therapeutic work continues in pretty much the same way as in any psychodynamic psychotherapy. What remains particular in the treatment of the alcohol abuser is the therapist's awareness of the ongoing danger of regression and return to active alcohol abuse. The focus on narcissistic injury as opposed to a focus on structural conflict also continues, but the balance shifts so that the therapeutic work encompasses both.

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CASE EXAMPLE

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Kirk, a tall, articulate man in his mid-twenties, entered psychotherapy because he was chronically depressed. Although a careful history was taken, nothing indicative of an alcohol problem was uncovered. Kirk was the third son of a prominent lawyer with whom he had an intense and stormy relationship. He told the therapist that his father, who loomed large in his mind, had 500 suits. Kirk said little about his mother, except that she fought frequently and violently with his father. His brothers, emotionally troubled

and unhappy individuals, were seven and twelve years older than he.

Kirk remembered himself as a lonely, self-conscious, overweight, socially awkward child. He had felt alienated and isolated. As he put it, "The cliques were already formed when I got to kindergarten." Feelings of estrangement, uniqueness, and alienation are well-nigh universally reported by alcoholics. Kirk felt the sense of being different with exquisite intensity. He seemed to have experienced little support from his self-involved and volatile parents. He remembered that he and his brothers would cry out, "Battle stations!" when their father returned home from work. When his oldest brother left for prep school, Kirk felt bereaved and abandoned. When the middle brother left, his fear turned to terror as he became the sole witness to his parents' erotic, violent quarrels. The one bright light during Kirk's childhood was his relationship with Maggie, the family's black housekeeper. An island of sanity in an ocean of irrationality, she gave him the feeling that he was important to somebody. At age eight, Kirk was sent to sleepaway camp, and when he returned, Maggie was gone. Not long after Maggie's disappearance, Kirk's parents transferred him out of his public school, where he felt somewhat comfortable, into a high-pressure private day school to which he never adjusted.

After the middle brother's departure, Kirk's parents increasingly involved him in their sexualized fighting. He was forced to play voyeur to

their exhibitionism. He learned to be a spectator rather than a participant in life, although he was not always a spectator: He once tried to stab his father. Although this kind of craziness is not uncommon in alcoholic households, nothing in Kirk's story suggested parental alcoholism. Given the histrionic quality of his home life, it was not surprising that Kirk developed an intense interest in movies.

Kirk had a miserable time during his preteen years. He became fat and remained obese into early adulthood. His compulsive overeating was his first addiction. Kirk went through high school in a fog. He mentioned smoking pot as if his use were nothing more than typical teenage exploration. Unlike his brothers, he did not attend an Ivy League college, making his father furious. Instead, he studied film. In the years since graduation, he had worked in menial jobs. Kirk's love life was restricted to anonymous, impersonal sex. He had few friends, although he was prone to engage in rescue operations of troubled people. He was particularly involved with an elderly couple who went from crisis to crisis; Kirk took them to psychiatric emergency rooms. His rescue efforts provided him with pseudo-intimacy and were unconscious reenactments of his attempts to rescue his mother from his father.

Kirk was a believer in God. When his mother, socially active in a wealthy Jewish congregation, told him she did not believe in God, Kirk was shattered, as he was when she said she was going to buy her infant granddaughter a

diaphragm. Both comments were in character yet deeply hurt Kirk. His disillusionment was a reflection of his intense need for an object worthy of idealization.

Kirk's history and current functioning were indicative of serious psychopathology. His object relations were impoverished, his vocational function marginal, and he was deeply depressed. He frequently thought of suicide. It was not without significance that Kirk's one enduring social activity was attendance at meetings of the family burial society.

Kirk's initial diagnosis was dysthymic disorder. Only later did his correct primary diagnosis, alcoholism, become apparent. He also suffered from a personality disorder that had both schizoid and narcissistic aspects.

During early sessions, Kirk was consumed with his feelings toward his powerful and difficult father. He made little mention of his mother. Ultimately, her alcoholism and Valium addiction became clear. Denial of other peoples' alcoholism is as common as denial of one's own. Kirk got some relief from pouring out his feelings and developed a strong and trusting bond with the therapist, but his depression did not improve. Kirk entered treatment starved for meaningful human contact. He had never had anyone *really* listen to him or treat him as an "end in himself." His current human relationships could hardly have been more empty, yet he yearned for intimacy as much as he

feared it. His hunger for relationship grew stronger than his fear. For all of his disappointments in people, he still wanted to be listened to, to be heard, to be responded to in a non-manipulative manner, and he was willing to take a risk to get that. Kirk desperately needed not to be impinged upon, to be left alone in the presence of an empathic other, to be understood rather than acted upon. Winnicott (1952/1958) has written about the deleterious effects of impingement; Kohut also stresses the dangers to normal development of unempathic overstimulation. Therefore, I was relatively "inactive." Kirk responded by developing an idealizing transference.

Denial is never complete. Alcoholics know at some level that they are destroying themselves. Fear prevents this knowledge from becoming fully conscious. On a conscious level, alcoholic denial manifests in dissimulation and evasiveness; on the preconscious level, in self-deception; on the dynamic unconscious level, in panic-terror of return of the repressed, which would confront the alcoholic with the necessity of giving up that which he believes he cannot live without. Kirk was in denial on all these levels. His denial encompassed not only his own alcoholism but also his mother's. He had started drinking in high school. By his senior year, he was getting high every day. His preference for alcohol was an identification with his mother. Kirk's drinking accelerated during college. By the time he had been out of college six months, he was getting drunk every night. He began to experience blackouts, was increasingly ill in the mornings, and suffered more and more from guilt,

remorse, self-reproach, and depression. However, Kirk did not allow himself to see the connection between his drinking and his increasing misery. The defense of isolation of thought and affect supported his denial. His conscious belief was that alcohol was a harmless pleasure. His nightly escapades were "fun." Thus, Kirk was being honest when he told me drinking was not a problem.

When he entered therapy, his denial was total. Treatment changed this. As he increasingly trusted, admired, and even loved his therapist, he became less guarded. He thus became aware of much that he had not previously known, and even the conscious became more emotionally real. Dialogue vivifies. Although I offered few interpretations, I did ask questions, seeking more specificity and detail. I was now eliciting far more spontaneous responses, and it became increasingly clear that Kirk drank a great deal. The more Kirk disclosed about his life, the more alcoholism became a probable diagnosis. Paradoxically, it was Kirk's denial that allowed him to provide the information I needed to diagnose his alcoholism. The same facts that spelled alcohol abuse to me spelled recreational drinking to him. Kirk's denial also protected him from facing his mother's alcoholism. Retrospective idealization of parents is common. Kirk's idealization of me gave him an alternative idealized object and enabled him to risk losing his mother as an ideal object. This loosened his whole defensive structure.

Alcohol served him as a source of omnipotent power; it too was an ideal object. His relationship with me gave Kirk the freedom to risk losing his most important love object, alcohol. Having replaced his relationship with alcohol before he actually had to relinquish it, he became willing to risk this loss—relationship and rum before relationship instead of rum. Kirk told me that he was alcoholic before he was able to tell himself. Such classic tipoffs as Monday morning absences from work, puffy face, and blackouts convinced me that Kirk was an alcohol abuser. He did not come in and report that he had had a blackout; rather, he would hesitatingly report incidents such as waking up in bed with someone he did not recognize. He also began talking about his mother's frequent drunkenness and dependence on tranquilizers. It was as if he had always known this without knowing it. By now it was apparent that Kirk's alcoholism was progressing and a danger to him. When he reported finding himself suddenly awakening in a subway train in a dangerous neighborhood at three in the morning, with no inkling of how he had got there, the diagnosis was no longer in doubt. The therapeutic relationship was solid, and I decided to make my move.

I told Kirk that he had had an alcoholic blackout and that blackouts are dangerous. I told him a lot about alcoholism. Confrontation overlapped education. Ignorance is the handmaiden of denial. Rational explanation does not replace the work of overcoming emotionally powerful resistance, but it does facilitate it. I confronted Kirk with a detailed account of his alcoholic

symptoms. I told him that he had a serious drinking problem and that his depression was incurable until he stopped drinking. Kirk did not respond. Consciously, he was still in denial; however, his unconscious responded with a dream. Early in treatment, he had reported the following dream: "I was walking along the street. A violent wind began to blow. I felt I would be swept away. Just as I was about to lose my footing and fly off, I reached out in desperation and barely managed to grab hold of a nearby fence. The wind started to blow me away and I was swept off my feet, my body flying upward. I held on by my fingertips as my body was about to be tom loose and carried away. I awoke sweating and trembling."

This dream has many meanings, but I understood it as a visual representation of Kirk's existential position—barely holding on by his fingertips as the winds of psychosis threatened to sweep him away. His hold on reality was tenuous, and his links with the earth could snap at any time. Kirk's basic conflict was between his unconscious wish to fly away, to get and remain "high," and his wish to remain on earth, to stay sane, to not get "high."

Kirk came to the session following my confrontation looking less distressed. He said, "I had a dream in which I was walking with my mother. We were going across town. A bus came along. We ran for it, but the door closed. I realized that we had a chance to catch the bus at the next corner. I thought, if we don't make the bus, we will never get there. I told Mother to

run and started running myself. I put on a burst of speed, running flat-out, and reached the bus just as the doors were closing, throwing myself aboard. The doors closed; we pulled away. I looked around and saw Mother on the street; she had missed the bus. I left her behind."

This was a dream about separation-individuation, about finally escaping his mother, her alcoholism, pill addiction, and masochism. Kirk was leaving his mother behind in two senses—as a real and troubled person in his daily life, and as a part of his mental world, an internal object, a pathological introject. Kirk, his sense of self none too firm and his boundaries none too clear, had taken a big step toward disidentification with his mother and her alcoholism. No emotional battle is won once and for all. Naturally, Kirk's unhealthy identification with his mother was not dissolved instantly and permanently, but a Rubicon had been crossed.

I elicited Kirk's associations and reflected the accompanying affects. I was struck by the contrast between Kirk's loss of contact with the ground in the first dream and his landing on his feet on the bus in the second dream. Every dream reported in treatment is also a transference dream; it was not without significance that the bus Kirk boarded was going toward my office. Kirk's dream was "about" leaving his mother for his therapist, leaving alcoholic drinking for sobriety. Although neither Kirk nor I knew it then, Kirk had taken his last drink. He has now been sober for over 10 years.

Kirk's education about the effects of alcoholic drinking on body, mind, and spirit continued and was to do so for a long time. Therapists must tell patients about alcoholism in such a way that they can hear it. Since there is resistance, information must be presented simply, clearly, and repeatedly. Education about their disease provides alcoholics with a cognitive structure that reduces anxiety, lessens guilt, and makes sense of their experiences.

Kirk proved to be a quick learner. He had already learned enough to bring about the psychic reorganization that resulted in his dream, and he learned a good deal more in subsequent months. My next educational step was to tell Kirk about AA. Shortly thereafter, he arrived at a session looking sheepish. He said, "I went to my parents' Passover Seder . It was horrible. Everyone except my father was drunk. I had decided not to drink because of what you said about blackouts. I realized that I hadn't seen my family when I was sober for a long time. My oldest brother drank glass after glass of wine, became louder and louder, and made less and less sense. His girlfriend couldn't even stand up. My middle brother wasn't much better, and he kept saying vile things about my parents. My mother got to the point where she was slurring her words. Then she started to bait my father. He cursed her, and they got into a shoving match. He was about to hit her, until I said, 'Daddy, stop it.' It was awful, awful. It was my childhood all over again. I thought, 'Next year, in Bellevue,' and I walked out. [The Seder ends with the line, 'Next year, in Jerusalem.']

"I realized that my whole family was alcoholic. I didn't much care about any of them except Mother. It really hurts to think of her as a drunk. She didn't give me all that I wanted, but she loved me in her way. I started to cry. Suddenly I thought, 'My therapist is right—I am an alcoholic too.' Funny, but that didn't hurt in the same way as thinking about my mother being alcoholic. In fact, it was sort of a relief. I cried some more, deep sobs this time.

"I don't know where I got the idea, but I decided to go to an AA meeting. Maybe the idea had been in the back of my mind for a while. It was wonderful. I cried all the way through. I felt at home. I felt safe. Sometime in the course of the meeting, I thought, 'A Seder is supposed to be about every man's journey from slavery to freedom. My family's Seder sure wasn't that, but this meeting is about *my* journey from slavery to freedom.' I didn't want to live the way I had been living; I didn't want to drink anymore. As they say in AA, I had hit bottom. I walked out exhausted, a little empty, but feeling clean. I don't think I'm going to drink again, but I'm scared. I don't know how to live without alcohol."

Kirk started to cry. The massive emotional reorganization that he underwent between his blackout on the subway train and his experience at his parents' Seder is characteristic of many recoveries from alcoholism. Powerful emotion is a necessary, if not always sufficient, condition of recovery.

The intensity of Kirk's experience had convinced him that drinking meant death and enabled him, at a deep unconscious level, to choose life rather than death. The slow work of securing the insight and emotional realignment he had gained in his moments of illumination now began. It would take many years of therapy and many hundreds of AA meetings to secure and build on Kirk's realization that he was an alcoholic. It was most certainly not to be a story of linear progression; quite the contrary, it was to be two steps forward and one step back, but Kirk never again experienced suicidal depression, nor was he ever tormented by a desire to drink. The curative factors in Kirk's recovery were the development of an idealizing transference, confrontation, education, and interpretation of his internal world and its externalization in his drinking.

TRAINING

Training and experience as a dynamic psychotherapist is easily built on to develop the skills to treat alcohol abuse dynamically. Therapists with such a background need to expand their knowledge base to include a working knowledge of the theories of Kohut and Winnicott and their clinical application. However, the most important knowledge acquisition required is knowledge of alcoholism. The therapist working with this population must have a thorough acquaintance with the somatic, cognitive, emotional, intrapsychic and interpersonal effects of alcohol abuse. Additionally, the

therapist needs to be comfortable with and thoroughly acquainted with 12-step programs. The easiest way to acquire this knowledge is to read AA literature and attend AA "open" meetings. Once this knowledge base is acquired, the therapist needs experience working with alcohol abusers. Given the prevalence of the problem, this experience is not difficult to acquire. Clinical experience with alcohol abusers should be under the supervision of a clinician thoroughly experienced in its treatment. With the acquisition of the above knowledge base and a modicum of supervised experience, dynamic therapists work well with this population.

I think the key skill is the proper dosing of activity and inactivity. This skill is acquired only through experience. Some alcohol abusers require activity and confrontation on the part of the therapist early in treatment, while others need to be left alone so that transference can unfold and bonding occur. Again, the supervision of an experienced alcohol abuse therapist is the easiest way to learn how to dose interventions.

EMPIRICAL EVIDENCE FOR THE APPROACH

Although I have no rigorous outcome data for this approach to the treatment of alcohol abuse, I do have informal outcome data. Over the past 10 years, I have treated over 100 alcohol abusers. Many have come and gone. Those who are pressed into treatment by spouses are particularly prone to

leave before much has occurred. I would say about one-third of my alcoholic caseload never settled down and were in therapy only briefly. Of the remaining two-thirds, the overwhelming majority became and remained sober. Although slips occurred, approximately 80% of the two-thirds who remained in treatment became sober in the first year of therapy. Their slips were mostly in the first two years. Almost all of these patients remained in treatment for extended periods of time. To the best of my knowledge, they did not drink. The outlook, particularly with the change in social attitudes toward drinking and sobriety, is quite good in alcohol abuse. However, the sample I am reporting on consists of middle- and upper-middle-class functional alcoholics who for the most part voluntarily sought treatment, albeit often not treatment for excessive drinking. This is an atypical group of alcohol abusers. Their ego strength and relative socioeconomic stability gave them clear advantages over the alcoholic population in general.

Although radical improvement in the quality of life is the rule following adjustment to abstinence, grave emotional problems often, though by no means always, remain. The chances of resolving these problems are pretty much the same as for non-alcoholics with similar psychodynamic difficulties. However, alcoholics have both an advantage and a disadvantage. The disadvantage lies in the damage they have done to themselves and in the energy they must devote to preventing relapse. Their vulnerability to acting out to avoid conflict is also a liability in recovery. However, there are also

advantages in being a recovering alcohol abuser struggling with other emotional difficulties, usually around narcissistic injury and deficit. The advantage is the gain in self-esteem that comes from overcoming an addiction, as well as the support system and socialization into looking within rather than projecting and externalizing that comes from participation in AA and its affiliates.

REFERENCES

Abraham, K. (1979). The psychological relations between sexuality and alcoholism. In *Selected Papers on Psychoanalysis* (pp. 80-90). New York: Brunner/Mazel. (Original work published 1908)

Alcoholics Anonymous World Services (1974). *Is AA for you?* New York: AA World Services.

Bateson, G. (1971). The cybernetics of "self": A theory of alcoholism. *Psychiatry,* 34,1-18.

Cloninger, C. R. (1983). Genetic and environmental factors in the development of alcoholism. *Journal of Psychiatric Treatment and Evaluation,* 5, 487-496.

Fenichel, O. (1945). *The psychoanalytic theory of neurosis* (pp. 375-386). New York: Norton.

Freud, S. (1953). *Interpretation of dreams.* In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vols. 4 & 5, pp. 1-621). London: Hogarth Press. (Original work published 1900)

Freud, S. (1958). On beginning the treatment. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 121-144). London: Hogarth Press. (Original work published 1913)

Freud, S. (1957). On narcissism: An introduction. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 67-104). London:

Hogarth Press. (Original work published 1914)

Freud, S. (1962). Beyond the pleasure principle. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 18, pp. 1-64). London: Hogarth Press. (Original work published 1920)

Freud, S. (1959). Inhibitions, symptoms, and anxiety. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 20, pp. 75-172). London: Hogarth Press. (Original work published 1926)

Freud, S. (1961). Dostoyevsky and parricide. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 21, pp. 173-194). London: Hogarth Press. (Original work published 1928)

Freud, S. (1985). *The complete letters of Sigmund Freud to Wilhelm Fliess* (J. M. Masson, Ed. & Trans.) Cambridge, MA: Harvard University Press. (Original work published 1897)

Glover, E. (1928). The aetiology of alcoholism. *Proceedings of the Royal Society of Medicine*, 21,1351-1355.

Goodwin, D. W., Schulsinger, F., Hermanson, L., Gaze, S. B., & Winokur, G. (1973). Alcohol problems in adoptees raised apart from alcoholic biological parents. *Archives of General Psychiatry,* 28, 283-243.

Hartocollis, P. (1968). A dynamic view of alcoholism: Drinking in the service of denial. *Dynamic Psychiatry,* 2,173-182.

Jellinek, G. M. (1960). *The disease concept of alcoholism.* New Haven, CT: College & University Press.

Jung, C. G. (1973). C. G. *Jung: Letters, Vol. II, 1951-1961* (pp. 623-625). Princeton, NJ: Princeton University Press. (Original work published 1961)

Keller, M. (1958). Alcoholism: Nature and extent of the problem. *Annals of the American Academy of Political and Social Science,* 315: 1-11.

Knight, R. (1937). The dynamics and treatment of chronic alcohol addiction. *Bulletin of the Menninger Clinic,* 1, 233-250.

Kohut, H. (1971). *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorders.* New York: International Universities Press.

Kohut, H. (1977a). Preface to *Psychodynamics of Drug Dependence* (pp. vii-ix). National Institute on Drug Abuse Research Monograph No. 12. Washington, DC: U.S. Government Printing Office.

Kohut, H. (1977b). *The restoration of the self.* New York: International Universities Press.

Krystal, H. & Raskin, H. (1970). *Drug dependence: Aspects of ego function.* Detroit: Wayne State University Press.

Levin, J. (1987). *Treatment of alcoholism and other addictions: A self-psychology approach.* Northvale, NJ: Jason Aronson.

Levin, J. (1991). *Recovery from alcoholism: Beyond your wildest dreams.* Northvale, NJ: Jason Aronson.

Levin, J. (1994). Alcoholism and regression/fixation to pathological narcissism. In J. Levin & R. Weiss (Eds.), *The dynamics and treatment of alcoholism: Essential Papers* (pp. 370-388). Northvale, NJ: Jason Aronson.

McClelland, D. C., Davis, W., Kalin, R., & Wanner, E. (1972). *The drinking man: Alcohol and human motivation.* New York: Free Press.

Menninger, K. (1938). *Man against himself.* New York: Harcourt, Brace.

Petrie, A. (1978). *Individuality in pain and suffering* (2nd ed.). Chicago: University of Chicago Press. (Original work published 1967)

Propping, P., Kruger, J., & Mark, N. (1981). Genetic disposition to alcoholism: An EEG study in alcoholics and their relatives. *Human Genetics,* 35, 51-59.

Rado, S. (1933). The psychoanalysis of pharmacothymia. *Psychoanalytic Quarterly*, 2, 2-23.

Schuckit, M. A., & Gold, F. O. (1988). A simultaneous evaluation of multiple markers of ethanol/placebo challenges in sons of alcoholics and controls. *Archives of General Psychiatry*, 45,211-216.

Selzer, M. L. (1971). "Michigan alcoholism screening test": The quest for a new diagnostic instrument. *American Journal of Psychiatry*, 127, pp. 1653-1658.

Simmel, E. (1948). Alcoholism and addiction. *Psychoanalytic Quarterly*, 17, 6-31.

Szasz, T. (1958). The role of the counterphobic mechanism in addiction. *Journal of the American Psychoanalytic Association*, 6, 309-325.

Tiebout, FI. M. (1957). The ego factor in surrender to alcoholism. *Quarterly Journal of Studies on Alcohol*, 15, 610-621.

Winnicott, D. W. (1958). Psychosis and child care. In *Through pediatrics to psychoanalysis* (pp. 219-228). London: Hogarth Press. (Original work published 1952)

Winnicott, D. W. (1965). *The capacity to be alone.* In *The maturational processes and the facilitating environment* (pp. 29-36). New York: International Universities Press. (Original work published 1958)

Winnicott, D. W. (1965). Ego distortion in terms of true and false self. In *The maturational processes and the facilitating environment* (pp. 140-152). New York: International Universities Press. (Original work published 1960)

Witkin, H. A., Karp, S. A., and Goodenough, D. D. (1959). Dependence in alcoholics. *Quarterly Journal of Studies on Alcohol*, 20, 493-504.

Wurmser, L. (1978). *The hidden dimension: Psychodynamics in compulsive drug use.* New York: Jason Aronson.

CHAPTER 8

Treating the Eating Disorder Patient with Borderline Personality Disorder: Theory and Technique

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HISTORY AND DEVELOPMENT

The treatment of Axis I disorders with accompanying Axis II psychopathology has received relatively little attention in the literature. In the field of eating disorders, a great deal of information has evolved on a variety of interventions, including cognitive-behavioral (Fairburn, 1981; Fairburn, 1985; Garfinkel & Garner, 1982; Garner & Bemis, 1985; Garner, Fairburn, & Davis, 1987), group psychotherapy (Love, Lewis, & Johnson, 1989; MacKenzie, Livesley, Coleman, Harper, & Park, 1986), psychotropic medication (Garfinkel & Garner, 1987; Mitchell, 1989; Pope & Hudson, 1984; Walsh, 1991), psychotherapy (Fairburn et al., 1991; Schwartz, 1988), behavior modification (Eckert, 1983; Halmi, 1985), psychoeducation (Connors, Johnson, & Stuckey, 1984; Gamer, Rockert, Olmsted, Johnson, & Coscina, 1985), nutritional counseling/intervention, and support group (Enright, Butterfield, & Berkowitz, 1985). Likewise, a variety of treatment approaches have been described for borderline personality disorder

(Chatham, 1985; Kernberg, 1984; Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989; Masterson & Klein, 1989; Waldinger, 1987). Only a few authors have attempted to describe their experience with and perceptions of the treatment of patients with both disorders (Dennis & Sansone, 1989; Dennis & Sansone, 1991; Johnson, 1991).

While traditional interventions have been effective for nonborder-line eating disorder patients, the borderline subgroup has been extremely difficult to treat. Of the two available studies examining for outcome in a mixed population of eating disorder patients, both reported a poorer outcome for eating disorder patients with borderline personality at one-year follow-up (Johnson, Tobin, & Dennis, 1990; Sansone & Fine, 1992). In a third study examining outcome in a group of borderline patients, those with eating disorders fared no worse or better than the remainder of the group during a 16-year period after initial assessment (Stone, Stone, & Hurt, 1987).

It is our impression that the borderline subgroup of eating disorder patients represents the recidivistic one-third of patients who do not seem to respond well to traditional treatment. Thus, this subgroup represents a significant challenge to clinicians. The ideal treatment, if any, remains unknown. It is this challenging subgroup that we focus on in this chapter.

It was this very subgroup of eating disorder patients that initiated our

interest in exploring more effective treatment designs for characterologically impaired patients. Experience, voracious reading, personal research efforts, and extensive dialoguing with colleagues guided us in the development of a treatment strategy.

First, we recognized that the psychological deficits in these patients were profound and that recovery needed to take place on an individual basis with psychological mentors. These mentors needed to be able to provide long-term psychotherapy to characterologically disabled patients and to have broad knowledge bases in eating disorders (e.g., nutrition, metabolism, medical complications) and borderline personality (e.g., developmental theory, psychodynamics, defense structure). In addition, the mentors needed specific skills, such as the ability to set limits without invoking control issues, tolerance for impulsivity, and the capacity to simultaneously "hold" and "let go." Individual psychotherapy developed as the foundation of our treatment approach.

Second, we recognized that, as a group, these patients would require a stable backdrop (i.e., holding environment) where the individual treatment could unfold. We realized that therapists would be limited in both time and emotional reserves and that they would need to focus their efforts on providing character disorder therapy. Thus, the "holding" needed to occur not only at an individual psychotherapy level but also within an extended

therapeutic milieu—be it an inpatient, partial hospital, or residential living setting—and the patient community. For the extended therapeutic milieu, we developed a cohesive treatment program that focuses on meeting patients' emotional needs. In addition, the program is geographically centralized (it accommodates both hospitalized and partial hospital patients in an outpatient setting), enabling the efficient use of team meetings throughout the week to coordinate multi-milieu efforts.

The issue of holding in the broader community was facilitated by including a 12-step component (AA World Services, 1952) to our biopsychosocial treatment model. This approach evolved from our experience with dual-diagnosed (eating disorder and substance abuse) recoverees who had benefited from 12-step intervention. This subgroup in particular appears to have a high prevalence of borderline personality (Suzuki, Higuchi, Yamada, Mizutani, & Kano, 1993; Sansone, Fine, & Nunn, 1994). The 12-step model provided us with an experienced example of a community milieu (i.e., holding environment) that provided ubiquitous support via sponsors and meetings, a value system organized through a repetitive and reinforcing language structure, and a philosophy that acknowledges the lack of sufficient personal resources to resolve problems (i.e., the First Step). The 12-step approach encourages dependence and reliance on others within the therapeutic community in an atmosphere of nonthreatening relatedness and spiritual belonging. While this has been a complicated conceptual interface, our early

impression is that there are benefits for dual-diagnosed patients in adding this component when extensive milieu treatment is indicated.

Finally, we implicitly recognized the need for extended intervention, that is, the proposed treatment approach needed to be feasible over a long time period, for a matter of years. This conclusion subsequently heightened our sensitivity to patients' life management issues, such as housing needs, the cost of treatment, and the feasibility and design of low-cost adjunctive interventions. In response, we developed on-campus residential living with reduced-cost leases, no-cost weekly aftercare groups, on-site 12-step meetings, and affordable meals in the facility's cafeteria.

In conclusion, we devised a long-term treatment program, founded on individual psychotherapy, that incorporates the extended therapeutic milieu and patient community as active treatment components. As stressed earlier, the ideal treatment for this subgroup of eating disorder patients remains unknown. However, our approach appears promising.

Diagnostic Approach

According to *DSM-IV* (APA, 1994), the diagnosis of anorexia or bulimia nervosa requires that multiple criteria be met. For anorexia nervosa, these include the refusal to maintain a body weight over a minimal normal weight for age and height (at least 15% below); an intense fear of gaining weight or

becoming fat even though underweight; a disturbance in how personal body weight, size, or shape is experienced; and, in females, the absence of at least three consecutive menstrual cycles that were otherwise expected to occur. In addition, anorexia nervosa is diagnostically divided into two subtypes, restricting or binge-eating/purging types.

For bulimia nervosa, the diagnostic criteria are recurrent discrete episodes of binge eating; the feeling of a lack of control over eating behavior during binges; the recurrent use of self-induced vomiting, laxatives, diuretics, strict dieting and fasting and/or vigorous exercise to prevent weight gain; a minimum average of two binge-eating episodes a week for at least three months; and persistent over-concern with body shape and weight. Like anorexia nervosa, bulimia nervosa is also divided into two diagnostic subtypes, purging and nonpurging types.

Both disorders are characterized by a typical onset in adolescence, disturbed attitudes toward body and weight, difficulties in relationships with others, and repeated efforts to control calorie intake and regulate body weight.

These diagnoses can become ambiguous in several clinical situations. For example, a diagnostic quagmire emerges when clarifying the criteria for binge-eating (Beglin & Fairburn, 1992; Habermas, 1991). Anorexic patients,

in particular, may describe a low-calorie food ingestion as a "binge." To resolve this dilemma, we arbitrarily define a binge as food consumption totaling 2,500 calories (i.e., two and a half times the size of a typical meal) or more during a discrete period of time, typically less than two hours.

In assessing borderline personality disorder, the *DSM-IV* criteria are: (1) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of over-idealization and devaluation; (2) impulsiveness in at least two areas that are potentially self-damaging; (3) affective instability; (4) inappropriately intense anger or lack of control of anger; (5) recurrent suicidal threats, gestures, or behavior, or self-mutilating behavior; (6) marked and persistent identity disturbance; (7) chronic feelings of emptiness; (8) frantic efforts to avoid real or imagined abandonment; and (9) transient stress-related paranoid ideation or severe dissociative symptoms. Meeting at least five criteria is necessary for diagnosis.

There have been several clinical concerns with the *DSM-IV* criteria for borderline personality. These include an overemphasis on affective symptoms, the lack of broader criteria for quasi-psychotic episodes, and indifference to the psychological defense structure (a limitation in all of the Axis II diagnoses) (Goldstein, 1985). In addition, the validity of the criteria has been challenged (Akiskal, Chen, Davis, Puzantian, Kashgarian, & Bolinger, 1985; Davis & Akiskal, 1986; Goldstein, 1983; Kroll, Sines, Martin, Lari, Pyle,

& Zander, 1981; Pope, Jonas, Hudson, Cohen, & Gunderson, 1983). Therefore, we tend to use the criteria established by Gunderson (Kolb & Gunderson, 1980) when contemplating a diagnosis of borderline personality disorder.

The Gunderson criteria for borderline personality can be easily organized by using the acronym PISIA (see Table 8.1). The *"P"* represents psychotic or quasi-psychotic episodes, usually brief and transient; the "I" stands for impulsivity, often long-standing and self-destructive; the "S" is for social adaptation; the second "I" represents interpersonal relationships, usually chaotic and unfulfilling; and the "A" is for affect, often chronically dysphoric and/or labile. The patient must meet criteria in each of these five areas of assessment.

Several investigators have examined the prevalence of borderline personality in various eating disorder populations (Gwirtsman, Roy-Byrne, Yager, & Gerner, 1983; Johnson, Tobin, & Enright, 1989; Levin & Hyler, 1986; Piran, Lerner, Garfinkel, Kennedy, & Brouilette, 1988; Sansone, Fine, Seuferer, & Bovenzi, 1989; Yates, Sieleni, Reich, & Brass, 1989; Zanarini, Frankenburg, Pope, Hudson, Yurgelun-Todd, & Cicchetti, 1990). Despite a variety of diagnostic instruments and differing subject pools, the existence of a subpopulation of eating disorder patients with borderline personality has been consistently confirmed (comprising approximately one-third of the overall eating disorder population). Therefore, we clinically screen all eating

disorder patients for borderline personality using the Gunderson criteria. The translation of the Gunderson criteria into *DSM-IV* criteria is fairly straightforward.

TABLE 8.1 Gunderson Criteria for Borderline Personality

Psychotic or quasi-psychotic episodes: brief and transient in nature; may include fleeting hallucinations or delusions, depersonalization, de-realization, rage reactions, unusual reactions to drugs, paranoia in which the patient recognizes the loss of reality, and dissociative experiences; quasi-psychotic phenomena tend to be stable over the lifetime of the patient.

Impulsivity: typically long-standing and self-destructive; may include substance abuse, self-mutilation, suicide attempts, self-regulation difficulties such as eating disorders and sexual promiscuity, high-risk behaviors, multiple accidents, interference with wound healing, abuse of prescribed medical treatments, engagement in physically or sexually abusive relationships; behaviors may be long-standing, concurrent, and/or substituted for each other.

Social adaptation: superficially intact but characterized by significant problems in functioning; may be evidence of high achievement, but long-term performance is often erratic and periodically impaired.

Interpersonal relationships: typically chaotic and unfulfilling; dichotomous style of relatedness, i.e., social relationships tend to be very superficial and personal relationships are extremely intense, manipulative, and dependent; fears of being abandoned and rage toward the primary caretaker, usually the mother.

Affect: chronically dysphoric and/or labile, exhibiting little normal mood since the age of 15; predominant affects are anxiety, anger, depression, and/or emptiness.

Source: Adapted from Kolb & Gunderson, 1980.

Compared with non-borderline eating disorder patients, the borderline subgroup demonstrates a variety of different clinical features (see Table 8.2).

Compared with borderline individuals without eating disorders, eating

disorder patients with borderline personality tend to be a better socialized, more sophisticated group with well-adapted psychopathology. As a result, the diagnosis of borderline personality can be easily overlooked. In ambiguous cases, we may use psychological testing as an adjunct to diagnostic confirmation.

Our current repertoire of psychological testing includes the Millon Comprehensive Multiaxial Inventory II, the Borderline Syndrome Index (Conte, Plutchik, Karasu, & Jerrett, 1980), the Borderline Personality Scale of the Personality Diagnostic Questionnaire-Revised (Hyler & Reider, 1987), the Minnesota Multiphasic Personality Inventory-2, the Separation-Individuation Questionnaire (Christenson & Wilson, 1985), and the Rorschach. This is not an exhaustive list of the available instruments but represents the ones that are personally familiar to us. We typically select only one or two instruments for adjunctive assessment based on factors such as cost, how long it takes for the test results to be returned, the ease of administration, and whether other psychological issues need to be explored (e.g., depression via the MMPI-2).

TABLE 8.2 Clinical Characteristics of Borderline Eating Disorder Patients Compared with Non-borderline Eating Disorder Patients

- Have more overall psychiatric symptoms
- Have more impairment in work and in social and life adjustment
- Report more disturbed interpersonal relationships
- Demonstrate a broader range of impulsive and self-destructive behaviors
- Report a history of laxative abuse
- Report a history of sexual abuse

- Grew up in dysfunctional families
- Report more drug and alcohol abuse
- Have undergone more treatment attempts
- Have poorer treatment outcome at one-year follow-up

Source: Adapted from Johnson, Tobin, & Enright, 1989.

INCLUSION/EXCLUSION CRITERIA

The primary exclusion criterion for entry into our treatment program is the patient's unwillingness to reasonably structure self-destructive behavior to enable successful entry into a psychodynamic treatment. (We are admittedly more ambiguous with this guideline for adolescents.) This criterion screens out a very small minority of borderline individuals, perhaps 5%, who are either highly lethal (i.e., invested in annihilating themselves) or unable to move beyond being gratified by defeating an authority figure, such as a therapist.

In addition, we are cautious about accepting into treatment borderline individuals who are unable to access a treatment relationship because of attachment difficulties (i.e., individuals with antisocial, schizoid, or schizotypal features) or cannot utilize psychological interventions owing to cognitive unavailability (e.g., those who experience ongoing psychosis). In the field of eating disorders, these individuals may account for up to 20% of the candidates seeking extended treatment. Screening for exclusionary criteria takes place during the initial assessment and is discussed with the patient

during the subsequent negotiation of the treatment-entry contract.

DYNAMIC ISSUES IN EATING DISORDER/BORDERLINE PERSONALITY DISORDER

Eating disorder syndromes are perceived as final common pathways from a variety of etiological substrates (Herzog, 1987; Johnson & Maddi, 1986; Johnson, Pure, & Hines, 1986; Johnson, Sansone, & Chewning, 1992), which may include developmental conflicts about separation-individuation and/or assuming the adult role; preexisting, or predisposition to, affective or anxiety disorders; dysfunctional family relationships; and personality traits or disorders (e.g., obsessive-compulsive, borderline, narcissistic). In effect, borderline personality represents a subset of a broader group of etiological substrates.

The etiology of borderline personality remains unknown, although many investigators believe that both genetic and environmental factors play significant roles. The genetic proponents generally believe that a nonspecific constitutional predisposition is at fault. As for environmental factors, problematic interaction between the mother or parents and the child in early development has been underscored by many investigators (Egan, 1986; Kernberg, 1967; Masterson, 1981; Masterson & Rinsley, 1975; Shapiro, Zinner, Shapiro, & Berkowitz, 1975; Zweig-Frank & Paris, 1991). In addition, numerous investigators have reported emotional, physical, and/or sexual

abuse during early development in these individuals (Brown & Anderson, 1991; Bryer, Nelson, Miller, & Krol, 1987; Favazza, 1989; Herman, Perry, & Van der Kolk, 1989; Ludolph, Westen, Misle, Jackson, Wixom, & Wiss, 1990; Meyer, 1984; Ogata, Silk, Goodrich, Lohr, Westen, & Hill, 1990; Shearer, Peters, Quaytman, & Ogden, 1990). The contributory roles of these variables is unknown. However, a relationship between compromised caretaking, maltreatment or abuse, and borderline personality is highly suggestive.

A detailed overview of the psychodynamics specific to borderline personality (Gunderson, 1984; Kernberg, 1967; Stone, 1980) and to eating disorders (Bruch, 1978; Johnson & Connors, 1987) is beyond the scope of this chapter but available to the reader elsewhere. In overviewing the dynamics of these two disorders when they coexist, the key conceptual theme is that the borderline dynamics are organized around eating disorder symptomatology. Table 8.3 offers several examples of this phenomena.

A psychodynamic issue of particular concern in these individuals is the repetitious emergence of self-destructive behavior (SDB). SDB can be understood as the repetition-compulsion of a developmentally familiar process (i.e., externally imposed abuse) that takes on different meanings in adolescence and adulthood (i.e., self-imposed abuse). The underlying meanings and/or functions of self-destructive behavior may include: (1) the regulation of unmanageable affective states; (2) displacement of anger at

others to self; (3) organization of a self that is fragmenting or disorganizing; (4) identity consolidation around self-destructiveness; and (5) the elicitation of caring responses from others (Favazza, 1989; Gunderson, 1984). In borderline individuals, eating disorder behaviors fulfill many of these psychological functions rather than being primary expressions of conflict over food/body/weight issues.

TABLE 8.3 The Manifestation of Borderline Dynamics in Eating Disorder Patients

Borderline Dynamic	Possible Manifestations in Individuals with Eating Disorders
Core self-regulation difficulties	Disturbed eating behavior Other impulsivity (e.g., self-mutilation, suicide attempts) Chronic dysphoria or mood lability that organizes around food/body/weight issues
Unresolved separation-individuation issues	Self-imposed dependency (e.g., emotional, financial) due to emotional, physical, and/or occupational debilitation caused by eating disorder
Cognitive style characterized by splitting	Organization of black-and-white thinking around food/body/weight issues (e.g., good/bad foods)
Core identity issues	Consolidation of unresolved self-issues around body issues (i.e., physical exterior)
Impaired capacity to self-sooth	Use of binging, weight loss, food restriction to self-sooth
Relationship difficulties Quasi-psychotic episodes	Relationship difficulties Dissociative defenses, particularly in victims of sexual abuse, dysmorphophobic features occasionally encountered in some diuretic abusers, and other typical borderline phenomena (e.g., rage reactions, derealization, depersonalization, fleeting paranoia)

Self-destructive behavior	Relentless use of food restriction, vomiting, laxatives, diuretics, exercise, Ipecac, stimulants
Inability to trust	Secrecy/isolation of eating disorder behavior

TREATMENT GOALS

The two central goals of treatment in patients with both eating disorder and borderline personality disorder are enhanced self-regulation and improved interpersonal relatedness. Self-regulation encompasses a variety of treatment foci, including stabilization of eating disorder symptoms, as well as adjunctive self-destructive behaviors, and promotion of object constancy to enable self-soothing. Each focus will be discussed.

Self-regulation

For the borderline patient who presents for the treatment of eating disorder, the initial assessment focuses on identifying the specific eating disorder behaviors, including their patterns and frequencies. The predominant goal is the reasonable structuring and reduction of these dysfunctional behaviors to enable sufficient stabilization to undertake a psychodynamic treatment.

Absolute eradication of nonlethal eating disorder symptoms is *not*

recommended, owing to the high probability in borderline individuals of symptom substitution (i.e., the substitution of one self-destructive behavior for another). Premature eradication can result in the emergence of a behavior that is potentially more lethal than the eating disorder behavior. Research data on the phenomenon of symptom substitution are not available. However, borderline individuals report multiple self-destructive behaviors throughout their lives, as evidenced in our research with the Self-Harm Inventory (Sansone, Sansone, & Wiederman, 1991). Eating disorder behavior that *is* potentially lethal needs to be promptly stabilized.

A second focus is the management of adjunctive self-destructive behaviors. In our experience with the Self-Harm Inventory, eating disorder symptoms are not the only self-destructive behaviors of these individuals. They invariably utilize a repertoire of self-destructive behaviors intermittently. We believe that the preceding management dictum holds—attempt stabilization but avoid premature symptom eradication, owing to the possibility of symptom substitution. If the behavior is potentially lethal, the goal is acute stabilization.

A third focus in the treatment is the enhancement of self-soothing through the consolidation of object constancy (attaining stable mental representations of others) (Burgner & Edgcumbe, 1972; Leon, 1987), discussed in detail later in the chapter.

Interpersonal Relatedness

The second goal in the treatment of these individuals is the enhancement of interpersonal relatedness. Separation-individuation is a fundamental issue in this regard (Mahler, 1971). Borderline individuals do not seem to be able to develop an emotional bridge to outside relationships until they resolve their intense enmeshment with family. For many, the family unknowingly promotes the patient's dynamics. These are families that for generations have punished members' separation attempts by threatening abandonment and do not address members' needs until a crisis develops. These families are unable to provide any level of emotional holding and may be hostilely gratified by the patient's dependency on them, regardless of the emotional expense. Exerting control over others is a persistent dynamic among family members, and intimacy and emotional growth are unfamiliar concepts.

The therapist can promote separation-individuation by actively valuing personal growth, challenging fears of disloyalty to parents and family, reframing abandonment (e.g., who is abandoning whom?), and because anger fosters continuing psychological enmeshment, neutralizing anger toward parents and family. The therapist's ability to provide emotional holding in the therapeutic relationship helps to buffer the family's influence when its members challenge the patient's growth. A therapist working separately with

the family can be useful in providing education, encouraging the patient's independence, and strengthening appropriate boundaries.

In addition to resolving separation-individuation issues, the reduction of self-destructive behavior promotes interpersonal relatedness. Repetitive self-destructive behavior, whether manifested as eating disorder symptoms or otherwise, results in interpersonal distancing in healthy relationships. If left unchallenged, these behaviors can "burn out" even the most loyal supports.

Interpersonal relationships are also enhanced by the capacity for object constancy. The inability under stress to internally evoke others as integrated images and to self-sooth can have disastrous consequences for relationships. These include extreme dependency ("I need to see you to know that you exist") and volatile good/bad perceptions ("I love you/I hate you").

Clearly, there is a delicate interplay between self-regulation and interpersonal relatedness. Both the management of self-destructive behavior and the consolidation of object constancy play intimate roles with each. Self-regulation eliminates the insult to relationships that occurs through repeated self-destructive behavior. In turn, successful interpersonal relatedness enhances self-regulation by providing personal stability, soothing, and intermittent ego support for the patient.

THEORY OF CHANGE

We believe that, to some degree, patients change because of their repeated exposure to healthy experiences in a benevolent relationship with a reasonably trustworthy mentor. Essential in this relationship is the mentor's ability to internally rewire the patient's conclusions from previous traumatic life experiences and to address the developmental suspensions and arrests that have occurred along the way.

Relationship growth is facilitated by therapeutic work with transference. During the initial phase of treatment, the therapist emphasizes the importance of the therapeutic relationship and incorporates a variety of relationship-building techniques. As the relationship develops, the transference often intensifies. The transference contains the themes of abandonment, abuse, and malevolence that the patient experienced during the early developmental years.

Using a traditional psychodynamic approach, the therapist must repeatedly clarify and challenge the transference dynamics on a cognitive and interpretive level. By doing so in a supportive manner, the patient's compromised view of interpersonal dynamics (i.e., distorted intrapsychic image world) becomes clearer to him or her. Essentially, the therapist "fine-tunes" reality through transference work and thus promotes the stabilization of the therapeutic relationship. We use a traditional psychodynamic approach

to transference clarification and resolution throughout the treatment experience. Transference dynamics intensify during periods of biological (e.g., calorie-deficit states, low potassium) and emotional stress.

Change also occurs in the patient's reliance on self-destructive behavior. In borderline patients, we specifically confront the use of self-destructive behavior as a threat to the therapeutic relationship and the treatment. This approach underscores our attention to this behavior and its impact on relationships and attachment.

We suspect that the accumulation of healthy experiences in the therapeutic relationship, the repeated exposure of the transference, and the challenging of SDB in the relationship context enable patient growth. Like the incorporation and internalization that occurs in the toddler, we believe that having many consistently positive interpersonal experiences enables these individuals to develop a healthier interpersonal style. Unlike the toddler, however, the borderline individual has an adult cognitive structure that is imbued with a mixture of both mature and characterological defenses, and simple exposure to positive experiences without transference resolution and the challenging of SDB in the interpersonal context is insufficient for change.

TECHNIQUES

The Milieu

Office

Prior to initiating treatment with eating disorder patients with borderline personality, several levels of milieu need to be developed. The first is the office milieu, in preparation for individual psychotherapy. In developing the office milieu, familiarity and sameness should prevail. For example, the waiting room and office areas need to provide not only comfort but familiarity in terms of decor and seating; avoid making frequent changes in furniture and accessories. A consistent appointment time and the same receptionist promote a stable rhythm to the treatment. In addition, the clear definition of the business structure of the treatment experience (duration of the therapeutic hour, payment of fees, changing/canceling appointments, therapist availability outside of standard office hours) promotes the expected. When possible, upcoming changes in the office rhythm, such as a new secretary or new furniture, need to be communicated to the patient well in advance of their occurrence.

Extended Treatment Milieu

Beyond the scope of the office environment and individual psychotherapy, the patient may be participating in other treatment settings, such as inpatient, partial hospital, or residential living. Thus, the extended treatment environment can include a variety of mini-milieus. The principles of familiarity and sameness also apply to these environments. In promoting

the expected, each environment needs to maintain clear expectations of the patient, written if necessary, that are reinforced by the treatment providers in all settings. For example, the curfew established in a residential living milieu needs to be reinforced by the individual psychotherapist. Likewise, the patient's individual psychotherapy schedule needs to be seen as a priority by the inpatient treatment team. The philosophy (e.g., role of emotional holding, style of establishing limits) and values (e.g., benevolence, tolerance) of the entire treatment environment need to be in sync as much as possible. Educational in-services, staff treatment-planning sessions, case conferences, ongoing discussion of program goals and approaches, and treatment-team retreats help to consolidate the treatment philosophy and synchronize the rhythm of these various milieus. The geographic compactness of the treatment setting can be particularly valuable.

Patient Community Milieu

The patient's community milieu cannot be overlooked in preparing for his or her treatment. There are numerous approaches to developing a patient community milieu. However, the philosophy about the community and its perceived value is the essential element. Therapists, as well as other treatment-team members, need to genuinely value the stability, reinforcement, and support that this milieu can provide. The patient community milieu can assist fellow patients and staff with crisis resolution

and provide emotional holding. At the same time, the patient can be challenged by the community to be more dependent on others. We consider learning to rely on others to be a fundamental step in recovery.

The treatment team can demonstrate its support of the patient community milieu by encouraging patients to socialize outside of treatment, supporting peer sponsors (e.g., the Big Sister program), reinforcing passes for inpatients to enable social networking with outpatients, and facilitating community events such as holiday dinners to convene the entire patient community. The treatment team may also want to consider campus and personal housing as part of the overall treatment setting or to develop behavioral contracts with patients that enlist the community.

Treatment Entry into Long-term Psychotherapy

We actively negotiate the patient's entry into a long-term psychotherapy relationship by assessing "readiness" and "fit." We define readiness as the patient's willingness at treatment entry to attempt to structure self-destructive behavior, that is, to learn to self-regulate. For highly lethal behaviors, such as the urge to act out suicidal ideation, we require 100% abstinence. We justify this requirement by framing suicidal intent as a realistic inability to commit to a long-term intervention (Fine & Sansone, 1990).

For nonlethal behaviors, such as purging, we selectively prioritize which ones to structure based on their potential for interfering with the treatment. We may require a 70%-80% reduction in a particular behavior as an indication of readiness. If a self-destructive behavior does not genuinely interfere with the treatment (e.g., superficial scratching), we may not structure it at all.

We emphasize to the patient that self-destructive behavior must be under sufficient control to avoid the diversion of the treatment from psychodynamic work to crisis intervention. As a caveat, we avoid proscribing nonlethal self-destructive behavior, owing to the possibility of symptom substitution of lethal behavior. The negotiation of readiness forms the basis for our treatment-entry contract.

In terms of fit, we evaluate a variety of factors regarding the emotional-therapeutic match between the therapist and the patient. We advise caution in accepting into long-term treatment those patients whose behaviors could eventually immobilize the therapist because of personal intolerance for them (e.g., gory self-mutilation). Accordingly, we pay close attention to the issue of interpersonal fit (i.e., is there sufficient chemistry between the patient and the therapist?).

We also assess the patient's treatment needs based on the history and

determine whether we have sufficient resources to address these needs. For example, a patient who has required repeated hospitalizations is a poor candidate for a therapist who has no access to inpatient care. Likewise, a patient who requires medication must have a treatment environment that can provide it.

Finally, there is the issue of the patient's fit into the general milieu if treatment beyond individual psychotherapy is indicated. Will the patient be accepted by the treatment team and other patients to enable sufficient emotional holding? In this population, we occasionally encounter somewhat eccentric schizotypal individuals who have difficulty relating to the therapist as well as others. Prior to admission, we often review the case with staff in the various milieus to assess the potential fit with other patients and the treatment environment.

Should there be a significant problem with either readiness or fit, we offer the patient alternatives and candidly present our reasoning. If the issue is readiness, but the fit appears appropriate, we leave open the opportunity for a future working relationship. If the issue is fit, a referral is made with an eye to resolving the particular impasse. In either case, a neutral closure is emphasized.

Consolidation of the Therapeutic Relationship

Relationship Building

The first phase of individual treatment is the consolidation of the relationship between the patient and the therapist. The emphasis on the relationship needs to be apparent to the patient from the outset of treatment (Horvath & Luborsky, 1993; Masterson, 1990; Meissner, 1992; Safran, 1993). Indeed, during the initial telephone contact and subsequent evaluation, the importance of the therapeutic relationship is repeatedly emphasized by the therapist. Even matters of fee payment are framed in terms of maintaining and preserving the relationship (e.g., "We need to discuss the financial feasibility of this long-term treatment, as I want to make every effort at the outset to protect our relationship from disruption.") This emphasis communicates a personal commitment to the relationship as well as an understanding of the relational issues (i.e., attachment).

Relationship building is an active, ongoing process. We encourage therapists to be genuine, spontaneous, and candid to promote the attachment. (The exception to this level of openness is personally conflictual self-disclosure by the therapist). Relationship building requires repeated focus on the therapeutic relationship. Useful strategies include limiting the amount of time spent in historical material (staying in the here and now), integrating dynamics involving persons outside the session into dynamics inside the session (e.g., "You say that your boss is always angry with you—do you ever

feel that way about me in our relationship?"), and actively and repeatedly exploring the patient's behavior in the context of the therapeutic relationship (e.g., "You've cut yourself, and my anxiety is high—what does this mean, and what can we do about it?").

Other relationship-building techniques include the integration of humor, reflecting positive impressions about the patient back to him or her to enhance core self-concept, and actively verbalizing a commitment to honesty. The honesty issue *includes* the therapist, specifically the willingness to openly address concerns and share impressions. If the therapist is unable to be honest in the relationship, we recommend supervision or consultation. If the patient is unable to be honest, honesty needs to be the primary therapeutic issue, as the subsequent phases of treatment are grounded in a trusting therapeutic relationship. Finally, we find it useful to routinely, without provocation, give borderline patients verbal reassurance of our investment in them to model caring in the absence of crisis.

Projective Identification

Potential disruptions in the consolidation of the therapeutic relationship can occur for a variety of reasons, one being the patient's relentless use of projective identification. Projective identification involves not only the projection of self but feeling at one with the projectee. In the

aftermath, the patient attempts to control the therapist and to elicit behavior from the therapist that is consistent with the projection (Goldstein, 1991; Porder, 1987; Ramchandani, 1989). An example would be a patient who is consistently late, provoking the therapist to angrily question the value of continuing the treatment; the patient responds, "See, I knew that you didn't really want to see me."

Projective identification can keenly challenge the therapist's sense of boundaries. Maintaining a careful awareness of boundaries with a demeanor of genuineness is a powerful prophylactic maneuver. When boundaries are challenged, it is necessary to confront the patient about the "confusion" with a demeanor that communicates a benevolent intent (e.g., "I feel like you are wanting me to dismiss you, and I really want to preserve our relationship."). We recommend supervision with a colleague in ambiguous situations. The risk of not clarifying projective identification in the therapeutic relationship is the conscious or unconscious acting out of the patient's projections by the therapist. At another level, the therapist runs the risk of blatant misinterpretation of the patient's intent by tuning in to the coercion rather than the process.

Elicitation of Caring

Another source of relationship disruption is the patient's historical style

of experiencing "caring." Borderline patients tend to reenact their historical roles as victims and to stage and act out the interpersonal scenario, "If you really care about me, you'll do this." Frequently, this scenario is undertaken rather provocatively by the patient in an attempt to coerce the therapist into mutually destructive behavior (e.g., the patient demands a stock bottle of amitriptyline because "you can trust me," or attempts to seduce the therapist so as to become a "special patient"). The therapist must repeatedly address the issue of caring by identifying and challenging elicitations of caring that are unrealistic or potentially destructive and by modeling healthy caring.

Self-destructive Behaviors

A final area of relationship disruption is the patient's overt self-destructive behavior. At some level, this behavior is engaged in to elicit responses from others. The patient may use self-destructive behavior to engage others when feeling abandoned as well as to distance others when feeling threatened by intimacy. In turn, responses by others tend to be either attempts to rescue the patient or to abandon him or her. In evaluating the dynamics, the context is critical.

We tackle self-destructive behavior through a variety of approaches. Our initial treatment-contract approach was described earlier. We challenge repeated slips in terms of the patient's readiness for treatment.

We also use cognitive techniques throughout the treatment (Beck, 1976; Beck, Rush, Shaw, & Emery, 1979). We elicit illogical beliefs, which may include:

1. It's acceptable to hurt myself.

2. I deserve punishment.

3. Self-destructive behavior is the only way to get others to really respond to me.

4. This behavior is necessary to convince others that I feel pain.

As expected, we challenge the logic of these beliefs on a cognitive level.

We also use interpersonal restructuring techniques, which are designed to challenge and restructure the interpersonal functions and meanings of self-destructive behavior. Several authors have discussed specific approaches (Kernberg, 1984; Kroll, 1988), but our favorite is that taken by Gunderson (1984). During acute crises, Gunderson suggests that the therapist: (1) explore what the patient is asking for through his or her threat or behavior; (2) clarify that self-destructive behavior heightens your anxiety, thereby limiting your effectiveness; and (3) state that your ultimate response to the situation will be based on legal and ethical concerns—that therapists choose to show caring in healthier ways than rescuing patients. Following the crisis, Gunderson recommends that the therapist: (1) explore the usefulness of the

employed intervention; (2) emphasize the need to understand the self-destructive drive; and (3) acknowledge satisfaction at being available while stating that availability in the future is not guaranteed.

We also attempt to explore the intrapsychic functions of self-destructive behavior, specifically attempting to help the patient to understand its role in identity, the regulation of affect, and self-organization.

Finally, we continue with psychodynamic intervention by clarifying that the therapist could interpret self-destructive behavior as the patient's attempt to abandon the therapeutic relationship, and that the therapist experiences a genuine negative emotional impact on the relationship (e.g., fear, distancing). The therapeutic effectiveness of these statements is contingent on a strong alliance in the treatment relationship.

We have not found medication to be dramatically effective in the management of self-destructive behavior in borderline patients beyond its immediate tranquilizing effects. In addition, we have not found the use of restraints or formal behavior modification techniques to be especially helpful, particularly in the absence of a therapeutic relationship or milieu context. Occasionally, we have successfully used symptom substitution (e.g., substituting strenuous exercise for purging) as well as sublimation techniques (e.g., writing or drawing out self-destructive drives), which tend to

be particularly useful for higher functioning patients. Finally, group psychotherapy approaches appear promising (Linehan, 1993a, 1993b; Sansone, Fine & Sansone, 1994).

Resolution of Internal Issues

As the therapeutic relationship consolidates, the therapist is increasingly able to help the patient work through the deeper issues entailed in borderline personality. One significant area of therapeutic work is the enhancement of object constancy, which is the capacity for constancy in relationships and/or the ability to internally maintain stable mental representations of others. The value of object constancy is the capacity for self-soothing, a notable deficit in borderline patients.

The prerequisites to object constancy are (1) evocative memory, or the ability to internally recall others in their absence; and (2) the resolution of splitting, which is the active separation of thoughts and feelings into the extremes of good and bad. Therapeutic efforts in both of these areas are essential (Wells & Glickauf-Hughes, 1986).

Evocative Memory

Evocative memory can be enhanced through a variety of techniques. Simply increasing the direct contact time between the patient and the

therapist can promote the internalization of the therapist. This can be achieved by increasing the frequency of appointments, scheduling telephone calls, and enhancing the therapist's visibility within the broader treatment setting (e.g., having therapists present during group meetings with patients). To be effective, these maneuvers need to be initiated in an anticipatory and responsive fashion, rather than from patient coercion.

Evocative memory can also be enhanced through cognitive techniques. During absences, the therapist can give the patient one of several of the following assignments: (1) writing a letter to the therapist to share upon his or her return; (2) writing out a therapy session at the time the session would have routinely occurred, or (3) developing the therapist as an "internal companion," that is, contemplating what the therapist might do in a particular situation and then journalizing the experience. Indeed, any type of journalizing involving the therapist is useful.

Recall cues can also be helpful for the patient. For example, tape recordings (auditory cues) of therapy sessions or relaxation inductions can help the patient access the therapist during absences. The therapist's voice on the office answering machine can also serve this function. In addition, transitional phenomena (tactile cues) imbued with the memory of the therapist can be useful. Examples include food records, program pamphlets, educational articles, and appointment cards. Each can be personalized by the

therapist with a written note. A "support book," in which program therapists and other patients write positive comments about their experience of the patient, is helpful. Environmental cues, such as visiting the office or institution, can stimulate the patient's recall of the therapist. In using these techniques, it is tactically important to strategize ahead of time to enable effective recall and subsequent soothing during times of crisis.

Splitting

The resolution of splitting is a major therapeutic undertaking during this phase of treatment. Splitting is particularly apparent during intense affective states and when discussing conflictual material. As an initial intervention, simply identifying the "extremism" is useful. In addition, Socratic exploration of the consequences (i.e., pointing out the conflicts with reality) can encourage reexamination. Humorous exaggeration can be a playful and effective intervention as long as the intent is benevolent and the relationship is reasonably stable. Splitting can also be dealt with by modeling integration. For example, thinking out loud in session during decision making allows the patient to observe and experience the process of weighing risks and benefits. At these times, the therapist can illustrate once again that few issues are solely black or white.

At some point, we make an effort to educate the patient about the

dynamic process of splitting. We have found several vehicles to be useful, one of our favorites being the movies. For example, *Star Wars* was initially characterized as a story about "good guys" and "bad guys." As the series continued, Darth Vader was developed as an individual with some admirable qualities, thus forcing the audience to deal with ambivalent feelings toward him. Hence, we underscore the shift from black-and-white to gray perception (i.e., integration). We also use the analogy of color versus black-and-white.

Both the enhancement of evocative memory and the resolution of splitting are ongoing treatment issues that promote object constancy. Progress with both is typically experienced by the therapist as two steps forward and one step back; any assessment of progress must take a longitudinal view. Under stress, fragmentation will occur. However, the general expectation is that the patient will enhance his or her capacity for self-soothing.

Self-destructive Behavior

Another issue during this phase of treatment is the continuing management of self-destructive behavior. As the therapeutic relationship evolves, so does the meaning and significance of SDB. In the beginning of the therapeutic relationship, the meaning is historically driven and interpersonally generic. However, as the relationship deepens and the

therapist begins to take on a genuine identity through transference work, the meaning of self-destructive behavior becomes rather dynamically specific to the relationship. Indeed, the therapist can expect to react to the behavior more intensely because of the deepening relationship with the patient. For example, the therapist may dispassionately tolerate self-cutting by the patient in the beginning of treatment, but as the treatment and familiarity with the patient progress, the therapist may find this type of dramatic self-violation more difficult to experience with the patient.

During this phase of treatment, the interventions described in the previous phase (cognitive techniques, interpersonal restructuring, psychodynamic exploration) are certainly applicable. However, psychodynamic intervention should be increasingly emphasized (see Figure 8.1). This type of intervention can be undertaken at the intrapsychic level by persistently exploring the internal functions of the patient's self-destructive behavior. These functions may include the regulation of affect, organization of self, displacement of anger, consolidation of identity around self-destructive behavior, and/or the elicitation of caring responses by others. When identified, each dynamic needs to be explored at a variety of levels (e.g., impact on self-concept and self-regulation). The patient needs to understand that each act of destruction legitimizes low self-worth and impacts negatively on self-esteem. The patient needs to become aware of a lingering negative aftermath for self-concept following each insult.

Psychodynamic intervention also needs to occur at the interpersonal level. The emphasis here is on the interpersonal function and the impact of self-destructive behavior. The borderline patient needs to fully understand that self-destructive behavior both engages and distances others. The immediate engagement of others may provide a sense of fleeting "intimacy" but persistent self-destructive behavior precludes intimacy. The therapist must candidly share his or her feelings about the personal impact of such behavior, as well as encourage the patient to explore the impact of this behavior in the extended therapeutic milieu and patient community. In the extended therapeutic milieu, these issues can be explored through homework assignments, community process meetings, and treatment groups centered on goals and progress with self-destructive behavior (Sansone, Fine, & Sansone, 1994).

FIGURE 8.1
The Management of Self-destructive Behavior in Individual Psychotherapy
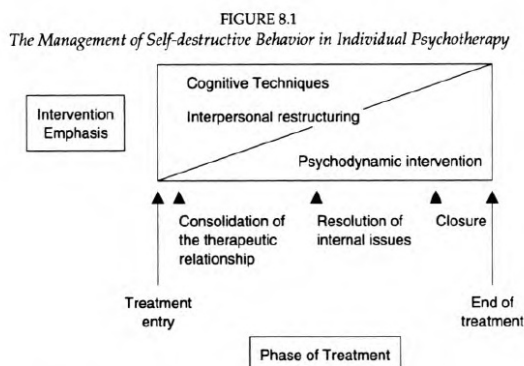
Self-regulation

Finally, during this phase of treatment we tend to examine the issue of self-regulation on a global level. We do so by consolidating the patient's broad-spectrum regulation difficulties (e.g., eating disorder behavior, self-mutilation, rage reactions, substance abuse) into one theme—that of regulation difficulties. This perspective allows us to focus on "the war" rather than each "battle," fosters neutrality during the exploration of specific behaviors, and allows the focus to turn to sensitive areas. Interventions can subsequently be framed as attempts to help the patient self-regulate rather than to help him or her to "be good."

Closure

Closure, in our opinion, is one of the most significant psychological working periods for the borderline patient and the therapist. For the patient, closure invariably stimulates the resurgence of the archaic difficulties around separation-individuation. For the therapist, closure is experienced as a regressive period fraught with the potential hazard of symptom reemergence (Sansone, Fine, & Dennis, 1991). Both patient and therapist are often filled with trepidation.

We have come to reframe closure as an intensely therapeutic period. It is one of the few opportunities for a psychological mentor to "rewire" the patient's experience of active separation. Rewiring occurs through repeated cognitive intervention, interpretation, and genuine reassurance and support. Again, the issue of intent is paramount to the closing of the relationship. Rather than perceiving it as a manipulative, control-oriented maneuver by an authority figure, as the patient has experienced in the past, the therapist needs to consistently frame closure as the culmination of a successful treatment relationship.

With the preceding conceptualization in mind, we offer several caveats around this phase of treatment. First, closure needs to be undertaken for a time period long enough to enable conceptual rewiring. We typically suggest at least six months.

Second, we view the regressive pull of the patient during closure as the key event in this phase of treatment. While reviewing relapse strategies is helpful, helping the patient to understand that separation will not result in annihilation is a more meaningful focus. Interpretation is a useful technique during this period, as well as cognitive intervention and reassurance.

Third, we "keep the door open" at the close of treatment. Closure does not mean that the therapist and patient will never see each other again. It means that the bulk of the therapeutic work has been completed.

Adjunctive Interventions

In the preceding material, individual psychotherapy has been emphasized as the fundamental intervention. The role of family therapy has been briefly addressed. Several other treatment components warrant further discussion.

The cognitive-behavioral techniques routinely used in the treatment of patients with eating disorders are extremely helpful. However, our expectations regarding their effectiveness are tempered by the patient's predisposition to self-destructive behavior and the usual recovery pattern of two steps forward, one step back. Cognitive techniques are generally soft-pedaled to sustain a predominant focus on individual psychotherapy.

Group psychotherapy of a psychodynamic orientation is a useful adjunctive intervention in our experience. However, if the group is not program-affiliated (i.e., not led by a member of the treatment team), there is a significant risk of patient splitting and regression early on in the treatment. We recommend deferring referral to nonprogram-affiliated groups until the therapeutic relationship has been reasonably well consolidated. For group treatment, we suggest a process focus coupled with structure in order to limit unproductive regression.

We have not been overly impressed by these patients' responses to psychotropic medication. While the use of antidepressants in bulimia nervosa is useful (Agras et al., 1992; Goldbloom & Olmsted, 1993; Hudson, Pope, & Jonas, 1983; Kaye, Weltzin, Hsu, & Bulik, 1991; Pryor, McGilley, & Roach, 1990; Walsh, 1991), we are not aware of any studies that have explored the effectiveness of psychotropic medication in the subgroup of eating disorder patients with borderline personality. The response of general borderline patients to psychotropic medication has been reported to be modest at best (Zanarini, Frankenburg, & Gunderson, 1988), an assessment that reflects our clinical experience.

The risks of prescribing psychotropic medication are potentially high. These may include the patient's (1) abuse of the medication, (2) use of medication issues to control the therapist, (3) addiction to those medications

that can addict, (4) perceptions that medication precludes other forms of treatment, (5) sensitivity to side effects, (6) exposure to potential drug interactions, and (7) use of medication to self-destruct. We recommend a careful initial assessment of risks and benefits, routine physician-patient dialogue to minimize risks, and ongoing reassessment of the overall benefit of medication.

Self-expressive experiences outside of individual and group psychotherapy (e.g., occupational therapy) run risks similar to those previously discussed. If these experiences are occurring in program-affiliated groups that encourage process but provide structure and maintain a close liaison with the therapist to prevent unnecessary regression, they can be very productive. If the group is not program-affiliated, we recommend deferral until the consolidation of the therapeutic relationship.

Nutritional intervention is a significant component in all eating disorder treatment programs. The caveats discussed earlier apply (i.e., temper expectations, anticipate two steps forward, one step back).

Table 8.4 presents an overview of the entire, integrated treatment process.

CASE EXAMPLE

Danni was 31 years old, single, and hospitalized in Virginia when her inpatient therapist first contacted us about her transfer to our long-term eating disorders treatment program. In reviewing her case with the therapist, a potential fit seemed likely. One of our therapists contacted Danni by telephone to do an assessment and determine her readiness for this type of treatment. She revealed the following information.

TABLE 8.4 Overview of Treatment for Borderline Eating Disorder Patients

Component	Comment
Individual psychotherapy	Treatment phases: 1. Treatment entry 2. Consolidation of the therapeutic relationship 3. Resolution of internal issues 4. Closure
Extended treatment milieus (inpatient, partial hospital, residential living)	Treatment environments are in sync with program values and philosophy Program components reinforce treatment goals of individual patients
Patient community milieu	Holding environment Arena for exploring and processing individual issues in community context
Family therapy	Emphasis is on family education, separation-individuation, reinforcement of boundaries
Cognitive-behavioral techniques for treatment of eating disorder	Expectations are tempered Emphasis is soft-pedaled to sustain focus on individual psychotherapy
Group therapy	Program-affiliated groups: Process is promoted, coupled with structure Non-program-affiliated groups: Referral is deferred until the therapeutic relationship is consolidated, to avoid unnecessary regression

Psychotropic medication	Responses are minimal to moderate Risks versus benefits must be carefully considered Frequent reassessment is necessary
Self-expressive experiences	Program-affiliated: Process is promoted, coupled with structure Non-program-affiliated: Referral is deferred until the therapeutic relationship is consolidated, to avoid unnecessary regression
Nutritional intervention	Expectations are tempered Emphasis is soft-pedaled to sustain focus on individual psychotherapy

Danni was born in Buffalo, New York, and was the youngest child and only daughter in a family of five. Her mother, age 56, was an ex-waitress who was originally described as "lost, no direction, codependent, and very loving." Her mother had developed anorexia nervosa shortly after Danni's birth. Her father, age 58, was an employee at a steel mill and described by Danni as "a temperamental alcoholic." The marriage was the first for both parents, and Danni's father had a lengthy history of extramarital affairs. Her older brother, age 34, was a successful career officer in the navy who had graduated from college with honors. He was described as "really into religion." Danni's other brother, age 32, was employed as a civil servant and described by her as very somatic and devoid of feelings. This brother was geographically closest to the parents and was involved in their caretaking.

Danni's birth and delivery were uneventful. Her recall of early life experiences was quite limited. She reported taking baths with her brothers until age eight, not having a door at the entrance to her bedroom, and being

repeatedly fondled by her oldest brother between the ages of four and seven. She also reported several head traumas, including an accident with a hatchet, a sledding accident, and an automobile accident.

Danni described herself as a chubby child who began dieting at age 12. Shortly thereafter, her attempts at prolonged calorie restriction were followed by episodic binging and purging. Danni's weight fluctuated throughout junior high and high school, reaching a peak of 178 pounds at 5'3" in the 10th grade. Danni expanded her efforts to control her body weight at this time and incorporated laxatives, illicit amphetamines, over-the-counter diet aids, and compulsive bouts of exercise. She denied any experience with diuretics or Ipecac. Since the onset of her eating disorder, Danni had developed irregular menstrual periods and severe dental erosion from vomiting. Body image issues were significant. Danni also acknowledged that she began to lie in high school and to experience brief episodes of depersonalization and derealization.

Danni graduated from high school with a B average, which she achieved by cheating. She worked for two years as a medical assistant, lived with a boyfriend in New Mexico for a year, then obtained training as a phlebotomist and worked for four years in a hospital. She began abusing alcohol and marijuana during this last job and was fired for being "irresponsible." Several more jobs and terminations occurred, and her drug usage expanded to

include cocaine, up to one gram per day.

During the years before her admission to our facility, Danni sporadically sold drugs, engaged in prostitution, and stole from family and friends. She experimented with a homosexual relationship and suffered repeated emotional and physical abuse from boyfriends. Her admission to the hospital in Virginia had been prompted by a gang rape in a bar; she was found by the police along a highway, clad only in panties.

Danni had been previously hospitalized in five psychiatric facilities. She had seen several therapists, including a male psychiatrist who requested that all treatment sessions take place with Danni wearing only her underwear. Prior to admission to our facility, Danni had abstained from both drugs and alcohol for several months.

The therapist in our facility negotiated with Danni over the telephone a strict contract to assess her readiness to enter treatment. Danni agreed to eat 80% of meals, maintain 80% abstinence with respect to purging, and eat sufficient calories to maintain her current body weight. She was then transferred.

During the acute hospitalization in our facility, the therapist met with Danni on a daily basis for up to 50 minutes, Monday through Friday. The initial focus was the consolidation of the therapeutic relationship. External

relationship issues were repeatedly integrated into the therapeutic relationship for exploration and clarification. Danni readily acknowledged her potential to sexualize the therapeutic relationship, her inability to trust, and fears that her healing would result in her mother's death. The therapist helped her sort out intimacy versus erotization, nontrust as a survival tactic based on previous experience, and her fears around separation-individuation. Much of this early work was undertaken on a cognitive and psychodynamic level, with a strong emphasis on the clarification of relationship issues in the therapeutic dyad.

During the hospitalization, the treatment team provided a high level of structure, consistency, and emotional holding. Danni's periodic ruptures with the treatment team were supportively interpreted as her ambivalence about closeness and fears about being disappointed. Her self-destructive behavior was initially approached using cognitive-behavioral techniques and interpersonal restructuring. The therapist repeatedly challenged Danni as to whether her behavior was an effort to abandon the treatment. As Danni began to stabilize, she experienced periodic slips, which were neutralized ("Everybody slips—we don't expect perfection"). Competitive pressures with other patients were often intense, particularly with one patient who was very attractive and seeing the same therapist. In addition, Danni engaged in episodic control struggles with the nursing staff, often older females.

As the inpatient treatment came to a close, Danni was able to consolidate a working relationship with the therapist and the treatment team. Her eating disorder behavior was under reasonable control, and she was able to utilize the patient community for emotional holding. The 12-step program for substance abuse was very helpful to her. She had begun separation-individuation with her parents and was able to tolerate her guilt about the process.

Danni was transferred to our residential facility and continued in the Eating Disorders Partial Hospitalization Program. During this time, she began to keenly focus on her diagnosis of borderline personality. She read about the disorder *(I Elate You—Don't Leave Me* by Kreisman & Strauss [1989]), commiserated with other borderline patients about their dynamics, and seemed to structure herself at a healthier level. The therapy at this point focused on transition issues and her integration into the local community. She continued to binge and purge throughout this period; these slips were managed using a combination of increased structure, cognitive-behavioral techniques, and interpretation. Danni was encouraged to use the extended therapeutic milieu and patient community for holding. She did so, at times with great reluctance.

As Danni had suspected earlier, her gradual recovery was paralleled by her mother's progressive emotional deterioration. Her mother was eventually

hospitalized twice with transient psychotic episodes and suicidal ideation. Danni had reached a level of differentiation that allowed her to successfully weather both of these hospitalizations.

As the issues consolidated in individual psychotherapy (e.g., sexual abuse, inadequate parenting, lack of healthy relationship experiences, negative self-concept), Danni was able to resolve them at increasingly deeper levels at the same time that her ability to self-regulate was enhanced. This process was paralleled by her increasing ability to internalize the therapist, utilize relationships for holding, and tolerate successes in the outside world.

After several months in the Eating Disorders Partial Hospitalization Program, Danni therapeutically decreased her participation to part-time. She continued in individual psychotherapy with her therapist and began working as a waitress. Life crises continued, and each was managed at the moment.

At this writing, Danni is 18 months into the treatment. She is seriously dating a young man who is employed full-time and is working on a master's degree. She completed her first semester of college with a 3.65 GPA. For the first time, she is successfully managing her own apartment and bills. Danni continues to experience slips with her eating disorder (purging about once every two weeks) but is able to curtail these episodes herself. She continues in individual psychotherapy and is working on the deeper aspects of

relationships, core self-concept, and the ability to self-sooth more efficiently.

TRAINING

Therapists who plan to incorporate our approach, or one similar to it, need clinical experience with both eating disorder and character disorder treatment. General eating disorder treatment experience can be obtained through training in an eating disorders program, repeated clinical exposure and consultation, and didactic education (reading, attending conferences). Exposure, experience, supervision, and academic grounding are the cornerstones of mastering this area.

Training in psychodynamically oriented character disorder therapy is a more difficult undertaking, owing to the longitudinal nature of the experience and the need for a longitudinal mentor. Perhaps this training can best be obtained by affiliating with treatment centers that provide long-term psychotherapy to characterologically impaired patients. Another alternative is to establish regular individual or group supervision with a known mentor in the local community.

EMPIRICAL EVIDENCE FOR THE APPROACH

The treatment outcome for this group of patients is difficult to study because of the variables involved:

1. Treatment takes several years and is subject to disruptions.

2. The natural recovery style of two steps forward, one step back appears erratic and is ongoing.

3. There seems to be a natural "leveling off" with age for character-disordered patients, if they survive adolescence and young adulthood, that is difficult to factor into outcome.

4. The ongoing personal growth of the therapist enhances the efficiency of subsequent treatments.

Our preliminary impression is that our treatment approach is moderately successful for the majority of eating disorder patients with borderline personality disorder whom we treat. Our program is still in its adolescence, and philosophical debates occur routinely. However, we remain committed to continuing to help these challenging individuals in their progress toward recovery and healthy emotional lives.

REFERENCES

Agras, W. S., Rossiter, E. M., Arnow, B., Schneider, J. A., Telch, C. F., Raeburn, S. D., Bruce, B., Perl, M., & Koran L. M. (1992). Pharmacologic and cognitive-behavioral treatment for bulimia nervosa: A controlled comparison. *American Journal of Psychiatry,* 149, 82-87.

Akiskal, H. S., Chen, S. E., Davis, G. C., Puzantian, V. R., Kashgarian, M., & Bolinger, J. M. (1985). Borderline: An adjective in search of a noun. *Journal of Clinical Psychiatry,* 46, 41-48.

Alcoholics Anonymous World Services. (1952). *Twelve steps and twelve traditions.* New York: Alcoholics Anonymous World Services, Inc.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: APA.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders.* New York: International Universities Press.

Beck, A. T., Rush A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression: A treatment manual.* New York: Guilford Press.

Beglin, S. J., & Fairburn, C. G. (1992). What is meant by the term "binge"? *American Journal of Psychiatry,* 149,123-124.

Brown, G. R., & Anderson, B. (1991). Psychiatric morbidity in adult inpatients with childhood histories of sexual and physical abuse. *American Journal of Psychiatry,* 148, 55-61.

Bruch, H. (1978). *The golden cage: The enigma of anorexia nervosa.* Cambridge, MA: Harvard University Press.

Bryer, J. B., Nelson, B. A., Miller, J. B., & Krol, P. A. (1987). Childhood sexual and physical abuse as factors in adult psychiatric illness. *American Journal of Psychiatry,* 144,1426-1430.

Burgner, M., & Edgcumbe, R. (1972). Some problems in the conceptualization of early object relationships: II. The concept of object constancy. *Psychoanalytic Study of the Child,* 27,315-333.

Chatham, P. M. (1985). *Treatment of the borderline personality.* New York: Jason Aronson.

Christenson, R. M., & Wilson, W. P. (1985). Assessing pathology in the separation-individuation process by an inventory: A preliminary report. *Journal of Nervous and Mental Disease,* 173, 561-565.

Connors, M. E., Johnson, C. L., & Stuckey, M. K. (1984). Treatment of bulimia with brief psychoeducational group therapy. *American Journal of Psychiatry,* 141, 1512-1516.

Conte, H. R., Plutchik, R., Karasu, T. B., & Jerrett, I. (1980). A self-report borderline scale: Discriminative validity and preliminary norms. *Journal of Nervous and Mental Disease*, 168, 428-435.

Davis, G. C., & Akiskal, H. S. (1986). Descriptive, biological, and theoretical aspects of borderline personality disorder. *Hospital and Community Psychiatry*, 37, 685-692.

Dennis, A. B., & Sansone, R. A. (1989). Treating the bulimic patient with borderline personality disorder. In W. Johnson (Ed.), *Advances in eating disorders* (Vol. 2, pp. 237-265). Greenwich, CT: JAI Press.

Dennis, A. B., & Sansone, R. A. (1991). The clinical stages of treatment of the eating disorder patient with borderline personality disorder. In C. Johnson (Ed.), *Psychodynamic treatment of anorexia nervosa and bulimia* (pp. 128-164). New York: Guilford Press.

Eckert, E. D. (1983). Behavior modification in anorexia nervosa: A comparison of two reinforcement schedules. In P. L. Darby (Ed.), *Anorexia nervosa: Recent developments in research* (pp. 377-385). New York: Liss.

Egan, J. (1986). Etiology and treatment of borderline personality disorder in adolescents. *Hospital and Community Psychiatry,* 37, 613-618.

Enright, A. B., Butterfield, P., & Berkowitz, B. (1985). Self-help and support groups in the management of eating disorders. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia* (pp. 491-512). New York: Guilford Press.

Fairburn, C. G. (1981). A cognitive behavioral approach to the management of bulimia. *Psychological Medicine*, 11, 707-711.

Fairburn, C. G. (1985). Cognitive-behavioral treatment for bulimia. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia* (pp. 160-192). New York: Guilford Press.

Fairburn, C. G., Jones, R., Peveler, R. C., Carr, S. J., Solomon, R. A., O'Connor, M. E., Burton, J., & Hope, R. A. (1991). Three psychological treatments for bulimia nervosa: A comparative trial. *Archives of General Psychiatry,* 48,463-469.

Favazza, A. R. (1989). Why patients mutilate themselves. *Hospital and Community Psychiatry,* 40,137-145.

Fine, M. A., & Sansone, R. A. (1990). Dilemmas in the management of suicidal behavior in individuals with borderline personality disorder. *American Journal of Psychotherapy,* 44,160-171.

Garfinkel, P. E., & Garner, D. M. (1982). *Anorexia nervosa: A multidimensional perspective.* New York: Brunner/Mazel.

Garfinkel, P. E., & Garner, D. M. (1987). *The role of drug treatments for eating disorders.* New York: Brunner/Mazel.

Garner, D. M., & Bemis, K. M. (1985). Cognitive therapy for anorexia nervosa. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia* (pp. 107-146). New York: Guilford Press.

Garner, D. M., Fairburn, C. G., & Davis, R. (1987). Cognitive-behavioral treatment of bulimia nervosa: A critical appraisal. *Behavior Modification,* 11, 398-131.

Garner, D. M., Rockert, W., Olmsted, M. P., Johnson, C., & Coscina, D. V. (1985). Psychoeducational principles in the treatment of bulimia and anorexia nervosa. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia* (pp. 513-572). New York: Guilford Press.

Goldbloom, D. S., & Olmsted, M. P. (1993). Pharmacotherapy of bulimia nervosa with fluoxetine: Assessment of clinically significant attitudinal change. *American Journal of Psychiatry, 150,* 770-774.

Goldstein, W. N. (1983). *DSM-III* and the diagnosis of borderline. *American Journal of Psychotherapy*, 37, 312-327.

Goldstein, W. (1985). *An introduction to the borderline conditions.* Northvale, NJ: Jason Aronson.

Goldstein, W. N. (1991). Clarification of projective identification. *American Journal of Psychiatry,* 148,153-161.

Gunderson, J. G. (1984). *Borderline personality disorder.* Washington, DC: American Psychiatric Press.

Gwirtsman, H. E., Roy-Byrne, P., Yager, J., & Gerner, R. H. (1983). Neuroendocrine abnormalities in bulimia. *American Journal of Psychiatry,* 140, 559-563.

Habermas, T. (1991). Meaning of the term "bulimia" (Letter). *American Journal of Psychiatry,* 148, 1274.

Halmi, K. A. (1985). Behavioral management for anorexia nervosa. In

M. Garner & P. E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia* (pp. 147-159). New York: Guilford Press.

Herman, J. L., Perry, J. C., & Van der Kolk, B. A. (1989). Childhood trauma in borderline personality disorder. *American Journal of Psychiatry*, 146, 490-495.

Herzog, D. B. (1987). *Advances in psychiatry: Focus on eating disorders* (Monograph). La Jolla, CA: Park Row Publishers.

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology*, 61,561-573.

Hudson, J. I., Pope, H. G., & Jonas, J. M. (1983). Treatment of bulimia and its disorders. In A. J. Stunkard & E. Stellar (Eds.), *Eating and its disorders* (pp. 259-273). New York: Raven Press.

Hyler, S. E., & Reider, R. O. (1987). *Personality Diagnostic Questionnaire-Revised* (*PDQ-R*). New York: New York State Psychiatric Institute.

Johnson, C. L. (1991). Treatment of eating-disordered patients with borderline and false-self/narcissistic disorders. In C. Johnson (Ed.), *Psychodynamic treatment of anorexia nervosa and bulimia* (pp. 165-193). New York: Guilford Press.

Johnson, C., & Connors, M. E. (1987). *The etiology and treatment of bulimia nervosa: A biopsychosocial perspective.* New York: Basic Books.

Johnson, C., & Maddi, K. L. (1986). The etiology of bulimia: Biopsychosocial perspectives. In S. C. Feinstein (Ed.), *Adolescent psychiatry: Developmental and clinical studies* (Vol. 13, pp. 253-273). Chicago: University of Chicago Press.

Johnson, C., Pure, D. L., & Hines, E. (1986). Assessment of bulimia: A multidimensional model. In K. D. Brownell & J. P. Foreyt (Eds.), *Handbook of eating disorders: Physiology, psychology and treatment of obesity, anorexia, and bulimia* (pp. 405-449). New York: Basic Books.

Johnson, C. L., Sansone, R. A., & Chewning, M. (1992). Good reasons why young women would develop anorexia nervosa: The adaptive context. *Pediatric Annals,* 21, 731-737.

Johnson, C., Tobin, D., & Dennis, A. (1990). Differences in treatment outcome between borderline and non-borderline bulimics at one-year follow-up. *International Journal of Eating Disorders*, 9, 617-627.

Johnson, C., Tobin, D., & Enright, A. (1989). Prevalence and clinical characteristics of borderline patients in an eating disorder population. *Journal of Clinical Psychiatry*, 50, 9-15.

Kaye, W. H., Weltzin, T. E., Hsu, L. K. G., & Bulik, C. M. (1991). An open trial of fluoxetine in patients with anorexia nervosa. *Journal of Clinical Psychiatry*, 52, 464-471.

Kernberg, O. (1967). Borderline personality organization. *Journal of the American Psychoanalytic Association,* 15, 641-685.

Kernberg, O. F. (1984). *Severe personality disorders: Psychotherapeutic strategies.* New Haven, CT: Yale University Press.

Kernberg, O. F., Selzer, M. A., Koenigsberg, FI. W., Carr, A. C., & Appelbaum, A. H. (1989). *Psychodynamic psychotherapy of borderline patients.* New York: Basic Books.

Kolb, J. E., & Gunderson, J. G. (1980). Diagnosing borderline patients with a semi-structured interview. *Archives of General Psychiatry*, 37, 37-41.

Kreisman, J. J., & Strauss, H. (1989). *I hate you—Don't leave me.* Los Angeles: Body Press.

Kroll, J. (1988). *The challenge of the borderline patient: Competency in diagnosis and treatment.* New York: Norton.

Kroll, J., Sines, L., Martin, K., Lari, S., Pyle, R., & Zander, J. (1981). Borderline personality disorder: Construct validity of the concept. *Archives of General Psychiatry,* 38, 1021-1026.

Leon, I. G. (1987). Object constancy as a developmental line. *Bulletin of the Menninger Clinic,* 51, 144-157.

Levin, A. P., & Hyler, S. E. (1986). *DSM-III* personality diagnosis in bulimia. *Comprehensive Psychiatry,* 27, 47-53.

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

Linehan, M. M. (1993b). *Skills training manual for treating borderline personality disorder.* New York: Guilford Press.

Love, S. C., Lewis, L. D., & Johnson, C. L. (1989). Group therapy in the treatment of bulimia nervosa. In W. Johnson (Ed.), *Advances in eating disorders* (Vol. 2, pp. 175-195). Greenwich, CT: JAI Press.

Ludolph, P. S., Westen, D., Misle, B., Jackson, A., Wixom, J., & Wiss, F. C. (1990). The borderline diagnosis in adolescents: Symptoms and developmental history. *American Journal of Psychiatry,* 147, 470-476.

MacKenzie, K. R., Livesley, W. J., Coleman, M., Harper, H., & Park, J. (1986). Short-term group psychotherapy for bulimia nervosa. *Psychiatric Annals, 16,* 699-708.

Mahler, M. S. (1971). A study of the separation-individuation process and its possible application to borderline phenomena in the psychoanalytic situation. *Psychoanalytic Study of the Child,* 26, 403-424.

Masterson, J. F. (1981). *The narcissistic and borderline disorders.* New York: Brunner/Mazel.

Masterson, J. F. (1990). Psychotherapy of borderline and narcissistic disorders: Establishing a

therapeutic alliance (a developmental, self, and object relations approach). *Journal of Personality Disorders,* 4, 182-191.

Masterson, J. F., & Klein, R. (1989). *Psychotherapy of the disorders of the self.* New York: Brunner/Mazel.

Masterson, J. F., & Rinsley, D. B. (1975). The borderline syndrome: The role of the mother in the genesis and psychic structure of the borderline personality. *International Journal of Psychoanalysis,* 56, 163-177.

Meissner, W. W. (1992). The concept of the therapeutic alliance. *Journal of the American Psychoanalytic Association,* 40, 1059-1087.

Meyer, J. M. (1984). Intentional self-cutting and the borderline personality disorder. *Dissertation Abstracts International,* 45 (5-B), 1591.

Mitchell, J. E. (1989). Psychopharmacology of eating disorders. *Annals of the New York Academy of Sciences,* 575, 41-48.

Ogata, S. N,, Silk, K. R,, Goodrich, S., Lohr, N. E,, Westen, D., & Hill, M. (1990). Childhood sexual and physical abuse in adult patients with borderline personality disorder. *American Journal of Psychiatry,* 147, 1008-1013.

Piran, N., Lerner, P., Garfinkel, P. E., Kennedy, S. H., & Brouilette, C. (1988). Personality disorders in anorexic patients. *International Journal of Eating Disorders*, 7, 589-599.

Pope, H. G., & Hudson, J. I. (1984). *New hope for binge eaters.* New York: Harper & Row.

Pope, H. G., Jonas, J. M., Hudson, J. I., Cohen, B. M., & Gunderson, J. G. (1983). The validity of *DSM-III* borderline personality disorder. *Archives of General Psychiatry,* 40, 23-30.

Porder, M. (1987). Projective identification: An alternative hypothesis. *Psychoanalytic Quarterly,* 56, 431-451.

Pryor, T., McGilley, B., & Roach, N. E. (1990). Psychopharmacology and eating disorders: Dawning of a new age. *Psychiatric Annals,* 20,711-722.

Ramchandani, D. (1989). The concept of projective identification and its clinical relevance. *American Journal of Psychotherapy,* 43, 238-247.

Safran, J. D. (1993). The therapeutic alliance rupture as a transtheoretical phenomenon: Definitional and conceptual issues. *Journal of Psychotherapy Integration,* 3, 33-49.

Sansone, R. A., & Fine, M. A. (1992). Borderline personality as a predictor of outcome in women with eating disorders. *Journal of Personality Disorders*, 6, 176-186.

Sansone, R. A., Fine, M. A., & Dennis, A. B. (1991). Treatment impressions and termination experiences with borderline patients. *American Journal of Psychotherapy,* 45, 173-180.

Sansone, R. A., Fine, M. A., & Nunn, J. A. (1994). A comparison of borderline with eating, substance abuse, and both eating and substance abuse disorders. *Journal of Personality Disorders*, 8, 219-228.

Sansone, R. A., Fine, M. A., & Sansone, L. A. (1994). An integrated psychotherapy approach to the management of self-destructive behavior in eating disorder patients with borderline personality disorder. *Eating Disorders: The Journal of Treatment and Prevention,* 2, 251-260.

Sansone, R. A., Fine, M. A., Seuferer, S., & Bovenzi, J. (1989). The prevalence of borderline personality symptomatology among women with eating disorders. *Journal of Clinical Psychology, 45,* 603-610.

Sansone, R. A., Sansone, L. A., & Wiederman, M. (1991). *Self-Harm Inventory (SHI).* Unpublished manuscript.

Schwartz, FI. J. (Ed.). (1988). *Bulimia: Psychoanalytic treatment and theory.* Madison, CT: International Universities Press.

Shapiro, E., Zinner, J., Shapiro, R. L., & Berkowitz, D. A. (1975). The influence of family experience on borderline personality development. *International Review of Psychoanalysis,* 2, 399-411.

Shearer, S. L., Peters, C. P., Quaytman, M. S., & Ogden, R. L. (1990). Frequency and correlates of childhood sexual and physical abuse histories in adult female borderline inpatients. *American Journal of Psychiatry*, 147, 214-216.

Stone, M. H. (1980). *The borderline syndromes: Constitution, personality, and adaptation.* New York: McGraw-Hill.

Stone, M. H., Stone, D. K., & Hurt, S. W. (1987). Natural History of borderline patients treated by intensive hospitalization. *Psychiatric Clinics of North America*, 10,185-206.

Suzuki, K., Higuchi, S., Yamada, K., Mizutani, Y., & Kano, H. (1993). Young female alcoholics with and without eating disorders: A comparative study in Japan. *American Journal of Psychiatry,* 150, 1053-1058.

Waldinger, R. J. (1987). Intensive psychodynamic therapy with borderline patients: An overview. *American Journal of Psychiatry,* 144, 267-274.

Walsh, B. T. (1991). Treatment of bulimia nervosa with antidepressant medication (Editorial). *Journal of Clinical Psychopharmacology*, 11, 231-232.

Wells, M., & Glickauf-Hughes, C. (1986). Techniques to develop object constancy with borderline clients. *Psychotherapy*, 23, 460-68.

Yates, W. R., Sieleni, B., Reich, J., & Brass, C. (1989). Comorbidity of bulimia nervosa and personality disorder. *Journal of Clinical Psychiatry*, 50, 57-59.

Zanarini, M. C., Frankenburg, F. R., & Gunderson, J. G. (1988). Pharmacotherapy of borderline outpatients. *Comprehensive Psychiatry*, 29, 372-378.

Zanarini, M. C., Frankenburg, F. R., Pope, H. G., Hudson, J. I., Yurgelun-Todd, D., & Cicchetti, C. J. (1990). Axis II comorbidity of normal-weight bulimia. *Comprehensive Psychiatry,* 31, 20-24.

Zweig-Frank, H., & Paris, J. (1991). Parents' emotional neglect and overprotection according to the recollections of patients with borderline personality disorders. *American Journal of Psychiatry,* 148, 648-651.

CHAPTER 9

Emotion-Focused Treatment for Panic Disorder: A Brief, Dynamically Informed Therapy

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Patients who meet diagnostic criteria for panic disorder experience recurrent panic episodes, anticipatory anxiety, and phobic avoidance. Panic attacks are characterized by the abrupt onset and rapid, crescendo escalation of intense apprehension, associated with physical symptoms such as heart palpitations, chest pain, shortness of breath, hot or cold feelings, trembling or shaking, dizziness or lightheadedness, feelings of unreality, and fears of such events as going crazy, having a heart attack or stroke, or losing control. Full panic episodes include at least four of these symptoms, while limited-symptom episodes are marked by three or fewer. Anticipatory anxiety is focused on fear of panic and/or panic-related physical sensations. Such fearfulness is the focus of a successful panic-targeted, cognitive-behavioral treatment approach. Fear of bodily sensations is a consequence of, and perhaps a risk factor for, the onset of panic episodes. Cognitive theorists see these fears as a manifestation of a learned false belief system.

Agoraphobia is a common complication of panic disorder and contributes substantially to morbidity. Agoraphobic individuals report fear and avoidance of situations in which they may feel either alone and unable to

get help or trapped and unable to escape if a panic attack occurs. Typical agoraphobic situations include being alone, traveling far from home, taking public transportation, being in crowded public places, and going over bridges or under tunnels. Recently, other types of panic-related phobic avoidance have been reported—for example, fear of situations in which frightening bodily sensations are evoked, such as physical exercise, watching exciting movies or sports events, and drinking coffee, and fear of social situations in which the panicking individual might feel embarrassed or trapped.

HISTORY AND DEVELOPMENT

In 1895 Freud described a syndrome called anxiety neurosis, characterized by spontaneous anxiety attacks, nearly identical with *DSM-III* panic disorder (Freud, 1895/1962). However, the modern diagnosis of panic disorder was not recognized until 100 years later when it appeared in *DSM-III* (APA, 1980). Freud (1926/1959) was very interested in anxiety, and understanding anxiety has remained a central interest of modem psychodynamic clinicians and theorists. Bowlby, a major modern psychodynamic theorist, was also interested in the panic/agoraphobic syndrome. Bowlby drew attention to the strong evidence supporting a primary instinct for attachment and hypothesized that separation anxiety, a form of pathological attachment, figures importantly in the pathogenesis of agoraphobia (Bowlby, 1973). Nevertheless, psychoanalytic views that differ

from current neurobiologic and learning theory explanations have not been incorporated into the panic disorder models that guide most research and clinical work.

Instead, identification of panic disorder is credited to psychopharmacological researchers working in the 1960s (Klein, 1964). These investigators observed that an antidepressant medication, imipramine, unexpectedly led to improvement in severe, hospitalized agoraphobic patients. Exploration of this effect led to the identification of unexpected panic attacks as the basis of agoraphobia. The modern history of panic disorder is thus interwoven with the growing new field of psychopharmacology. Documentation of efficacy of pharmacologic treatment followed quickly, and a recent NIH consensus development panel on the treatment of panic disorder (Wolfe & Maser, 1994) endorsed medication treatment as a standard, adequately proven treatment strategy.

A second line of important panic disorder treatment research grew out of behavior therapy studies of phobias. Having successfully treated phobic symptoms using exposure strategies, behavior therapists turned their attention to the more important clinical problem, agoraphobia. Initial efforts to use exposure to agoraphobic situations were moderately successful, but there was a need for further improvement (see Barlow, 1994). This led to identification of panic as a core symptom of agoraphobia and to strategies for

targeting panic directly. Panic was conceptualized as a conditioned fear of bodily sensations, and exposure to the feared sensations was the hallmark of the behavioral treatment. This treatment has now been expanded to include a cognitive component in which sensation fears are augmented by catastrophic misinterpretation. Thus, cognitive-behavioral therapy for panic is targeted at breaking the link between bodily sensations and fearfulness, using both exposure and cognitive strategies. Efficacy of this approach has been documented, and like medication, cognitive-behavioral treatment was endorsed by the NIH consensus development panel.

In general, psychodynamic research has been slow to get under way, and psychodynamic thinkers have not shown a focused interest in the understanding or treatment of panic disorder. The NIH consensus development panel noted that, as yet, there have been too few outcome studies to allow evaluation of this form of treatment.

Models of Panic Disorder

The two prominent schools of treatment present different models of panic disorder. The neurobiologic model postulates a defect in brain function, possibly involving the mechanism that mediates response to cues of separation (Klein, 1981) or to suffocation (Klein, 1993). Panic is thought to occur because a deranged sensor fires sporadically, with or without a trigger.

Neurobiologic studies suggest a variety of neurotransmitters (noradrenaline, GABA, serotonin) may have a role in panic vulnerability. Imaging studies point to the involvement of the parahippocampal areas. In the neurobiologic model, anticipatory anxiety and phobic avoidance, as well as other psychological disturbances, are seen as secondary to the experience of panic. Treatment is targeted at blocking panic through raising pharmacologically the sensor's threshold. Medication is considered the treatment of choice (Fyer & Samberg, 1988).

The cognitive-behavioral model postulates a different mechanism. Chambless and her colleagues observed that fear of fear is common in agoraphobics (Chambless & Goldstein, 1981), and Clark (1986), Beck (1988), and Barlow, Craske, Cerny, and Klosko (1989) developed a more specific theory that fear of bodily sensations explains the occurrence of the sudden, rapidly escalating sense of panic in agoraphobics. Panic is thought to occur because bodily sensations provoke catastrophic fearfulness, by a process of conditioned fear response and/or cognitive misinterpretation. In this model, physiologic abnormalities are seen as secondary to behavioral disturbances such as hyperventilation. Unlike the neurobiologic model, anticipatory anxiety is a predisposing trait for panic episodes. Studies confirm that panic patients report high levels of fear of bodily sensations (McNally & Lorenz 1987; Apfeldorf, Shear, Leon, & Portera, 1993), and studies of memory and attentional processes show cognitive biases that support the interoceptive

sensitivity model (Cloitre, Shear, Cancienne, & Zeitlin, 1994). Treatment is accomplished using strategies to correct cognitive misinterpretations and/or strategies to extinguish reactivity to interoceptive cues.

DYNAMIC ISSUES IN PANIC DISORDER

Since psychoanalysis has roots in neurobiology, learning theory, and evolutionary perspectives, psychodynamic thinking provides a unique, integrated model of anxiety (Michels, Frances, & Shear, 1985). However, a modern psychodynamic theory provides an explanation of the etiology and pathogenesis of panic somewhat different from that provided by current neurobiology or learning theory. In general, a psychodynamic model hypothesizes a relationship between current psychological functioning (including symptoms), early experiences, and ongoing psychological traits. Both biological and psychological contributions to symptom formation are postulated. We recently proposed a psychodynamic model of panic disorder based on a series of clinical interviews and a set of observations in the literature (Shear, Cooper, Klerman, Busch, & Shapiro, 1993). Interviews of panic disorder patients revealed themes of early life anxiety and shyness, unsupportive parental relationships, and a chronic sense of being trapped and troubled by frustration and resentment. Reports in the literature document that panic patients describe frightened, controlling, or critical parents (Arrindel, Emmelkamp, Monsma, & Brilman, 1983; Heckelman,

Spielman, & Shear, 1992; Parker, 1979; Silove, 1986), and most report feelings of inadequacy and/or self-reproach. Aggression is threatening and unwanted, and reaction formation has been identified as a common defense mechanism, possibly more common in panic patients than in other anxiety disordered patients (Pollack & Andrews, 1989; Busch, Shear, Cooper, Shapiro, & Leon, 1992). Personality traits of dependency, avoidance, fearfulness, neuroticism and introversion, and low assertiveness have been observed (Brodbeck & Michelson, 1987; Chambless, Hunter & Jackson, 1982; Chambless, 1985; Emmelkamp, 1980; Fischer & Wilson, 1985). The onset of panic exacerbates these problems, but there is evidence that psychological disturbance occurs prior to the onset of a panic disorder (Faravelli, Webb, Ambonetti, Fonnesu, & Sessarego, 1985; Garvey, Cook, & Noyes, 1988) and persists after amelioration of panic symptoms (Katon, 1978).

These observations led us to propose that fearfulness and neurotic traits represent a risk factor for, as well as a reaction to, the onset of panic episodes. This idea was supported by reports that children of panic disorder patients show evidence of high physiologic reactivity and behavioral inhibition in response to unfamiliar situations (Rosenbaum et al., 1988), and that these children are predisposed to childhood anxiety disorders (Biederman et al., 1990). Studies of nonhuman primates (Soumi, 1987) document the existence of a similar subgroup of high reactive individuals who appear to be socially submissive and more fearful than normal individuals.

Moreover, there is evidence that both constitutional factors and rearing experiences contribute to the high reactivity in primates. Similarly, both genetic and developmental factors seem to contribute to panic diathesis in humans. Panic disorder is common in family members of panic patients, and this association is thought to be genetically determined (Weissman., 1990). As noted, panic patients remember parents who were critical and/or controlling, suggesting that the object world may be generally viewed as threatening and that establishing a comfortable degree of dependence-independence is difficult. Avoidance by the inhibited child of the unfamiliar would result in less opportunity to learn to predict threats accurately or to develop maximally adaptive defensive and coping strategies. Thus, inborn fear of unfamiliar situations, augmented by frightening, over-controlling parental behaviors, would predispose to problems in finding a comfortable distance from others. We have observed that some panic-vulnerable individuals are separation-sensitive and overly reliant on others, while others are suffocation-sensitive and overly reliant on a sense of independence. In both instances, object relations are characterized by weak self and powerful other representations.

A consequence of dominant, easily activated fantasies of being alone and abandoned, or of being trapped and suffocated, is a tendency to react with strong negative affects to psychological challenges interpreted as threatening separation or entrapment. Moreover, negative effects, however

activated, are likely to be threatening and thus engender anxiety. This "secondary" anxiety acts to augment affect intensity and to promote escape and avoidance mechanisms. The result is a tendency to avoid acknowledgment of these negative feelings and their triggers in an effort to ward off painfully intense emotions, which nevertheless often figure prominently in the mental life of panic patients. Avoidance of negative effects, especially anger, results in shifting attention to the somatic aspect of the emotion. This begins a vicious cycle, well described by cognitive psychologists, in which dysphoric physiologic symptoms generate fear, leading to more physiologic symptoms and more fear, ultimately culminating in a panic episode. However, the origin of dysphoric bodily sensations is different.

This psychodynamic model is consistent with the current neurobiologic model in postulating differentiation of panic from other forms of anxiety. However, it differs from current neurobiologic theory regarding the issue of panic onset. In the neurobiologic model, panic episodes occur spontaneously; in other words, they lack psychological content. The dynamic model, like the cognitive-behavioral model, holds that panic is triggered by frightening thoughts, images, and sensations. However, from a dynamic perspective, frightening fantasies that trigger panic are related to fears of being trapped by and/or separated from powerful others and/or of being weak and out of control. Furthermore, triggering thoughts and images may be unconscious. In

this model, minor physical sensations provoke panic because they originate from an overly threatening negative affect that escape/avoidance strategies are inadequate to control. As Bowlby (1973) suggests, fearfulness in panic/agoraphobic patients results from a chronically impaired sense of safety, due in large part to insecure attachment. Complementary effects of constitutional characteristics and developmental experiences contribute to attachment problems. Patterns of object relations, ego strengths and weaknesses, and defenses typical of these patients maintain fear and inadequate control of negative emotions.

Impairment of autonomy, self-worth, and self-confidence increases sensitivity to threat. There is a bidirectional relationship between the ability to regulate anxiety and an individual's sense of well-being and effectiveness. The better the anxiety-regulating mechanism, the higher the self-esteem, and the higher the self-esteem, the better the anxiety-regulating mechanisms. Faulty anxiety regulation consequently leads to loss of self-confidence, worsening of anxiety regulation, further erosion of confidence, and so on. Moreover, low autonomy and low self-confidence are often associated with distortions in object relations. Thus, in general, poor anxiety regulation, diminished self-esteem, and troubled relationships occur simultaneously and exacerbate each other.

Two models of etiology and pathogenesis proposed by prominent panic

researchers can be linked to this psychodynamic model. One is Donald Klein's theory (1981), which also proposes an etiologic role for dysfunction in separation and/or suffocation anxiety mechanisms. We provide a psychological explanation for vulnerability to separation and suffocation, while for Klein the disturbance is in hardwired neurophysiologic systems. A different theory, proposed by David Barlow (1991), focuses on the importance of a learned sense of uncontrollability in panic pathogenesis. We agree that impairment in the sense of controllability contributes importantly to the feelings of inadequacy associated with distorted object relations. Learning about predictability of threats and developing realistic self-confidence in coping with threat provide the underpinnings of confidence in the controllability and safety of the world. The fearful, inhibited child has less opportunity to learn these skills.

Symptomatic treatment of anxiety states can have a highly beneficial effect, improving self-esteem and interpersonal relationships. For some patients, further psychological benefits follow naturally. However, ongoing disturbances in emotion regulation may underlie anxiety proneness and persist following symptomatic treatment. If so, the patient will continue to be vulnerable to anxiety, as well as other psychological disturbances. Psychological treatment directed at correction of this problem might enhance the durability of remission.

Emotion-Focused Treatment

Amelioration of panic symptoms can unquestionably be achieved using any of a variety of approaches. Each includes the presentation of a model of symptom formation and a rationale for the treatment strategy chosen. As mentioned above, medication and cognitive-behavioral treatment were endorsed by an NIMH consensus development panel in the fall of 1991. The principles and practice of these approaches can be found in relevant references (Craske, 1988; Fyer & Samberg, 1988).

Cognitive-behavioral treatment for panic was designed as a highly specific intervention targeted at correcting cognitive errors and promoting habituation of reactivity to interoceptive cues. Efficacy of this treatment, in comparison with a wait list control, is now well established (Craske, 1988; Craske, Brown, & Barlow, 1991). Moreover, the response obtained with this intervention appears to be similar to, or even greater than, the response with medication (Clark, Salkovskis, Hackmann, Middleton, Anastasiades, & Gelder, 1994). However, there is little information regarding the specificity of this treatment. We undertook a study to compare cognitive-behavioral treatment with a psychotherapy intervention, utilizing a psychoeducation component followed by a nonprescriptive, empathic, reflective listening approach. Our prediction that the highly directive and specific psychotherapy would be superior was not supported. Instead, we found the two treatments to be

equally effective (Shear, Pilkonis, Cloitre, & Leon, 1994).

Systematic review of the empathic listening treatment was conducted at weekly study meetings. These discussions, along with the dynamic model outlined above, formed the basis for the treatment we present here. However, although it is derived from a psychodynamic model, emotion-focused treatment (EFT) is not a strictly psychodynamic treatment. It differs from standard psychodynamic approaches in that it does not emphasize interpretation of unconscious material, nor does it focus on linking early experiences with present symptoms. Discussion of transference is not prohibited but is unlikely to play a prominent role in this treatment. Instead, EFT is centered on discussion of problems in the present. Interventions target fear and avoidance of negative effects and their triggers. In the context of a supportive, empathic relationship, the patient is helped to clarify and accept emotional reactions, to identify triggers of these emotions, and to explore new ways of managing disturbing emotionality. This work leads to an increased sense of internal control, as well as better controllability of the external world. The resultant increased self-confidence diminishes sensitivity to fears of being abandoned or suffocated by others. EFT also incorporates a psychoeducational component, similar to that utilized in another recent dynamically informed treatment, interpersonal treatment of depression (Klerman, Weissman, & Rounsaville, 1984), but different from most other psychodynamic approaches.

Description of the Treatment

There are two major components of emotion-focused treatment for panic disorder. The first is a psychoeducational component: information about panic disorder is provided, and the hypothesized role of emotions is explained. The informational segment of the treatment removes blame from the patient for having symptoms and provides accurate information about physiologic changes during panic. Cooper (1985) notes that patients treated with a combination of medication and psychotherapy benefit from being presented with a model of symptom formation that does not hold the patient fully responsible for the dysphoria and affective intensity they experience. We explain to the patient that anxiety is a normal reaction, necessary for an optimally adaptive organism. The problem experienced by patients with panic and other pathological anxiety states is that the reaction is triggered too easily, too often, and/or too intensely, in response to stimuli that are not associated with a high degree of actual danger. The reason for this heightened reactivity is not fully understood. However, there is evidence that both constitutional factors and learned responses play a role. These processes are outside of the control of the individual.

The second component of this treatment is the identification and clarification of emotional reactions and their consequences. The principle technique in EFT is empathic reflective listening. The development of a solid

rapport with the patient is essential for any effective treatment, and reflective listening is a particularly effective strategy for developing rapport. In addition, skilled use of reflection serves to communicate empathy. Reflective comments are used to guide further elaboration of the components of emotional reactions, their triggers, and responses. The EFT therapist utilizes reflective listening to identify and clarify emotional reactions that the patient may not acknowledge. The therapist attempts to fully elucidate triggers, individualized interpretations of the triggers, the specific quality of the ensuing emotion, and the response to the emotion. A modification of a technique called focused evocative unfolding, developed by Laura Rice (Rice & Saperia, 1984; Laura Rice, personal communication, 1990), involves systematic exploration of the quality of a targeted unexplained emotional reaction and the context in which the reaction occurs.

TREATMENT GOALS

The overall goal of the treatment is to ameliorate panic disorder by targeting panic symptoms directly and focusing on better identification, acceptance, and management of a range of negative emotions. The treatment is conducted in an 11-session acute phase, followed by a 6-session, monthly maintenance phase. The acute phase is divided into initial, middle, and termination subphases. The goal of the initial phase of treatment is to provide information about panic, anxiety, and other emotional reactions and to

explain the rationale for the treatment. The middle phase of treatment is aimed at identifying and working with emotional reactivity by encouraging the patient to identify, re-experiencing , and think through specific problematic emotional reactions. The presence of a supportive, accepting therapist facilitates reevaluation of the meaning of affect-provoking stimuli and of the strategies used to cope with difficult emotions. The termination phase is used to discuss reactions to ending treatment, to review the progress of the treatment, and to help the patient consolidate gains. The maintenance phase is used to troubleshoot and continue this work.

THEORY OF CHANGE

Both of the active ingredients of this treatment, the psychoeducation and the emotion-focused components, contribute to improvement. Like all treatments that ameliorate panic, we provide more accurate information about the physiologic underpinnings of panic and emphasize that a panic episode, in and of itself, is not dangerous. This is quite reassuring for patients who have been frightened that they are losing their minds or that something is seriously wrong with them physically. The rational model of panic and the experience of monitoring and focusing on the panic episodes provide a sense of control and predictability.

The central focus on emotion is unique and therefore responsible for

therapeutic effects more specific to this treatment. Systematic detailed exploration of emotional reactions, their triggers and context, and the response to them helps the patient to feel less frightened of his or her feelings and less buffeted by external events. Better understanding of panic and other unexplained emotions leads to improvement in self-confidence and self-esteem and less vulnerability to the vicissitudes of relationships with others. Better control of emotions lowers sensitivity to threats in general, and panic in particular. Panic attacks often occur in response to a feeling of being pressured or treated unfairly by someone whom the patient is fearful of losing, but the patient ignores the feelings of annoyance and hurt. The therapist helps the patient to recognize these feelings. We find that the patient's response to this recognition is surprise and relief.

The ability to identify and manage emotions frees the patient to be more exploratory and assertive in the world, further enhancing self-esteem. Their view of others as powerful, critical, and not necessarily trustworthy is modified. An increased sense of reliability and stability in relationships improves the patient's tolerance of changes and losses in interpersonal relationships, decreases vulnerability, and diminishes susceptibility to anxiety.

TECHNIQUES

As noted above, therapists use a modification of Laura Rice's technique of focused evocative unfolding to clarify unexplained emotional reactions. The therapist works with a specific reaction, such as an unexplained panic attack, and encourages exploration of the stimulus and the process by which the reaction was triggered; the thoughts, images, and physical reactions associated with the reaction; and behavioral and/or cognitive coping responses that follow. In this process, the generalizability and broader relevance of the stimulus response and coping patterns are brought to light.

There are six aspects of the focused evocative unfolding procedure used in this treatment: (1) exploration of the primary reaction; (2) elucidation of the setting and context in which the reaction occurred; (3) confirmation of the specific quality of the internal emotional reaction and the nature of the eliciting stimulus; (4) identification of the idiosyncratic personal meanings of the stimulus and of the qualities of familiarity and repetitiveness of the emotional response; (5) clarification o* the generalizability of the stimulus-response paradigm and its importance; and (6) identification and exploration of the response to the primary emotional reaction.

Emotional reactivity can be understood using a stimulus-response paradigm. Certain stimuli elicit a fairly universal emotional reaction. However, personal idiosyncratic interpretations often mediate the reaction to a stimulus and account for the specific quality and/or intensity of the

emotional response. For panic patients and others, the experience of a negative affect often results in a secondary response of guilt, shame, or fear. The secondary reaction augments the intensity and the dysphoria of the initial emotion, and this augmented negative affect promotes more powerfully the use of disavowal or avoidance-type mechanisms in dealing with the original stimulus and/or the original reaction. In this way, unacknowledged and unwanted emotional reactions are experienced as a vague dysphoric feeling, accompanied by unexplained bodily sensations. The sensations become a focus of attention and a source of anxiety and are further augmented. The focused unfolding procedure facilitates identification and acceptance of feelings that have been hidden, diminishing the secondary augmenting reactions engendered by these emotions. Identifying a "nameless fear" makes it less frightening, less uncontrollable, and less likely to provoke a panic episode. Successful use of focused unfolding breaks the pattern of the sense of helplessness engendered by automatic, poorly articulated emotional reactions. A more complete description of focused unfolding follows, illustrated with clinical vignettes.

Exploration of the Primary Reaction

A central aim of the focused unfolding procedure is to clarify and explore an unexplained emotional reaction. An unexplained emotional reaction is one in which the therapist judges that the patient has experienced

a negative affect without knowing its cause. "Spontaneous" panic attacks are an example. Puzzlement may be explicitly stated by the patient: "I don't know why I felt that way." The patient may provide a shallow, unconvincing explanation. Other unexplained emotional reactions may be expressed as having no feeling, or as an unconvincing positive feeling in the context of describing a distressing situation.

Unexplained emotional reactions typical of panic patients include:

1. Unexpected, "spontaneous" panic or near-panic episodes.

2. Uncomfortable physical sensations ("My stomach was upset all day," "I had this strange wobbly feeling," "Whenever I am with her, I get a feeling of unreality").

3. Feelings described in vague terminology ("I was upset," "I felt a kind of nameless dread," "I didn't like what he said").

4. Emotional states that are explicitly unexplained ("I was having a bad day; I don't know why," "I was just irritable and angry, for no reason").

5. Unexplained behavior ("I just walked out of the room; I don't know why I did that," "I didn't tell him I wasn't coming; I don't know why").

6. Interpersonal disturbance that is mentioned and dropped or otherwise not well explained ("My husband and I weren't

getting along; I went to my sister's house and we watched TV," "I never see my grandchildren anymore; it makes me sad and I'd rather not talk about it").

7. Out-of-context positive interpersonal comments that are vague and global ("I wasn't in a very good mood when I left for work this morning, but my boss is fine," "I was anxious when my husband left for work; my husband is a good man").

This list is not meant to be comprehensive. There may be other comments by the patient that catch the therapist's attention as indicative of an emotionally important event.

The therapist noting one of these types of communication proceeds to simply reflect the patient's statement: "Your stomach was upset," "You had a wobbly feeling," or "You were upset." Such an intervention focuses the patient's attention, underscores the therapist's interest, and encourages the patient to elaborate on the statement. This begins the process of focused unfolding.

Elucidation of the Setting and Context in Which the Emotional Reaction Occurred

After reflecting the unexplained reaction, the therapist then listens for other cues in order to further define the emotional reaction and triggering stimulus. We usually elicit the description using a reflective technique. For example, the therapist might reflect, "You were sitting alone watching TV

when all of a sudden you noticed your heart beating very fast." This technique invites the patient to recall and attend to the situation without structuring the attentional processes. We wish to facilitate activation of a wide array of associative material and a free expression of the material.

For example, Ms. Smith reported a panic episode one morning, while watching TV with her husband. She noted that she was having a perfectly good day and this feeling came out of the blue. Her heart began to race, and she felt very frightened. She experienced tingling of her hands and feet and felt slightly dizzy. Her stomach was in a tight knot. She added that her relationship with her husband was a good one, but he was under stress at his job and she had been worrying about him. She told the therapist she wondered if this worry had triggered the panic attack but added that she did not really think it did. After the therapist reflected that the patient's heart began to race, the patient remembered feeling very frightened. She remarked that she didn't think she was reacting to the TV. She then remembered a very upsetting phone call from a friend of her mother's earlier that morning, and she thought this call was probably still on her mind. The patient described the phone call and then began to elaborate on her feelings about her mother's death, her loneliness, and her feeling that no one understood. She then thought about her panic episode and recalled that the sense of fear and heart palpitations had been preceded by a pain in her stomach that she always got when she thought about her mother. She feared that the pain meant she was

very ill and would require hospitalization, which would involve abandoning her children and leaving responsibility for their care to her husband, who was already under stress at his job. She feared, in turn, that he would not withstand this pressure and would also become ill.

Another patient, Ms. Jones, is a 40-year-old woman who was having problems at work and with her mother, whose health was deteriorating from illness. She described a panic episode: "I woke from sleep. *I wasn't dreaming.* I went to the bathroom, returned to bed, and noticed a strange feeling in my stomach. I felt afraid and didn't know why. Suddenly my heart was beating very fast, and I was very frightened. It lasted about 10 minutes. I got up and read a book and eventually calmed down and went back to sleep." The therapist identified the primary reaction as the strange feeling in the patient's stomach, and reflected to the patient the scene she described of herself lying in bed feeling a strange feeling in her stomach. The patient then elaborated: "It was a hollow feeling, a lonely feeling—I may have been thinking about being all alone, my mother's illness, no one to talk to. I think I was missing John [a very close friend who had died many years earlier], I remember I had just had a dream in which John and I were together. It's a dream I sometimes have, and it seemed very real. It was as though he were really alive and with me. I think when I woke up and thought about that dream and John, I was very aware that he was gone and I felt very lonely. I felt sad and resentful. Why wouldn't he let me be with him while he was dying? He went back to his

family when he got sick, and I wasn't able to go to the funeral."

The therapist can also conduct a focused unfolding procedure for other types of unexplained emotions. For example, in the course of reporting about her past week, a patient commented that her boss was fine. The patient had earlier indicated that she had problems at work. This information led the therapist to suspect that the vague statement about the boss might represent an unacknowledged emotional reaction. The therapist simply reflected, "Your boss is fine."

The patient responded by elaborating: "Well, I think he means well, but sometimes he isn't really fair. He expects me to perform perfectly, and he doesn't seem to have a good idea of what is entailed in my job. He's very busy, and he doesn't have time to answer questions." The patient continued with a litany of complaints against her boss. Then she stopped and commented sheepishly, "I guess I'm sort of angry with my boss. I hadn't realized that."

Confirmation of the Specific Quality of the Internal Emotional Reaction and the Nature of the Eliciting Stimulus

The therapist reiterates the emotional reaction and the context in which it occurred in order to further clarify the stimulus and response. For example, the therapist reflected the onset of a panic episode and the scene in which the panic occurred: "You were lying in bed, trying to get to sleep, and suddenly

you felt very short of breath." The patient recalls, "It was pretty late, and I was tired. Nothing was on my mind." The therapist reflects, "You were tired and trying to go to sleep, and nothing was on your mind when you began to feel short of breath." The patient considers this: "Well, I guess I was worried about whether I could function if I couldn't get to sleep *[pause]*, I have this job, which hasn't been going that well. I can't seem to please my boss, no matter how hard I work. She is a workaholic with no children. I think she resents me because I am married and pregnant. She doesn't seem to trust me anymore *[silence].* My career was always important to me. Maybe I shouldn't have gotten pregnant *[silence],* I feel a little short of breath. Lately, whenever I think about being pregnant, I get this suffocating feeling *[silence].* Actually, I'm pretty sure that's what I was worrying about when I started to feel short of breath in bed the other night. Then I got frightened that I would have a panic attack and that these panic attacks would never go away. I wouldn't be able to work or to take care of my child. My heart started to race, and I felt very hot and shaky. I had to get up and go downstairs for some fresh air."

Identification of the Idiosyncratic Personal Meanings of the Stimulus and of the Qualities of Familiarity and Repetitiveness of the Response

The procedure for elucidating these meanings can be illustrated by further work with Ms. Green, who reported a tight feeling in her stomach that was then determined to be a manifestation of an angry feeling triggered by

her boss's behavior. Having established the link between the bodily sensation and the emotional reaction, and the trigger of the emotional reaction, the therapist returned to reflect on the stimulus, saying, "Your boss asked you to prepare a report, and you weren't clear on what he wanted." The patient continued: "Yes. I felt very frustrated, but I didn't know what to do. I decided to just do the report. I was sitting at my desk working on it when I felt this awful tight feeling in my stomach. I was certain I must have an ulcer and I would get terribly sick and have to go to the hospital. I tried very hard to continue to work, but I just couldn't concentrate. The pain was getting worse. I finally had to stop and went to tell my boss that I wasn't feeling well. He was very nice and said I looked pale and maybe I should go home. I didn't really want to leave, but I felt I didn't have a choice. I went home, but the feeling didn't really go away for the rest of the day. I had to stay home from work the next day too."

Listening to this elaboration, the therapist recognized that the patient had probably made an idiosyncratic interpretation of the boss's request, and the following discussion ensued:

> Therapist: You felt you had to prepare the report even though you didn't really know what your boss wanted in the report?

> Patient: Yes. I know he wanted me to do that. He just expects me to read his mind. It's so unfair.

> Therapist: You believed he expected you to read his mind.

Patient: I know he does. I know about people like him. My father was like that, and my ex-boyfriend, and the first boss I had. If you don't do what they want, no matter how unreasonable it is, they get very angry and critical. Most really successful men make women in their lives their slaves.

Details of the idiosyncratic interpretation were now clear, and the therapist reflected, "You were certain he expected you to read his mind, and you felt you must do this or suffer the consequences." The patient silently considered this statement for a few minutes. She then thought aloud, "I know I get the feeling very strongly that I must do whatever he wants," indicating she was beginning to make a distinction between her feelings and the reality of the situation. The therapist reinforced this distinction by reflecting, "You get a strong feeling." The patient now added, "He reminds me so much of my father," and went on to describe the situation in her childhood home. Her father was a tyrant boss with both her mother and the children.

The patient was frequently frightened by his angry outbursts, especially ones directed at her mother, who seemed to be helpless to defend herself. She ended this discussion by saying, "Maybe I see my father in all men. My boss is really kind of different. He's pretty disorganized, and he probably doesn't realize he hasn't made his priorities clear to me."

Another example of an idiosyncratic reaction is provided by a patient who described an unexplained panic episode while watching TV with his wife. Further discussion led to a recognition that the panic episode had occurred

after the patient had tried to talk with his wife about an important interaction with a coworker that he had experienced that day. She was preoccupied and did not pay attention to him, and he became enraged, his heart began to beat wildly, and a full-blown panic attack ensued. After the anger was identified, the therapist returned to the original situation and reflected, "You wanted to tell your wife about your day, and she wasn't listening." The patient now responded, "She makes me so angry. She doesn't pay attention to me, and she doesn't pay attention to anyone. I know she does this with the children too. She is just like my aunt. She is going to ruin our children."

The therapist recognized an idiosyncratic interpretation of the wife's behavior and explored further the idea that the wife didn't ever listen and was just like his mother's sister, whom the patient intensely disliked. His parents often argued about this aunt, and her father would angrily complain, "She's a good-for-nothing leech! She is full of crazy ideas and never listens to anyone!" The therapist reflected the patient's view of the similarity between his wife and his aunt, leading him to now report marked differences between his shy, somewhat preoccupied, highly organized wife and his uneducated, brash aunt, who was loud and unpleasant and never listened to anyone else. He recognized that his wife's problems were very different from his aunt's, and this enabled him to feel more empathic with his wife, less anxious about her behavior, and less angry with her. He now commented that he thought he frequently overreacted to women who seemed not to be listening.

Clarification of the Generalizability of the Stimulus-Response Paradigm and Its Importance

The generalizability of an emotional stimulus-response paradigm is related to its thematic content. For example, Ms. Green, whose familiar reaction of interpreting the behavior of her disorganized boss as demanding and demeaning toward her reflected a general tendency to fear confrontation and disapproval and the feeling of humiliation and subjugation evoked for her when she admired a man and wished to please him. In working with this patient, the therapist reflected the patient's new recognition: "When your boss doesn't communicate clearly, he makes you mad and reminds you of your tyrannical father. Then you feel you can't confront him or he will fire you." The patient concurred. The therapist waited, and the patient remarked, "I think I am almost always afraid of confronting people. I feel that if I don't do what someone else wants, they won't want me around."

Ms. Jones, who awoke from sleep with a strange feeling in her stomach, was feeling demoralized at a job she had held for years. She felt she had worked hard to improve herself and had achieved a position of some standing. But now younger people were in charge, and although they did not know the field as well as she did, they did not have the proper respect for her. She felt angry about this and wanted to walk away and leave them in the lurch. On the other hand, she was frightened that she would lose her job and not be able to find other employment. She said, "I keep feeling like I am

between a rock and a hard place." She recalled that her friend John had helped her through a similar difficult time at work many years earlier. She had been missing him quite a bit. She also explained that her mother had been a great support to her throughout her life and had been the one person in her lower-class family who had encouraged her and had faith that she could succeed. Her father, on the other hand, was an alcoholic who was frequently verbally abusive and favored her sister. After learning that the patient's panic attack occurred following a dream about John, the therapist reflected, "You miss your friend a great deal." The patient agreed and described how unfair it was that she couldn't even go to John's funeral. When she thought about it, she felt very angry. It seemed like she was always getting pushed around and she was helpless to do anything about it. She said, "When you stand up for yourself, you get criticized for being selfish. If you make people mad, they retaliate. The best thing to do when you are mistreated and you feel angry is to try to ignore it—try to forget about it."

The generalizable stimulus-response paradigm identified in a focused unfolding procedure reflects the thematic pattern of unexplained emotional reactions typical for that patient. Common themes related to unexplained emotional reactions in panic disorder patients include fear of too much interpersonal distance, of feeling alone, and of being abandoned; fear of feeling controlled or trapped, with too little interpersonal distance; fear of and/or guilt about anger and assertiveness; fear of the disapproval of others;

fear of or guilt about selfishness or greed; fear of submissiveness; guilt about wishes for independence and success coupled with chronically low self-confidence; shame about wishes to be close and dependent; fear of weakness, helplessness, uncontrollability.

Panic patients frequently experience and/or report emotional reactions related to these themes using physical or bodily metaphors. For example, fear of interpersonal control was expressed by one patient as a feeling of being pressured. Fear of distance or separation was expressed by another patient as a sense of unreality. Guilt or shame about dependence/independence might be experienced as feeling small.

A common way for the therapist to detect a thematic concern is by its noticeable absence in the content of what the patient is saying and/or its overt disavowal by the patient. For example, Ms. Brown was careful to avoid acknowledging that she ever experienced anger. She would describe her boyfriend's abusive behavior in great detail, but in a bland manner. The therapist reflected the patient's hostility, which was evident from the content of her report, along with her discomfort about feeling angry, which was evident from her avoidance of mentioning or expressing this reaction. By the end of the treatment, the patient had acknowledged how angry she felt toward her boyfriend and had taken action to end her relationship with him. She told the therapist, "You taught me the word *anger.*"

Sometimes the disavowal of an obvious emotion is direct. One patient insisted that he was never afraid of being rejected. Another patient stated that she was independent and needed help only when she had panic attacks. In these cases, the therapist identified the "missing emotions" and reinstated them in the patient's vocabulary. This is accomplished by reflecting the patient's statements using emotional vocabulary. For example, the patient who denied fear of interpersonal rejection reported a panic episode that occurred in an interaction with his boss. Further discussion revealed that his boss had recently chosen someone else for a promotion and the patient had felt rejected and hurt. Just before the panic episode, the boss had made a request of the patient. The patient experienced a surge of resentment associated with the thought, "Why should I go out of my way for him? He just takes advantage of me. I can never please him anyway." The therapist reflected, "You felt pretty angry when he asked you to do that special report." The patient responded, "Yeah, I guess I really wanted his approval, and I was hurt when he didn't promote me." The theme of shame about wishes to have the approval of others became a focus of the treatment.

Identification and Exploration of the Response to the Primary Emotional Reaction

After the stimulus-response characteristics of the targeted emotional reaction have been fully specified, the therapist focuses on how the patient manages this reaction. The therapist accomplishes this through a reflective

intervention, acknowledging the pain involved in experiencing the distressing affect and the need to find a way to lessen the pain. It is important that the patient not feel criticized for the reaction he or she has had, and that he or she feel understood. This facilitates examination of the coping strategy and its rationale and at the same time permits exploration of alternative solutions to the problem of controlling distressing affect.

For example, in working with Ms. Jones who had just recognized that her panic episode occurred in reaction to distressing feelings evoked by her dream about her friend John, the therapist commented, "You had a disturbing dream that led you to feel very sad, resentful, and lonely. You then tried to put it out of your mind." The patient responded, "Well, he's dead now, and there's nothing else to do except try to forget it." The therapist then reflected, "Your friend is dead, and you feel you must forget your feelings." The patient then said, "Maybe I want to forget. It's too painful to think about him and feel lonely and angry and helpless." The patient then paused and reflected on this: "Maybe I've never let myself really say good-bye to John. Maybe I've been too mad at him and his family to give him that respect *[pause].* It's also a kind of guilty feeling. What if I found someone else? I feel it wouldn't really be fair to him. Maybe it would make him mad." She said it's easier just to put it out of her mind whenever she has a spontaneous thought about him. The therapist reflects: "These feelings are too difficult. The only way to cope with them is to put them out of your mind." This leads the patient to consider, "Do you think

there's something else I could do?" The therapist reflects the question: "You're wondering if maybe there could be another way of handling this situation." The patient responds, "I don't know." The therapist encourages further thoughts about this: "You're wondering if it's possible to find a solution to situations like losing your friend, where you feel angry and guilty and afraid. A way that might not leave you feeling so helpless. But you're not sure there's anything to do but tell yourself, 'Forget it.'" The patient agrees and elaborates: "I guess *[pause].* I wonder if I could ever feel there was someone else who could care for me as much, someone who would understand me.... I really need another friend like John *[pause].* Maybe John would want that for me too."

The therapist working with Ms. Green, the patient whose perception was that her boss was making unreasonable demands upon her, reflected that perception to her, leading the patient to add that she felt that all successful men want to make women their slaves, a conviction that made her feel it was futile to stand up to her boss. Her solution was to bury her feelings. The patient thought about this and responded, "I guess I could have asked what exactly he wanted me to do. I could ask him to set priorities if I can't do all the things he asks." The therapist reflected, "You don't like feeling resentful, but if you think you can get through to someone, it's not too hard to think of different ways to manage the resentment."

In each of these cases, the therapist used a sequential unfolding process to identify a difficult negative affect. The therapist then encouraged discussion of the affect, its origin, and alternative ways to think about both the stimulus for the affect and the response to it. Throughout the treatment, this process is used to identify negative emotions, discuss them, and reevaluate stimuli that trigger the reactions. Responses to emotions are also identified and considered.

TRAINING

The administration of this treatment requires general training and experience in the use of psychodynamic psychotherapy and/or in experiential psychotherapeutic techniques. The therapist who uses this treatment should also be familiar with panic disorder patients and skilled at differential diagnosis. In addition, the therapist should receive some specialized, supervised training experience, as outlined below.

Our training procedures include careful reading of the treatment manual and an opportunity to review the principles and techniques described in the manual with one of the authors or someone else trained to administer the treatment. This is accompanied by study of case examples and listening to or watching taped treatment sessions. We pay particular attention to ensuring that the therapist is familiar with the psychoeducational principles.

Techniques for managing resistance are included in the manual, and the prospective therapist studies this information. To complete training, the therapist conducts at least two supervised cases while being monitored on adherence to treatment procedures. An adherence monitoring form is included with the treatment manual.

EMPIRICAL EVIDENCE FOR THE APPROACH

Emotion-focused treatment is not yet empirically well validated. However, there is preliminary support for its efficacy, based on results of studies using supportive, nondirective treatment as a control therapy and on case reports of the usefulness of psychodynamic treatment. A prospective controlled study of EFT is under way, but results are not yet available. In the absence of that data, it is helpful to know that treatment approaches using nondirective empathic support appear to ameliorate symptoms and that case reports document some utility in more classic psychodynamic treatment. We see these approaches as more similar to EFT than the direct, symptom-targeted strategies used in cognitive-behavioral treatments. For this reason, we will highlight some reports available in the literature here.

Case Reports in Psychoanalytic Literature

Mann (1973) reports a case of a housewife disabled by agoraphobic

symptoms whose dependency and lack of assertiveness were seen as central to symptom formation. The report includes a detailed description of a brief therapy, focused heavily on transference interpretations, that produced virtual recovery. Sifneos (1972) also describes a psychodynamic treatment in some detail. The patient was a young mother, employed part-time as a fashion model, who complained of frigidity and agoraphobia. A treatment focused on guilt feelings about sexual pleasure and guilt about her aggressive, competitive feelings toward her mother produced remission that was sustained at seven-year follow-up. Milrod and Shear (1992) summarized tentative generalizations from case reports of successful psychodynamic treatment: Initial management of panic symptoms appears to have occurred through the establishment of a relationship with the physician and the patient's knowledge that a treatment would begin. In some cases, the patient's family was contacted during the early phase of treatment in order to educate them. After a therapeutic relationship was established, the patient began to acknowledge and discuss upsetting feelings that seemed to have contributed to the onset of panic symptoms. In the middle phase of treatment, patients' central conflicts were identified and explored. Therapists used transference interpretations to elucidate the meaning of panic symptoms, as well as of other identified problems. In these cases, treatment with psychodynamic psychotherapy resulted in disappearance of panic and a sense of greater overall psychological stability.

Previous Studies of Supportive/Nondirective Treatment

Klein, Zitrin, Woerner, & Ross (1983) reported similar results with either systematic hierarchical desensitization or supportive psychotherapy in agoraphobics, and Borkovec and Matthews (1988) reported an equivalent outcome with cognitive-behavioral treatment and a nondirective reflective listening treatment in a mixed group of subjects with panic or generalized anxiety. As noted above, we reported the results of a study comparing cognitive-behavioral therapy with a panic-focused, affect-processing treatment very similar to the one described in this chapter (Shear, Pilkonis, Cloitre, & Leon, 1994). Post-treatment and six-month follow-up assessments revealed a good response to both treatments. We observed a high rate of panic remission and significant improvement in associated symptoms in each group. A replication study is currently under way, along with a comparison with an inactive control.

In summary, we present the background and methods for a brief emotion-focused therapy intervention for panic disorder patients. This treatment is derived from psychodynamic principles but is not, strictly speaking, a psychodynamic psychotherapy. Efficacy of this treatment has some early empirical support, but full confirmation of its efficacy and effectiveness in comparison with other active treatments awaits further study.

REFERENCES

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

Apfeldorf, W., Shear, M. K., Leon, A., & Portera, L. (1993). The relationship of symptomatology to impairment in patients with panic disorder. *Journal of Psychiatric Research,* 27(4), 361-367.

Arrindell, W., Emmelkamp, P. M., Monsma, A., & Brilman, E. (1983). The role of perceived parental rearing practices in the etiology of phobic disorders: A controlled study. *British Journal of Psychiatry*, 143,183-187.

Barlow, D. H. (1991). Disorders of emotion. *Psychological Inquiry,* 2(1), 58-71.

Barlow, D. H. (1994). Effectiveness of behavior treatment for panic disorder with and without agoraphobia. In B. E. Wolfe & J. D. Maser (Eds.), *Treatment of panic disorder: A consensus development conference* (pp. 105-120). Washington, DC: American Psychiatric Press.

Barlow, D. H., Craske, M. G., Cerny, J., & Klosko, J. (1989). Behavioral treatment of panic disorder. *Behavioral Therapy*, 20,261-282.

Beck, A. (1988). Cognitive approaches to panic disorder: Theory and therapy. In S. Rachman & J. Maser (Eds.), *Panic: Psychological perspectives* (pp. 91-109). Hillsdale, NJ: Lawrence Erlbaum Associates.

Biederman, J., Rosenbaum, J. F., Hirschfeld, D. R., Faraone, S. V., Boldue, E. A., Gersten, M., Meminger, S., Kagan, J., Snidman, N., & Reznick, S. (1990). Psychiatric correlates of behavioral inhibition in young children of parents with and without psychiatric disorders. *Archives of General Psychiatry*, 47, 21-26.

Borkovec, T. D., & Matthews, A. M. (1988). Treatment of nonphobic anxiety disorders: A comparison of nondirective, cognitive, and coping desensitization therapy. *Journal of Consulting and Clinical Psychology*, 56, 877-884.

Bowlby, J. (1973). *Attachment and loss: II. Separation anxiety and anger.* New York: Basic Books.

Brodbeck, C., & Michelson, L. (1987). Problem-solving skills and attributional styles among agoraphobics. *Cognitive Therapy and Research*, 11, 593-610.

Busch, F. N., Shear, M. K., Cooper, A. M., Shapiro, T., & Leon, A. C. (1992). An empirical study of defense mechanisms in panic disorder. Manuscript submitted for publication.

Chambless, D. L. (1985). The relationship of severity of agoraphobia to associated psychopathology. *Behavior Research and Therapy*, 23, 305-310.

Chambless, D. L., & Goldstein, A. J. (1981). Clinical treatment of agoraphobia. In M. Mavissakalian & D. H. Barlow (Eds.), *Phobia* (pp. 103-144). New York: Guilford Press.

Chambless, D. L., Hunter, K., & Jackson, A. (1982). Social anxiety and assertiveness in phobic populations. *Behavior Research and Therapy*, 20,403-404.

Clark, D. M. (1986). A cognitive approach to panic. *Behavior Research and Therapy*, 24, 461-470.

Clark, D., Salkovskis, P. M., Hackmann, A., Middleton, H., Anastasiades, P., & Gelder, M. (1994). A comparison of cognitive therapy, applied relaxation and imipramine in the treatment of panic disorder. *British Journal of Psychiatry*, 164, 759-769.

Cloitre, M., Shear, M. K., Cancienne, J., & Zeitlin, S. B. (1994). Implicit and explicit memory for catastrophic associations to bodily sensation words in panic disorder. *Cognitive Research and Therapy*, 18, 225-240.

Cooper, A. M. (1985). Will neurobiology influence psychoanalysis? *American Journal of Psychiatry*, 142,1395-1402.

Craske, M. G. (1988). Cognitive behavioral treatment of panic. In A. Frances and R. Hale (Eds.), *Annual Review of Psychiatry* (Vol. 7, pp. 121-137). Washington DC: American Psychiatric Press.

Craske, M. G., Brown, T. A., & Barlow, D. H. (1991). Behavioral treatment of panic: A two-year follow-up. *Behavioral Therapy*, 22, 289-304.

Emmelkamp, P. M. G. (1980). Agoraphobics' interpersonal problems. *Archives of General Psychiatry*, 37,1303-1306.

Faravelli, C., Webb, T., Ambonetti, A., Fonnesu, F., & Sessarego, A. (1985). Prevalence of traumatic early life events in 31 agoraphobic patients with panic attacks. *American Journal of Psychiatry*, 142, 1493.

Fischer, L. M., & Wilson, G. T. (1985). A study of the psychology of agoraphobia. *Behavior Research and Therapy,* 23,97-107.

Freud, S. (1962). On the grounds for detaching a particular syndrome from neurasthenia under the description of anxiety neurosis. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 3, pp. 85-116). London: Hogarth Press. (Original work published 1895)

Freud, S. (1959). Inhibitions, symptoms and anxiety. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 20, pp. 77-175). London: Hogarth Press. (Original work published 1926)

Fyer, A. J., & Samberg, D. (1988). Pharmacologic treatment of panic disorder. In A. Frances & R. Hale (Eds.), *Annual Review of Psychiatry* (Vol. 7, pp. 88-120). Washington, DC: American Psychiatric Press.

Garvey, M. J., Cook, B., & Noyes, R. (1988). The occurrence of a prodrome of generalized anxiety in panic disorder. *Comprehensive Psychiatry*, 29,445-449.

Heckelman, L., Spielman, L. A., & Shear, M. K. (1992). Reported parental attitudes and current interpersonal problems in panic disorder. Presented at the Society for Psychotherapy Research, San Francisco.

Klein, D. F. (1981). Anxiety reconceptualized. In D. F. Klein & J. G. Rabkin (Eds.), *Anxiety: New research and changing concepts* (pp. 235-263). New York: Raven Press.

Klein, D. F. (1964). Delineation of two drug-responsive anxiety syndromes. *Psychopharmacology*, 5, 397-408.

Klein, D. F. (1993). False suffocation alarms, spontaneous panics, and related conditions: An integrative hypothesis. *Archives of General Psychiatry*, 50, 306-317.

Klein, D. F., Zitrin, C. M., Woerner, M. G., & Ross, D. C. (1983). Treatment of phobias II. Behavioral therapy and supportive psychotherapy: Are there any specific ingredients? *Archives of General Psychiatry*, 40,139-145.

Klerman, G., Weissman, M., & Rounsaville, B. (1984). *Interpersonal psychotherapy of depression.* New York: Basic Books.

Mann, J. (1973). *Time-limited psychotherapy.* Cambridge, MA: Harvard University Press.

McNally, R. J., & Lorenz, M. (1987). Anxiety sensitivity in agoraphobics. *Journal of Behavior Therapy and Experimental Psychiatry,* 18, 3-11.

Michels, R., Frances, A., & Shear, M. K. (1985). Psychodynamic models of anxiety. In J. Maser and H. Tuma (Eds.), *Anxiety and the anxiety disorders* (pp. 595-618). Hillsdale, NJ: Lawrence Erlbaum Associates.

Milrod, B., & Shear, M. K. (1991). Psychodynamic treatment of panic. *Hospital and Community Psychiatry,* 42(3), 311-312.

Parker, G. (1979). Reported parental characteristics of agoraphobics and social phobics. *British Journal of Psychiatry*, 135, 555-560.

Pollock, C., & Andrews, G. (1989). Defense styles associated with specific anxiety disorders. *American Journal of Psychiatry*, 146, 1500-1502.

Rice, L. N., & Saperia, E. P. (1984). Task analysis of the resolution of problematic reactions. In L. N. Rice & L. S. Greenberg (Eds.), *Patterns of change: Intensive analysis of psychotherapy process* (pp. 29-66). New York: Guilford Press.

Rosenbaum, J., Biederman, M., Gersten, D., Hirshfeld, S., Meminger, J., Herman, J., Kagan, S., Reznick, N., & Snidman, N. (1988). Behavioral inhibition in children of parents with panic disorder and agoraphobia. *Archives of General Psychiatry*, 45,463-470.

Shear, M. K., Cooper, A., Klerman, G. L., Busch, F., & Shapiro, T. (1993). A psychodynamic model of panic. *American Journal of Psychiatry*, 150(6), 859-866.

Shear, M. K., Pilkonis, P. A., Cloitre, M., & Leon, A. C. (1994). Cognitive behavioral treatment compared with nonprescriptive treatment of panic disorder. *Archives of General Psychiatry,* 51, 395-401.

Sifneos, P. E. (1972). *Short-term psychotherapy and emotional crisis.* Cambridge, MA: Harvard University Press.

Silove, D. (1986). Perceived parental characteristics and reports of early parental deprivation in agoraphobic patients. *Australian and New Zealand Journal of Psychiatry*, 20, 365-369.

Soumi, S. (1987). Genetic and maternal contributions to individual differences in rhesus monkey biobehavioral development. In E. M. Blass, M. A. Hofer, & W. P. Smotherman (Eds.), *Perinatal development: A psychobiologic perspective* (pp. 397-419). Orlando, FL: Academic Press.

Weissman, M. M. (1990). Epidemiology of panic disorder and agoraphobia. *Psychiatry of Medicine*, 8(2), 3-13.

Wolfe, B., & Maser, J. (1994). *Treatment of panic disorder.* NIH Consensus Development Conference Consensus Statement, September 25-27, 9(2).

CHAPTER 10

Supportive-Expressive Therapy of Cocaine Abuse

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HISTORY AND DEVELOPMENT

In June 1884, Sigmund Freud wrote to Martha Bernays, his fiancée, playfully warning her of his upcoming visit, when he would arrive "a big wild man who has cocaine in his body" (Jones, 1953, p. 84). He had begun experimenting with the drug earlier that year and found it "a magical substance" that counteracted his tendency toward depressive moods, increased his energy and concentration, and suppressed his appetite, leaving him feeling "that there is nothing at all one need bother about" (p. 84). These properties of cocaine have been attested to by many subsequent users. It is interesting that, given the conflicted role cocaine came to play in Freud's personal and professional life (not the least, the painful involvement he had with his friend Fleischl von Marxow's cocaine addiction), little subsequent psychoanalytic literature on substance addiction focused specifically on cocaine. Although Freud used the drug for 10 years, he denied being addicted to it. He did recognize its addictive potential for certain individuals but hypothesized that it was attributable to a personality predisposition, not to any direct physiological effects.

Since these initial speculations, the psychoanalytic understanding of all types of substance abuse has emphasized predisposing personality factors. At the same time, the way in which these personality factors have been viewed exemplifies the shifting lens of metapsychology that has characterized the development of psychoanalytic thought in this century. Early psychoanalytic writers, following Freud's lead, were mainly interested in states of intoxication and emphasized the libidinal significance of drug taking, casting its dynamics in terms of unconscious pleasure seeking, psychosexual development, and constitutional factors. (A comprehensive review of the early literature is provided by Yorke, 1970.) Thus, Abraham (1908/1979) wrote of the regressive release of infantile component instincts involved in alcohol abuse and compared its dynamics to those of the perversions, with their attendant substitute sexual gratifications. Freud (1897/1950) linked addiction to masturbatory activity. Freud had not ignored the object relational significance of drug use—for example, comparing what alcoholics say about wine to a model of a "happy marriage"—but this attachment was always cast in intrapsychic, libidinal terms. Likewise, Freud and other early theorists were not oblivious to the defensive function of substance use as a buffer against painful experience, but they tended to highlight its wish-fulfilling function. Finally, much of the early focus tended to be on alcoholism. Rado (1926) was one of the only early theorists who expressed an interest in the differential effects of drugs and their progressive interaction with

psychological experience and development.

Glover (1932) was the first to explicitly state that the unconscious mental content evident in addiction involved not just regressive processes but "reparative" activity. While his focus remained on unconscious fantasy according to the dominant "lens" of the time, he nevertheless anticipated what recent authors have termed the "prosthetic" or "self-medicating" function of drugs. With the advent of ego psychology, a view of substance abuse as a faulty effort at adaptation began to be emphasized and articulated more clearly. As Krystal and Raskin (1970) described it, substance abuse is an attempt at self-help that fails. Attention shifted to the various components of ego functioning—affect, cognition, memory, and so on—and their respective vulnerabilities in the development of substance abuse. While ego psychology may have initially tended to give equal weight to the various components, the impact of recent developmental research has begun to give primacy to components such as affectivity or object relations, and this new focus is reflected in numerous current theories—some of which we allude to later.

History of Our Own Approach to Treatment

Supportive-expressive (SE) psychotherapy was originally developed at the Menninger Foundation in the 1940s and 1950s. Luborsky (1984) defined and operationalized its core principles. The specific approach we describe in

this chapter, a time-limited SE treatment for cocaine patients, has evolved over the course of the last 14 years. In 1978 a study with opiate-addicted patients was begun (see Woody et al., 1983, for details) in which the typical time frame for treatment has been six months of weekly or twice-weekly sessions. Since that time, two additional projects have been undertaken, another with opiate addicts and one with cocaine-dependent patients. For the latter project, a treatment manual was developed (Mark & Luborsky, 1992). This chapter revises and amplifies that treatment manual.

One of our major assumptions has been that it is useful to understand the phenomenon of drug addiction, whatever the causes, in the context of a person's life, including an understanding of the person's personality or character structure. When the therapist sees and understands the patient as a person who abuses drugs rather than primarily as a drug addict, the basis for establishing a sound therapeutic alliance is enhanced. Viewing the patient as a person with a problem rather than as a stigmatized category of being (a drug addict) allows the therapist to be more responsive to the entire person and therefore able to take a more flexible approach to the patient. This is important because it has repeatedly been demonstrated that psychotherapeutic outcome is correlated with the therapeutic alliance.

We have also assumed that the core conflictual relationship theme (CCRT) (Luborsky, 1984) provides a useful framework for understanding a

person's personality or character structure.

As we worked with substance abuse patients, it became clear that certain aspects of SE psychotherapy treatment would have to be modified with this population. The therapist often has to take a more active role than is usually practiced in SE therapy. In addition, we believe the use of drugs has another very serious implication for psychodynamic therapy. The ordinary assumption in dynamic therapy is that the experiences that occur in the sessions generate interest, curiosity, and concern for the patient. Eventually, these experiences are recast as interpretations that are offered back to the patient. This often new experience of having interpretations offered in the context of a supportive relationship is regarded as therapeutic. However, cocaine, like any abused drug, substitutes a chemical reaction for experience. Actual reactivity to external events, including the impact of another person, is frequently obliterated by the chemically generated hyper-excitability, tension, irritability, and paranoia induced by cocaine. Whether high or not, the cocaine-dependent individual usually has a tremendously impoverished and impaired capacity to experience. Therefore, the traditional methods of support and interpretation are insufficient. Techniques that cultivate such a capacity to experience and that generate curiosity and concern for the patient become particularly vital with this population. Such techniques and shifts in emphases will be discussed in detail below.

INCLUSION/EXCLUSION CRITERIA

Naturally, the patients chosen for this treatment will meet the criteria for cocaine abuse or dependence. In our experience, it is rare to find an individual who abuses only cocaine; most patients will also meet the criteria for other *DSM-IV* substance abuse disorders, particularly alcohol abuse and dependence. Although we view our approach as flexible enough to be effective for differing degrees of severity, some contraindications should be mentioned. A patient should have achieved a reasonable degree of stability related to his or her drug use at the beginning of SE treatment. We do not expect total abstinence. Relapsing is typical, and the advantage of our approach is that it offers a means for understanding the meanings of these "slips" in the context of the person's relationships. However, if a patient is actively binging, is in need of hospitalization for detoxification, or has been hospitalized within the last 30 days, we believe more stability needs to be demonstrated before he or she can effectively utilize our method. Similarly, other conditions that may serve to limit a person's ability to actively engage with our method include dementia or other irreversible organic brain syndrome, schizophrenia or other psychotic disorders, bipolar disorder, current suicide or homicide risk, or a life-threatening or unstable medical condition that can create marked changes in mental status.

DYNAMIC ISSUES IN SUBSTANCE ABUSE

In this section, we discuss some of the psychodynamic issues presented by substance-abusing patients that have informed our treatment strategies. Because our approach is grounded in the core conflictual relationship theme method (Luborsky, 1984), we will describe the principles and components of this method, as well as how recent theories of substance abuse relate to these principles. We will then turn to a discussion of particular aspects of cocaine abuse in light of these considerations.

Core Conflictual Relationship Theme

We have borrowed freely from Luborsky's descriptions of the CCRT but altered the meaning of the terms in some respects. The CCRT consists of three basic components. The core response from others (RO) is the component that refers to the person's predominant expectations or experiences of others' internal and external reactions to them. By the terms *predominant* and *core* we mean those expectations or experiences that are most causally related to the person's difficulties in living. The RO could include any of the following: other's actual responses to the person, the person's anticipations of others' responses, and the person's fantasies of others' responses.

The second component, the core response of the self (RS), refers to a more or less coherent combination of the following: somatic experiences, affects, actions, cognitive style, self-esteem, and self-representations.[1]

The final component, the wish, refers to what a person desires or yearns for. By definition, the wish includes an RS and an RO. That is, wishes cannot exist apart from the person who has them; wishes originate from a self, and therefore include an RS. (Imagine a wish without a bodily experience, an affect, or a self-representation.) Furthermore, a person cannot wish without wishing *for* something, and therefore a wish necessarily includes an object. Usually, but not always, that "object" is another person. We want to emphasize that these "wishful" ROs and RSs are different from the person's core ROs and RSs discussed previously. The wishful RS and RO are part and parcel of the wish; they are related by definition, as it were. In contrast, the core RS and RO are related contingently to the wish.

For example, the core RS of Mr. Block (to be discussed in the case example) includes the sense of himself as incompetent, foolish inter-personally, and unlikable; his core RO includes "others don't like me," "others exploit me," and "others ridicule me." His core wish, to be loved, often took the specific form of a wish to be admired and appreciated. The associated wishful RO was, not surprisingly, an admiring, grateful audience, while the associated wishful RS was of a young boy with great promise and talent.

The Core RO Component

We have found that cocaine patients typically expect or experience a

whole range of negative responses from others. These include being criticized, rejected, misunderstood, controlled, and/or humiliated. Typical responses of the self that go hand in hand with these include feelings of extreme shame and guilt that can defensively flip into a sense of omnipotent entitlement and devaluation of the other, as well as feelings of helplessness, neediness, and despair that can vacillate with a withdrawn self-isolation and disavowal of needs.

It is in this context that substance abusers may seek to find solace in a relationship with a drug that seems a more reliable companion and friend than other people. Interestingly, Greenspan (1979) has speculated that the choice of a particular substance may be related to its ability to reevoke pleasurable experiences in the original attachment to a caregiver.

Feelings of victimization and entitlement can fuel the rather remarkable interpersonal violations substance abusers are capable of committing to acquire their drug. At the same time, this behavior begins a cycle of destruction in their potentially meaningful relationships that again amplifies their predisposing problems. Substance abusers breed tremendous anger, distrust, and rejection in those close to them and endure social contempt from the general culture—the very reactions they inherently fear most.

These reactions from others, in turn, can evoke overwhelming shame,

guilt, and self-loathing in the substance abuser, who may then attempt to cope with these painful states by "enacting" them. For example, it is very difficult for anyone, the therapist included, not to take a parental position in relation to the substance abuser; for example, it is difficult to avoid saying, in effect, "You shouldn't be doing that!" The point here is that once someone else takes such a position, the substance abuser is often thereby relieved of feeling that way toward himself or herself and is further liberated by the righteous sense of having been misunderstood and mistreated.

The Core RS Component

The compelling need to externalize painful affective states, as discussed in the previous paragraph, points to one of the most conspicuous and consistently observed features presented by substance-abusing individuals— their difficulty identifying, tolerating, modulating, and/or expressing their emotional experiences. In Greenspan's (1977) terminology, they function at primitive levels of *representational elaboration.* As a consequence, their emotional experiences can remain amorphous, threatening, and frequently somatized, reinforcing their sense of being a victim—here, of their own bodies, not just of others. Wurmser (1978) has referred to this problem as "hypo-symbolization," and Krystal (1987) similarly describes a "dedifferentiation" of affect and a form of alexithymia among many substance abusers. In this context, the use of substances can be seen as a kind of self-

medication for treating overwhelming and painful affective and related disruptive self-states (see Wilson, Passik, Faude, Abrams, & Gordon, 1989).

To use a drug like cocaine in order to cope with poorly integrated and painful affect states not only serves to confound the predisposing dynamics but powerfully perpetuates the use. In this process of "symptom substitution," the original painful effect of anxiety or anger, itself poorly integrated and diffuse, becomes replaced by an urge or craving—"I need a drug" (e.g., to feel physically better, to exorcise this feeling of being a bad person, to get back at a family member who's wronged me). This is an example of how an initial core RS can be transformed into a wish. In turn, the subsequent pharmacological effects and withdrawal effects (as well as the guilt and shame attendant to using the drug) can either mask or resonate with the original painful feelings. In the process, attention is further directed away from the original emotional and psychological contexts and meanings of the drug use toward physiological factors and drug effects. We have found that taking this "psychopharmacogenic" perspective (Wieder & Kaplan, 1969), in which we remain cognizant of the physiological and psychological effects of a drug as they interact with a patient's dynamic issues, is often critical when we attempt to tease apart the presenting experience of a patient. The therapist must be knowledgeable about the biochemical profile of specific drugs and their likely impact. This dynamic confound on the frontier between biology and subjectivity is part of what makes work with substance abuse so

challenging and interesting.

Finally, therapists working in the substance abuse field often refer to the "manipulativeness" of substance abusers. Some studies have suggested that a large percentage of substance abusers meet the criteria for antisocial personality disorder (Rounsaville, Weissman, Kleber, & Wilber, 1982; Khantzian & Khantzian, 1984). This has not been our experience with cocaine patients. In any case, we would note that, whether the individual was pre-morbidly psychopathic or not, the "lifestyle" of substance abuse often requires the use of conning, deception, and other sociopathic behaviors in relation to others.

The Wish Component

Certain wishes can be expected from any cocaine patient. With regard to the substance itself, there is typically a conflict between the wish to stop using cocaine and the wish to continue to use, albeit without suffering the consequences. (This latter wish takes the form in most patients of hoping to control their use). In addition, the wish to continue using is, at least initially, either denied—whether to oneself or others—or relegated to the status of a craving devoid of any psychological context, or invoked as an explanation after the patient uses in order to give the illusion of control. This nonreflective, reassuring explanation does not involve an *experience* of

intention, thus differing from a true awareness of the wish to use cocaine prior to a potential drug-taking episode.

Of course, the cocaine abuse itself inevitably damages the person's interpersonal relationships and thereby generates certain wishes that typically are prominent for cocaine patients. For example, many of them wish to be understood. (The precise associated wishful RO and RS differ with the personality of the patient, though the RS, of course, includes a representation of oneself as "good" and presents others as "kind and understanding.")

Personality style: Related to the wish component, we have found that a general presenting feature that typifies many substance abusers is what Shapiro (1965) has termed a "passive-impulsive," narcissistic style. A defining element of this style involves an extreme vacillation in the ordinary experience of deliberateness and intention—in particular, a striking absence of this experience around activities that, to the outsider, would seem to require a great deal of planning and intent. This style is most obvious when drug users say that they "don't know how" they ended up in a situation where drugs were available, or "don't know why" they keep taking drugs—"It's not me."

Defenses: The defenses typically associated with substance abusers, denial and externalization of responsibility, can be seen to follow from this

particular intentional style. Statements like, "I just ended up at the crack house," "I didn't mean to do it, but someone gave it to me," and, "I guess I just wasn't myself," reflect an underlying experience of passivity, of *disclaimed action,* to use Schafer's (1983) term. A therapist must be especially attentive to the ways in which the currently prevalent disease model of addiction can be used by the patient as a clever foil for such externalizations. This is not to suggest that there is no merit in the disease model or that drugs do not exert genuine detrimental effects. Nevertheless, the "progression" of the illness is neither predictable nor inevitable and is characterized by choice and necessity all along the way.

Narratives or relationship episodes: The narratives of substance abusers often reflect this experience of themselves as "disclaimed" or passive agents, with the fabric of meaning appearing thin, tattered, and disconnected (Mark & Luborsky, 1992). Therefore, it is particularly critical that intervention techniques serve to enrich and extend meaningful narrative data with these patients.

The Dynamics of Cocaine Abuse

Although once a source of debate, it is now clear that cocaine can be both physiologically and psychologically addictive and that tolerance and withdrawal do develop. The specific pharmacological effects of cocaine may

partially explain the tremendous craving it induces. Cocaine is a highly powerful central nervous system stimulant. It alters circulating levels of dopamine, norepinephrine, and epinephrine, as well as hypothalamic-pituitary-adrenal axis hormones. Most important, its effects are experienced rapidly and diminish just as quickly (the drug is metabolized by the liver in five to fifteen minutes). When cocaine is smoked or injected rather than snorted, these effects are amplified tremendously. Cocaine provides what many users report as a rush of self-confidence (if not feelings of omnipotence), boundless energy, enhanced concentration, a sense of wellbeing, and a lack of inhibition (recall Freud's "wild man"). These effects are followed by experiences of lethargy, fatigue, irritability, and depression when the drug action diminishes, representing in part a biochemical "rebound" effect. This sequence of effects, when repeated, becomes one of quick and labile cyclings of highs and lows in which the user searches for the initial peak but never quite gets there again and the low seems to fall deeper and deeper. It is intriguing to note how much the form and content of these effects parallel and reinforce many of the predisposing personality conflicts and vulnerabilities we have reviewed: feelings of impotence, emptiness, and poor self-esteem, which may be defended against through narcissistic and omnipotent disavowal of need; labile and disorganized emotional experience; and an impulsive cognitive style characterized by speed, abruptness, and discontinuity.

TREATMENT GOALS

Goals at the Beginning of Treatment

The first in a series of goals has typically been referred to as, for example, "establishing a collaborative relationship," or, "building a therapeutic alliance." Such phrases must be understood as an ideal description of what ought to occur, not as a prescription to the therapist as to what to do. (See Greenberg, 1981, for a discussion of the distinction between description and prescription in the context of the theory of therapy.) The problem with regarding "establishing a collaborative relationship" or "building a therapeutic alliance" as a goal that the therapist self-consciously sets out to achieve is that such a goal almost inevitably comes across to the patient as artificial or manipulative. This impression is a particularly serious liability with substance abuse patients, who frequently carry out, suffer from, and anticipate such artifice or manipulation.

It is more useful if the therapist attempts to (1) instill a sense of curiosity in the patient regarding his or her psychological functioning (see the case example), (2) encourage a sense of hope in the patient, and (3) establish a sense of purpose and relevance for the therapeutic sessions early in the therapy. To facilitate the latter two tasks, it is recommended that the therapist inquire about the patient's goals at the beginning of treatment. Luborsky (1984) notes that "the most common goals for many patients are

the control of anxiety, depression, and problems of personal functioning" (p. 62).

Cocaine patients, however, tend to create certain "technical" difficulties with regard to goals early in treatment. If the therapist is to create a sense of purpose and relevance to the therapeutic sessions, it is very important that the agreed-upon goals are within the therapist's realm of competence. For a number of reasons (e.g., the devastating impairment in functioning due to the drug abuse, previous experience with drug counselors, ignorance about psychotherapy, narcissism, hopelessness, defiant hostility), cocaine patients frequently state goals that are more appropriate to present to an employment or housing agency than to a therapist (e.g., "I need a job," or, "I need a place to live away from my mother"). A more subtle example of this difficulty occurs when the patient says something like, "I need someone to talk to about my problems. I have no one to talk to." In all of these examples, the therapist cannot provide what is missing in the patient's life. It is therefore crucial that the therapist help frame the patient's goals in terms that are within the therapist's realm of competence. For example, the patient and therapist could agree to pursue the question, "Why is there no one in your life you can speak with?"

It is assumed that a collaborative therapeutic relationship in the context of a secure therapeutic frame creates the necessary conditions of safety and

trust to permit patients to be as open as possible, to be able to convey and absorb their most significant experiences. With cocaine patients, however, the issues of abstinence and attendance complicate the establishment of a secure frame as well as a collaborative relationship. Patient attendance is often poor; a primary reason, of course, is that the patient often uses during the course of treatment. When patients use during the course of treatment, their motivation for continued treatment decreases and they are often too ashamed even to make appointments for—much less attend—future sessions. (Therefore, the therapist should, in most instances, call the patient after a missed session rather than wait for the patient to make contact.)

Generally speaking, the therapeutic atmosphere ought to be one of warm naturalness. It does not seem to be a good idea with substance abuse patients to rigidly adhere to a "role," particularly that of the anonymous, neutral analyst. Within a generally flexible frame, certain aspects of the treatment ought to be carefully established and attended to, such as drug use, the patient's attendance in individual sessions, groups, and CA/NA/AA meetings, as well as lateness to sessions.

No discussion of goals in the treatment of cocaine patients would be complete without broaching the issue of abstinence. It seems to us that insisting on abstinence unnecessarily generates an adversarial relationship between therapist and patient. Typically, the patient wants to continue to use,

but without the negative consequences of the use. This wish is often expressed in such phrases as, "I want to control my use of cocaine." It is not useful to enter into an argument on the virtues of abstinence. Instead, the therapist must stress that, while he or she would recommend abstinence from all drugs, including marijuana and alcohol, such a goal is for the patient to decide on. Sometimes demonstrating to the patient the severity of the addiction and the untenability of "controlled use" can be accomplished by proposing an experiment in which the patient is asked to abstain from any drugs for a mutually agreed amount of time. The amount of time should obviously be longer than the usual nonuse period for the patient. Cocaine patients in particular often wait between paychecks before binging.

It is useful, however, to allow patients to experience and express how vital they feel drugs to be in their lives. Such a communication is most likely to experientially come alive in the context of a relapse, a dream about a relapse, or an experience of craving, rather than in response to a simple question from the therapist. Once such a deeply felt acknowledgment of the significance of drugs in the patient's life occurs, a problem-solving attitude may be set in motion. That is, the patient begins to wonder, "Why is cocaine so essential?" and, "What can begin to take its place?"

Finally, it is recommended that the therapist advise the patient to attend CA/NA/AA meetings. The goal in the early phase of treatment is simply to get

the patient to try out these self-help groups.

Goals in the Middle Phase of Treatment

The central goal for the middle phase of treatment is to frame the patient's goals in a core relationship theme context while proceeding to work on them. The hope is that consistent demonstration of the pervasive functioning and significance of the CCRT will encourage a problem-solving attitude. The issues discussed in therapy become shaped by and focused on the CCRT. This focus permits the therapy to be time-limited. Specifically, the CCRT is used to establish a focus in the following three areas:

1. The meanings, functions, and consequences of the patient's cocaine use are drawn out in terms of the CCRT.

2. The CCRT is used to illuminate the roadblocks encountered during the patient's attempts to become drug-free. Even when the patient genuinely wishes to discontinue using drugs, the process is never as simple as "Just say no." For example, a person who intensely derogates self and others will have great difficulty getting help from a sponsor, as well as from the therapist.

3. The patient's difficulties in living without drugs are framed within the CCRT.

Goals Related to the Patient's Participation in Self-help Groups

Patients frequently relapse after a month or so of abstinence. In such cases, it is particularly useful to investigate the nature of the patient's difficulties participating in CA/NA/AA groups or obtaining and using a sponsor. Often the patient has attended only a few meetings, or has not really "engaged," or is still waiting to find the "right" sponsor. By the middle phase of treatment, it should be possible to frame such difficulties in terms of the patient's CCRT. Such understanding often renews the patient's interest and involvement. For example, Mr. Brown felt enormously uncomfortable not being the center of attention at the meetings. He was certain he was not liked. Describing his predicament in terms of the CCRT enabled him to suggest that perhaps he should try to listen to others at the meetings and that, if he did, he might find that others liked him for being a good listener.

Goals for the Last Phase of Treatment

It is important to keep in mind that the conclusion of time-limited treatment does not mean the end of the process of recovery. Such knowledge may help the therapist refrain from assuming excessive responsibility for the patient or from pressuring the patient to do more than is realistic. If the therapy has been useful, the therapist ought not to be the only positive and therapeutic agent in the patient's life—the patient should be engaged in some form of ongoing group. Thus, one of the central goals for the end of individual treatment is for the patient to have invested in a social network that will

sustain the patient, help him or her avoid isolation, and provide practical help in minimizing or circumventing a relapse. The therapist has done a good job if he or she has been a reasonably helpful, benevolent person at a potentially crucial time in the patient's life, if central problems associated with cocaine use and its cessation have been worked through, and if the patient's core relationship patterns have been identified in an experientially meaningful fashion. Accomplishing these goals can provide the patient with the hope and courage to continue the process of recovery. More than that the therapist cannot do.

THEORY OF CHANGE

There are three components of change during the course of a successful SE time-limited treatment of cocaine abuse: (1) the use of drugs, (2) changes in interpersonal patterns and relationships, and (3) intrapsychic changes.

It goes without saying that there will be no stable changes in the intrapsychic or interpersonal realms if the patient continues the use of cocaine. Nothing is so corrosive to the patient's interpersonal and intrapsychic functioning as the continued use of cocaine. This basic fact necessitates the dynamic therapist's careful attention to, and continuous monitoring of, many of the patient's behavioral routines: Who is the patient socializing with? and when? What do they do? Is the patient still hanging out

in bars, even if "only" to imbibe nonalcoholic beverages? What is the patient doing with his or her paycheck? *The dynamic therapist must focus on behavioral matters as much as the traditional drug counselor or cognitive-behavioral therapist does.* The difference lies in the particular skills the dynamic therapist uses in dealing with these behavioral matters, including:

1. A capacity for comprehending the meaning of the patient's cocaine use within a CCRT framework, thus often providing greater understanding for both therapist and patient. Such understanding ought to permit the patient's shame, guilt, tendency to devalue others, and so on, to be expressed and worked through even as it increases the therapist's capacity to tolerate and work through his or her own reactions to being caught up in this complex web.

2. Sensitivity to indications the patient is concerned about relapsing. Frequently, such indications are communicated subtly and indirectly. For example, a patient may tell of an incident in which he helped a drug supplier fix his stereo. The dynamically oriented clinician, attuned to the subtleties of communication, may wonder with the patient why the patient chose to bring this incident up with the therapist. The patient can then reveal his doubts about his potential actions.

3. Careful attention to the patient's anxiety, resistance, and transference, as well as to the therapist's own anxiety, may permit a more thorough inquiry into the specifics of the patient's behavior surrounding drug use, the handling of

money, friends, and so forth. Considerable skill is often required to elicit these details, which are often crucial to obtain because patients can almost always rationalize their behavior if the details are not on the table between patient and therapist. It becomes harder to dismiss the significance of critical actions and experiences once both patient and therapist are in possession of the relevant data.

Interpersonal Changes

What follows is a "typical scenario" of the changes in interpersonal relationships during the course of time-limited SE therapy with cocaine patients. Such a scenario, needless to say, does not describe the experience of every patient—it merely occurs, in more or less this fashion, frequently enough to be considered typical. The purpose of such a description is to help the therapist understand, accompany, and, when more active measures are called for (e.g., when the patient is in a state of despair over his or her relationships), guide the patient through these changes.

At the beginning of treatment, cocaine-dependent patients are usually profoundly isolated from the majority of their significant others. These relationships are frequently characterized by mutual suspicion, dishonesty, hostility, hurt, and alienation. The cocaine-dependent patient's sense of isolation is relieved, if at all, only by involvement in the drug subculture, namely, in relationships with other cocaine users. Given the essential

destruction of whatever positive qualities existed in their previous (i.e., prior to their addiction) relationships, it is not surprising that cocaine users frequently form intense relationships within the cocaine subculture. However intense, and whatever love and sacrifice for each other is manifested, such "cocaine relationships" are, in a very basic sense, poisoned by the dependence on the drug. Not only are such relationships inevitably unstable, but a mutually exploitative quality to the relationship is inescapable. Not only do they subordinate all sorts of relational qualities like trust, honesty, and reliability to the cocaine, but cocaine users need to keep each other down, to keep the other(s) dependent on the drug—or else the one who continues to use will fully experience the isolation that has been staved off by the cocaine relationship.

In our typical scenario, the cocaine patient has achieved a certain amount of "clean time" early in treatment. The patient now frequently "anticipates," or acts as if he or she anticipates, that all will be forgiven and forgotten by his or her family. (It should be mentioned that this anticipation is often not overtly stated by the patient. Indeed, the patient often says quite the opposite, e.g., "I know it will take time to mend my relationships." Cocaine patients are neither as narcissistic nor as stupid as they are often considered —they know the culture's, and therefore the therapist's, likely response to such an open acknowledgment of an "expectation" of familial forgiveness.) The evidence that the patient shelters such hopeful anticipations is usually

forthcoming once these hopes are dashed, as in, "I haven't used for two months, but do you think they'll ever forget!" Indeed, such hopes usually are dashed when family members, especially those exposed to any previous failed attempts by the patient at recovery, are quite dubious about the degree of change, the stability of the recovery, and even the truthfulness of the patient's assertion regarding clean time. The patient, who has been in a near-manic state, denying any difficulties ahead, becomes crushingly disillusioned. This disillusionment is often covered over with a standard piece of cultural advice, such as, "It doesn't matter what they think, I know what I've accomplished. I've got to do this for myself." Unfortunately, such advice rarely sustains the patient. The therapist has a crucial stabilizing role to play during all of this: interpreting the hopes and anxieties that lurk beneath the manic assertions of smooth sailing, and providing encouragement and support during the periods of disillusionment.

One might think the ideal end point of this scenario is reached when the patient truly believes that "it doesn't matter what anyone else thinks but me." Perhaps it is, but we have the impression that before such an ideal of independence is achieved, family members become convinced about the security of the patient's sobriety, i.e., improvement in family relationships is largely secondary to the patient's clean time (although the lag time before family members trust the patient again is, as stated above, often intolerable to the patient). The changes in family relationships—for those successful

patients who achieve a substantial amount of clean time—are often considerable. Nevertheless, certain basic "structural" aspects of these relationships do not change, or at any rate change far less than the therapist might wish. For example, a patient may come to find himself treated in a friendly, trusting manner by his father, but the patient's basic wish—to strike just the right note with his narcissistic father—is still unchanged.

The patient's relationship to group (therapy group and/or self-help group) frequently follows a path similar to the one traveled in family relationships: the path travels from isolation, alienation, and a defensive superiority to the patient experiencing himself or herself as a genuine member of the group. Once again, the therapist may be distressed by the character of the patient's involvement with others, for example the patient's involvement with a self-help group may seem rigid, mechanical, or dogmatic. We can only remind the therapist of the not insignificant changes that have occurred and caution him or her against forcing an ideal standard upon the patient.

Before discussing the changes in the therapeutic relationship, one point needs to be made. With many other kinds of patients, the therapist need not become actively embroiled in the patient's interpersonal patterns in short-term therapy. In effect, the treatment ends before the therapist gets caught up in the interpersonal field between patient and therapist. In such treatments, it

might be reasonably appropriate to consider the transference relationship one that is primarily subject to intrapsychic changes. With cocaine abuse patients, however, therapists ought to become more or less dramatically embroiled in the patient's core relationship patterns. Indeed, the therapist who does not become at all embroiled has probably not done his or her job, such as those therapists who are able to maintain a steady therapeutic posture and remain outside the patient's core relationship patterns by avoiding careful inquiry into the particulars of the patient's life (such inquiry inevitably generates resistance and countertransference).

What, then, are the typical changes in the therapeutic relationship over the course of the six months of treatment? Consider the aspect of the therapeutic relationship involving the patient's hope or cynicism about the potential helpfulness of the therapist. Obviously, cocaine abuse patients differ in the proportion of hope or cynicism they manifest at the beginning of treatment. (What distinguishes cocaine abuse patients as a group from many other kinds of patients is the relative ease with which profound cynicism may inject itself into the therapeutic relationship.) From the therapist's side at the beginning of treatment, the therapist (if not too cynical himself or herself) wants to be helpful, benign, and understanding. In addition, naturalness and warmth are advantages in working with substance abuse patients, as contrasted with a concern for maintaining the "role" of therapist.

Sooner or later, often very soon indeed, the therapist's initial therapeutic spirit is sorely tested. We intend no implication of intent, either conscious or unconscious, on the part of the patient in using the term *tested.* It may all be more impersonal than that. The patient does what the patient does: coming late, missing sessions and not calling, getting high, lying, acting contemptuously, and obscuring critical realities in his or her life. And the therapist does what the therapist does: making a strenuous effort to maintain "sympathetic understanding" without becoming a fool or a phony. The therapist attempts to avoid feeling furious or disgusted and to avoid moralizing, acting parental, or coming across as a disciplinarian. Because the therapist usually is unable to do this—he or she withdraws and makes no demands on the patient—the therapist typically becomes anxious and guilty. The therapist then becomes still more angry with the patient, who is experienced as forcing the therapist to feel and act in ways not considered in keeping with the therapeutic ideal.

Cocaine patients, like all substance abusers, are enormously sensitive to being treated with derogation, contempt, withdrawal, moralizing, authoritarianism, or, by way of reaction formation, the inauthentic opposite of these attitudes, on the part of the therapist. Such sensitivity in the patient increases the therapist's guilt and anxiety about leaking out any such characteristics. One can see how a destructive therapeutic crisis could easily ensue.

If the therapist is not oppressed by unrealistically high ideals regarding acceptable therapeutic attitudes, several positive consequences follow. Because they are not handled defensively (e.g., by repression, reaction formation, or blaming the patient), these attitudes are registered by the therapist earlier in treatment than they otherwise would be. This makes it possible for the therapist to "metabolize" these attitudes. For example, the therapist may discover an authoritarian or moral streak in himself or herself. Such a discovery moderates the intensity of the therapist's reaction. Furthermore, it is very possible that it is not merely the above-mentioned attitudes themselves but the therapist's denial, either overtly or more usually implicitly, of these attitudes that is particularly noxious for the patient.

Thus, the patient hits a point fairly early in treatment when the therapist is experienced as being much like many other people in his or her life, for the very good reason that the therapist is reacting much like many other people in the patient's life. This experience can elicit many different reactions from the patient: disappointment, resignation, rage, cynical confirmation of the uselessness of others. Ideally, the therapist, sometimes with the patient's help, finds a way to continue a therapeutic inquiry while not continuing to enact aspects of the core relationship pattern.

Intrapsychic Changes

The following areas of intrapsychic change during the course of a successful time-limited SE treatment of cocaine abuse obviously overlap a great deal. In addition, we do not claim that the following list is complete.

Hope. Perhaps no other population is so thoroughly demoralized as substance abuse patients, and cocaine patients are no exception. A central aspect of change is the patient's increased sense of hope that a life can be lived without drugs, and lived happily and productively.

Meaningfulness. The patient begins to develop a sense of purpose that involves a set of values, beliefs, and goals. As the patient maintains sobriety, the idea that it is actually possible to live up to something of these values, beliefs, and goals begins to take root. Subsequently, occurrences in life begin to make sense. Drug taking and the urge to use cocaine no longer seem to strike the patient at random—a sense of coherence develops.

Self-esteem. As cocaine use decreases, patients are able to pursue their interests more steadily and consistently. All this enhances their sense of effectiveness. They also experience a genuine increase in self-respect, rather than swings from self-contempt to grandiosity.

Alienation. Cocaine patients begin to appreciate that their problems are ordinary, human problems. This perspective contrasts with their previous swings between intense states of despair—affected by a belief that their

problems are extraordinary, almost demonic in nature—and a manic state in which they deny all difficulties.

Experience. The patient's experience becomes more refined and articulated. With regard to both internal and external stimuli, more is registered, felt, and considered than when cocaine substituted for experience.

Defenses. The use of frequently employed defenses, such as denial and grandiosity, decreases.

The "Curative Factors"

In the dynamic therapy literature, it is often debated whether "relationship" or "insight" is responsible for change. It seems to us that such a debate is fruitless—surely, interpretations that generate insight inevitably affect the therapist-patient relationship, and the quality of the relationship places constraints on the efficacy and resonance of interpretations. A third factor ought to be mentioned: namely, the therapist's ability to foster an environment, even cultivate events (e.g., through "extending enactments" or developing more coherent, concrete narratives, as discussed below), in which the patient can absorb and integrate experience.

TECHNIQUES

As the name implies, SE therapy includes both supportive and expressive methods. Because these techniques have been described elsewhere (Luborsky, 1984; Luborsky & Mark, 1991), we concentrate here on those techniques emphasized and/or modified for cocaine abuse patients. First, however, we will describe the principles involved in choosing an expressive technique over a purely supportive one.

Two principles help the therapist decide when support, compassion, and encouragement are called for and when more expressive methods are required. (For a review of the major supportive components of therapy, the reader is referred to Luborsky, 1984, chap. 6.) The first principle is that supportiveness generally decreases anxiety, while expressive techniques tend to increase anxiety. The second principle is that progress in therapy is most likely to occur when the patient feels mild to moderate degrees of anxiety.

The particular techniques emphasized and/or modified for cocaine-dependent patients are: (1) the interpretation of "collective" wishes; (2) the development of relatively coherent and complete narratives; (3) interpretations of drug taking or craving and of drug-taking narratives; (4) modifying the "basic" rule; (5) extending enactments; (6) staying close to the patient's immediate experience; and (7) the short-term time limit.

The Interpretation of Collective Wishes

The interpretation of wishes has been regarded as an expressive technique that tends to increase anxiety (especially when the wishes focused on were considered to be almost exclusively of a forbidden sexual or aggressive nature). Yet one of the very significant supportive approaches with cocaine patients is the interpretation of collective wishes. Strictly speaking, the term *collective* does not refer to a discrete category but rather to an aspect of divers wishes. We define *collective* as a reference to what is consensually understood as the culture's definition of what constitutes humanity, of what allows a person to feel he or she partakes in the human community. Addiction almost inevitably involves violations of interpersonal commitments and cultural norms; the most damaging consequence is that the addicted person feels less than fully human and excommunicated (accounting perhaps for the creation of a drug subculture, including its specialized argot). Thus, interpretations that identify the addicted person's lost or disowned desire to reconnect with the human community are uniquely powerful.

For example, a patient started a session by talking for 10 minutes about how careful he was to make sure his children were safe and taken care of whenever he left to get high during a period of time when he had been left with the sole responsibility for them. The therapist has a very delicate path to travel when such assertions are made by a patient in an effort to seek reassurance from the therapist. On the one hand, the patient's self-esteem is far too vulnerable for the therapist to lead off with an interpretation of the

CCRT like, "I wonder if you are telling me at such great length about how you, unlike some other people you know, made sure your children were always left in a protected environment whenever you left to get high, in order to get some reassurance from me that you really are a good, caring person and parent?" On the other hand, to simply respond supportively ("So even in your addiction, you, unlike many others, really went to great lengths to protect and care for your children") is to collude with the patient in minimizing the traumatic consequences of his cocaine abuse.

The therapist will need to make certain points, as demonstrated in the following examples:

1. "You have the wish to be a good, caring responsible parent" (the collective wish).

2. "As one of the terrible consequences of the cocaine abuse, it has been impossible to fulfill that wish on a steady, consistent basis."

3. "This damages the way you regard yourself."

4. "You attempt to bolster your self-esteem in a way that cannot succeed in the long run—by obtaining reassurance from others, perhaps especially from others who are in a position of authority."

5. "The only way to truly reassure yourself in this regard is to stay off

cocaine so you can fulfill your wish to be a good parent."

While the interpretation of the wish component is an expressive technique, the interpretation of the collective wish is also very likely to be experienced supportively by the patient. For it conveys that in spite of the failures that have occurred in the patient's life as a result of the drug abuse, the patient's wishes are ordinary, human ones. Hence, the underlying fear of being less than fully human ("What sort of parent would be so irresponsible?") is addressed. The interpretation also provides hope, suggests a solution, and allows the patient to think, "If I stay off drugs, I can give myself a chance to fulfill my wish of being a good parent."

A Review of the Logic of the CCRT Method

The formulation and interpretation of the central relationship pattern has been considered "the most vital expressive technique" (Luborsky & Mark, 1991). Because many of the modifications for the treatment of cocaine patients have to do with developing useful data upon which CCRT formulations are made, it might be useful to first review the logic of the CCRT method. The CCRT formulation is derived either from enactments between the patient and therapist or, more frequently, from narratives, called relationship episodes (REs), told by the patient (Luborsky, 1984). The narratives from which the CCRT is derived are very different from the narratives of Spence (1982) and Schafer (1983). According to them, the

narrative is not the raw data of the therapy session but what is constructed from the raw data—the interpretive scheme into which the raw data are cast. On the other hand, with the CCRT method, the narratives are the raw data and the CCRT is constructed from these data. Most of the relationship episodes in a psychotherapy session—including psychoanalysis, psychodynamic psychotherapy, and cognitive-behavioral therapy—are explicit narrations of the patient's relationships with others (Luborsky & Crits-Christoph, 1990).

Patient narratives as such have received scant attention in the psychodynamic literature, in part because the original psychoanalytic model advocated minimal verbal activity on the part of the therapist. Therapist interventions were thought to contaminate the transference. The therapist was not to interrupt the flow of the patient's associations except to interpret resistance or content. Short-term psychodynamic approaches advocate a more active therapeutic role, but primarily to accomplish the same goal as in psychoanalysis—to interpret the transference and make reconstructions (Malan, 1963, 1976), only sooner and more vigorously. Not surprisingly, this quicker, more vigorous activity on the part of the therapist often results in a highly confrontational and adversarial style (Davanloo, 1980; Sifneos, 1972). Even since supportive interventions have become an accepted part of the psychodynamic armamentarium, scant attention has been paid to the development of data in the psychoanalytical approach to psychotherapy.

The Development of Relatively Complete and Coherent Narratives

Because the narratives provide the bulk of the raw material for the CCRT formulation, it is particularly important that these narratives be relatively coherent and complete. The problem of narratives that are scattered, highly condensed, and virtually without psychological significance is especially acute with cocaine abuse patients. Their attention is frequently scattered, and they often talk a great deal about symptoms, such as anxiety, entirely isolated from psychologically meaningful contexts. This lack of "representational elaboration" (Greenspan, 1977) is striking.

It takes a great deal of skill for a therapist to know when and how to intervene with questions and comments that help develop the patient's narratives. No manual can teach such a skill. Acquiring it takes supervision; therapist and supervisor listen to tapes of sessions together to hear, evaluate, and discuss how to develop narratives. However, within the context of this manual, we can suggest some questions that may be helpful to the therapist.

1. Does the narrative appear to engage the patient, concern the patient, or matter to the patient in some way? Does the narrative raise a question for the patient about what the patient or another person in his or her life felt, thought, or did? Does the narrative have the quality of search (Zucker, 1967)?

2. Does the narrative have a graphic, vivid quality (Zucker, 1967)? Can

the therapist picture what is being narrated? Are some aspects unexpectedly missing (Cooper & Witenberg, 1983)?

3. Is the narrative relatively coherent, with an intelligible sequence, or is it fragmented?

The Use of Cocaine

What to Interpret

Where does drug taking fit in with regard to the components of the CCRT? As originally conceptualized in the CCRT, the response from self includes symptoms such as anxiety or depression. The CCRT also views cocaine dependency, or any form of drug dependence, as a response from self, but drug use has a complex, often ambiguous and evolving status with regard to the CCRT. Early in the development of the addiction—though not necessarily at the very beginning—the use of drugs may have been regarded as a symptomatic response from self, usually as a consequence of the frustration of a wish that resulted from a negative response from other. Eventually, however, the drug use became more than merely a symptom and a response from self. Drug use became something actually wished for, unlike anxiety, depression, or obsessions. Therefore, in terms of the CCRT, as drug use evolves it is not just a negative response from self but also a wish. Sooner or later, the wish for the drug becomes dissociated, so that the drug-dependent patient experiences the drug use as compulsive. And somewhat

more than other compulsions, drug dependence becomes a way of life, with a relatively established subculture to sustain it. Drug addiction thus eventually becomes a central determinant of a person's physiological state, identity, and relationships with others. It is only well into the recovery process that a "slip" may once again be regarded merely as a symptomatic negative response from self. In addition, once the drug becomes a significant aspect of the patient's life, it occasionally makes sense to think of the cocaine as the "other" whose negative response (NRO) is often "to harm, humiliate, protect, or enhance me."

When to Interpret

How does the therapist decide whether to interpret the cocaine use as a wish or as a response of the self? As a general rule, very early in treatment the drug use will tend to be interpreted as a response of the self. Such an interpretation is usually experienced supportively; it decreases anxiety because it decreases responsibility for the drug taking. As soon as possible, the therapist begins to interpret the cocaine as a wish. This increases responsibility and anxiety. Still later in treatment, the wish for cocaine is seen as a derivative wish rather than a primary wish.

CCRT Patterns with Cocaine as the Central Wish

What are some typical CCRT patterns involving cocaine as the central

wish?

1. When the wish to use cocaine is defended against with an NRS of either helplessness ("I had no idea he [a drug-using acquaintance] would be there, and he just offered it to me. It was in my face. There was nothing I could do") or disavowal (the patient drove around and around just to relax and "happened" to arrive in his old drug-using neighborhood).

2. When the wish to use cocaine brings into (typically fleeting or intermittent) awareness the consequences, such as NRO-anger, hurt, disappointment in self, getting fired (often accompanied by the NRS of shame). In turn, these consequences are defended against with an NRS of devaluation of others, grandiosity, and so forth.

3. When the wish to use cocaine brings into awareness (again, fleeting or intermittent) the NRS of guilt. In turn, this guilt is often defended against by justifying the use, usually by an NRO in response to which the patient accuses and blames others ("My wife doesn't understand me, so I went out and found someone [a coke-using prostitute] who does"). In other instances, the NRS of guilt is alleviated by an enactment involving an NRO of "Blame me, punish me." This is often observed in the transference.

The purpose to establishing the patient's wish to use cocaine is not to humiliate him or her (though it may do so). Clearly, patients are not in a position to take relatively simple steps (such as avoiding "people, places, and

things") if they have not yet convinced themselves they do not want to use. Therapists are often reluctant to interpret the patient's wish to use for fear that such an interpretation will exacerbate the patient's shame and guilt. Several points need to be made: It's a sign of progress if the patient can experience shame and guilt rather than the defenses against them of reproach, grandiosity, devaluation, and so on. The therapist's capacity to draw out these affects, rather than nervously shy away from acknowledging their existence, and to hold the patient to the experience is an important aspect of SE therapy with cocaine patients. To put it another way, the patient's experience of shame or guilt in the presence of another person (the therapist) who is neither anxiously reassuring nor punishing or humiliating ought to be useful. Furthermore, there are positive aspects to both shame and guilt in and of themselves. The presence of these affects may signal the existence of a desire (a collective wish) to rectify relations with others, a concern for others, or personal standards and values. Pointing this out to the patient ought to provide motivation for sobriety. Finally, drawing out the patient's wish to use cocaine increases the patient's responsibility for his or her actions. While a sense of responsibility may exacerbate shame and guilt, it ought also to provide hope for the patient. After all, feeling helpless about your addiction can be a terribly despairing state; responsibility implies that you can do things to improve your condition.

We do not want to give the one-sided impression that we advocate only

interpreting the wish to use cocaine. The CCRT ought also to be used at moments when the wish to not use cocaine comes into the foreground. For example, substance abuse patients receive some standard pieces of advice, such as, "Avoid people, places, and things," "Call your sponsor if you're experiencing a craving," and, Don't let yourself overwork, get too lonely," and so on. As discussed earlier, the patient's inability or unwillingness to follow such advice should not always be regarded merely as the wish to use. Rather, his or her inability or unwillingness ought to be placed in the context of the CCRT.

Drug-taking Narratives

It is often useful to obtain a relationship episode around which an incident of drug use or a craving to use occurred. Sometimes it is possible to discover a core conflictual theme that stimulates the craving for the use of drugs. Inferences regarding a CCRT are far more sound when the patient has not used drugs for quite a while than when the patient has been using compulsively or steadily (e.g., after each paycheck). If the patient is using drugs compulsively or routinely, it is not sound practice to infer the underlying dynamics motivating the drug use episode.

Even under these latter conditions, however, it is useful for the therapist to carefully obtain the drug-taking relationship episode. A relatively complete

RE often permits the patient and therapist to identify some of the immediate triggers of the drug-taking episode. In addition, the joint effort to identify such triggers by obtaining relatively complete drug-taking REs is frequently experienced supportively by the patient. The patient experiences this effort as a collaborative undertaking that may also reduce anxiety by attempting to make sense out of the obviously destructive and often incomprehensible behavior of drug taking.

Modification of the "Basic Rule"

In dynamic therapy, some variation of the "basic rule"—"You can talk about the things you want to talk about"— is typically suggested. For cocaine patients, particularly in a short-term format, such an opening is too vague. We recommend a direct invitation to the patient to bring up a significant narrative. In addition, we indicate to the patient that we expect them to discuss any craving or cocaine use experience. Thus, instead of the basic rule, we might begin several of the early sessions as follows: "What has occurred since we last met that concerned you, raised a question for you, made you anxious? If you've used or felt tempted to, naturally that would be useful to bring up in here."

Extending Enactments

To briefly review, the CCRT is formulated on the basis of patient narratives and enactments between patient and therapist. Because cocaine patients have learned to scatter, divert, and short-circuit experience so effectively, special therapeutic attention must be given to the development of meaningful data—both patient narratives and enactments. Enactments are behaviorally expressed events between patient and therapist. Particularly for cocaine patients, spontaneously occurring enactments often need to be drawn out or extended before their meanings are clear or can be absorbed by the patient.

Mr. Block provided an example of extending enactments. He often refused to talk about certain matters once they became uncomfortable for him. To draw out this form of oppositionality, which blocked every effort to enter into an exploration of the problems in his life, the therapist would say to him, "Okay, you don't want to discuss going back to work. What do you want to talk about?" The patient would then bring up something else, for example, "my depression." Before long, he would find a way to block further discussion of his depression, insisting that nothing more needed to be said about it. Again, the therapist would ask the patient what he wished to discuss. After several rounds like this, the structure of his responses had been revealed sufficiently to make it virtually unavoidable for him to acknowledge it. Thus, by allowing the behavior to occur a number of times *without* interpretation, the ground can be prepared by the therapist for the patient to more readily

acknowledge and absorb an interpretation when it's offered, in this case about how he blocked every attempt to enter into a discussion of something troubling in his life.

Staying Close to the Patient's Immediate Experience

Although an event may have been extended sufficiently to generate a meaningful experience, the therapist may recognize that the material is no longer in the patient's awareness, or perhaps is somewhat unacceptable to the patient. Interpretation will only create defensiveness on the part of the patient and thus be premature. In these instances, it is useful to stay as close to the patient's immediate experience as possible. Doing so involves much more than merely reflecting back what the patient is saying, especially when the patient is discussing something entirely removed from the therapeutic relationship.

For example, a patient, a rather macho, 43-year-old cocaine abuser, was talking to the therapist about how he would get his old job back. His words communicated utter certainty about his course of action. He conveyed equal confidence that his reception at his old workplace would be positive, even grateful. Nevertheless, he went on at great length, and he frequently cast a hungry look at the therapist, as if he were really quite unsure of himself and needed the therapist to affirm what he was saying.

The therapist decided to stop the patient shortly after the patient had shot him that quick, hungry look, saying, "Sam, I have a sense that you are looking at me very carefully. Do you have a sense of that?" Thus, rather than simply asking, "What are you feeling now?" the therapist tried to stay as close to the experience as possible by making direct reference to something that was concretely occurring. Particularly with drug abuse patients, who are apt to convert affective experience into drug deficiencies ("I don't have enough benzos"), it is important to keep the level of abstraction to an absolute minimum whenever possible.

The Time Limit

In a certain sense, the short-term time limit (we are currently using a six-month treatment for an ongoing National Institute of Drug Addiction study of cocaine abuse) is far more acceptable to this population than to many others. It has been our experience that patients whose primary symptoms have been anxiety and depression are often very uncomfortable with the short-term nature of the treatment, frequently wondering how anything will be accomplished in so short a period of time. Not so with the cocaine patients. There are many reasons for the cocaine patient's relative lack of expressed anxiety over the short-term nature of the therapy, not the least of which is that the dynamically oriented therapist, who has typically spent years and years in school and is used to treatments lasting for years, regards six months

as a considerably shorter period of time than does the cocaine patient, who may not have had too many relationships, projects, or goals last for six months.

The six-month limit on the treatment, which is clearly discussed with the patient at the beginning of treatment, can be used to provide the therapist with a certain leverage when it comes to the frequent complaint by the patient that attending all of the sessions is an impossible burden. The therapist can remind the patient that whatever burdens are anticipated will be for a limited period of time. The patient is, in effect, asked to make a commitment with a definite limit on it; this is more palatable than if the commitment were open-ended.

CASE EXAMPLE

The following case was a time-limited (six months) SE treatment for cocaine abuse in which the patient was seen twice weekly. The major purpose of this case example is to illustrate how the CCRT can be used to help understand the meanings and functions of a person's drug use and the difficulties involved in becoming drug-free, as well as the difficulties that exist for the person facing life without drugs.

Mr. Block was an unmarried, 26-year-old lower-level manager of a midsized factory. He had owned his own home and allowed a male friend to

live in his house rent-free. Mr. Block had used a variety of substances recreationally for 10 years, but his drug use had increased dramatically in the two years prior to treatment. Mr. Block had been depressed since high school. In fact, he certainly would have met the criteria for dysthymic disorder since high school, and that of major depression since shortly before his first cocaine use two years before. Clearly, the self-medication hypothesis of drug abuse (Glover, 1932; Khantzian & Khantzian, 1984) is very relevant in this case.

Some cocaine abuse patients come to therapy stating that cocaine is their only problem and nothing else concerns them. Other patients come to therapy insisting that cocaine is not a problem, that it is strictly subsidiary to some other difficulty, often a troublesome parent or spouse. Mr. Block began the therapy with a variation of the latter presentation. With an extraordinary sense of shame, he "confessed" that he had never had a girlfriend—more specifically, he had never had sex with a woman without "paying for it." He insisted that the cocaine itself was not a problem and that if the therapist were to make an issue of it he would bolt the treatment.

The beginning of treatment with Mr. Block illustrates two other aspects of therapy with cocaine abuse patients mentioned earlier in this chapter. First, the goals need to be shaped into something within the therapist's realm of competence. For example, the patient's "presenting complaint," of never having had sex without paying, was experienced with such intense shame that

it was impossible for him to consider the meanings and significance of the issues involved; rather, he remained enveloped in a vague, yet acute, distress he simply wanted eradicated (illustrating Shapiro's passive-impulsive style). The therapist needed to propose a viable working arrangement, and since he was neither in the business of procuring dates nor capable of magically and instantaneously eradicating Mr. Block's agony, he attempted to get Mr. Block curious about certain questions (one of the early goals of treatment): Why *such* shame? How did Mr. Block relate to others?

The beginning of treatment with Mr. Block also illustrates how quickly the therapist is placed in the middle of a transference-countertransference bind. Almost instantly, the therapist was feeling controlled and threatened while simultaneously being appealed to as a source of pity. As the therapist struggled with this, the interpersonal field itself became a focus for the therapy. The patient acknowledged that he had placed his parents and certain friends in a very similar position. The consequences of doing so were elaborated. For example, getting what he wanted from others by way of pity, threat, and intimidation left him very uneasy about where he stood in relation to others. In addition, his threat to bolt the treatment and explode with rage if pushed had consequences for him apart from its effects on others, and his tendency to explode and flee whenever he encountered a difficulty in living became a problem in its own right in the therapy. His subjective experience of cocaine—as a means of obliterating his distress—shows how cocaine

functioned as a ready vehicle for flight for him.

Mr. Block's cocaine use (as well as the above issues) grew out of a variety of core relationship problems. For example, even before his cocaine use became unmanageable, his self-esteem was artificially, and therefore precariously, maintained. More specifically, his central response of the self, in addition to the cocaine abuse and depressive symptoms, included: a self-image of being a fool, interpersonally incompetent, and unlikable; central affect states of shame and humiliation; actions that would be described by most members of the culture as foolish, incompetent in the interpersonal realm, explosive, and threatening; and a tendency to flee in the face of perceived difficulties and humiliations.

The core RSs serve as the impetus for the patient's wishes, which in turn either reinforce existing RSs or generate new ones. For example, the precariousness of Mr. Block's self-esteem and sense of security was perpetuated by the nature of the relationships he created. He repeatedly resorted to two modes of living. One was to strive to be the center of attention (a wish derivative of wanting to be loved and appreciated) via a special achievement or by acting the clown. He exhibited this mode in his behavior and in his dreams. In one dream he was to perform in an international competition and was accompanied there by his entire family—a much larger entourage than his actual family. When he went out to a party to meet

someone, he regularly took along pictures, souvenirs, or joke items and left them in his car. He then retrieved them when he struck up a conversation with someone, using them for their attention-getting value. This practice had inevitable consequences for his core RS—it exacerbated his sense of himself as interpersonally incompetent and added to this self-image a sense of being a sham. Mr. Block was so focused on being the center of attention that other aspects of his experience atrophied. Personal meanings of events and relationships, outside of considerations regarding the limelight, were relatively undeveloped. This deficit contributed to his inability to create meaningful relationships and intensified his need to become the center of attention.

The other mode of living in which Mr. Block demonstrated a desire for love and appreciation from others (but evidenced no idea of how to build such a relationship) was his pattern of offering a quick commodity—often drugs or money—to "buy" friendship (recall the presenting complaint). Not surprisingly, he often ended up feeling exploited by others—the central negative response from others. Examples of the above pattern included providing cocaine for his group of friends, having a male friend living in his house rent-free, and frequently paying for groups of friends at restaurants and bars. His success at work provided him with the money for these often lavish expenditures and gestures. It also provided another substitute for relatedness: praise and attention from his superiors. Indeed, at least early in

his cocaine addiction, he believed the cocaine enhanced his work performance.

His increasing cocaine abuse, while at first improving his work performance, inevitably began to impair it. He began to miss workdays more frequently, and his motivation at work diminished. When this lost him the respect of his superiors, he turned his efforts to impressing his coworkers with his ability to "get away with murder" at work—namely, to use cocaine heavily yet remain on the job.

Eventually, however, he lost his job and then his house. These losses can be more deeply understood in terms of the CCRT: he not only lost his job and his house, even his self-esteem, but the very means by which he had created the illusion of relatedness.

Thus, we can see how his cocaine use was intricately interwoven with his core relationship problems. At first, the cocaine served as one manifestation of his tendency to flee when confronted with a difficulty (an RS), while it also provided him with the means to both excel at work, thereby impressing his superiors, and literally buy the friendship of others (satisfying the wish to be loved and appreciated). Even after his cocaine use severely impaired his work performance, it still functioned to capture the limelight with his coworkers.

As discussed earlier, the desire to use cocaine and the desire not to use cocaine occupy the foreground at different times in the treatment. It was only after Mr. Block underwent a particularly severe binge two months into the therapy that he was able to profoundly acknowledge his desire to use cocaine. Concurrently, this acknowledgment provided the opportunity to nondefensively experience the desire to stay off drugs. Many patients experience a slip or even a severe binge during the course of treatment. This need not be a cause for dismay, despair, or panic on the part of the therapist; as in Mr. Block's case, the drug use often can be turned to therapeutic advantage.

Once Mr. Block acknowledged his desire to stay off drugs, the problem became how to achieve sobriety. This desire is complicated by a number of factors. The CCRT provides a means not only of appreciating the gravity of the losses involved but also of instilling the hope that alternative means of achieving the desire exist.

The man living at his house rent-free was heavily involved in drug dealing. Thus, getting off and staying drug-free while his friend was in his house was virtually impossible. Until Mr. Block comprehended his pattern of relatedness—being repeatedly exploited by others, an exploitation he invited by his need to buy friendship (his central RO)—he did not feel able or willing to do whatever was necessary to get his friend out of the house.

Early in treatment, Mr. Block would touch only very lightly on his pattern of being exploited by others. That is, his exploitation by others was not always unconscious, but he would quickly lose awareness of it by getting high or getting so enraged in such a diffuse way that he lost touch with what it was that had hurt or upset him. Sometimes he would claim that he "had" depression, owing to "bad genes." Thus, more was involved than simply cutting off contact with a drug-using friend (i.e., "people, places, and things"); an entire system of relatedness had to be challenged.

We now turn to how the CCRT provides a useful lens for appreciating the problems associated with facing and sustaining a drug-free life. One of Mr. Block's central difficulties was a lifelong tendency to resort to destructive extremes when confronted with conflicts or disappointments with others and, more generally, when things did not go according to his wishes. Evidence of this tendency, one aspect of his central response from self, was revealed in several of his relationship episodes. As a youngster he had wanted to go to a school play with his friends unaccompanied by a parent. It was a safe, suburban neighborhood, and all the other children were going without their parents. However, Mr. Block's father insisted on going with his son, maintaining that it would be too dangerous for his son to go without an adult. Mr. Block's response was to lock himself in his room. His parents begged him to come out and offered to modify their position, but to no avail. Much later, when he had grown up, two friends accused Mr. Block of mistreating another

friend. Even though Mr. Block was able to defend his position in a way that made his two friends understand, he was so upset that they initially had sided with the other friend that he disappeared for a week, flying to another city without telling anyone. In therapy, when the therapist asked when Mr. Block intended to attempt to return to work—he had been drug-free for about three months but still had made no effort to return to work—Mr. Block began the next session by saying he had decided it was time to terminate therapy. He also made suicide threats during anxiety-provoking moments during treatment. The cocaine abuse itself was another form of going to dire and self-destructive extremes.

Awareness of and work on this lifelong tendency to threaten to engage in such extreme behavior when things did not go as he wanted them to, or when others disappointed him, was delayed while he abused cocaine. Looking at his tendency another way, the inevitable anxiety a person faces after emerging from a long period of abusing drugs was, in Mr. Block's case, compounded by his characteristic response to flee from, avoid, or deny difficulties, conflicts, and disappointments.

Again, the therapist's appreciation of this tendency allowed him both to empathically convey an understanding of Mr. Block's predicament and to keep the issue clearly "on the table," despite the patient's often desperate efforts to obfuscate matters with dramatic threats such as quitting therapy or

even committing suicide. For instance, when Mr. Block threatened to quit therapy following the session in which the therapist raised the issue about his plans to return to work, the therapist at first sidestepped the termination issue altogether. He felt that he must first demonstrate that Mr. Block was avoiding the conflict, difficulties, and humiliation generated in the previous session. Only after this demonstration would the therapist have leverage to engage the patient around the defensive meanings he associated with the issue of termination. Otherwise, the exchange would very likely have degenerated into an involved and circuitous debate on termination and would never really have dealt with his pattern of avoidance. Here is how it went:

> Therapist: Can you recall what we talked about last time?

> Patient: No.

> The therapist was not surprised. It reflected the degree to which the patient had banished a troubling topic. However, after the topic was exhumed, the therapist attempted to interest Mr. Block in looking at his skill at burying difficulties and disappointments. The discussion of his fleeing in the face of challenges had a good chance of proceeding meaningfully because Mr. Block had recently experienced a demonstration of that tendency right there with the therapist. A little later in the session, the dialogue continued:

> Patient: This talk about work is going nowhere. I don't really care about work. Let's just leave it at that.

> Therapist: You want to drop the topic?

> Patient: I would be more depressed if I worked.

Therapist: Could you say more about that?

Mr. Block's last remark offered a ray of light. Now it became not simply a matter of not wanting to talk about work, or considering work irrelevant to his life, but feeling that he would be "more depressed" if he worked. The therapist hoped to open this topic up and so asked for an elaboration. A little later in the session, after Mr. Block said he "dreaded" work, the dialogue continued:

Therapist: Should we try and understand what this fear is about? Is there another way, other than dropping the matter altogether?

Patient: I've never done that before.

Therapist: Well, let's see if we can get a hold of it. What about your dread about this situation, of returning to work?

At this point, the beginning of a meaningful discussion of his relationships at work began. Aspects of the CCRT had been re-created in the session—in this case, a tendency to create a storm, to resort to extremes, to enter a kind of oblivion (reminiscent of cocaine intoxication) when faced with a difficulty or disappointment, as seen in Mr. Block's threats to quit therapy or his insistence that "this is going nowhere." This reaction pattern showed itself with particular intensity once he stopped abusing cocaine. In that same session he said he was afraid to return to work in part because he had only "one more chance," given his performance during the time he was heavily using cocaine at work.

At termination, Mr. Block had been drug-free since the ninth week of treatment and had begun to work. He had connected with a sponsor and was

regularly attending NA meetings. He believed he was far less explosive with others (one of his goals of treatment) but did not feel that his ability to form a meaningful relationship with a woman was substantially improved. It was agreed that this was a serious problem that would require therapeutic attention, but that it was a problem that had a better chance of being improved as long as he stayed drug-free.

TRAINING

Substance abuse patients are never easy to treat, and our experience has been no different in this respect from that of others in the field. After a careful selection process in which more than 50% of the applicants for learning the SE treatment were rejected before the pilot phase of the study (all of whom had at least five years' experience after obtaining their M.D., PH.D., or M.S.W. degree) and a careful training process in which the therapists received frequent supervision on three different cases (approximately one hour for every two sessions), we would estimate that only about 70% of the remaining therapists deliver the treatment at an acceptable level of competence.

We believe it is important to select therapists who have experience with both dynamic therapy and substance abuse patients. Ideally, the therapists are the kind of person who is able to maintain a reasonably consistent

background sense of warmth, concern, and interest while keeping the significant issues meaningfully present between the patient and therapist. Our experience was that some therapists became hostile or moralistic, or withdrew from the patient; most, however, maintained a surface warmth and concern, but they often did so by failing to engage the patient around the significant areas that might have provided therapeutic traction.

Exploration of the transference tends to be banal and frequently occurs in the absence of a relationship episode, thereby giving the investigation of transference an excessively abstract and general character (e.g., "How does it feel in here with me?" or, "Do you feel that way with me?"). The issue of excessive generality can be solved if the therapist is reminded that investigation of the transference ought to occur in the context of an RE. In addition, the investigation of the transference ought to provoke anxiety for the therapist as well. If the transference implicates the therapist as well as the patient, then an inquiry that suggests a struggle for only the patient ought to be looked on with great suspicion; the odds are that such an inquiry is serving more to make the therapist comfortable than to draw out the central areas of feeling, tension, and difficulty between patient and therapist.

Our experience has been that supervisors must begin the supervisory sessions by reviewing with the therapist matters such as the patient's drug use, attendance at the sessions and groups, and lateness. Even our relatively

experienced sample of therapists often does not give sufficient attention to such matters. Supervision has occurred with the aid of tapes of the sessions to be reviewed by supervisor and therapist. We believe that this is essential. After the supervisor has listened to the session, certain issues ought to be routinely reviewed with the therapist:

1. Identify the various REs.

2. Ask the therapist to attempt to envision the event the patient has described. Are central aspects of the event, either internal or external, missing? If so, the RE has been insufficiently elaborated.

3. Ask the therapist his or her reaction to the RE described. In effect, ask the therapist to react to the event narrated as if he or she were a friend hearing about the incident, rather than a therapist. We have found that therapists are often afraid to react to the patient's material for fear of being judgmental, a reaction that would be considered an indication that the therapist has left the patient's subjective frame of reference. Yet such a reaction is the very basis of interpretations.

4. Identify the relationship components manifested in the REs. We have found that therapists have difficulty maintaining a consistent focus. Therefore, every few sessions we ask the therapists to formulate the CCRT in writing.

EMPIRICAL EVIDENCE FOR THE APPROACH

The efficacy of applying SE therapy to cocaine-dependent individuals is currently being tested in an ongoing NIDA-funded, multisite, controlled study —the Cocaine Addiction Collaborative Study. Studies researching the effectiveness of SE treatment for methadone-maintained patients with a primary diagnosis of opiate dependence have been completed (see Chapter 5 on opiate addition).

REFERENCES

Abraham, K. (1979). The psychological relations between sexuality and alcoholism. In *Selected papers on psychoanalysis* (pp. 80-90). London: Hogarth Press. (Original work published 1908)

Cooper, A., & Witenberg, E. (1983). Stimulation of curiosity in the supervisory process of psychoanalysis. *Contemporary Psychoanalysis,* 19,248-264.

Davanloo, H. (1980). A method of short-term dynamic psychotherapy. In H. Davanloo (Ed.), *Short-term dynamic psychotherapy* (pp. 43-71). New York: Jason Aronson.

Freud, S. (1950). Extracts from the Fliess papers. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 1). London: Hogarth Press. (Original work published 1897)

Glover, E. (1932). On the aetiology of drug addiction. *International Journal of Psychoanalysis,* 13, 298-328.

Greenberg, J. (1981). Prescription or description: The therapeutic action of psychoanalysis. *Contemporary Psychoanalysis,* 17, 239-257.

Greenspan, S. (1977). Substance abuse: An understanding from psychoanalytic, developmental, and learning perspectives. In J. D. Blain & D. A. Julius (Eds.), *Psychodynamics of drug dependence* (pp. 73-87). NIDA Research Monograph No. 12. Washington, DC: NIDA.

Greenspan, S. (1979). *Intelligence and adaptation: An integration of psychoanalytic and Piagetian developmental psychology.* Psychological Issues No. 47-48. New York: International Universities Press.

Jones, E. (1953). *The life and work of Sigmund Freud* (Vol. 1). New York: Basic Books.

Khantzian, E. J., & Khantzian, N. J. (1984). Cocaine addiction: Is there a psychological predisposition? *Psychiatric Annals,* 10(14), 753-759.

Krystal, H. (1987). *Integration and self-healing: Affect, trauma, and alexithymia.* Hillsdale, NJ: Analytic Press.

Krystal, H., & Raskin, H. (1970). *Drug dependence: Aspects of ego functioning.* Detroit: Wayne State University Press.

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

Luborsky, L., & Crits-Christoph, P. (1990). *Understanding transference: The CCRT method.* New York: Basic Books.

Luborsky, L., & Mark, D. (1991). Short-term supportive-expressive psychoanalytic psychotherapy. In P. Crits-Christoph & J. P. Barber (Eds.), *Handbook of short-term dynamic psychotherapy* (pp. 110-136). New York: Basic Books.

Malan, D. (1963). *A study of brief psychotherapy.* New York: Plenum.

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

Mark, D., & Faude, J. (in press). *Dynamic therapy of cocaine abuse.* New York: Jason Aronson.

Mark, D., & Luborsky, L. (1992). *A manual for the use of supportive-expressive psychotherapy in the treatment of cocaine abuse. Unpublished manuscript, Hospital of the University of Pennsylvania.*

Rado, S. (1926). The psychic effects of intoxicants: An attempt to evolve a psychoanalytical theory

of morbid cravings. *International Journal of Psychoanalysis,* 7, 396-413.

Rounsaville, G., Weissman, M., Kleber, H., & Wilber, C. (1982). Heterogeneity of psychiatric disorders in treated opiate addicts. *Archives of General Psychiatry,* 39, 161-166.

Schafer, R. (1983). *The analytic attitude.* New York: Basic Books.

Shapiro, D. (1965). *Neurotic styles.* New York: Basic Books.

Sifneos, P. (1972). *Short-term psychotherapy and emotional crisis.* Cambridge, MA: Harvard University Press.

Spence, D. (1982). *Narrative truth and historical truth.* New York: Norton.

Wieder, H., & Kaplan, E. H. (1969). Drug use in adolescents: Psychodynamic meaning and pharmacogenic effect. *Psychoanalytic Study of the Child,* 24, 399-431.

Wilson, A., Passik, S., Faude, J., Abrams, J., & Gordon, E. (1989). A hierarchical model of opiate addiction: Failures of self-regulation as a central aspect of substance abuse. *Journal of Nervous and Mental Disease,* 177, 390-399.

Woody, G., Luborsky, L., McLellan, T., O'Brien, C. P., Beck, A. T., Blaine, J., Herman, I., & Hole, A. (1983). Psychotherapy for opiate addicts: Does it help? *Archives of General Psychiatry,* 40, 639-645.

Wurmser, L. (1978). *The hidden dimension.* New York: Jason Aronson.

Yorke, C. (1970). A critical review of some psychoanalytic literature on drug addiction. *British Journal of Medical Psychology,* 43, 141-159.

Zucker, H. (1967). *Problems of psychotherapy.* New York: Free Press.

Notes

1 These terms, *affects, somatic experiences, self-esteem,* and so on, do not represent discrete categories,

nor are they at the same level of abstraction. Furthermore, these terms differ in that some represent immediate "first-person" experience (e.g., a particular affect state or somatic experience), but others are inferred and in clinical practice tend to come from the "third person" (i.e., the therapist). We believe these distinctions have important implications for clinical practice, but we do not have space here to elaborate. See our forthcoming book (Mark & Faude, in press).

CHAPTER 11

Psychodynamic Psychotherapy of Multiple Personality Disorder and Allied Forms of Dissociative Disorder Not Otherwise Specified

Richard R Kluft

HISTORY AND DEVELOPMENT

Clinical psychoanalysis begins with the *Studies on Hysteria* (Breuer & Freud, 1893-95/1955). The first case in that work is that of Fraulein Anna O. In the words of Ernest Jones (1953), Freud's preeminent biographer:

More interesting, however, was the presence of two distinct states of consciousness: one a fairly normal one, the other that of a naughty and troublesome child, rather like Morton Prince's famous case of Sally Beauchamps. It was a case of double personality. The transition from one to the other was marked by a phase of autohypnosis from which she would awake clear and mentally normal. This phase happened by luck to be the time when Breuer visited her. (p. 223)

Thus began the uneasy, uncomfortable, and often mutually avoidant relationship between psychoanalytic thinking and the study of multiple personality disorder (MPD). It is ironic that as Freud developed the concept of repression and made it a cornerstone of psychoanalytic thinking, both clinical and theoretical, he distanced himself from the importance both he and Breuer had accorded to dissociation, hypnosis, and the use of MPD as a paradigmatic condition for the understanding of mental structure and function. In their 1893 paper on the mechanism of hysterical phenomena, they wrote:

The longer we have been occupied with these phenomena the more we have become convinced that the splitting of consciousness which is so striking in the well-known classical cases under the form of "double consciousness" is present to a rudimentary degree in every hysteria, and that a tendency to such a dissociation, and with it the emergence of abnormal states of consciousness (which we will bring together under the term "hypnoid") is the basic phenomenon of this neurosis, (p. 12)

They further noted that a susceptibility to altered states, severe exogenous trauma, and

massive suppression was an etiological factor.

However, as Freud found his own voice and metapsychology, he left behind his interest in dissociation and dissociative phenomena. He came into conflict with Janet, the master scholar of dissociative conditions, and later Jung, whose own psychology bore striking parallels to dissociative models of mental function and psychopathology (Ellenberger, 1970; Noll, 1989; Satinover, 1993). Freud's later observations on MPD are perfunctory and dismissive. In "A Note on the Unconscious," Freud (1912/1958) acknowledged the reality of MPD but vehemently rejected the notion that there could be a "consciousness apart."

I venture to urge against this theory that it is a gratuitous assumption, based on the abuse of the word "consciousness." We have no right to extend the meaning of this word so far as to make it include a consciousness of which its owner is not aware.... The cases described as splitting of consciousness ... might better be denoted as shifting of conscious .. . oscillating between two different psychical complexes which become conscious and unconscious in alternation, (p. 263)

Berman (1981, p. 285) notes that Freud's defensive and polemical tone suggests that he was worried that cases of MPD might promote views contradictory to his own, a concern Freud voiced later when he stated that such cases "prove nothing against our point of view" (1915/1957, pp. 170-171). However, when not on the defensive, Freud made it clear that he was less than satisfied with his ability to explain dissociative phenomena. In "A Disturbance of Memory on the Acropolis," he notes: "Depersonalization leads us on to the extraordinary condition of 'double conscience,' which is more correctly described as 'split personality.' But all of this is so obscure and has been so little mastered scientifically that I must refrain from talking about it anymore to you" (1936, p. 245). He also made contributions of lasting importance to our understanding of MPD. In "The Ego and the Id," he noted that "the character of the ego is a precipitate of abandoned object cathexes and that it contains the history of those object choices" (1923, p. 29), an observation used to explain aspects of the formation of the personality system by Kluft, Braun, and Sachs (1984). He went on to make another vital observation about the ego's object-identifications:

If they obtain the upper hand and become too numerous, unduly powerful and incompatible with one another, a pathological outcome will not be far off. It may come to a disruption of the ego in consequence of the different identifications becoming cut off from one another by resistances; perhaps the secret of the cases of what is described as "multiple personality" is that the different identifications seize hold of consciousness in turn. (1923, pp. 30-31)

The psychoanalytic scholarship relevant to MPD is sparse and of uneven quality,

although it contains many significant insights and at times is remarkable for its anticipation of recent findings. For example, Fairbairn (1952, 1954) envisioned the structural model of the mind as only one of the ways the mind might differentiate and speculated that the processes of differentiation that create the id, ego, and superego might in other cases give rise to other independent formations, among which were separate personalities. This hypothesis has been explored recently by Fischer and Pipp (1984), who introduced the term "growing up strangely" to describe alternative pathways of development. The term has been applied to MPD in a thoughtful essay by Armstrong (1994).

Readers interested in the classic psychoanalytic attempts to grapple with MPD are referred to Berman's (1981) scholarly review. Notwithstanding these contributions, it would not be an exaggeration to state that for three generations psychoanalysis has dissociated MPD and the study of dissociation from its mainstream. This is not the place for a lengthy exploration of why this occurred, but two relevant observations may help the reader to place this intellectual dissociation in context. First, the emerging Freudian paradigms were inimical to the work of Janet and Jung, which was profoundly influenced by dissociation and related concepts. Kuhn's classic study *The Structure of Scientific Revolutions* (1970) notes that scientific progress is not a smooth process but rather a saltatory one characterized by the embracing of a series of new paradigms. A scientific revolution is "a noncumulative developmental episode in which an older paradigm is replaced in whole or in part by an incompatible new one" (p. 91). "After a revolution scientists are responding to a different world" (p. 111). The proponents of different paradigms "are looking at the world, and what they look at has not changed. But in some areas they see different things, and they see them in different relationships to one another. That is why a law that cannot even be demonstrated to one group of scientists may occasionally seem to be intuitively obvious to another" (p. 150). In sum, the emerging psychoanalytic paradigm had no place for dissociation and MPD. Unable to be reconciled with the psychoanalytic paradigm, these subjects were treated as unscientific and effectively were eliminated from the rank of topics deemed appropriate to psychoanalytic study.

The second factor is psychoanalysis's traditional uneasiness about the role of exogenous traumatic abuse in development and psychopathology. Such antecedents are reported by as many as 97% of MPD patients (Putnam, Guroff, Silberman, Barban, & Post, 1986). It has become fashionable to "bash" psychoanalysis and psychodynamic psychotherapy as blind to the horrendous impact of child abuse and its consequences. Although it is clear that such attacks are egregious overstatements with regard to the realities of daily practice, it is also quite clear that generations of psychoanalytic publications have given the subject short shrift. A psychoanalytic literature search will unearth more about incest fantasies than about incest; it is only in recent years that

more than a few psychoanalytic authors have begun to accord importance to abuse-related topics.

Therefore, MPD, a dissociative disorder usually emerging in the context of antecedent child abuse, has long been far from the central concerns of psychoanalytic scholarship. Among recent psychoanalytic and psychodynamic contributors of note are Armstrong (1994), Berman (1981), Counts (1990), Gabbard (1994), Grotstein (1981), Kluft (1987a, 1991a, 1992a, 1993a, 1994a), Lasky (1978), Loewenstein (1993), Loewenstein and Ross (1992), Marmer (1980, 1984, 1991), Smith (1989), Stolorow and Atwood (1982), Ulman and Brothers (1988), and Wilbur (1984). *Psychoanalytic Inquiry* (1992), *Psychoanalytic Dialogues* (1992), and the *Bulletin of the Menninger Clinic* (1993) have devoted special issues to the study of such patients and their treatment from a psychodynamic perspective. Gabbard's (1994) discussion of the psychodynamic psychotherapy of dissociative patients is an excellent overview.

The modem psychodynamic psychotherapy of MPD includes analysts' descriptions of encountering and treating such patients in unmodified analyses (Lasky, 1978; Marmer, 1980; Kluft, 1987a) and descriptions by psychodynamic psychotherapists of their efforts with such patients. Because very few MPD patients can tolerate a classical analysis, and many MPD patients are known to have had unsuccessful analyses or even to have remained undiagnosed while in analysis (Kluft, 1987a), the latter literature is of most relevance. Schreiber's *Sybil* (1973), a lay book that describes the treatment of a young woman by the late Cornelia B. Wilbur, MD, offers a vivid description of the problems encountered in working with MPD. Dr. Wilbur had to contend with amnesia, fugues, suicide attempts, self-injury, hallucinations and quasi-psychotic symptoms, evasions, massive resistances, regressions, somatoform symptoms, prolonged and refractory depression, periodic incapacity to function, reenactments of traumatic scenarios, traumatic nightmares, accounts of repugnant abuse—all in a patient without a unified and available observing ego whose "autonomous" ego functions were distributed across many alters. Owing to the often opaque amnestic barriers, work with one alter did not necessarily impact on the others until late in the treatment. This series of difficulties has been discussed in detail elsewhere (Kluft, 1984a).

Most of these difficulties are considered contraindications or relative contraindications for psychoanalysis or a purely expressive psychodynamic psychotherapy. Furthermore, trauma victims in general and MPD patients in particular do poorly with a relatively passive and technically neutral therapist (Kluft, 1994a). They may develop traumatic transferences early and perceive the therapist as abusive (Kluft, 1994a; Loewenstein, 1993). Unless he or she is "real" enough to be seen through (or in tandem with) such negative projections, there is strong potential for stalemate in or interruption of the therapy. Also, this group of patients is highly hypnotizable, and the dissociative

defenses indeed have the auto-hypnotic dimension first noted by Breuer (Breuer & Freud, 1893-95/1955). Not infrequently, their symptoms are refractory to interpretive defenses yet yield readily to hypnotherapeutic interventions or interventions derived from hypnotic techniques (Kluft, 1982). It is hard to be a traditional psychodynamic therapist with this highly traumatized population, although psychodynamic concepts are increasingly appreciated to be essential for their optimal treatment. Such considerations dictate that most MPD patients will receive a psychotherapy that is psychodynamically informed rather than conventionally psychodynamic in form and structure (Kluft, 1992a).

My current approach to the treatment of MPD patients has developed gradually over the last 25 years. I began working with them while still in training and made energetic efforts to apply the models of therapy I had been taught. I pored over texts and asked senior clinicians for advice. Very little was helpful. My early learning was retarded by the authoritatively delivered misinformation that *Sybil* (Schreiber, 1973) was a fraud, so I never considered calling Cornelia Wilbur for advice. Years later I discovered that I had deprived myself of a wonderful resource and mentor. I found that my basic psychodynamic approaches were adequate to initiate a therapeutic dialogue with most MPD patients. They were of some help to all, and of considerable help to those who had the most conventional ego strength and coconsciousness across alters.

In one instance, an analytic control case showed no signs of MPD that I recognized. Midway through her fifth year of analysis, however she rose from the couch and told me, "You can analyze *her,* but I'm leaving." I responded, "You are in analysis too. Please return to the couch and let us continue. Please say whatever goes through your mind, withholding nothing." To my utter astonishment, she complied, and we were able to complete an unmodified analysis. However, more often my psychodynamic approach was insufficient to deal with the clinical problems I encountered. Frequently I was unable to access personalities essential to the progress of the treatment, had to contend with patients leaving the session in alters ill-equipped to manage the remainder of their day (or even find their cars!), and was confronted with scared-child alters huddled in a corner, unwilling to speak or leave their refuge, even when the session was at an end. Furthermore, somatic memories and the physical discomforts associated with abuse experiences that had not yet been recalled or resolved often disrupted treatment and /or greatly inconvenienced the patient.

I became aware that all of these were problems with which I was familiar from my training in hypnosis, and I wondered whether I might supplement my psychodynamic therapy with hypnosis. Despite receiving discouragement from those I consulted, and even though many famous authorities in the world of hypnosis warned that I would iatrogenically worsen my patients' plights with such a misadventure, my determination

to find some way to help my patients compelled me to attempt such a synthesis.

Fortunately, I vaguely recalled the successful treatment of an MPD patient described by Ellenberger in his classic *The Discovery of the Unconscious* (1970). I found that Antoine Despine, a French general practitioner, had combined hypnosis with a number of other modalities in the treatment of a child with MPD in 1834. Therefore, in the absence of a contemporary mentor, I learned from Despine and was able to find part of the second edition of his original publication (Despine, 1840; see also Fine, 1988).

In this manner, I developed a style of working psychodynamically, with three major modifications. First, I used hypnosis to access alters and make them available in the therapy sessions. Second, I used hypnosis to facilitate coconsciousness across the alters so that whichever alter was "out" could report the comments from other alters that it heard inwardly about the subject under discussion. Elsewhere I have observed: "Paradoxically, the more of the mind one can access in this manner, the more alters one can persuade to simultaneously listen in on the psychotherapy, the more the therapy resembles a standard psychodynamic treatment" (Kluft, 1991a, p. 4). I used hypnosis to catalyze the strengthening of ego capacities and the availability of ego contents. Third, I used hypnosis to alleviate distressing symptoms and to put distressing materials aside between sessions to minimize the likelihood that the patient would be overwhelmed by them in the absence of the therapist. In this manner, I was able to convert most therapies from crisis-ridden efforts with frequent hospitalizations to more mundane and manageable enterprises. It is often stated that one MPD patient is enough for a practice —such patients are too time-consuming and difficult. With these modifications as a foundation, and others I used as needed, I was able to carry an average of approximately 40 MPD patients in my practice for a period of 12 years, after which I undertook some administrative responsibilities and cut back my hours of private practice proportionately. These techniques are described in detail elsewhere (Kluft, 1988a, 1989a, 1993b; see also Fine, 1991).

INCLUSION/EXCLUSION CRITERIA

The fourth edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* has renamed MPD dissociative identity disorder (DID) and promulgated revised diagnostic criteria (APA, 1994). I strongly disagree with the name change for two reasons. First, I think that "identity" is as problematic a concept as "personality," and I would prefer a change that offers a solution rather than a new set of problems. Second, the name change was in large part a political concession to those hostile to the MPD field. However, I concede that the name change may have the potential to move MPD more smoothly into the psychiatric mainstream because it puts much of the controversy that has surrounded MPD behind it.

The *DSM-IV* criteria are reasonable for clinical and research usage:

1. The presence of two or more distinct identities or personality states, each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self.

2. At least two of these identities or personality states recurrently take control of the person's behavior.

3. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

4. Not due to the direct effects of a substance (e.g., blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play. (APA, 1994, p. 487)

There is some difference of opinion among experts as to whether to make the diagnosis on the basis of history, without having encountered alter personalities on one or more occasions (Coons, 1984). One does not wish to be duped by a factitious disorder patient or some other form of "wannabe." However, the overtness of MPD fluctuates over time in 80% or more of MPD patients (Kluft, 1985, 1991b), and it is rather precious to withhold the diagnosis in an otherwise well-documented case that is currently rather covert. There is much to be said for being flexible and for using criteria more stringent than *DSM-IV* only for specialized research purposes.

Most MPD patients do not fulfill *DSM-IV* criteria at all times during their illness, and there are a great many patients who suffer dissociative disorders with the structure of MPD but never appear to fulfill diagnostic criteria (Kluft, 1985; Boon & Draijer, 1993). Nonetheless, these patients respond very well to the type of treatment used for full MPD. For this latter group, dissociative disorder not otherwise specified (DDNOS) includes a subclassification: "Clinical presentations similar to Dissociative Identity Disorder that fail to meet full criteria for this disorder. Examples include presentations in which: (a) there are not two or more distinct personality states, or (b) amnesia for important personal information does not occur" (APA, 1994, p. 490). It is unfortunate that section (a) is not further elaborated, because such cases include patients who have well-articulated alters that never emerge, whose alters are vaguely delineated, and whose alters are crisply delineated but not very elaborate (and often present in large number).

Diagnosis may be made on the basis of overt phenomena and/or characteristic symptom complexes spontaneously manifested (Kluft, 1991b), elicited in response to

questions about suggestive signs (Kluft, 1991a, 1991b), clarified by the use of a specialized mental status (Loewenstein, 1991a), brought out in a structured interview (Ross, 1989; Steinberg, 1993), or found with the exploratory use of hypnosis or drug-facilitated interviews (Kluft, 1991a, 1991b). The Dissociative Experiences Scale (Bernstein & Putnam, 1986; Carlson & Putnam, 1992; Carlson et al., 1993) is a useful 28-item screening measure; most overt MPD patients attain a score of 30 or more, and 99% of those scoring less are not likely to have MPD. Sophisticated psychological testing protocols (Armstrong, 1991; Armstrong & Loewenstein, 1990) now allow the discrimination of MPD patients from other clinical groups.

Of the two structured interviews, the Dissociative Disorders Interview Schedule (DDIS) (Ross, 1989), which consists of 236 yes or no questions, is easier and quicker to administer and score (45-75 minutes). However, the Structured Clinical Interview for the Diagnosis of DSM-IV Dissociative Disorders (SCID-D) (Steinberg, 1993) is a more complex and flexible instrument. Although it requires more time to administer and must be studied to be used well, the SCID-D yields incredibly rich data about the patient's dissociative experiences and subjective perspectives. The Dissociative Disorders Unit I supervise uses the DDIS on all admissions, but on the few occasions when I feel the need to use a structured instrument in my private practice, I use the SCID-D because it gives me a wealth of data about the patient's inner life that is immediately relevant to treatment, even though it was not designed to generate such information.

I have not found it useful to employ psychodynamic criteria in approaching the MPD diagnosis because traumatized patients in general may have strong reactions and apprehensions that the psychodynamic clinician may find difficult to appreciate as a trauma response rather than as an indicator of some other form of severe psychopathology. Also, this group of traumatized patients demonstrates phenomena characteristic of many diagnostic groups (Bliss, 1980; Kluft, 1991b), including neuroses, psychoses, and character disorders. Inferences may be drawn that the psychodynamics of those conditions are present.

Overgeneralizations may be drawn from early findings before the patient is completely understood. MPD is a layered psychopathology. Not uncommonly, each layer suggests another type of difficulty. This has been particularly troublesome with regard to borderline personality disorder and MPD (V.I.), which will be discussed in greater detail below. Furthermore, there may be extensive co-morbidity—the average MPD patient qualifies for two or more additional *DSM-III-R* or *DSM-IV* diagnoses (Kluft, 1991a, 1991b). It may be difficult to discern which dynamics are more prevalent. In addition, the languages of psychodynamic psychotherapy and the dissociative disorders field have yet to become compatible and mutually enriching. What is implied by a term

in one context can lead to unfortunate misapplication when applied in the other.

Early transference phenomena (or established transference paradigms in patients with prior therapy experiences) may prove quite deceptive. MPD patients have transference patterns that may mislead, perplex, or even frighten the clinician. These include: (1) traumatic transferences in which the clinician is perceived as an abuser; (2) flashback transferences in which the clinician is seen as reenacting a circumscribed role in a specific scenario; (3) quasi-positive submissive transferences in which the therapist is seen as an abuser who had to be told he or she was loved (almost always misunderstood until the rage emerges); (4) multiple transferences across alters in which the therapist has the uncanny feeling of being perceived several ways either simultaneously or in rapid succession; and (5) dissociative transferences in which the patient's hypnotic capacities lead to misperceptions of the therapist or abrupt intensifications of affect toward the therapist (Kluft, 1994a; Loewenstein, 1993). It is my experience that many clinicians misinterpret these as borderline or psychotic phenomena.

Armstrong (Armstrong, 1991, 1994; Armstrong & Loewenstein, has demonstrated that MPD patients are often thought to have very severe characterological pathology based on the chaos caused by the switching of the alters, when the actual compromise of ego integrity is far less extensive. Of the first 50 patients tested and thought to suffer both MPD and borderline personality disorder (BPD), only one appeared to be truly borderline. In my study of 30 patients who appeared to have both conditions (Kluft, 1991a), one-third stopped demonstrating BPD phenomena as soon as therapy settled down (a matter of months), one-third gradually lost their BPD phenomena as their MPD integrated, and one-third showed core borderline phenomena even after integration of their MPD. Horevitz and Braun (1984) noted that although 70% of their MPD cohort satisfied diagnostic criteria for BPD, the remainder did not, and that fulfilling BPD criteria was most correlated with overall dysfunction and distress.

The chaos of MPD may generate phenocopies of conditions with which the clinician is likely to be more familiar, and the assumption that those conditions' dynamics are present may be made erroneously. Although many attempts have been made to link MPD to specific developmental stages and phenomena, it is my experience that none of these formulations has demonstrated generalizability beyond the case under study. I often find myself questioning whether the formulations offered fit the data or have been imposed upon them by a clinician finding what he or she is looking for and disregarding alternative hypotheses (i.e., confirmatory bias).

Pragmatically, the treatment of a traumatized individual must begin with stabilization and the attainment of safety (Herman, 1992). Only then is extensive exploration

reasonable. The decision as to whether the patient will be able to profit from a psychodynamic psychotherapy often must be deferred until the initial interventions have improved the patient's function and diminished the chaos that often attends the MPD patient's entry into treatment. I well recall a patient whose first three years of treatment resembled a three-ring circus more than psychotherapy but who became an almost classic analytic patient for the remainder of the work.

DYNAMIC ISSUES IN MPD/DDNOS

Patients with MPD and related forms of DDNOS are a very diverse group in terms of their levels of function, Axis I co-morbidity, and Axis II findings (Fink, 1991; Kluft, 1991a). This is hardly surprising because dissociation is among the normal responses to exogenous trauma, even in nonpatient cohorts (Spiegel, 1993), and severe trauma can befall anyone at any age. MPD has been linked most frequently with the impact of untoward events from infancy through latency; it is unusual for it to be attributed to a first traumatization occurring after age eight. It may begin in children whose prior development was either smooth or troubled and whose maturation along lines of psychodynamic development has been either successful or stifled in one manner or another.

Marmer observes:

Trauma, conflict, and deficiency all play a contributing role in the genesis of MPD. The blend of each of these ingredients may account, in part, for the different levels of function from one patient to another, as well as among alters within a particular patient. When trauma alone, without much conflict or deficiency, is the causal factor for a patient, there is greater likelihood of higher function, greater chance of well-functioning internal self-helpers, and more health to work with in the integration process. (1991, pp. 678-679)

Elsewhere (Kluft, in press a) I have reviewed the major competing theories of etiology and models for understanding MPD. Here I will summarize the most widely taught theory of etiology, the four-factor theory (Kluft, 1984b, 1986a), but I will not explore the several hypothetical models that are currently being discussed in the literature.

The four-factor theory is generally accepted because of its flexibility and capacity to encompass most other credible models (e.g., Braun & Sachs, 1985; Stern, 1984) in a relatively simple, pragmatic, and therapy-relevant frame. It holds that the individual who develops MPD will have (1) the biological capacity to dissociate, which will be mobilized when (2) the nondissociative defenses are traumatically overwhelmed by unfortunate life experiences, and (3) will develop alters in a manner consistent with his

or her unique shaping influences and substrates. This type of adaptation will become relatively fixed and stable if there is (4) an inadequate provision of stimulus barriers to further overwhelming experiences and/or an absence of sufficiently restorative experiences from significant others. Data are available to confirm the relevance of each of these factors (Kluft, 1986a, in press a).

Factor 1 indicates the importance of a biological diathesis, largely coextensive with hypnotizability but representing dissociativity, a somewhat different construct. Both are very high in those who develop MPD. Factor 2 indicates the role of exogenous stressors. It has often been equated with child abuse because 97% of MPD patients report such histories (Putnam et al., 1986). However, it refers as well to stressors other than intentionally inflicted abuse, such as object loss; exposure to the death of a significant other; witnessing violence, accidental injuries, or dead bodies; illness with pain, debility, and/or near-death experiences; cultural dislocation; brainwashing by embattled parents in a custody battle; being treated as if one were different genders by different caretakers; or extensive family chaos. It is clear that certain factors may lower the threshold for dissociation: illness, fatigue, pain, observable congenital anomalies or difficulties, problems with separation-individuation, and severe narcissistic hurts.

Factor 3 refers to those developmental lines, mental structures, inner conflicts, and external influences that determine the form taken by the dissociative defenses and the alters. Their combination appears to be unique in each MPD patient. Of particular importance is the constellation of significant others, which often is recapitulated in the alter system (Kluft, Braun, & Sachs, 1984), either explicitly or implicitly.

Many have studied the formation of alters in terms of splitting (seeing MPD as related to borderline personality disorder) or dissociation (distinguishing the two conditions on this basis). There has been some conflict between those who espouse different perspectives. As of this writing, problems with imprecise definitions, decontextualized inferences, and adherence to different paradigms of understanding the mind (often to the point of disregarding clinical data) have prevented a fruitful synthesis. This has left the dissociation paradigm predominant within the dissociative disorders literature, and splitting more commonly referred to by psychoanalytic clinicians trying to build bridges from psychoanalysis to the dissociative disorders.

Clinicians and scientific investigators familiar with large numbers of MPD patients generally concur that MPD patients "divide" to preserve connectedness rather than to create distance (Kluft, 1984b, 1991b; Armstrong, quoted in Marmer, 1991). Armstrong summarizes her extensive experience in testing MPD and BPD patients:

The MPD/DD group exhibits many attributes that contradict predictions one would make from a borderline perspective, and which support Kluft's assertion that the

majority of these patients have a more complex and structured personality system. Rather than holding oversimplified attitudes, they are attuned to the subtleties of experience. Their generally introversive personality style reflects a capacity for internalization, for ideational organization of anxiety, for taking analytic distance from themselves and others in a complex and empathetic fashion. . . . Although at gross level certain vulnerabilities resemble borderline characteristics, the processes underlying these phenomena are quite distinct. Moreover, unexpected areas of strength and maturity also exist. These findings suggest that we are not viewing a developmental arrest, but rather are seeing the signs of what developmental psychologists call a "strange development" [Fischer & Pipp, 1984], i.e., an atypical developmental pathway created by unusual interactions with the world. (Armstrong, 1991, p. 544)

One of the major difficulties psychodynamic thinking has encountered in the study of MPD has been based on a fundamental disregard of the nature of the personalities and their relationship to consciousness, a problem Freud (1912/1958) grappled with when he peremptorily disregarded the possibility of a consciousness of which its owner was unaware. The alters may be mutually aware or unaware of one another, or Personality A may be aware of Personality B, which lacks awareness of A. Much as Bollas (1987) described the study of the structures postulated by Melanie Klein as the analysis of the "unthought known," I would like to imitate his felicity of expression and propose that in MPD the therapist faces the analysis of the "elsewhere thought known." Instead of a traditionally understood unitary ego and consciousness, the therapist contends with the patient's ongoing, simultaneous parallel processing of information and thought in several channels, each working with somewhat different operating principles, drawing upon different autobiographical recollections and using somewhat different cognitive processes. These enacted channels, or personalities, generate alternate views of reality based on the stances, information, and thinking patterns with which they are associated. Thereby, multiple personality disorder generates multiple reality disorder (Kluft, 1991a, 1991b), and living in alternate versions of reality in turn reinforces and appears to validate the structure of the multiple personalities.

The personalities develop "when an overwhelmed child who cannot flee or fight adverse circumstances takes flight inwardly, and creates an alternate self-structure and psychological reality within which and or by virtue of which emotional survival is facilitated. This involves the elaboration of alters, which allows the enactment of alternative approaches to trying circumstances" (Kluft, 1991b, p. 610). For example, a female abuse victim might form an alter that is amnestic for the abuse, or to whom all recollection of abuse would be delegated. In this manner, it would be possible to live in difficult circumstances without appearing to react to them or be troubled by them. Likewise, the formation of a male alter in a girl might not reflect a core gender identity problem but rather the strategy of wishing to be a boy in the belief that if she were a

boy, she would not be abused.

Factor 3 also includes cultural influences and the impact of the media and treatment. Here the therapist sees the influences of the patient's social situation and background. For example, Native American MPD patients frequently have alters based on animals that have unique meanings in their tribe or clan. Some patients are impacted by what they have learned from the media—an interesting example was a young boy who formed alters based on identification with the Teenage Mutant Ninja Turtles. In addition, the expectations of the therapist may influence manifestations of the condition.

The first three factors indicate how MPD may be created. Factor 4 speaks more to how it is solidified and maintained. Without protection from further mishap, the MPD adaptation may be reinforced and solidified. Without restorative experiences of solace and comfort, the MPD child has nothing to substitute for such inner consolation as he or she has achieved by creating the alters. This factor speaks to the issue of deficit as well. Barach (1991), Liotti (1992), and Gabbard have addressed the importance of the mother-child bond in this group and noted how its failure may contribute to the initiation or maintenance of MPD.

MPD patients are preoccupied with safety and relatedness. Since they usually have been hurt by those to whom they were forced to turn for care and comfort, they develop patterns of testing and seeking for reassurance that often prove exasperating to those who treat them. It is not unusual for them to be preoccupied with controlling the therapist. A particularly difficult trait is their tendency to provoke critical and/or rejecting responses from the therapist by exasperating and/or outrageous behaviors, and then to insist that the therapist's response is proof that he or she really does not care about them. When the therapist can access the personality system comprehensively, he or she usually can determine that this testing pattern is either due to some alters' efforts to sabotage the therapy (which they feel will eliminate them or expose them to long-shunned painful material) or is the expression of the patient's efforts to actively bring about what he or she fears—rejection. Another common rejection enactment occurs when the therapist is pursuing a theme that causes the patient to feel or fear criticism. A switch is made to a particularly vulnerable child alter. If the therapist pursues the inquiry or does not welcome the child alter, the patient then switches to an alter that angrily berates the therapist for his or her cruelty. Such maneuvers usually are best managed by gracefully greeting the child alter but firmly insisting that the previous conversation be continued. Allowing the therapy to be sidetracked in the ostensible interest of the needs of a child alter acts out in the countertransference what Ogden (1992) has called the tyrannizing transference. Also related to these themes are pressures from the patient to establish regressive dependency in the doctor-patient

dyad. In one case known to me, the therapist went so far as to adopt the MPD patient legally.

MPD patients also develop specific transferences that challenge the clinician. Among them are multiple transferences from several alters at once (Wilbur, 1984), which can prove affectively confusing and cognitively overwhelming. Traumatic transferences (Kluft, 1994a; Loewenstein, 1993; Spiegel, 1991) in which the therapist is repetitively seen as an abuser are also quite common and usually associated with repetitive cycles of projective identification in which the therapist must contain, and return in modified form, the most malevolent forms of the patient's identifications with abusive individuals (Gabbard, 1994). Some forms of traumatic transference have been called flashback (Loewenstein, 1993) or scenario-based (Kluft, 1994a) transferences: events more than object relations are experienced as being reenacted in the treatment. One also encounters submissive false-positive transferences in which the therapist is experienced as an abuser who must be told he or she is loved and whose virtues must be praised. These are often mistaken for conventional positive transferences, and the course of therapy can become derailed.

Dissociation as a defense involves the segregation of some subsets of information from other subsets of information in a relatively rule-bound manner (Spiegel, 1986). In this it often resembles the obsessive-compulsive defenses of reaction formation, intellectualization, rationalization, and isolation (of affect from ideas, ideas from ideas, and affects from affects). The therapist can talk to one alter about something without impacting the others, experience the patient failing to register accurately what the therapist has said, or witness a patient's immediate forgetting of what has been under discussion.

Related but different are a series of autohypnotic defenses that are not unique to MPD patients but are commonly encountered among them. Although autohypnotic defenses have been described in the analytic literature, it is unusual to encounter them in profusion except in patients with marked dissociative tendencies. Withdrawal into quasi-catatonic states, abrupt aphonia, redissociation of threatening material, abrupt amnesia for questions or interventions perceived as threatening, spontaneous age regression, and switching of personalities are quite common devices.

Furthermore, because the MPD patient encompasses several relatively autonomous vehicles for the expression of alternate conations, MPD patients may handle anxieties and fears of all sorts in terms of their subjectively-believed-in inner worlds, which can come to have a compelling reality. For example, some personalities punish others, battle with them, and deny them access to the therapy. Personality A may be in the process of telling the therapist something that Personality B wishes to keep from the

therapist. A may hear B's voice threatening A, or suddenly a hand may strike the face while A is experiencing the pain of the blow. On occasion, B may control A or render A mute. Or C, D, and E, who see themselves as allied with A, may "imprison" B somewhere within the inner landscape to which the patient accords reality. More confusing still, in some patients one personality (B) can impose its feelings or experiences on another (A) or create in another an illusion, delusion, or hallucination to which the other responds as if it were reality.

Because the dissociative defenses leave the patient without a sense of ownership of much of life's experience, defensive disavowals of all sorts are common. One consequence of this relates to the issue of responsibility. MPD patients are notorious for refusing to own and accept the consequences of their actions, usually because the alter that has done the behavior in question is different from the one being confronted. The latter protests its innocence with tearful earnestness, conveying that it is deeply wounded by the unjustness of the accusation that has been made. It is often useful to be especially on guard for one's own potential countertransference exasperation and sadism when confronted with such dynamics. The therapist must gently but firmly insist that responsibility belongs to the entire human being, and that all alters "are in it together" and are held jointly accountable.

Identification is a major substrate for personality formation and serves a number of functions in each particular case. It is not uncommon for the family and the major protagonists in abusive scenarios to be recapitulated in the system of personalities, as are idealized protectors and ego ideals (Kluft, Braun, & Sachs, 1984). Some of these identifications are unprocessed introjects of important object relations, and some are internalizations of important objects who have been lost or whose loss is feared. In one extreme case, an Old Order Amish woman with MPD was shunned by her extended family and congregation when she accused her brother of incest. Shunned by her entire community, she formed alters based on over 70 relatives, neighbors, and fellow congregants. Some alters are formed on the basis of identification with the aggressor, leading to the creation of internal persecutors. Although their initial defensive purpose was to deny the abject helplessness of the trauma victim, in the inner world of the alters these alters may repeatedly enact the role of abuser. Nor is it uncommon for alters to be based on persons who have been helpful or who, it is believed, could have been helpful. Also, alters identified with favored siblings, friends with nicer families, or fictional figures from literature or the media may be created in order to personify the wish to have escaped traumatization and to preserve the potential for growing up safely. The last type may prove a staunch resistance when the patient insists that they must be allowed to have actual childhoods of their own in which to grow up and attempts to get the therapist and others to enact this. My own stance is identical to that of Putnam (1989), who indicates that the proper persons to do this upbringing are the

other personalities who are so eager for it to occur.

Projective identification is not uncommon in MPD patients, but it often takes a form that provides valuable information about parts of the mind as yet unknown to the therapy. That is, often what is projected into the therapist is an aspect of mind associated with an alter as yet unfamiliar to most of the personality system or the therapist. This is especially common with very negative projections early in the treatment, before the alter system is well known. For example, in the treatment of an MPD patient who not only had been abused severely but had mistreated a younger sibling (but did not know the full details, which were very serious), the patient became convinced that I was a hurtful and mean person who probably hurt those entrusted to his care. Her efforts to push me into such a role were heroic and sustained. When I was able to explore, I found I was being perceived as the alter who had done the worst abuse. Once that alters existence became known to the alter system, these projections came to a halt.

A final note on the dynamics of the MPD patient regards the ubiquity of shame. The traumatized person often suffers exquisite shame (Nathanson, 1989). The typical MPD patient avoids openness and revelation because a recounting of his or her history would involve sharing incident after incident in which he or she experienced intolerable humiliation and mortification. Furthermore, most alters manifest one or more of the patterns of coping with shame that Nathanson (1992) has described as "shame scripts": responding to shame by attacking the self, attacking the other, avoidance, or withdrawal. An appreciation of the shame scripts and a willingness to engage the patient in discussing them often relieves what otherwise might become an impasse in the therapy.

TREATMENT GOALS

Several factors make it difficult to determine the overall goals early in the treatment. Often the patient is first diagnosed while in a state of incipient decompensation and appears healthier than he or she will appear after treatment has begun. A young lawyer with a glowing reputation was seen in consultation after she had been diagnosed with MPD and become unable to work. I learned that she had begun to have severe flashbacks of childhood abuse that distressed her and disrupted her professional life. When her MPD was diagnosed, she had already become incapacitated; shortly thereafter, she required hospitalization. It took years for her to restabilize. Conversely, the patient is often diagnosed when severely decompensated and showing little evidence of the hidden strengths that reside within. I have brought to integration several patients who, although they had spent years on the back wards of state hospitals misdiagnosed as refractory schizophrenics, went on to earn doctoral degrees and

practice in the healing professions.

Also, it is not unusual for the patient to begin treatment in a state of denial of the diagnosis, or with an unrealistic or derealized perception of MPD and what the treatment entails. The patient may crave nurture and/or symptomatic relief, often associated with an initial preference that the other alters be removed and/or that all traumatic material be banished from their minds. These wishes generally survive well into the treatment process, even though more appropriate goals may be verbalized. Although there are exceptions, it is common to find that the goals of both therapist and patient have been revised repeatedly over the course of the therapy.

In addition, the treatment of MPD often resembles a series of short-term therapies imbricated within the structure of a single long-term therapy. It is not unusual for some of those briefer therapies to have different goals and foci. For example, a period of work on a specific issue that requires a gentle uncovering emphasis may be followed by energetic directive and structured approaches to a particular symptom or traumatic scenario. This period may give way to a time of working to resolve conflicts among particular alters, which in turn may yield to working on the patient's adaptation in the here and now.

From the perspective of the therapist, the unification of the MPD patient, despite its drama and subjective significance to the patient, is only one aspect of the overall treatment and becomes an incidental consideration in many therapies.

The tasks of the therapy are the same as those of any reasonably intense change-oriented approach. However, these tasks are pursued in an individual who lacks a unified personality (and hence observing ego). The several personalities may have different perceptions, memories, problems, priorities, goals, and different degrees of involvement with and commitment to the treatment and one another. It usually becomes essential to replace dividedness with unity, at least of purpose and motivation, for any treatment to succeed. Work toward this goal and possible integration of all personalities distinguishes the treatment of MPD. (Kluft, 1984b, p. 11)

To summarize research reported elsewhere (Kluft, 1984b, 1986b, 1993c, 1994b), although there is considerable sympathy with attempting to help the MPD patient become more adaptive without integrating—and many patients refuse to work toward integration—integrated patients are more stable and more likely to make an adaptation they find gratifying. Patients who remain multiple are more likely to become dysfunctionally multiple under stress. In my series, most patients who opted for functional multiplicity returned for integration, while only 4% of the stably integrated patients chose to reactivate their MPD on a standing basis. All those who chose to restore their MPD were suffering severe physical illnesses and wished to escape their

life circumstances.

Dissociated patients were subject to repeated revictimization (Kluft, 1990), while integrated patients were less likely to suffer such incidents. This outcome for dissociated patients is due to the secondary loss associated with the ongoing use of defenses that do not allow the mind access to all its autobiographical memory, rendering the patient differentially vulnerable and unable to learn from experience. Also, dissociating individuals are less likely to be consistently appropriate in their parenting functions. Kluft (1987b) found that although 38% of MPD mothers were competent or excellent parents, 16% abused their children, and 46% were impaired in their parenting functions.

The goals set at the beginning of the treatment rarely emphasize either integration or the working-through of traumatic material, although these are two of the major foci of the treatment, because (1) safety, stabilization, and enhancing the patient's strengths take priority early in the therapy; (2) the patient is usually terrified at the thought of facing known and unknown past traumata; and (3) the alters often experience themselves as separate people and hear integration as a strategy to annihilate them rather than to include them in the reuniting of the mind.

The early stages of the psychotherapy prioritize safety, adaptation, and learning to work together. This goal has been articulated most completely by Fine (1991) and Kluft (1993b). The treatment of the traumatized individual is triphasic, an observation first made by Janet (1889) and studied in depth by Herman (1992). In brief, the first stage of treatment emphasizes establishing safety for the patient. This involves containing troublesome symptoms and behaviors, mastering adaptive strategies, contracting for safety, and learning to work with the therapist. In essence, the patient is stabilized and shown how further mastery of what he or she had experienced as out of control will be possible. The patient is strengthened and learns how to deal with the type of traumatic material likely to be encountered in the next phase. Such goals are often at odds with those of the first phase of an expressive psychodynamic psychotherapy, which is most likely to involve the loosening of troublesome superego injunctions against allowing material to emerge in preparation for the exploration of fantasy and transference material.

The goals of the second stage in the treatment of the traumatized patient involve the exploration and metabolism of the patient's overwhelming experiences. Fortified by the accomplishments of the first phase, the patient is helped to abreact what has occurred to him or her and to correct the damaged sense of self and the maladaptive patterns associated with these experiences. The therapist must attempt to titrate the process to prevent the patient's becoming destabilized. Many patients require the assistance of

many nonpsychodynamic techniques in order to manage this work (Kluft, 1982, 1988a, 1989a, 1993a, 1993b, 1993c).

The third phase involves integration—the integration of the self, the patient's interpersonal relationships, and the trajectory of the patient's life. Once most of the alters near and achieve integration, traditional psychodynamic psychotherapy is invaluable in helping the novice "single personality disorder" patient work through what has been learned in the other phases. Transference and its interpretation become less suffused with traumatic expectations and more the focus of contemplative inquiry. The therapist must encourage a patient who wants to believe the treatment has already reached its conclusion to do the working-through that will stabilize the gains of the treatment and to approach residual difficulties that have not yet been addressed and/or resolved. An elegant description of this type of treatment has been published by Fink (1992).

It is important to note that although the decision as to whether to do any part of the work is the patient's, the therapist who is informed about the consequences of particular choices may wish to indicate the potential pluses and minuses associated with various decisions and should try to do so when the patient is considering available options, but before the patient has taken a strong stance from which he or she will find it difficult to retreat.

THEORY OF CHANGE

In the course of a successful treatment, the dissociative defenses that separate the alters are understood to become more porous and to collapse. This intrapsychic change is both simultaneous with and subsequent to the alters' increasing empathy, cooperation, and identification with one another and to their coming to share one another's autobiographical memories. The alters come together in one or several pathways to integration.

The modem treatment of MPD has developed from the collaboration of psychoanalytically oriented clinicians with colleagues who were more eclectic and used hypnosis as a major therapeutic modality. The concepts of integration and fusion evolved side by side, overlapping but not identical. Integration involves the psychotherapeutic undoing of the dissociative defenses and structures. It speaks to the process of intrapsychic change. As such, it is understood to begin long before the alters begin to come together and to continue long after they have done so. Fusion refers to the coming together of the alters according to the patient's subjective experience and the clinician's phenomenologic observation. It is defined on the basis of three successive months of (1) continuous contemporary memory; (2) an absence of overt

behavioral signs of MPD; (3) a subjective sense of unity; (4) an absence of alters on re-exploration; (5) a modification of the transference phenomena consistent with the bringing together of the personalities; and (6) clinical evidence that the unified patient's self-representation includes acknowledgment of attitudes and awarenesses that previously were segregated in separate personalities (Kluft, 1982,1993c).

The actual process of the alters' coming together is little understood, and extant descriptions are more metaphoric than explanatory. Six pathways have been described (Kluft, 1993c). In the first, gradual merging, the involved alters report that they are (and are reported by the others to be) gradually fading and becoming less distinct, or slowly blending into or joining others. This pathway is consistent with the erosion of dissociative boundaries across and between alters. They become more aware of one another, feel one another's feelings more and more, share more, and begin to experience identity diffusion and confusion; some simply retain their identities as they fade.

In the second pathway, alters blend in connection with rituals facilitated by hypnosis that involve both an imagery of joining and suggestions toward unifying. It is important for the psychodynamic practitioner to appreciate that such techniques are never a substitute for the hard work of psychotherapy; they merely help alters over a dissociative hurdle that has not been surmounted pari passu during the treatment. They invariably fail or lead to only transient fusions if the alters involved have left important therapeutic work undone (Kluft, 1986b).

A third pathway occurs most frequently when there are many alters that encapsulate discrete traumatic memories. When their abreaction of their experiences reaches completion, they are found to have integrated spontaneously. This rarely occurs with alters that are elaborate or have substantial roles in daily life.

A fourth pathway occurs when alters say they have decided it is time to go, that they are not needed any longer or their functions are now being managed by other alters, and they are heard of no more. While this occurs, it is often a diversion so that the alters can remain secretly and return at will, or such a statement is offered in connection with the involved alters wish to evade further painful work.

A fifth pathway could be designated a brokered departure. An alters decision to cease being separate is negotiated among the alters in order to achieve a particular objective. For example, in a system constructed to defend a child alter against pain, a decision was made for strong protector alters to blend with that child alter before it would have had to work on painful material in order to spare it the full force of the pain.

The sixth pathway involves the consequences of calling alters out to temporarily

integrate in the service of facilitating the attainment of specific treatment objectives. Usually after several temporary integrations, the involved alters find it impossible to restore the status quo and request help (often hypnotic) in effecting an integration. Again, all of the above descriptions are metaphoric.

The dissociative diathesis is understood to be constitutional, and its use is well practiced. It cannot be altered per se, but the likelihood of its remaining a primary mechanism of defense and adaptation can be diminished by the elimination of the delivery systems of the most extreme dissociative defenses, the personalities, and by the patient's developing more adaptive defenses and coping strategies. Follow-up studies demonstrate that without the alternate personalities, MPD patients can give up the use of dissociative defenses, but that when the personalities are allowed to persist in what is thought to be a healthier adaptation (a so-called resolution), under stress they often recommence their dysfunctional autonomies (Kluft, 1984b, 1986b, 1993c).

Therefore, the models of therapy that have proven most successful have been consistent with the triphasic model noted above. They have provided the patient with alternatives to dysfunctional dissociative defenses long before focusing on traumatic materials, and they have attempted to bring about a degree of coconsciousness early on, familiarizing the patient, often more implicitly than explicitly, with the idea of functioning with a deep shared pool of data and resilient ego strengths without "leaving the scene." Elsewhere (Kluft, 1992a) I have tried to explain the psychodynamic and ego psychological underpinnings of such approaches. They attempt to create the facsimile of an observing ego that can withstand the pressure to switch by having the alters that are likely to be brought out under such circumstances already co-present and coconscious with the ostensible host. That works in the service of moving the preconscious MPD ego functioning, in systems with parallel distributed processing and unshared thinking, toward coconscious functioning in which the motivations for switching are partially preempted and the subjective experience across all alters of functioning with more data, resilience, and expertise is a powerful assault on the value the patient accords to dissociative coping strategies. Also, as alters share more and more, they become more and more alike and conflicts and narcissistic investments are mollified.

Related to this thrust toward more integrated ego function is the need to process traumatic memories and detoxify them so that they can be accepted without destabilization and/or redissociation; so that the distorted understanding of self and others associated with the traumatic material can be remediated; and so that the patient can appreciate the continuity of his or her personal history and use this in the construction of a cohesive self-image, self-representation, and identity.

It is a cruel irony for those who earnestly search for "the truth" about what has happened to such patients that the vicissitudes of memory rarely allow the desired degree of certainty to be attained. As of this writing, there is no way to distinguish between true and false memories. Nonetheless, recovery from MPD involves the patient's development of a sense of his or her autobiographical self and memory. The therapist cannot always make it possible for the patient to know the full truth, but the therapist can conduct the therapy in a manner that makes it possible for the patient to come to his or her own decisions about what seems to be his or her personal truth. I have addressed these thorny issues elsewhere (Kluft, in press c).

MPD patients rarely enter treatment with conscious awareness of the major pathogenic events of their lives. In my experience, notwithstanding the difficulties that surround the understanding of recovered memories of childhood traumata, the reconstruction of the autobiographical past is essential to the development of a unified self, which is crucial to the healing of the MPD patient. Associated with the recovery of this material is the need to abreact it, or at least to allow the ventilation of the feelings associated with what is recalled to have occurred.

In my experience, circumspect abreaction associated with diligent efforts to process and integrate the material and study its implications has proven essential to the stable recovery of MPD patients, despite the fact that simply reliving the traumatic past without additional precautions and interventions can be disruptive, regressive, and counter-therapeutic. I know of no compelling evidence that affect associated with traumatic material is in some way strangulated and must be released in order for the patient to progress beyond the hurts of the past, but my clinical experience is that MPD patients behave as if this is so and do best if approached with this possibility in mind. Whether some sequestered strong emotion must be liberated or the abreaction of traumata is a healing ritual syntonic with my patients' culture and expectations is a question beyond my capacity to answer. Thankfully, however, clinical tools have been developed that allow the patient to be healed nonetheless. Therefore, I will discuss abreaction in the context of clinical experience with MPD, leaving aside unresolved theoretical issues.

I conceptualize abreaction as a procedure that unburdens the patient's ego functions and rehabilitates shattered self-esteem in that it replaces the sense of passive victimization with one of mastery and self-efficacy, allows the patient to choose to participate in counterphobic and then well-disciplined mastery rather than live in constant fear of the return of the dissociated material, and convinces the patient that he or she can achieve skill at self-regulation. To use Nathanson's (1992) concepts, noted briefly above, it allows the patient to move from the paralyzing mortification of shame (and the enactment of dysfunctional shame scripts) to the active self-respect of hard-won pride.

What once terrorized the patient and held him or her in thrall by threatening to reiterate the traumatic past in the present is detoxified and vanquished. It is impressive to complete the abreaction of the traumata associated with a particular alter and find it dramatically changed by the intervention. The first time this is achieved for any alter, and the other alters observe its relief and improved function and self-esteem, it is not uncommon for the therapeutic alliance and the patient's overall improvement to be enhanced substantially.

To summarize the above observations, it has been my experience that the MPD patient recovers when, strengthened with new coping and defensive assets and made comfortable enough to reveal what overwhelming pains and humiliations he or she has endured, the alters can risk moving beyond the massive dissociative defenses, pool their assets for certain tasks in the treatment, and dare to face and master what previously was intolerable. With the secrets revealed and the shame replaced with self-efficacy and pride, the raison d'être for the alters becomes obsolete. Their blending ends the MPD, but not the need for treatment.

Notwithstanding the specific MPD-related observations above, it is essential to bear in mind that the MPD patient, once integrated, not only needs to complete the working-through of all that has been discovered and shared across the alters, he or she needs to deal with any residual single personality disorder issues. It is a rare patient who does not require additional years of treatment to complete the working-through process and to deal with concomitant problems and issues.

TECHNIQUES

No one paradigm of treatment is sufficiently comprehensive to address the full spectrum of clinical interventions useful in work with MPD. Therefore, although the treatment should be psychodynamically informed, the unique features of each individual case will dictate how closely a given therapy resembles traditional psychodynamic psychotherapy in technique. A high-functioning MPD patient may be able to share freely across coconscious alters and utilize psychodynamic psychotherapy with minimal modification. A disorganized and decompensated MPD patient may require an extensively structured treatment that rapidly contains any difficult subject matter or potentially destabilizing effect. Patients with extensive co-morbidity may present problems that must receive attention before addressing the MPD—for example, a severe affective disorder or an active addiction.

In treating MPD, the therapist takes a warm, active stance and shows a range of affective responses. Traumatized populations have difficulty with a passive, neutral, and bland therapist. Already feeling flawed and unlovable, they experience such a

therapist as confirming their worst fears about their acceptability by others. Furthermore, into the void left by the therapist's relative anonymity may flow a premature rush of negative transferences, which the passive therapist may perceive as proof of a borderline character structure. This creates many complications early in treatment, when solidifying the therapeutic alliance and avoiding a premature approach to unsettling materials is essential. Also, if the patient becomes drawn into a flashback and misperceives it as contemporary reality, the therapist who is not seen as a distinct individual may have more difficulty negotiating the reorientation of the patient than the therapist who has become a three-dimensional individual. Finally, it is good countertransference "insurance." It is difficult to avoid countertransference gaffes with MPD. However, countertransference insurance is not in the service of covering up the errors of the therapist. When errors occur in a therapy in which the therapist has attempted to be fairly anonymous and bland, they are jarring and may disrupt treatment. Conversely, in a treatment in which the patient has come to expect a more involved and affectively diverse therapist, the deviation from baseline at such moments is less likely to scuttle the therapeutic enterprise. To illustrate, I once undertook to treat a young woman whose previous therapist had made a fetish of strict neutrality and bland friendliness. However, when finally provoked by the patient's often outrageous behavior, she lost her composure and shouted at the patient, waving a clenched fist. The therapy, then in its seventh year, could not be salvaged. Appreciating the difficulty of working with this patient, from the first I allowed myself a considerable range of affective expression. When I myself became caught up in the craziness this patient could generate and expressed my anger, the patient's response was only, "Gee, you are even more grouchy than usual today." Therapy continued uneventfully, preserving the patient's considerable investment in our work together.

Another unusual technical feature is abstaining from making interpretations of what we might call the patient's drives. Trauma victims almost inevitably experience such interpretations as indictments, as proofs that they deserved the misfortune that befell them. A colleague covering a self-loathing MPD patient for me during my vacation correctly appreciated that she was very attracted to him. He interpreted her sexual feelings for him, and she decompensated, becoming highly suicidal. I found that the patient had understood his observation to mean that she had been harboring sexual urges toward the men who had exploited her, and that therefore the exploitation was her responsibility.

Another fairly unique technical issue is that any observations and interpretations should reflect the therapist's awareness of the double bookkeeping of the MPD patient: the therapist is simultaneously addressing the total human being and the several personalities. For example, I might say, "You seem to be conflicted about whether to share what you remembered with me. Perhaps that is why when Chrissie started to

speak she was replaced by Christa, who immediately assured me that Chrissie was lying and that whatever she said could be disregarded." The personalities that express the conflict should be addressed as well as the dynamics.

This type of intervention promotes the push toward coconsciousness and unity while reducing the tendency of alters to act out if they are not acknowledged. Their narcissistic issues are addressed by their receiving explicit attention, yet every time alters listen in or respond to such a comment, they are implicitly acknowledging their participation in a single person who experiences himself or herself as divided rather than as a series of autonomous people.

The above leads us to yet another set of techniques and approaches. To promote the generalization of gains across alters and minimize having to engage each alter in a treatment of its own, it is useful to make regular outreach efforts to alters that are as yet unknown, inaccessible, or hostile to the treatment process. This process involves issuing serial invitations to the alters to enter the therapy and to share their views on topics under discussion. *Absint* such gestures, it is not uncommon for alters that are not involved in the treatment to oppose it on the grounds that the therapist does not care about them. Although this observation may sound ridiculous to those inexperienced with MPD patients, experience has shown it to be a frequent problem. A relevant consideration is that parts involved in suicidal and para-suicidal behaviors often remain at a distance from the therapy because it opposes their agendas. As a result, such behaviors may occur without warning. Conversely, if such alters are involved rapidly, it may be possible to develop safety contracts and preclude such events. A facility in reaching and engaging such alters early in treatment is characteristic of the work of the most successful MPD therapists.

Useful techniques include "talking over" the alter ostensibly in control and addressing the others, using "you all" as a way of acknowledging them, and asking other alters who have something to say about the topic under discussion to make their comments inwardly so that they are heard by the alter "in control" as inner voices and can be repeated to the therapist. Often alters that decline to talk will write in a journal or draw and allow their drawing to be brought in. Not infrequently, they will emerge spontaneously when the therapist remarks on their contributions.

Many therapists have a great aversion to addressing alters directly, and many MPD patients are eager to deny their condition. Under such circumstances, it is sometimes possible to work with mutually acceptable circumlocutions, but it must be emphasized that it is not unusual for this approach to lead to a stalemate that goes unrecognized because therapist and patient alike are colluding to avoid a main thrust of the therapy, the MPD. Therapists who proceed in this manner might express themselves: "Do you

suppose that the part of yourself that holds your angry feelings is pressing to express itself because you find it so difficult to own these emotions?"

Work with MPD often confronts the therapist with such a bewildering and overwhelming deluge of material that it is difficult to decide what to prioritize and address. Although generalizations are difficult, I have found it useful to select for intervention those materials, dynamics, alters, or symptoms that pose the most immediate threat to adaptation and coping if the patient's stability is an issue, but otherwise to prioritize by keeping on track with the work on a particular alter or issue until closure has been reached. Otherwise, it is possible that more and more alters and issues will be brought into the treatment without being contained, and the patient may become overwhelmed.

The therapy must prioritize the maintenance of the therapeutic alliance and the stability of the patient. This often leads to rather aggressive and focused work on potentially disruptive symptoms and a treatment that often gives the appearance of a series of short-term psychotherapies imbricated within the matrix of a superordinate long-term psychotherapy. Frequent target symptoms for such approaches are intrusive quasi-psychotic symptoms such as disruptive inner voices, passive influence phenomena, somatic memories, acute fugues, and the disruptive actions of particular alters (Kluft, 1984a, 1987c). Although hypnosis may be necessary to explore them, in many patients they may be accessed by inquiries that draw on what coconsciousness is available or that indirectly or implicitly call upon the patient's own autohypnotic talents.

For example, a patient with an acute headache may be asked to allow whatever is behind the headache—be it an alter trying to emerge, a memory, a conflict, a strong affect—to emerge or speak inwardly so that its message may be conveyed by the alter presently in control. Often it is then possible to resolve the matter, or to make a bargain to deal with the emerging issues at a later date. One patient with a severe migraine attack refractory to standard measures and narcotics was asked, "Who is behind the headache?" Another alter emerged and protested that its concerns were being neglected by the others and by the therapist. A deal was struck to allow that alter the majority of the next session, and the migraine ceased.

The abreaction of traumatic materials plays a major role in most MPD treatments. The emergence of traumatic material, usually triggered by serendipitous events or the process of therapy, can be very painful and may disrupt the patient's ability to function for protracted periods of time. If the material exposes the patient to intolerable realizations, abrupt suicidal and para-suicidal behaviors may occur. The MPD patient often does not have the resilience to tolerate strong abreaction without considerable support and containment.

Therefore, for most MPD patients it becomes highly desirable to control occurrence of abreactions rather than allow them to take place naturalistically in the course of the therapeutic process. Practicing such containment often is difficult for a psychodynamic therapist because it is so contrary to the psychoanalytic paradigm. However, a few experiences of being unable to terminate sessions because an MPD patient has become so disorganized that hours are necessary to achieve restabilization will prompt reflection. Having to hospitalize an MPD patient who has become regressed and disorganized, "stuck" in a terrified child alter, or acutely suicidal owing to the impact of a long-dissociated trauma will also cause any therapist to reconsider his or her stance.

Pragmatism and concern for patients' safety usually dictate that the therapist try to prevent the MPD patient from moving toward abreaction late in the session and try to help the patient initiate abreactions early in a session designated for that purpose. If the patient is helped to do the abreactive work in a contained manner, it is likely that the patient will gradually become convinced that the trauma of the past can be put to rest without contemporary retraumatization. In the MPD field, many clinicians take Kluft's rule of thirds (Kluft, 1991a, 1993a) quite literally: If you cannot get into the material that you planned to abreact in the first third of the session, so that you have the remainder of the first third and the second third to do the abreaction and the third third to process the material and restabilize the patient, do not begin the abreactive work. The adverse impact of the patient leaving the session destabilized is unacceptable and leads to another of the author's clinical rules: The slower you go, the faster you get there. All too often, the treatment of MPD must focus on cleaning up the aftermath of premature or uncontained work with traumatic material. Not only is such a focus unfortunate in and of itself, but it can cause the patient to be too afraid to continue dealing with the pain of the past for fear of retraumatization.

This experience has led to an approach to abreaction that focuses more on mastery and understanding than on the mere reliving of trauma and the release of associated affect. The techniques applied are most often associated with hypnosis; although their detailed exposition is beyond the scope of this chapter, a summary will be offered. (For a detailed exposition, see Fine, 1991; Kluft, 1988a, 1989a, in press b). In traditional psychodynamic psychotherapy, abreaction occurs in the process of the treatment without planning; conversely, in traditional hypnotherapy, the patient is helped to re-experiencing the traumatic material until its impact is exhausted. My techniques of fractionated abreaction (Kluft, 1988a, 1989a) were designed for work with MPD. In these approaches, the patient is encouraged to approach the material bit by bit; hypnosis is used to titrate the percentage of the affect that is felt, the portion of the trauma to be dealt with at a given session, the number of involved alters that will participate, and so on. The patient is not allowed to proceed until the affect is exhausted

because the patient is likely to become overwhelmed. Instead, the patient has a series of experiences in which the material is dealt with piecemeal until most of its pain is drained; the patient can then deal with the rest. After each experience of pain, the patient is restabilized and comes to expect that trauma can be mastered without decompensation. Hypnotic techniques are very useful here.

One MPD patient, unable to abreact without decompensation in a prior therapy, was allowed to have only 30 seconds of Re-experiencing a particular trauma in a single alter before being brought back to the present. In this manner, a time line of the trauma was established and the alters involved were identified. Then one alter at a time was brought through at only 10% of the pain. When each alter had gone through the sequence at pain increments up to 100%, it was possible to go through the whole event, to the relief of all involved alters. The material was then shared with the other alters, some of whom had to abreact it also.

Hypnosis can play a major role in containment during the treatment of MPD. Although hypnosis is thought by many to be most useful in retrieving repressed memories, recall that the treatment of MPD is the psychotherapy of the "elsewhere thought known," so that most material is retrieved simply by accessing the involved alters. The use of hypnosis for memory retrieval per se has a role in this work, but owing to the problems associated with the use of hypnosis in this context (the risk of confabulation and pseudomemory), it is less useful in gathering historical information than might be imagined. When hypnosis is used in this way, the patient should be informed of the possibility that what is retrieved, although it may be quite useful in therapy, may be historically inaccurate (see Kluft, in press c).

Hypnosis can play a major role in providing containment and support until the patient's increasing integration brings more strength. Often it can be used to bring order to a chaotic MPD patient's life and treatment. Here I will illustrate its usefulness, referring the reader elsewhere for the details of relevant techniques (Kluft, 1982, 1988a, 1989a, 1992a, 1992b). Hypnosis can be used to *access alters.* If the therapist is told that Alter A is suicidal, it is useful to be able to intervene with A. Hypnosis can be used to *substitute alters.* Not uncommonly, a major alter is on the brink of collapse, with potential adverse consequences. If the therapist can call out another alter to take over until the former alter is refreshed, the therapist can substitute an experience of mastery for one of incipient decompensation.

Closely related is *reconfiguration:* the therapist requests changes in the way the alter system is functioning in order to further the goals of the treatment. For example, if one alter is deeply distressed and its plaintive utterances are paralyzing the therapy, another alter can be assigned to be its companion and support. Also, if several alters are

impinging on the one ostensibly in control, causing many quasi-psychotic symptoms, they can be encouraged to move far enough back in the mind so that they will not impair function.

Ideomotor questioning, the use of (usually finger) signals to answer inquiries, is profoundly useful in keeping in touch with the alters that are not playing a role in the ongoing therapy and in requesting answers in areas in which the patient fears to speak. There are many sophisticated applications, such as rendering the patient's signal hand anesthetic to all other alters so that the information's accessibility can be rationed. For example, for most patients I use the established signals to make weekly inquiry as to whether there is anything brewing that I need to know about and of which the alter currently "out" is not aware. For example, "If there is any part of the mind struggling with urges to kill itself or hurt the body, let the finger rise at the count of three."

It is possible to create the hypnotic image of a safe place in order to *provide sanctuary* for beleaguered and terrified alters. It is easier to create a safe place for child alters than to struggle for months with their incessant requests for cuddling, play, and nurture or their inconsolable terror. Failure to address alters' requests for the therapist to address the needs of child alters can paralyze a therapy. By the same token, becoming overly involved with these needs will complicate treatment.

When strong affect threatens to overwhelm the patient, it is often possible to *bypass affect* by using hypnotic imagery to place it in a vault that will not open until the next session, or to use *slow leak techniques* to suggest that the affect will come through only at a rate and in a manner that will be safe. Allied with this are *techniques to curtail abreactions,* exemplified by creating the expectation that the abreaction, having gone on for the planned duration, will come to an end at the count of 10, by which time "all that needs to come out for today" will have done so. Also useful for abreactive work is *time sense alteration,* which allows the patient to experience events more slowly or more rapidly than clock time. Such alteration can be a real mercy when, for example, the therapist can either help a patient to have the subjective experience of an event completely relived in a lesser amount of time—allowing the processing of the event to be completed in a session of conventional length—or make more time for the processing of the traumatic event. The therapist can also intensify the affect with suggestion to allow *facilitation of the abreaction. Distancing maneuvers* are routinely used by many therapists (e.g., Putnam, 1989) who encourage the patient to review traumata as seen on a screen rather than being fully relived. *Fractionated abreaction* techniques have been noted above; one of the most interesting is to create for patients the image and subjective conviction that they can control the percentage of pain they feel with a mental rheostat. It is a wonderful experience for a patient who experiences a spontaneous flashback or abreaction between sessions to find that he or she can turn off

its disturbing qualities instead of becoming disrupted.

Hypnosis, as noted above, is wonderfully suited to the *exploration and resolution of the acute symptoms* that so often punctuate the treatment of MPD patients. Also, as discussed elsewhere here, it is very useful for *facilitating integrations*.

Other techniques quite useful in working with MPD are journaling and ancillary creative arts therapies. Journals often allow expression by alters that fear or refuse to enter the therapy until they can participate in a more conventional way. Also, many alters prevented by others from emerging in therapy may be able to express themselves freely. For example, many patients fear that their more hostile and/or seductive alters will ruin the therapist's opinion of them or destroy the therapy; for them, the journal may be their way to be heard. I advise the patient to write no more than 20-30 minutes per day and to bring in the uncensored material. More than that is unwieldy and can get out of hand. The censorship that will be exerted despite the therapist's instructions is often an excellent guide to the resistances that will be encountered.

Group therapies are often unhelpful unless they are structured dissociative disorder groups run by therapists who know MPD well. Support groups are cherished by these patients but are almost uniformly counter-therapeutic. While the patients enjoy feeling less alone with their conditions and feel well understood and validated, the problems of contamination, contagion, and being decompensated ("triggered") by others' issues and the complications of the interpersonal relationships engendered in these groups have led me to refuse to treat MPD patients who insist on participating in them.

MPD patients usually benefit tremendously from art therapy and movement therapy groups with similar patients. They often are able to express issues in the nonverbal therapies long before they can put them into words. Unfortunately, few of these groups are available for outpatients.

Medications are not effective for MPD per se but may be very beneficial in addressing co-morbid affective disorders and post-traumatic anxiety symptoms. The interested reader may wish to consult an authoritative review by Loewenstein (1991b).

All of the techniques noted above are useful at most phases of the therapy, with some obvious exceptions. In all but the simplest cases, the alter system is layered and becomes manifest bit by bit (Kluft, 1984b). For example, as the therapist is moving to integrate some alters, others are being readied for such work and others have just been met or remain unknown. Therefore, in many therapies aspects of several phases of treatment are in process simultaneously.

In general, the therapist would not be likely to use hypnosis to effect an integration

before work on traumatic material had occurred, nor would the therapist use abreactive techniques prior to the establishment of safety and containment. However, some exceptions occur: when very complex cases are encountered and some integration of alters without traumatic memories can be done at an early phase in order to enhance ego cohesion, or when the patient enters treatment overwhelmed by traumatic flashbacks that elude containment and some preliminary abreactive work is necessary to stabilize the patient.

It is difficult to discuss the length of treatment for MPD in an era that prizes rapidity of results and praises the limited utilization of available resources. MPD patients are a very heterogeneous group. Some can be treated very effectively in two or three years of twice-weekly psychotherapy, or even less. However, many MPD patients have been traumatized so badly that they must proceed at a pace that may feel intolerably slow for patient and therapist alike, and they are so fragile that very intense treatment of long duration is necessary to sustain them and move them forward. It is often useful to begin with a reflection that a single major physical and/or sexual assault may have such devastating effects that years of treatment may prove necessary to restore the victim to health. The average MPD patient reports abuse over a 10-year period (Schultz, Braun, & Kluft, 1989). If one assumes rather continuous abuse at a rate of twice a week over that period, it is not unthinkable that the patient may have experienced over 1,000 serious assaults from which to recover. Perhaps this figure will offer a useful perspective.

In some respects, the concerns raised by MPD patients most resemble those a therapist must take into account in working with patients who have been sexually exploited by prior therapists. Trust and safety concerns require that the treatment not outstrip the patient's tolerance. Many therapists have adopted my clinical adage, "The slower you go, the faster you get there." Often slower is not only better, it is the only safe option. Pressing the pace of the treatment often leads to crises and complications that prolong the treatment considerably.

The termination of MPD patients is little-studied, except by the handful of therapists who have concluded the treatment of more than a few such patients. On the basis of having integrated over 150 MPD patients during 24 years of clinical practice, I offer the following advice.

For patients who value the psychoanalytic ideal and have very good ego strength, a standard termination phase may be in order. For those without such concerns, and for those with strong attachment and separation issues, I have found it most useful to taper the frequency of sessions gradually until a transition is made to what I call follow-up status. By this I mean sessions at less than monthly intervals but of full-session length.

After a year of sessions every two months, I might consider a year of sessions every three or four months. In this manner, I allow a tapering off to sessions every year or two years. It has been my experience that I need not push for a termination; most of my patients seize the right time for them to insist upon it or claim that it is useful for them to touch base periodically. There are three added benefits of tapering:

1. Coming in and reporting residual difficulties is perceived as less of a narcissistic blow than it is to patients who have convinced themselves that therapy is finally over and that any further need for help is a mortifying defeat.

2. Being able to return and discuss successes in normal life usually is stabilizing and enhancing to the patient's self-esteem.

3. It provides reinforcement for positive identifications with the therapist and the skills acquired in the course of the therapy.

CASE EXAMPLE

Christa, a 32-year-old psychiatrist, sought treatment for social inhibitions, difficulties in her career, anxiety attacks, and numerous phobias, obsessions, and compulsions. She had interviewed and begun with eight other psychiatrists over the previous 10 months, and her explanations of why she left each of my predecessors could be summarized as a vague but increasingly compelling sense that there was something not quite right or something uncomfortable in each situation.

Christa was an attractive mid-westerner of Scandinavian-German ancestry. An only child, she was brought up in an atmosphere of religious fervor by her parents, stalwart members of an ultraconservative church. She described her life as circumscribed. She had a salaried position and hoped to do research and contribute to the literature. However, much of her free time was involved in elaborate cleaning and washing rituals. She was almost always late to work because she changed clothes several times before she could leave the house, and she almost always had to return to make sure that electrical appliances had not been left on. She tried to read and plan her research in the evenings, but she often became agitated when she tried to study and almost invariably fell asleep by 9:00 P.M. Although Christa was well liked and respected, she always feared being fired because she never could bring herself to take full histories from her patients—she found it too upsetting. She was unable to remain in a room with a man or men without severe discomfort unless other women were present. She chose clothing that did not reveal her figure. On several occasions, she had made implausible excuses and dashed out of the offices of male superiors. Her social life was restricted to attending bland movies and plays, concerts, and professional lectures with older female

colleagues, to whom she related in a dependent and childlike manner. At times she became acutely anxious without any apparent precipitant. She was afraid of tools such as screwdrivers and wrenches and also feared fish. She would not go to a restaurant that had a fish tank or live lobsters on display.

Because of her high ego strength and psychological-mindedness, her many symptoms and characterologic concerns, and her stated preference, we decided to proceed with psychoanalysis. However, once on the couch, Christa became virtually mute. Weeks went by in which only a handful of words were spoken. Although Christa spoke of me in a quite positive and respectful manner and assured me she was confident that I had her best interests at heart, she responded to my tentative interpretations of her resistance and apprehensions about making revelations or losing control as if they were scathing criticisms that mortified her. Often she replied tearfully that she was doing the best she could; at other times she insisted she was working hard and I could not appreciate this. On still other occasions she wondered why I was not as polite as people in her hometown church, who would never embarrass one another.

I noticed that often she responded to my interventions as if I had not spoken, or that she seemed to be addressing her remarks to a question I had asked some time before my last observations. At times her voice became small and childlike, which I attributed to regression. At times she would sit bolt upright and stare uncomprehendingly or fearfully at me, or cry wordlessly. Despite interpretation and encouragement, she rarely was able to speak a word after such events; often she would make an apology for her failure to speak just as she left the office.

After 13 months, she indicated that she had a secret that was too embarrassing to share. Two months later, she confessed that since her teens she had been involved with the married pastor of her church in a sexual liaison. She was mortified because she knew their affair was absolutely wrong yet accepted this man's convoluted use of biblical precepts to justify it. The relationship continued during her visits to her hometown and during his various trips across the country.

After two years of classical analysis, during which most sessions were dominated by silence, apologies, and the trivial accounting of the day's events, Christa had shown little if any ability to respond to interpretations. My supervisor and I decided that perhaps the patient could not tolerate the couch. The patient was requested to sit up. Although she spoke more freely, her material provided little grist for the mill.

After several months the effort to undertake a classical analysis was abandoned, and I began to take a more active and supportive stance. Christa became more relaxed and open. I began to focus on particular here-and-now problems that concerned her, and she began to make slow but steady progress in some areas. She became more

comfortable with male colleagues. After she failed to pass her psychiatry boards, I asked her a series of probing questions in what I thought would be an effort to reassure her of her competence (since I was sure she would answer them accurately). I was astonished to find how limited her knowledge was. Christa protested that I was embarrassing her with my inquiries. She told me that she was unable to study in a normal manner because she was unable to stay up later than 9:00 p.m. every night. We worked on this issue for some three months and explored aspects of her wish to fail, her wish to avoid growing up, her sense that the completion of the boards would be the final step in having outdone her parents, who were intelligent but uneducated people. Her father was a farmer and part-time mechanic on a large dairy farm, and her mother was a housewife. Although our explorations brought up useful material and elicited strong affect, it was clear to both of us that something was missing. I pressed more aggressively, and Christa began to have more periods of silence, during many of which she sat tensely, her eyes filled with tears, and her expression suggesting she was about to scream.

Now approximately four years after beginning the treatment, I gave serious thought to a trial of hypnosis to explore her blocks and unvoiced concerns. Much to my surprise, Christa readily assented. After the induction of trance, Christa opened her eyes and began to talk about "Christa" in a somewhat different voice, and with a smiling, unruffled expression. When I observed that she was talking about herself as if she were someone else, I was informed that I was talking to "Chrissie." Chrissie and the others had hoped that I could treat Christa without discovering them, but after four years of failure it was clear that the secret would have to be shared. Chrissie went on to say that Christa was very sad, even suicidal at times. She knew part of her despair was related to the activities of the other personalities, which usually restricted their activities to between 9:00 P.M. and 1:00 a.m. When these alters had been triggered to emerge in therapy, they had tried to not talk or to pass for Christa. Chrissie said the majority of Christa's despair was due to events in her past of which she was unaware.

Christa had no recollection of my conversation with Chrissie. Over a period of weeks, I elicited from Christa a great deal of information suggestive of MPD. For example, she had clothing in her closet that she did not recall buying, her telephone bills included charges for calls that she did not recall making, and it was clear that things were being done in her apartment for which she could not account. For example, one morning she awoke to find her living room furniture rearranged. She also admitted with great embarrassment that she suffered brief periods of time loss almost every day. She stated that during a recent visit from her mother she had inexplicably attacked and almost strangled her mother before she regained self-control. She was so confused and upset by these things that she had denied them and/or minimized their importance.

Confronted with this evidence, Christa became flustered and floundered helplessly. After several unsuccessful attempts to explain her situation to her, I used hypnosis to elicit Chrissie and other alters for part of each session. I suggested that Christa would begin to allow herself to become aware of these conversations as she could tolerate them, and that all parts of her mind could listen in to therapy whenever they were willing to do so. Gradually Christa became able to hear the voices of the other alters as voices within her own head, although she was unable to remember any difficult material they suggested for several months. I furthermore requested that whichever alter was out report what the others said inwardly, just as if these words were his or her own thoughts, and identifying the source when possible. This allowed therapy to address more and more alters at the same time and reinforced the unspoken principle that all of the alters and their ways of interacting constituted personality in the usual sense of the word. It also allowed therapy to proceed in a manner that required fewer and fewer specific interventions to access the various alters. If Chrissie was out, for example, and Christa or another alter had an observation on the subject at hand, Chrissie would voice what she heard within, in effect sharing "the mind's" contents. To illustrate, I will contrast the comments made by Christa and Joan, a non-MPD patient, about nearly identical upsetting dreams of sexual traumatization. In each case, the dream, a traumatic nightmare, involved the experience of forced sexual intercourse with a figure previously regarded with unequivocal positive regard.

Joan: That was a horrible nightmare. What could it mean? I remember him as kind and good. And yet I have the feeling that this may have happened. That would be horrible! I couldn't live with that. No, it can't be real. It has to be just a dream, just my imagination. Maybe it is really about you, you know, that I have these impulses toward you that I can't accept, so in the dream you force it upon me. My God! You know, I always was upset by his sexual jokes, and I wondered why he always tried to French kiss me instead of a normal kiss. Could this dream be a memory? Oh, God. I feel awful.

Christa: It was awful to have a dream like that. Why should I have a dream of being raped by a man who was like a father to me? Yet I can't shake the sense it really happened. Chrissie says that's because it did happen. No, Chrissie, you must be lying. Or maybe it's your fantasies. She says, "No, Christa, I'm sorry, but it happened. To Ginny." Ginny says she wants to kill herself now that I know and you know. Dr. Kluft, don't you think it has to be transference? I don't have any feeling toward you, but maybe some other part does. Maybe it's a rape fantasy, you know, 'cause I always say I have no sexual feelings, so I give them to you? Chrissie is reminding me that I always was upset that he touched my breasts when he hugged me, and kissed me so hard I was uncomfortable. I told my mother, but she said it must be my imagination or a mistake —he would never do that. My God! What if it's a memory? Chrissie and Ginny are

saying it is true, but I am afraid to even consider it might be true.

By virtue of the therapist encouraging the alters to be present and to contribute to the treatment and urging the alter that is out to regard the observations of other alters as mental contents it must report as if they were its own, the cooperative patient gradually raises the same types of issues and conflicts that might be expressed by a patient without this type of disorder and becomes amenable to a more familiar type of treatment, with every session implicitly encouraging integration of all mental contents and of the structures described as personalities.

Christa gradually accepted the presence of the alters, and she and they became coconscious for contemporary events, effectively eliminating the amnestic spells and the disremembered behaviors. The alters allowed one another time to pursue particular interests, and since their differences were not terribly extreme, each felt enriched by the others. In this process, the younger alters experienced themselves as growing more mature, and the male alters accepted that they were part of a female and ceased to demand a separate life.

While this process was going forward and being encouraged, in therapy the amnestic barriers were not eroded except by agreed-upon interventions. For example, many of the alters revealed extremely traumatic sexual abuse at the hands of her father, material Christa could not hear without becoming dysfunctional. He had not only violated and brutalized her, he tortured her by inserting his tools into her vagina and inflicting great pain. Therefore, for some time I worked with the alters that held these memories outside of Christa's awareness. Only after Christa began to have frequent dreams of these experiences and spontaneous flashbacks of the traumatic material did she accept the necessity of dealing with the possibility she had been abused. Gradually she began to listen in to the material the other alters were working on and abreacting.

Christa arrived at one summer session extremely upset. She and a friend had visited a seaside town. After a pleasant day on the beach, they had gone to a picturesque restaurant on a pier at which fishing boats docked. On their way to dinner, they had passed a fisherman filleting his catch. She had immediately gone into a profound panic attack but tried to pretend it was not happening. She had gone on to the restaurant and, although she did not usually drink, medicated herself with alcohol.

As the alcohol took effect, she had just begun to relax when she had an awful flashback. She and her father were in a boat, fishing. She had always recalled these trips as idyllic and was perplexed by her fish phobias, which had not begun until she left home. In this flashback, her father had insisted she perform fellatio in the boat, and she had refused. He slapped her, and she continued to say no. At this point her father had pulled up the string of fish they had caught and hacked them to pieces with his

knife, shouting that he would do the same to Christa if she defied him. Kneeling in the gore, still hearing the wounded fish flapping and gasping, and terrified for her life, she had complied. She was flooded with images of the traumatic scenario and kept feeling the physical sensations associated with it, so-called somatic memories.

Christa was not stable enough to see her own patients that day. She was seen in an extra session that evening. Traumatic material was continuing to pour through. Christa was sensing the experiences of the other alters as genuine, and more memories were coming through. She was exhausted, and it appeared she would not be able to function. Hypnosis was used to sequester the intolerable material with permissive amnesia, and we used the image of putting all of the memories and overwhelming affect in a strong vault that was sealed with a time lock so that it would not open in between sessions. The alters that had experienced and previously sequestered the experiences now flooding Christa were conducted with hypnotic imagery to a safe place and put to sleep between sessions with a suggestion their sleep would be dreamless. Christa was also given hypnotic anesthesia for the somatic memories.

Thereafter, Christa would come to sessions and the hypnotic restraints were relaxed in order to work with the various alters and their materials. When an alter had abreacted and worked through a trauma, it was gradually shared with Christa, who often had to abreact it herself as well. Usually Christa could then retain it in memory, and the involved alter would spontaneously integrate with Christa. It took several months for this material to be reabsorbed and worked through in a gradual enough manner so that Christa could continue her practice without interruption. Although she had many difficult days, she did not miss work after the initial flashback at the seashore.

Even as Christa and her alters continued their work, the pressure to deny that any of the material was true remained intense. Christa felt very guilty that she might be speaking ill of her father and often spoke of all the traumatic material as if it were derealized. However, Christa began to improve dramatically as the work was done. Her fish phobias abruptly disappeared; no substitute symptoms developed. After two months of work on this material, she was able to extricate herself from her relationship with the clergyman. After abreacting and working through the incident on the boat, her compulsions and cleaning rituals gradually diminished. She had been forced to wash the boat down after the carnage and had spent several hours in the shower trying to clean herself thereafter. Her compulsions with regard to electrical plugs and appliances abruptly disappeared after recalling and working through her father's frequent use of power tools to threaten her with mutilation if she ever revealed his abuse of her.

After two years of work on this material, Christa was comfortable with men other than her abusive father and the clergyman. Interestingly, she also saw me as terrifying and

potentially abusive, a clear traumatic transference (Kluft, 1994a; Loewenstein, 1993). Although Christa knew her fear was transferential, it was so compelling, especially in some alters, that she would arrive at sessions late and try to leave early, as if to minimize the time at which she was at risk with me. She also became very sexually provocative with me, stated that she was very turned on by me, and said that she was so stimulated that she felt on the verge of orgasm in sessions.

I interpreted this sexualization as serving a number of functions and as carrying a number of messages. For example, I saw the erotization as a defense against perceiving the brutality of the assaults and as her way of rehabilitating her father by taking on herself the burden of sexual encounters between them (convincing herself and him that she wanted him). I also saw her as reenacting a style of behaving as if she welcomed and enjoyed her father's advances, a stance her father insisted upon, beating her when she did not manifest it. Although many alters and Christa admitted much of what I inferred, this sexual behavior persisted at a high level of intensity until I came to appreciate that her apparent erotic arousal was directly proportional to her suppressed rage. When I interpreted this, it was denied, but the patient became so aroused that she appeared to be having a vigorous orgasm with violent pelvic thrusting. I continued to interpret, and the patient dissociated openly into an alter unknown to me or to the alters with which I had worked. This alter confirmed my hypothesis and told me that the other alters could not accept the rage Christa had felt and the actions she had taken. Indeed, Christa was without any overt anger and was profusely guilty and apologetic for any real or imagined inconvenience she caused anyone. In fact, Christa's response to overhearing this material was not only to dissociate it anew but to become suicidal because she was sure that in some way she was a bad person. Every time I raised the issue of anger, Christa claimed to be sexually aroused and proceeded to engage in orgasmic behavior with pronounced pelvic thrusting.

Gradually and gently I met a group of alters that had the rage. These alters included some that had planned to kill her father, and several had made attempts. To summarize voluminous material, when one alter tried to hurt or kill the father, another that loved him would take over and impede the attack. On several occasions, Christa had been rendered catatonic in the midst of attacking her father with a buck knife, or while setting the house on fire. Gradually the pattern of defending against the hostile alters by intensifying sexual arousal had become established. The angrier the total human being was, the more vigorous and aggressive was her sexual behavior with her abusive father. This was what had been reenacted in the transference.

Slowly, Christa owned her anger. While at an early stage of this work, her father fell ill and Christa was abruptly summoned home. She was very conflicted about going but rapidly denied the reality of her abuse experiences and went home to see her father.

Her father had neglected the early warning signs of a malignancy; now he faced a terminal illness. Apparently he was well aware of his impending death and spent all of his time reading the Bible and in prayer. On the last day of her visit, Christa's father called her to him and asked her to pray with him. After prayer, her father began to cry. He said that he was sure he was going to hell for what he had done to her and begged her forgiveness. Christa said she forgave him. She was absolutely stunned by his confession.

Christa's father died shortly after her visit. After grieving him, an especially painful process for Christa and those alters that initially had had no subjective experience of abuse at his hands, therapy accelerated, and most of the remaining alters integrated rapidly. After further work on her rage and the recovery of more episodes in which she had tried to strike back at her father, the remaining alters integrated and Christa began to become increasingly assertive and capable of appropriate anger. Her new strength became apparent at her workplace, and she was promoted to a prestigious position requiring the strong exercise of considerable authority.

After having been integrated for several months, it became clear that alters had integrated before dealing fully with their intense affects, and that although Christa had no remaining alters, she had the sense of a sequestered area in her mind full of strong affect. When interpretive efforts failed to access it, hypnosis proved effective in allowing Christa to experience it within session. Gradually it was accessed, expressed, and owned. It rapidly entered the transference and resolved with interpretive interventions.

Christa remains in treatment at a reduced level of intensity to continue the working-through process and to manage the occasional emergence of additional traumatic materials. She is also working on her realization that her mother knew of the incest and did not intervene. Christa has confronted her mother on the basis of material recovered in therapy. After much denial, her mother admitted that Christa's recovered recollections are accurate. Christa is enraged that her mother then immediately insisted that Christa, as a devout Christian, was obligated to forgive her. She now appreciates that her attempt to strangle her mother many years before was based on her briefly recalling her mother's complicity during an argument on another subject. She had rapidly repressed the memory, recalling only that she had inexplicably begun to strangle the older woman.

Christa's treatment was quite prolonged, but it has resulted in her stable integration and the alleviation of all of her distressing symptoms. She is able to socialize easily with men and is involved in a constructive relationship. Her chief regret is that because she could not consider an intimate, mutually respectful relationship with a man until she

was past 40 and would not consider becoming a single mother by insemination or adoption, she has been deprived of the experience of motherhood.

TRAINING

I have spent two decades consulting with colleagues treating MPD (Kluft, 1988b, 1988c), teaching therapists to use my techniques, and counseling mental health professionals overwhelmed by their attempts to work with this group of patients (Kluft, 1989b). Treating the severely traumatized is not for everyone, and a minority of colleagues find themselves deeply troubled and distressed by their efforts to work with MPD. Some experience vicarious traumatization or counter-identification and develop post-traumatic symptomatology. The countertransference strains of working with MPD have been described by Kluft (1994a), Loewenstein (1993), and Watkins and Watkins (1984), among others.

It is not uncommon for therapists beginning to work with such patients to feel unskilled and insecure. The literatures of child abuse, post-traumatic stress, memory, hypnosis, and the dissociative disorders are not familiar to many psychodynamic clinicians who find themselves confronted with MPD, often in a patient whom they have treated for years under another diagnosis and are loath to transfer to another therapist.

Fortunately, the modem literature includes many excellent texts to study. Putnam's (1989) masterful *Diagnosis and Treatment of Multiple Personality Disorder* is an excellent starting point, followed perhaps by Kluft and Fine's (1993) *Clinical Perspectives on Multiple Personality Disorder* and the September 1991 issue of *Psychiatric Clinics of North America,* edited by Loewenstein.

Because MPD patients are highly hypnotizable, dissociative patients, and because hypnosis in the form of spontaneous trance and autohypnosis will pervade every MPD treatment even if the therapist never induces hypnosis deliberately (heterohypnosis), knowledge of hypnosis is highly desirable, even essential. Because I know hypnosis as well as I do, I often can avoid the use of formal hypnosis, exploiting instead opportunities provided by spontaneous trances and autohypnotic phenomena. Hypnosis cannot be learned from textbooks as well as it can be mastered in a workshop setting. Most psychoanalytic caveats about hypnosis are clinically and historically inaccurate.

Hypnosis is not a treatment in and of itself, it is a facilitator of treatment. In Freud's era, hypnosis was used to facilitate the authoritarian treatment of the day, and the failure to distinguish hypnosis from the interventions with which it was associated at the end of the nineteenth century persists to this day in the psychoanalytic literature. It is useful to get hypnosis education from programs that teach about hypnosis rather than a particular

school of thought within hypnosis. At the time of this writing, a profusion of organizations purport to teach hypnosis. However, among them, only the American Society of Clinical Hypnosis has adopted standards specifying that beginning workshops teach the topics I consider essential to a firm foundation in hypnosis. Its workshop schedule can be obtained by calling 708-297-3317. Other reliable sources are courses sponsored by the Society for Clinical and Experimental Hypnosis and by Division 30 of the American Psychological Association.

Specific courses on treating MPD are available through the meetings of the American Psychiatric Association and the International Society for the Study of Multiple Personality and Dissociation (ISSMP&D), among others. The many local study groups affiliated with the ISSMP&D are useful sources for training. Interested therapists can also seek individual consultation with more experienced practitioners.

EMPIRICAL EVIDENCE FOR THE APPROACH

Although no controlled studies on the treatment of MPD are available as of yet, sufficient data are available to advocate the use of psychodynamic psychotherapy facilitated by hypnosis, which, empirically, is the most widely practiced approach to such patients (Putnam & Loewenstein, 1993). The data come from several studies by myself (Kluft, 1982,1984b, 1985,1986b, 1994b) and Coons (1986).

I followed 210 MPD patients (Kluft, 1985) for varying periods of time. Of those MPD patients who received no treatment, all had MPD on follow-up. Of those who were treated by therapists who did not believe in the MPD diagnosis, all had MPD on follow-up. Of patients in treatments in which the MPD was acknowledged but not addressed specifically, 2-3% were cured of their MPD. Of those treated by me with psychodynamic psychotherapy facilitated when necessary with hypnosis, there was a 90% treatment adherence; 90% who remained in treatment integrated, and several others were satisfied with results short of total integration. In Coons's series, 95% of the therapists were neophytes with their first MPD case. On an average 39-month follow-up, two-thirds of the patients were much improved, and 25% had stable integration (although many others were near this goal or had achieved it briefly). My patients were seen largely in private practice; Coons's were seen in an academically affiliated state hospital clinic.

These outcomes suggest that MPD has a very good prognosis when a highly motivated patient encounters a therapist with considerable experience in working with MPD, and that a neophyte therapist addressing the MPD directly will be more successful than a more experienced practitioner who tries not to deal with the MPD. However, the situation is not that simple. More recent findings (Kluft, 1994b) suggest that several

subgroups of MPD patients have rather different treatment trajectories. Studying my private practice, which may be a skewed sample, I found that one subgroup, among newly initiated treatments, and the largest (70%), quickly developed an excellent therapeutic alliance and began to move rapidly in therapy. A second, the smallest (10%), made little progress and had continued crises. The third (20%) ran an intermediate course and included patients who improved continuously, but at a low rate, and patients whose course fluctuated widely, with mercurial ups and downs for protracted periods of time. I think that my group of high-trajectory patients, many of whom are high-functioning MPD patients (Kluft, 1986c), was unlikely to be highly represented in Coons's state hospital clinic cohort, which probably included more patients with low or medium trajectories.

Members of the high-trajectory group most approximate the traditional expressive psychodynamic patient and often require relatively little in the way of hypnotic interventions beyond those used to access alters or to facilitate integration. The continuous but slow-to-improve intermediate group approximates this. However, the intermediate group with major fluctuations and the low-trajectory groups required much more structure and directive interventions, and their treatments were more psychodynamically informed than psychodynamic in form and structure (see Kluft, 1992a). As of this point, the research does not allow conclusions as to whether specific co-morbid conditions are responsible for these differences. Additional explorations are in progress.

REFERENCES

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.

Armstrong, J. (1991). The psychological organization of multiple personality disorder patients as revealed in psychological testing. *Psychiatric Clinics of North America,* 14, 533-546.

Armstrong, J. G. (1994). Reflections on multiple personality disorder as a developmentally complex adaptation. *Psychoanalytic Study of the Child,* 49, 349-364.

Armstrong, J. G., & Loewenstein, R. J. (1990). Characteristics of patients with multiple personality and dissociative disorders on psychological testing. *Journal of Nervous and Mental Disease,* 178, 448-454.

Barach, P. M. M. (1991). Multiple personality disorder as an attachment disorder. *Dissociation,* 4, 117-123.

Berman, E. (1981). Multiple personality: Psychoanalytic perspectives. *International Journal of Psychoanalysis,* 62, 283-300.

Bernstein, E., & Putnam, F. W. (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease*, 174, 727-735.

Bliss, E. L. (1980). Multiple personalities: Report of 14 cases with implications for schizophrenia and hysteria. *Archives of General Psychiatry,* 37, 1388-1397.

Bollas, C. (1987). *The shadow of the object: Psychoanalysis of the unthought known.* New York: Columbia University Press.

Boon, S., & Draijer, N. (1993). *Multiple personality disorder in the Netherlands: A study on reliability and validity of the diagnosis.* Amsterdam: Swets & Zeitlinger.

Braun, B. G., & Sachs, R. G. (1985). The development of multiple personality disorder: Predisposing, precipitating, and perpetuating factors. In R. P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 37-64). Washington, DC: American Psychiatric Press.

Breuer, J., & Freud, S. (1955). Studies on hysteria. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 2, pp. 1-305). London: Hogarth Press. (Original work published 1893-95)

Carlson, E. B., & Putnam, F. W. (1992). *Manual for the dissociative experiences scale.* Beloit, WI: Beloit College, Department of Psychology.

Carlson, E. B., Putnam, F. W., Ross, C. A., Torem, M., Coons, P., Dill, D. L., Loewenstein, R. J., & Braun, B. G. (1993). Validity of the Dissociative Experience Scale in screening for multiple personality disorder: A multicenter study. *American Journal of Psychiatry,* 150, 1030-1036.

Coons, P. M. (1984). The differential diagnosis of multiple personality. *Psychiatric Clinics of North America,* 7, 51-67.

Coons, P. M. (1986). Treatment progress in 20 patients with multiple personality disorder. *Journal of Nervous and Mental Disease*, 174, 715-721.

Counts, R. M. (1990). The concept of dissociation. *Journal of the American Academy of Psychoanalysis,* 18, 460-479.

Despine, P. (1840). *De I'emploi du magnétisme animal et des eaux minérales dans le*

traitement des maladies nerve uses, suivi d'une observation très curieuse de guérison de neuropathie [On the use of animal magnetism and mineral waters in the treatment of nervous maladies, followed by a very curious observation on the cure of a neuropathy], Paris: Germer, Balliere.

Ellenberger, H. F. (1970). *The discovery of the unconscious.* New York: Basic Books.

Fairbairn, W. R. D. (1952). *Psychoanalytic studies of the personality.* London: Routledge & Keegan Paul.

Fairbairn, W. R. D. (1954). Observations on the nature of hysterical states. *British Journal of Medical Psychology,* 27, 105-125.

Fine, C. G. (1988). The work of Antoine Despine: The first scientific report on the diagnosis of a child with multiple personality disorder. *American Journal of Clinical Hypnosis,* 31, 33-39.

Fine, C. G. (1991). Treatment stabilization and crisis prevention: Pacing the therapy of the multiple personality disorder patient. *Psychiatric Clinics of North America,* 14, 661-675.

Fink, D. (1991). The comorbidity of multiple personality disorder and *DSM-III-R* Axis II disorder. *Psychiatric Clinics of North America,* 14, 547-566.

Fink, D. (1992). The psychotherapy of multiple personality disorder: A case study. *Psychoanalytic Inquiry,* 12, 49-70.

Fischer, K. W., & Pipp, S. L. (1984). Development of the structures of unconscious thought. In K. S. Bowers & D. Meichenbaum (Eds.), *The unconscious reconsidered* (pp. 88-147). New York: Wiley.

Freud, S. (1958). A note on the unconscious in psycho-analysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 255-266). London: Hogarth Press. (Original work published 1912)

Freud, S. (1957). The unconscious. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud (Vol. 14, pp. 159-215). London: Hogarth Press. (Original work published 1915)*

Freud, S. (1961). The ego and the id. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 19, pp. 3-66). London: Hogarth Press. (Original work published 1923)

Freud, S. (1964). A disturbance of memory on the Acropolis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 22, pp. 237-248). London: Hogarth Press. (Original work published 1936)

Gabbard, G. (1994). Dissociative disorders. In G. Gabbard (Ed.), *Psychodynamic psychiatry in clinical practice: The DSM-IV edition* (pp. 291-326). Washington, DC: American Psychiatric Press.

Grotstein, J. (1981). *Splitting and projective identification.* New York: Jason Aronson.

Herman, J. L. (1992). *Trauma and recovery.* New York: Basic Books.

Horevitz, R. P., & Braun, B. G. (1984). Are multiple personalities borderline? A study of 33 cases. *Psychiatric Clinics of North America,* 7, 69-87.

Janet, P. (1889). *L'automatisme psychologique.* [Psychological automatism], Paris: Felix Alcan.

Jones, E. (1953). *The life and work of Sigmund Freud* (Vol. 1). New York: Basic Books.

Kluft, R. P. (1982). Varieties of hypnotic intervention in the treatment of multiple personality. *American Journal of Clinical Hypnosis,* 224, 230-240.

Kluft, R. P. (1984a). Aspects of the treatment of multiple personality. *Psychiatric Annals,* 14, 51-55.

Kluft, R. P. (1984b). Treatment of multiple personality disorder: A study of 33 cases. *Psychiatric Clinics of North America,* 7, 9-29.

Kluft, R. P. (1985). The natural history of multiple personality disorder. In R. P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 197-238). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1986a). Treating children who have multiple personality disorder. In B. G. Braun (Ed.), *Treatment of multiple personality disorder* (pp. 79-105). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1986b). Personality unification in multiple personality disorder: A follow-up study. In B. G. Braun (Ed.), *Treatment of multiple personality disorder* (pp. 29-60). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1986c). High-functioning multiple personality patients: Three cases. *Journal of Nervous and Mental Disease,* 174, 722-726.

Kluft, R. P. (1987a). Uncommon multiple personality disorder: An uncommon source of protracted resistance, interruption, and failure in psychoanalysis. *Hillside Journal of Clinical Psychiatry,* 9, 100-115.

Kluft, R. P. (1987b). The parental fitness of mothers with multiple personality disorder: A preliminary study. *Child Abuse and Neglect,* 12, 272,280.

Kluft, R. P. (1987c). First-rank symptoms as a diagnostic clue to multiple personality disorder. *American Journal of Psychiatry,* 144, 293-298.

Kluft, R. P. (1988a). On treating the older patient with multiple personality disorder: "Race against time" or "make haste slowly." *American Journal of Clinical Hypnosis,* 30, 257-266.

Kluft, R. P. (1988b). On giving consultations to therapists treating multiple personality disorder: Fifteen years' experience. I: Diagnosis and treatment. *Dissociation,* 2(3), 23-29.

Kluft, R. P. (1988c). On giving consultations to therapists treating multiple personality disorder: Fifteen years' experience. II: The "surround" of treatment, forensics, hypnosis, patient-initiated requests. *Dissociation,* 2(3), 30-35.

Kluft, R. P. (1989a). Playing for time: Temporizing techniques in the treatment of multiple personality disorder. *American Journal of Clinical Hypnosis,* 32, 90-97.

Kluft, R. P. (1989b). The rehabilitation of therapists overwhelmed by their work with multiple personality disorder patients. *Dissociation,* 2, 244-250.

Kluft, R. P. (1990). Dissociation and subsequent vulnerability: A preliminary study. *Dissociation,* 3, 167-173.

Kluft, R. P. (1991a). Multiple personality disorder. In A. Tasman & S. M. Goldfinger (Eds.), *American Psychiatric Press Annual Review of Psychiatry* (Vol. 10, pp. 161-188). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1991b). Clinical presentations of multiple personality disorder. *Psychiatric Clinics of North America,* 14, 605-629.

Kluft, R. P. (1992a). The perspective of a specialist in the dissociative disorders.

Psychoanalytic Inquiry, 212, 139-171.

Kluft, R. P. (1992b). Hypnosis with multiple personality disorder. *American Journal of Preventive Psychiatry and Neurology*, 3, 19-27.

Kluft, R. P. (1993a). Conducting the psychotherapy of multiple personality disorder. In R. P. Kluft & C. G. Fine (Eds.), *Clinical perspectives on multiple personality disorders* (pp. 19-50). Washington, DC: American Psychiatric Press.

Kluft, R. R (1993b). The initial phases in the treatment of multiple personality disorder. *Dissociation,* 6, 145-161.

Kluft, R. P. (1993c). Clinical approaches to the integration of personalities. In R. P. Kluft & C. G. Fine (Eds.), *Clinical perspectives on multiple personality disorders* (pp. 101-133). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1994a). Countertransference in the treatment of multiple personality disorder. In J. P. Wilson & J. Lindy (Eds.), *Countertransference in the treatment of posttraumatic stress disorder* (pp. 122-150). New York: Guilford Press.

Kluft, R. P. (1994b). Treatment trajectories in the psychotherapy of multiple personality disorder. *Dissociation,* 7, 63-76.

Kluft, R. P. (in press a). Multiple personality disorder: A legacy of trauma. In C. R. Pfeffer (Ed.), *Intense stress and mental disturbance in children.* Washington, DC: American Psychiatric Press.

Kluft, R. P. (in press b). The management of abreactions. In B. M. Cohen & J. A. Turkus (Eds.), *Multiple personality disorder: Continuum of care.* New York: Jason Aronson.

Kluft, R. P. (in press c). An overview of the treatment of patients alleging that they have suffered ritualized or sadistic abuse. In G. A. Fraser (Ed.), *The phenomenon of ritualized abuse.* Washington, DC: American Psychiatric Press.

Kluft, R. P., Braun, B. G., & Sachs, R. G. (1984). Multiple personality, intrafamilial abuse, and family psychiatry. *International Journal of Family Psychiatry,* 5, 283-301.

Kluft, R. P., & C. G. Fine (Eds.). (1993). *Clinical perspectives on multiple personality disorders.* Washington, DC: American Psychiatric Press.

Kuhn, T. S. (1970). *The structure of scientific revolutions* (2nd ed., enlarged). Chicago:

University of Chicago Press.

Lasky, R. (1978). The psychoanalytic treatment of a case of multiple personality. *Psychoanalytic Review*, 65, 355-380.

Liotti, G. (1992). Disorganized/disoriented attachment in the etiology of the dissociative disorders. *Dissociation,* 5, 196-204.

Loewenstein, R. J. (1991a). An office mental status examination for chronic complex dissociative symptoms and multiple personality disorder. *Psychiatric Clinics of North America,* 14, 567-204.

Loewenstein, R. J. (1991b). Rational psychopharmacology in the treatment of multiple personality disorder. *Psychiatric Clinics of North America,* 14, 721-740.

Loewenstein, R. J. (1993). Posttraumatic and dissociative aspects of transference and countertransference in the treatment of multiple personality disorder. In R. P. Kluft & C. G. Fine (Eds.), *Clinical perspectives on multiple personality disorders* (pp. 51-85). Washington, DC: American Psychiatric Press.

Loewenstein, R. J., & Ross, D. R. (1992). Multiple personality and psychoanalysis: An introduction. *Psychoanalytic Inquiry,* 12, 3-48.

Marmer, S. S. (1980). Psychoanalysis of multiple personality disorder. *International Journal of Psychoanalysis,* 61, 439-451.

Marmer, S. S. (1984). The dream in dissociative states. In J. M. Natterson (Ed.), *The dream in clinical practice* (pp. 163-175). New York: Jason Aronson.

Marmer, S. S. (1991). Multiple personality disorder: A psychoanalytic perspective. *Psychiatric Clinics of North America*, 14, 677-694.

Nathanson, D. L. (1989). Understanding what is hidden: Shame in sexual abuse. *Psychiatric Clinics of North America,* 12, 381-388.

Nathanson, D. L. (1992). *Shame and pride.* New York: Norton.

Noll, R. (1989). Multiple personality, dissociation, and C. G. Jung's complex theory. *Journal of Analytic Psychology,* 34, 353-370.

Ogden, T. H. (1992). Consultation is often needed when treating multiple personality disorder. *Psychodynamic Letter,* 1 (10), 1-4.

Putnam, F. W. (1989). *Diagnosis and treatment of multiple personality disorder.* New York: Guilford Press.

Putnam, F. W., Guroff, J., Silberman, E. K., Barban, L., & Post, R. (1986). The clinical phenomenology of multiple personality disorder: Review of 100 recent cases. *Journal of Clinical Psychiatry, 47,* 285-293.

Putnam, F. W., & Loewenstein, R. J. (1993). Treatment of multiple personality disorder. *American Journal of Psychiatry, 150,* 1048-1052.

Ross, C. A. (1989). *Multiple personality disorder: Diagnosis, clinical features, treatment.* New York: Wiley.

Satinover, J. (1993, October). *Archetypal structures and the neural basis of dissociability: An integrative model.* Paper presented at the 10th International Conference on Multiple Personality/Dissociation, Chicago.

Schreiber, F. R. (1973). *Sybil.* Chicago: Regnery.

Schultz, R., Braun, B. G., & Kluft, R. P. (1989). Multiple personality disorder: Phenomenology of selected variables in comparison to major depression. *Dissociation, 2,* 45-51.

Smith, B. L. (1989). Of many minds: A contribution on the dynamics of multiple personality. In M. G. Froman & B. L. Smith (Eds.), *The facilitating environment* (pp. 424-458). New York: International Universities Press.

Spiegel, D. (1986). Dissociating damage. *American Journal of Clinical Hypnosis, 29,* 123-131.

Spiegel, D. (1991). Dissociation and trauma. In A. Tasman & S. M. Goldfinger (Eds.), *American Psychiatric Press Annual Review of Psychiatry* (Vol. 10, pp. 261-275). Washington, DC: American Psychiatric Press.

Spiegel, D. (1993, October). *Dissociation, trauma, and DSM-IV.* Paper presented at the 10th International Conference on Multiple Personality/Dissociation, Chicago.

Steinberg, M. (1993). *Structured clinical interview for DSM-III-R dissociative disorders (SCID-D).* Washington, DC: American Psychiatric Press.

Stem, C. R. (1984). The etiology of multiple personalities. *Psychiatric Clinics of North America, 7,* 149-160.

Stolorow, R. D., & Atwood, G. E. (1982). Psychoanalytic phenomenology of the dream. *Annual Psychoanalysis,* 10, 205-220.

Ulman, R. B., & Brothers, D. (1988). *The shattered self.* Hillsdale, NJ: Analytic Press.

Watkins, J. G., & Watkins, H. H. (1984). Hazards to the therapist in the treatment of multiple personalities. *Psychiatric Clinics of North America,* 7, 111-121.

Wilbur, C. B. (1984). Treatment of multiple personality disorder. *Psychiatric Annals,* 14, 27-31.

CHAPTER 12

Relational Therapy for Grief Disorders

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Mourning the loss of a loved one is a common and often intensely painful experience in the human life cycle. Approximately 12 to 20 million people in the American population are newly bereaved each year through the loss of a family member (Osterweis, Solomon, & Green, 1984). Although expressions of support and sympathy are important and helpful, most of the bereaved do not need psychotherapy. Some individuals, however, have great difficulty coping with bereavement. They may experience a sustained loss of social or occupational functioning, prolonged or severe depression, or intense anger, guilt, anxiety, or self-blame. Others may appear not to grieve at all but may still show maladaptive changes in their lives, including increased alcohol consumption, social withdrawal, irritability, or a studious neglect of any reminders of the deceased. Psychotherapy can be helpful for these individuals.

In this chapter, I present a relationally focused psychotherapy model for treating grief disorders. It is relational in the sense that it focuses on the bereaved's mental representations of self and others and on the maladaptive interpersonal behavior patterns these representations are presumed to organize. For convenience, I refer to the model as relational therapy for grief

(RTG). RTG is adaptable to either a time-limited or time-unlimited format and is based on the work of Mardi Horowitz and his colleagues at the University of California at San Francisco (Horowitz, 1986; Horowitz, Marmar, Weiss, DeWitt, & Rosenbaum, 1984). The focus of this chapter is on spousal, sibling, and parental bereavement in adults; see Raphael (1983) and Crenshaw (1990) for treatment guidelines for child and adolescent grief.

At the outset, I wish to clarify how the terms *grief, mourning,* and *bereavement* are used in the chapter. "Grief" refers to the painful emotions and thoughts experienced in connection with the death of a significant other. "Mourning" is the developmental process of adapting to the loss of a loved one; it entails moving from a state of grieving to one of nongrieving. "Bereavement" refers to the social, cultural, and interpersonal status of an individual who has lost someone important to him or her.

HISTORY AND DEVELOPMENT

Freud (1917/1957) was the first to present a psychodynamic model of grief. According to Freud, the grieving individual is unable to immediately relinquish the tie to the deceased and thus maintains it through a process of identification. The bereaved directs psychic energy inward, internalizing an image of the deceased in order to maintain the relationship. With the passage of time and the expenditure of considerable psychic energy, the individual

gradually relinquishes the strong tie to the deceased and is able to initiate new love relationships. Abnormal mourning occurs when the individual is unable to accomplish the task of disengagement from the deceased. A key obstruction occurs when the relationship to the deceased was characterized by *ambivalence.* The bereaved might have loved the deceased but also might have directed feelings of anger or hatred toward him or her, consciously or unconsciously. The death catalyzes feelings of guilt as the individual irrationally blames himself or herself for the loss.

Freud's trauma theory also contributed to the model presented in this chapter. Freud (1920/1962) argued that psychological trauma, such as that incurred in mourning, is associated with an excess of stimuli that overexcite the mind. The mind's "stimulus barrier," which normally modulates the entry of external and internal perceptual information into awareness, is overwhelmed by the strong flow of energy associated with the trauma. As a result, the trauma victim may oscillate between "Re-experiencing " phenomena and denial or numbing. Re-experiencing phenomena include surges of crying, a high level of arousal, lowered threshold for a startle reaction, repeated memories associated with the event, nightmares, and the rapid onset of symptoms following an event seemingly unrelated to the trauma. Denial or numbing reflects the "binding" of psychic energy. In contrast to Freud's emphasis on transformations of psychic energy, the present model emphasizes disruptions and maladaptive distortions in the

flow of ideas and feelings that prevent resolution of the trauma and re-integrational experiences.

A second influence is the work of Bowlby (1980), who rejected Freud's emphasis on psychic energy, stressing instead the bereaved's attachment to the deceased. According to Bowlby, striving to recover the lost person is more significant in grief than is the redirection of psychic energy inward through identification with the deceased. He identified four main phases of grief. Initially, the bereaved "protests" the loss, then begins an agitated search for the deceased. When the search fails, as it inevitably will, despair and depression set in. Eventually, the bereaved forms new interpersonal attachments. Bowlby's reliance on concepts from cognitive science, such as "working models" of the self and attachment figures, is also an influence on the present model.

RTG draws as well from object relations theory (e.g., Kernberg, 1975; 1984; Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989), self-psychology (Kohut, 1971), and social cognition researchers who utilize the self-schema concept (e.g., Segal & Blatt, 1993; Singer & Salovey, 1991.) For additional background on psychodynamic theories of mourning, see Abraham (1924/1948), Fenichel (1945), and Deutsch (1937).

Recent History

The more recent history of RTG originates in observations that some grief experiences are similar to those of psychosocial trauma in general. Horowitz (1986) coined the term "stress response syndrome" to label a set of intrusive and "omissive" experiences associated with psychological trauma. Intrusions are images, thoughts, or emotions that encroach on an individual's conscious experience. In grief, intrusions may take the form of intensely disturbing images of the deceased as endangered and calling out for help, as lying in state, or as physically damaged. The bereaved may also experience transient auditory hallucinations of the deceased, such as hearing his or her name called. Additional intrusive phenomena may include self-blame, searing guilt, mental replaying of events related to the death, unexpected outbursts of anger or tears, ruminations about what one might have done differently to help the deceased, and misperceiving others as the deceased. Omissions are symptoms indicating deflections of normal conscious awareness. They include emotional numbness, forgetfulness (including forgetting parts of the relationship with the deceased), distractibility, depersonalization or derealization experiences, depressed mood, poor concentration, and confusion.

Disruptions in a person's "completion tendency" also play a role in stress response syndromes. According to Horowitz, individuals are motivated to minimize discrepancies between enduring mental models, or "schemas," of self and others and current "working models" of reality. For example, a

recently bereaved individual may have an enduring schema of a deceased individual as alive. This schema contrasts with the reality of the individual as deceased. Most individuals move toward a resolution of this discrepancy, as a function of the completion tendency. Grief disorders may arise, however, when this process is disturbed.

INCLUSION/EXCLUSION CRITERIA

Most bereaved individuals with adequate motivation and verbal skills to express their thoughts and feelings are appropriate for RTG. Exclusion criteria include individuals with psychotic or dementing disorders and those with primary substance abuse or dependence disorders. Those with substance abuse disorders may be appropriate for treatment when the abuse pattern has been controlled. Many individuals with grief disorders use small or moderate amounts of alcohol or nonprescription mood-altering substances in an attempt to self-medicate for the intrusive symptoms of grief. Such patterns need not, in themselves, exclude the individual from treatment but might be explored during therapy. Individuals with prominent personality disorders have a more variable response to RTG and may do best in a time-unlimited format. Those with borderline or narcissistic personality disorders, in particular, are generally not appropriate for the time-limited format.

Symptom Patterns of Grief Disorders

There is no consensus as to the symptom patterns that distinguish grief disorders from normal grief (Middleton, Raphael, Martinek, & Misso, 1993). In large part, the lack of consensus is due to the high degree of variability in individuals' responses to bereavement. In a review of the empirical literature, Wortman and Silver (1989) show that many individuals do not experience intense distress following a loss and do not develop symptoms later in life. In fact, individuals who have fewer and less intense symptoms just after a loss show the best adaptation months and years later (e.g., Parkes & Weiss, 1983; Vachon, Rogers, Lyall, Lancee, Sheldon, & Freeman, 1982). Of course, one cannot conclude from this consistent empirical finding that the expression of intense distress following a loss is harmful to an individual.

There is also considerable variability as to the length of a grief response. Early theorists and researchers assumed that the bereaved could adjust to a loss in a matter of a few weeks or months (Engel, 1961; Lindemann, 1944). Recent research, however, shows that depression, anxiety, and rumination about the loss can extend for years. Vachon and her colleagues (Vachon, Rogers et al., 1982; Vachon, Sheldon, Lancee, Lyall, Rogers, & Freeman, 1982), for example, classified 38% of widows as highly distressed one year after the death of their spouse; 26% remained so after two years. Similarly, Parkes and Weiss (1983) found that 40% of their sample of widows and widowers were moderately to severely anxious two to four years after the loss. In a long-term study of adaptation to major life stressors, including bereavement, Tait and

Silver (1989) reported that more than half of their sample continued to ruminate about losses that had occurred decades earlier. Forty percent still searched for the meaning of the death.

Notwithstanding the variability in bereavement, most researchers and clinicians agree that deviant forms of grief exist. For example, Parkes and Weiss (1983) identified chronic, delayed, and inhibited grief. Chronic grief is characterized by intense distress beginning just after the news of the death and extending for a long period of time, perhaps years. Delayed grief, which Parkes (1991) considers relatively rare, is a pattern in which the emotional upheaval of grief begins after a period of apparent emotional quiescence. Inhibited grief, also rare, is characterized by the absence of intense emotions accompanied by other signs of maladjustment, for example, intense over-activity, somatic symptoms, lengthy social withdrawal, or depression without a sense of loss. As noted earlier, however, many individuals who show few signs of distress immediately after a loss continue to function well years later. Therefore, clinicians should not precipitously conclude that a patient with a recent loss is "repressing" his or her grief if painful affects are not experienced. Instead of psychopathology, these responses may indicate resilience to stress.

The major conclusion to be drawn from the above review is that responses to bereavement are highly individualized and variable, but that

some individuals do respond maladaptively to loss, sometimes for extended periods of time and at great cost to their well-being and to that of others. To help clinicians identify the latter group, two symptom clusters are suggested: depressive symptoms and psychological trauma symptoms. Depressive symptoms include guilt, dejected mood, loss of interest in usual activities, irritability, poor concentration, crying spells, and low energy. Positive self-esteem may be left intact more often in bereavement than it is in depression (Freud, 1917/1957). Symptoms of trauma include the psychological intrusions and omissions cited earlier as characteristic of a stress response syndrome. An additional symptom often observed in bereaved individuals is the emergence of identification processes. For example, the bereaved may take on the mannerisms of the deceased or develop physical symptoms similar to those of the deceased. When these symptoms are present in intense or prolonged forms, or when the bereaved's social or occupational functioning is significantly impaired, treatment is indicated. It is noteworthy that bereaved individuals may initially present with complaints of anxiety or depression that they do not connect to their loss. Only during the initial meeting might it become apparent to the clinician that these symptoms are related to a loss.

There is no diagnosis of "grief disorder" in the *DSM-IV,* although bereavement is listed as a V code. Most individuals who are appropriate for RTG will meet diagnostic criteria for one or more of the following Axis I

diagnoses: adjustment disorder, major depressive disorder, or posttraumatic stress disorder, depending on the circumstances of the death and the individual's response to it.

DYNAMIC ISSUES IN GRIEF DISORDERS

I will set the stage for discussing dynamic issues in grief disorders by reviewing risk factors in bereavement. Available data clearly show that the bereaved are more vulnerable than the nonbereaved to a host of psychological, social, and health problems, including increased mortality, especially among men between 55 and 74 (Helsing & Szklo, 1981; Stroebe & Stroebe, 1987); poorer physical health (Stroebe & Stroebe, 1987); increased use of alcohol and cigarettes (Osterweis, Solomon, & Green, 1984); increased rates of depression (e.g., Parkes & Weiss, 1983; Vachon, Sheldon et al., 1982); and greater risk of suicide (Bock & Webber, 1972; Carter & Glick, 1976).

What predicts a poor adjustment to loss? Researchers and theorists have implicated the age of the bereaved and the deceased, the circumstances of the death, concurrent stressors, social support, the nature of the relationship with the deceased, the personality of the bereaved, and early losses faced by the bereaved. (For reviews, see Osterweis, Solomon, & Green, 1984; Sanders, 1993; Stroebe & Stroebe, 1987.) With regard to dynamic issues in grief disorders, the latter three factors may be the most important.

Nevertheless, I will briefly review the former because they provide an important backdrop to dynamic factors.

Age has been studied primarily in the context of conjugal bereavement. Sanders (1981) and Ball (1977) showed that younger spouses had more difficulty adjusting to the loss than older spouses. As for the circumstances of the death, several studies show that adjustment is poorer if a loss is unexpected, untimely, or violent. When a person dies after a long illness, the bereaved have had time to review the impending death, to "say good-bye," and to otherwise bring the relationship to a conclusion. When the death is sudden, these opportunities are missed. Violent deaths more than nonviolent deaths may give rise to disturbing images of the deceased as suffering and needing help and of the bereaved as unable to help despite injunctions that one "should." There is also evidence that adjustment is poorer when the bereaved is facing other recent losses, is in poor health, has dependent children, faces economic hardship, or has a poor social support network.

Ambivalent and excessively dependent relationships with the deceased have long been associated with poorer adaptation to a loss. As noted earlier, Freud (1917/1957) argued that ambivalence inhibits mourning because the hostility toward the deceased is internalized and produces feelings of guilt, shame, and anxiety, as well as self-reproach. The bereaved may also minimize or deny the hostility, leading to an idealization of the deceased. Parkes and

Weiss (1983) reported that widows and widowers who report lower levels of conflict with their spouses experienced less anxiety, depression, guilt, and yearning. Horowitz, Stinson, Fridhandler, Milbrath, Redington, and Ewert (1993) associate the combination of ambivalence and "over-control" with poor adaptation to bereavement. Ambivalence is conceptualized not simply as contradictory ideas or feelings but as "simultaneous and contradictory schemas of self and other in the present, with conflicts of self-versus self, value versus value, and wish versus wish" (p. 372). Over-control is viewed as the "habitual and nonconscious intention to ward off turbulent emotionality when any topic of high importance to the self-contain[s] conflict" (p. 372).

Excessively dependent relationships may complicate adaptation to bereavement because the self-identity of the surviving spouse was not developed independently of the deceased. The "stronger" individual in the relationship may suffer just as much from a loss as the "weaker" one, because his or her identity is also enmeshed in the dependent relationship.

There is empirical evidence that personality factors such as external locus of control, emotional instability, insecurity, and chronic anxiety are associated with poorer outcome in bereavement (Parkes & Weiss, 1983; Stroebe & Stroebe, 1987). In addition, early losses, such as the death of a parent in childhood or divorce, may lead to greater vulnerability to a poor outcome.

In RTG, personality, relationship, and developmental risk factors for grief disorders are conceptualized in terms of the bereaved's schemas of self and others and maladaptive habitual controls over ideas and feelings related to the self and others. The assumption is that a grief disorder reflects the presence of unintegrated, partially conscious or unconscious, and contradictory views, or schemas, of self and others. These may relate primarily to the relationship with the deceased or to earlier relationships. For example, a middle-aged widow entered therapy after her husband, to whom she was happily married, died unexpectedly and violently. She viewed herself as a supportive, nurturing wife in a relationship with a husband who was a good provider. Her adjustment to his death, however, was complicated by a less conscious view of herself as not loving him as much as he loved her (Horowitz et al., 1993). The contradiction between these two schemas of self and other prolonged and intensified her mourning process.

The death of a loved one may also activate early schemas of the self as helpless, weak, childlike, inadequate, incapable, destructive, or evil. These "latent self-images" (Horowitz, Wilner, Marmar, & Krupnick, 1980) are assumed to form early in life as a consequence of harmful interactions with significant caretakers. Critical scenarios may have involved themes of abandonment, disappointment, betrayal, or frustrated anger. As the individual matured, more adaptive and compensatory concepts of self and other were learned and dominated personality. Additionally, latent negative

self-schemas may have been held in check through the supportive context of the relationship with the deceased.

Also critical in RTG are the habitual defensive controls an individual uses to ward off problematic themes and schemas of self and others related to a death. As noted earlier, Horowitz emphasizes "over-control" as predictive of a grief disorder. These controls may permit partial access to the emotions of grief but are rigidly maintained and prevent resolution of mourning. As reviewed below, a major goal of therapy is thus to explore the bereaved's repertoire of schemas of self and other related to the deceased and to loosen excessive inhibitory controls on these themes.

TREATMENT GOALS

The primary treatment goal is symptom reduction through an active focus on the meaning of the death to the patient's concepts of self and other. At a minimum, the goal is to restore the individual to his or her level of functioning prior to the death. A further goal is for the individual to achieve a more adaptive and integrated level of functioning than that experienced prior to the event. This is accomplished through a systematic review of the repertoire of the patient's images of and relationship schemas with the deceased and other significant others in his or her life. The patient is not asked to "give up" the relationship with the deceased but to review it and put

it in a perspective that enables the patient to continue on adaptively in life. RTG has been successful if, at the conclusion of treatment, the patient is better able to modulate his or her emotions, is functioning adaptively in interpersonal relationships, feels productive and active in life, has achieved a more stable sense of self, and has reached a more stable internal relationship with the deceased.

THEORY OF CHANGE

Relational therapy for grief is based on the assumption that mourning is an adaptive, evolution-based response to the loss of a significant attachment. Mourning thus requires a new adaptation to the self, to others, and to the world. The movement from a state of grieving to one of nongrieving represents the operation of a "completion tendency" in the individual. The work of grieving is thus a developmental process, and a grief disorder represents an incomplete mourning and a completion tendency gone awry.

To describe the theory of change in RTG, it is useful to contrast it with an idealized phase model of mourning. I present the model not as a description of normal mourning but for didactic purposes. The reader should recognize that not all individuals go through all phases and that progress through the phases is not necessarily sequential. As reviewed earlier, any phase model of mourning belies the underlying variability of individuals'

responses.

The phase model is based on the assumption that the bereaved's cognitive and emotional responses to the death of a significant other are functions of discrepancies between "enduring schemas" of the deceased and internal "working models," which include the reality of the absence of the deceased. Enduring schemas are relatively stable knowledge structures that help organize an individual's self-concept, concept of others, and dominant self-and-other relationship patterns. They result from overlearned and generalized interpersonal experiences—as well as from constitutional, genetic, and intrapersonal sources—that become ingrained in an individual's psychological makeup. Enduring schemas are not consciously experienced but influence conscious experiences.

Working models represent a combination of the activated schema organizing the individual's current state of mind and perceived and subceived environmental stimuli. A working model may not be congruent with "reality," owing to the effect that enduring schemas can have on perceptual processes. Similarly, working models may be incongruent with enduring schemas, owing to the influences of reality. When either form of incongruence occurs to a marked degree, intense emotional experience may result.

The phase model, initially presented by Horowitz (1990), includes the

following five phases: outcry, denial, intrusions, working-through, and completion (see Table 12.1). Each phase is assumed to reflect the activation of schemas and working models that organize the individual's dominant states of mind during mourning. For example, the initial "outcry" phase of grief is marked by a wrenching outpouring of sadness and tears. In schematic terms, this phase reflects the discrepancy between a working model involving the potential loss of an intimate relationship and an enduring schema representing continuity in the intimate relationship. Columns 1 and 2 of Table 12.1 illustrate the difference in schematic terms before and just after the news of a death. In the first column, "before grief," the working model of the current situation matches an enduring schema of the relationship. The state of mind is calm because the relationship is undamaged. Just after the death, as shown in the second column, a mismatch exists between the working model and the enduring schema. The news of loss changes the working model to one representing harm to the relationship, but the enduring schema expects stability and episodic togetherness. This mismatch between the working model and enduring schemas leads to an alarm reaction, resulting in a sudden, sharp emotional expression, or outcry. The outcry is the result of both the news of the harmful event and the discrepancy between working models and enduring schemas. The discrepancy can be so marked and "inconceivable" that the bereaved enters the "denial" phase of mourning.

TABLE 12.1
Relationship Between Enduring Schemas and Working Models During Grief

Stage of Grief	Before Grief	Outcry	Denial	Intrusive	Working-through/Completion
Current Working Model of Relationship	Self — Mutuality — Other	Self — Need / Help — Harmed Other	Self — Deny → Absent Other	Self — Need → Absent Other	Self — Need → Absent Other
Enduring Schema of Relationship	Self — Mutuality — Other	Self — Mutuality — Other	Self — Mutuality → Other	Self — Mutuality ⇄ Other	Self — Need → Absent Other
Accord of Working and Enduring Schemas	Match	Mismatch	Mismatch	Mismatch	Match
Emotional Systems	Equilibrium	Alarming Rate of Arousal	Blunted	Alarming Rate of Arousal	Equilibrium
Predominant States of Mind	Calm	Fearful Outcry	Depressed	Agitated Sadness	Poignant Sadness or Resignation

Source: Adapted from Horowitz, 1991, pp. 18, 20. Reprinted with permission.

During the denial phase (see column 3), the bereaved is unable to fully accept news of the death and consequently dampens his or her emotions. Schematically, this may represent an attempt to maintain the enduring

schema of the other as alive, but the bereaved is unable to do so, owing to knowledge of the death and, consequently, a response of suppressing higher order sensory and perceptual systems altogether. Within limits, the denial functions adaptively, protecting the bereaved from the devastating psychological impact of the death.

The fourth column depicts the "intrusive" phase of mourning. During this phase, turbulent ideas and pangs of intense sadness occur upon encountering familiar situations in which the bereaved person was usually with the deceased. Now, however, the situation is painfully empty. As indicated, the working model of being alone is discordant with an enduring schema of being together in a mutual relationship. The result of this mismatch is a sharp emotional arousal, leading to a state of agitated sadness.

Gradually the bereaved individual enters the "working-through" phase of mourning and develops an enduring model of the deceased as permanently absent. With repetitions of new situations and their working models, new enduring person schemas gradually develop. The fifth column of Table 12.1 illustrates the working-through process as it is played out in empty situations. The lonely situation, while still evoking sadness, no longer arouses the anguish it did during the intrusive phase. A mood of poignant sadness replaces one of agitated sadness. New enduring schemas have developed, and mismatches between working models and activated enduring schemas are

lessened. When the new enduring schemas are well established, the bereaved individual has entered the "completion" phase.

In RTG, the therapist intervenes at points in this phase model of mourning where progress appears to be suspended. For example, if an individual is in a denial phase, the goal would be to facilitate greater emotional expression. If the individual is in an intrusive phase, the goal is to help the patient modulate his or her emotions and to encourage an exploration of their meaning. The assumption is that interventions of this type will free up the individual to move toward fuller completion of the mourning.

TECHNIQUES

As noted, RTG is adaptable to either time-limited or time-unlimited formats. For a time-limited format, general treatment principles offered by practitioners such as Mann (1973) or Malan (1976) are appropriate. Weekly sessions are recommended.

When patients experience the painful effects of grief, some therapists may consider the concomitant use of antidepressant, antianxiety, or sleep medications with RTG. In general, these agents are not needed. The therapist will usually see positive changes in a patient's state of mind within four to six weeks. If a patient does not experience significant symptom reduction after

this length of time, consideration of a medication may be warranted. Medication should also be considered if the patient becomes suicidally depressed or otherwise presents a danger to self or others. When considering a pharmacological intervention, it is important to explore the patient's thoughts and feelings about it.

Treatment Phases

RTG is organized as five treatment phases: (1) initial formulation; (2) establishment of a therapeutic relationship and treatment frame; (3) labeling schemas of self and others; (4) learning schemas of self and other; and (5) termination. In actual practice, there are no clear boundaries between these phases, and the therapist may move back and forth across them.

Initial Formulation

A psychotherapy case formulation differs from therapy techniques. The formulation provides a blueprint for the treatment process; it guides the therapy, facilitates the therapist's conceptualization of the patient, and serves as a marker for progress. It is not static but is elaborated and refined as the therapist comes to understand the patient better. Therapy technique, on the other hand, refers to the therapist's interventions and tactics during the treatment hour that are directed at helping the patient. A provisional formulation can often be completed by the end of the first or second session.

The goal in constructing the formulation is to provide links between biographical information gathered from the patient, behavioral observations made by the therapist and patient, and inferred psychological structures and processes. Biographical information that is particularly important for bereaved patients is presented in Table 12.2. Regarding inferred structures and processes, RTG focuses on the patient's prominent states of mind, schemas of self and others, and habitual strategies for controlling ideas and affect (Horowitz, 1987).

Cognitive/affective states. A state of mind is a recurrent pattern of experience that is revealed by verbal and other behavioral cues. Indicators of a patient's current state of mind may include abrupt changes in facial expressions, intonation and inflection in speech, general arousal level, shifts in the expression of or apparent capacity for empathy, affective display, and posture. It is often convenient to label a state of mind. Common state labels for bereaved individuals include "intrusive crying," "frozen," "scared and disorganized," "businesslike and together," "plodding on," "vindictive and angry," and "self-reproaching." When inferring a patient's states of mind, begin with those that comprise the major symptomatic phenomena. The therapist should include states over which the patient has greater emotional and cognitive control (e.g., "compulsively overworking"), as well as less well controlled states (e.g., "overwhelmed by grief").

Schemas of self and other. Patients may have multiple and contradictory concepts of self and significant others. For example, a young widow may see herself as a "loyal wife" in relation to her deceased husband, but also as a "betrayer" as she begins to date again. The patient's concepts of self and others are revealed in statements such as "I'm a *shy* person," "My [deceased] father loved me but got mean when he drank" (suggesting a schema of father as *loving* and *mean),* and "I'm the sort of person who looks after himself" (suggesting a self-schema as *self-reliant).* The therapist can also identify schemas in the narratives a patient tells in therapy.

Schemas of self and other can be linked in transactional scripts to form "self-other schemas." As shown in Table 12.3, a self-other schema can involve a woman who views herself as a "depressed mourner" "seeking comfort" from an individual she views as a "selfish partner." He "withholds" comfort, and she responds by "withdrawing." We will return to this case later. Some self-other schemas are more adaptive than others, and some reflect predominantly feared or wished-for interactions.

TABLE 12.2 Information to Gather Early in Relational Therapy for Grief

Signs and Symptoms

• Symptoms? Intrusions? Omissions? Are there fantasies of joining the deceased? Insomnia? Mood? Appetite? What gives you pleasure in life now?

• How is your physical health at present?

• Are you currently taking any prescription drugs?

• Do you drink alcohol? If so, how much? Has this amount changed since the death? Illicit drug intake?

• Why are you seeking help now?

• Anniversary reactions?

Circumstances of the Death

• When did the death occur? How did you learn of the death? Where were you? What were you doing? What thoughts or experiences did you have as you heard the news? What did you do next? Did you tell others? How did they respond?

• How did [deceased] die? Was the death expected?

• Was there a funeral? How was that decision made? Did you go? If so, did going provide any relief? Do you visit the grave now? If not, why not? If so, does it provide relief?

• What became of [deceased's] belongings?

• What about his or her room?

• Was there a will? How was it handled? What role, if any, did you play? How was it decided that [person] would make these arrangements? What are your thoughts about how the will was handled?

Nature and History of the Relationship

• Tell me about your relationship with [deceased].

• *(If deceased was a spouse):* How did you meet? How did you decide to get married? How long did you know each other before marrying? Did you have children? How was that decision made? How old are your children now?

• How did you and [deceased] support yourselves?

• How were decisions in the relationship made?

• What problems were there in the relationship?

• How about other important past relationships in your life?

Circumstances Since the Death

• How have you managed your life since [deceased's] death?

• Since the death, have you sought other professional help? Psychotherapy? Medication? Was it helpful?

• How has your life changed as a result of the death?

• What other stressors are you facing?

• Financial? Interpersonal? Legal? Dependents? Recent moves?

• Have you been able to express your painful feelings to others in your life?

• Are you working now? Does work provide relief or add to your stress?

• How do you spend your days? Do you leave home often? How often do you see others?

• Where do you see your life going from here? What would you like to be doing a year from now? Five years?

• *(If deceased was a spouse)*: Have you developed any new relationships since the death? If not, why haven't you? Would you like to?

Habitual style of controlling ideas and affect. "Habitual style" refers to the processes employed to control the flow of ideas and emotions. The therapist can begin to complete this component of the case formulation by labeling the previously identified states and schemas as relatively available or relatively unavailable to conscious awareness. The woman who saw herself as a "betrayer" of her deceased husband was relatively less aware of this self-schema than she was of the view of herself as a "loyal wife." Similarly, many grieving patients may be better able to elaborate on thoughts associated with a state of "intrusive crying" than those that go with a "vindictive and angry" state. Indicators of a patient's style of controlling ideas and affect include rapid shifting of topics, overly vague or excessively precise presentation of thoughts and feelings, disavowal of previously offered information ("My

[deceased] father was mean to me but really loved me"), and denial. Benjamin's (1993) "wrong-patient syndrome" illustrates a pattern of control seen in some narcissistic patients who discuss the problems of others more than their own problems. A list of defense mechanisms, such as that provided in the *DSM-IV,* can be useful in identifying control processes.

TABLE 12.3

Case Formulation of Ms. Everett. Schemas of Self and Other, Aims, and States of Mind

Schemas of Self	Aims	Schemas of Other	States of Mind
	Problematic Relationship Schema		
Depressed mourner	Seek comfort ⟶	Selfish partner	Sad, tearful, anxious
	Withhold ⟵		
	Withdraw ⟶		
	Adaptive Relationship Schema		
Responsible, healthy person	Control ⟵	Irresponsible boyfriend	Well-modulated, controlled
	Resent ⟶		
	Compulsively discuss, subtly blame ⟶		
	Feared Relationship Schema		
Weak, helpless victim	Exploit, control ⟵	Powerful, cruel manipulator	Panic, guilt
	Submit ⟶		
	Destroy, abandon ⟵		
	Wished-for Relationship Schema		
Talented daughter/protégée	Admire ⟶	Powerful, principled father/mentor	Enthralled
	Guide ⟵		
	Idealize ⟶		
	Habitual Controls of Thought and Affect		
	"Wrong-patient syndrome" Splitting Devaluation Omnipotence Idealization Role reversal		

Once the elements of the case formulation are gathered, the therapist assembles them to make a coherent story. It is useful to think in terms of cyclical wish-fear-defense triads. To illustrate, a young widow may *wish* to let go of her strong attachment to her husband who died years earlier, but she

fears that letting go will lead to painful states of abandonment and the view of herself as a betrayer. As a *defensive* compromise, she may withdraw from people and compulsively throw herself into states of distraction and overwork. Her compromise, however, may lead to states of loneliness and back to the *wish* to let go.

Establish a Therapeutic Relationship and Treatment Frame

As with most forms of psychotherapy, it is important in RTG to establish a positive and structured working relationship with the patient. This is accomplished in part when the therapist takes a collaborative and affirming stance with the patient. It is also accomplished by actively listening to the patient, by preserving the patient's sense of autonomy, and by striving to understand the patient's world as she or he sees it. Each of these actions helps the patient to see that the therapist is a potentially helpful individual.

Establishing a therapeutic contract and treatment focus, or "frame" (Langs, 1981), is also critical to forming and maintaining the therapeutic relationship. The treatment frame includes arrangements as to the frequency of meetings, length of treatment, length of sessions, fees and the method of their payment, treatment goals, and the respective roles of the patient and therapist in pursuing the goals. The frame provides a context for the ongoing relationship that therapy requires; it also provides a point of orientation from

which the therapist may understand the patient. For many bereaved patients, the frame represents a comforting and predictable structure in an otherwise out-of-control world. It provides a safe environment in which the patient's contradictory views and powerful feelings toward the self and the deceased can be understood.

The frame is set during the first or second session, always after the therapist has made an initial formulation and determined that psychotherapy can be helpful. The frame is established knowing that it may be challenged or broken at some point during the therapy, perhaps at many points, especially when the patient is angry, frightened or threatened or has prominent Axis II psychopathology. When the frame is violated, the first treatment priority (barring imminent threats to the patient's safety or that of others) is to reestablish it and to understand the reasons it was broken. These reasons often relate to the patient's feelings about the therapist, the treatment, and the deceased.

Consider a young man who entered therapy several months after the unexpected death of his twin brother, toward whom he had often felt jealous and submissive. Several sessions into the therapy, the patient accused the therapist of overbilling him and refused to pay for one session. On further review, it became apparent that the patient had misread his bill. Without accusing the patient of wrongdoing, the therapist invited him to explore any

possible meanings in the misunderstanding. Upon further discussion, it became apparent to the patient and the therapist that the mistake reflected the patient's displaced aggression toward his brother. In the following sessions, the patient reported greater assertiveness in his interpersonal relationships and less preoccupation with the death of his brother.

As in this example, the breaking of the treatment frame can often be interpreted in light of a patient "acting out" thoughts and feelings toward the deceased, as represented by the therapist, rather than talking them out with the therapist.

Labeling Schemas of Self and Others

Once the initial formulation is made and the frame is established, therapy proper begins. Usually, symptom control is an initial focus of work. Symptom reduction is often significant during the first four to six sessions as the patient experiences the comforting structure provided by the therapist and the treatment frame. Once symptoms are under better control, it may appear that a focus on the deceased is no longer necessary or that treatment can end. Early symptom reduction, however, may reflect movement into a denial phase of mourning rather than into a completion phase. Further, treatment goals are usually broader than symptom reduction alone; they may include adaptive changes in the patient's social and occupational functioning.

At this point, therapists need not be overly concerned with encouraging abreaction. Denial can have an adaptive function, permitting the patient to prepare for the hard work ahead. The therapist should patiently allow the patient to recover at his or her own pace but at the same time should intervene if the patient seems stuck in the denial phase.

When symptoms are better modulated by the patient, the treatment should refocus to when and why the patient enters the painful, intrusive states of mind. Doing so involves identifying and labeling the patient's schemas of self and other, particularly of the deceased but also of other significant individuals in the patient's life. The primary strategy is to encourage the patient to relate detailed and concrete narratives about his or her relationships. Psychotherapy narratives have four components: (1) a temporal sequence from beginning to middle to end; (2) initiating actions, thoughts, and feelings of the self; (3) imagined and/or actual responses of the other; and (4) responses of the self to the responses of the other (Luborsky & Crits-Christoph, 1990). The therapist can elicit narratives by using questions from Table 12.2, framing them according to the details of the patient's life. When a patient offers part of a narrative, the therapist can ask for other parts. One patient expressed anguished guilt and self-condemnation about not saying "I love you" to his father, who was gravely ill in the hospital and about to die. With the aim of exploring this narrative further, the therapist asked what the father might have experienced during the meeting, and what the

patient wished the father had said and done. This exploration enabled the patient to better understand his father's capacity for forgiveness as well as his weaknesses.

As narratives are elicited and evaluated, the patient's repertoire of schemas of self and other will emerge. The therapist then uses the stories to point out these concepts to the patient.

Learning Schemas of Self and Other

Labeling is only the first step in understanding and correcting maladaptive views of self and other. Without a fuller appreciation of the meaning of these concepts, the patient risks using them in an intellectualized and defensive manner. Learning one's maladaptive schemas of self and other means appreciating the consequences they have had on one's life, reappraising their significance, and developing the capacity to choose alternative interpretations or actions. As more narratives are told, the therapist and patient may explore them as variations on themes that emerged earlier. The patient-therapist relationship may become a more important focus during this portion of the therapy as the patient tests out maladaptive beliefs on the therapist. An emergence of previously warded-off thoughts and feelings toward the deceased may also occur. As patients gain greater familiarity with previously unacknowledged aspects of self, many show an

improvement in social and work functioning. They may initiate new relationships or undertake new activities to fill the void left by the deceased.

Termination

The goals of the termination phase are to prepare for continuing the mourning process without therapy and to achieve a successful ending of the relationship with the therapist. It is important for the therapist to set the stage early in treatment for its termination. Termination is first discussed as part of the frame; if the patient does not bring it up in later sessions, the therapist should. During the termination phase, goals are reviewed with respect to whether they were achieved. If goals have not been achieved, the impediments to greater change are discussed. Termination provides the opportunity to end an important relationship in a different and more fulfilling manner than that in which the bereaved may have ended the relationship with the deceased. Just as the patient begins to form a healthy identification with the deceased, he or she can do the same with the therapist. There may be discussions of continuing the mental relationship with the deceased, as well as with the therapist, in a supportive and nonintrusive manner. Sometimes intrusive symptoms will reemerge during the last sessions as the patient prepares for another loss. The therapist should frame these as expressions of the impending loss rather than as a setback.

The termination phase might also include a discussion of future contacts. If therapy was conducted in a time-limited format and additional work is deemed important, an interim period of one to three months is recommended prior to reinitiating treatment. This interval will give the patient time to test out and consolidate any therapy gains.

Specific Techniques

As with most forms of psychodynamic treatment, the specific techniques used in RTG can be classified as supportive or expressive (Luborsky, 1984; Wallerstein, 1986). The goals of supportive techniques are to maintain the therapeutic alliance and to strengthen a patient's current adaptive strategies. Expressive techniques, on the other hand, are aimed at helping the patient understand obscure, contradictory, or otherwise puzzling aspects of self and others, usually through encouraging the expression of thoughts and feelings. In RTG, adaptive changes outside of therapy are also monitored regularly. Primary exploration focuses on the relationship with the deceased and other significant others, although the therapist-patient relationship is a secondary focus.

Below are specific techniques that can facilitate the explorations required in RTG. The therapist should use them in a manner crafted to the specific problems of the patient rather than in a stereotyped manner. The

selection of techniques is guided by the patient's personality style, the therapist's case formulation, and his or her assessment of where in the mourning process the patient is impeded.

Not Taking Sides

It is important to create an atmosphere that facilitates the exploration of negative as well as positive images of self and other. This goal is facilitated when the therapist avoids "taking sides" with respect to the patient's repertoire of schemas of self and others. The therapist's goal is neither to endorse nor to dispute a patient's "version" of self or other, but to invite the bereaved patient to explore all aspects of his or her significant relationships. It is particularly important to take this stance in grief work because it counters denial processes and facilitates the exploration of latent negative self-images that may be complicating the mourning process. If the therapist precipitously reassures the patient that he or she is not "unforgivable," "weak," or "destructive," these aspects of the patient's self-organization are not explored and integrated. The therapist's stance, instead, is to remain a stable, consistent, and predictable presence as the patient explores these frightening self-schemas. Not taking sides also provides a framework through which the patient's thoughts and feelings about the therapist can be explored. "Not taking sides" does *not* mean that the therapist is consistently silent or non-interactive during the therapy. On the contrary, the RTG therapist is

quite interactive with the patient.

Stating the Core Conflict

The core conflict, as summarized in the case formulation, should be communicated to the patient during the course of treatment. It is preferable for the therapist to speak in short, simple sentences and to communicate the formulation in pieces at appropriate moments in therapy rather than as a single intervention. Suitable opportunities to communicate the formulation occur after the patient has engaged in a topic that relates to the core conflict. A skilled therapist avoids using a didactic style, aiming instead at crafting questions that lead the patient to portions of the core conflict. A short, clearly stated intervention is more likely to be effective than lengthy interventions, which can deplete the emotional charge of a session. It is preferable for the therapist to speak in terms intended to match or mismatch the patient's current state of mind, depending on the therapist's goals for the intervention. If a histrionic patient is in an intrusive, tearful, childlike state of mind and the therapist wants to help the patient gain more control, she or he can use "adult" language with more abstract concepts. Similarly, if an obsessive patient is intellectualizing, the therapist can use simpler, more emotionally evocative language. On the other hand, if a histrionic patient is emerging from a denial phase of mourning, the therapist may match the patient's childlike language to encourage the expression of genuine affect. Similarly, if an

obsessive-compulsive patient has expressed considerable affect toward the end of a session and is moving into a well-modulated, "defended" state of mind, the therapist can facilitate this state transition by matching the patient's intellectual style.

Supportive Techniques

The support conveyed by a therapist can go a long way in comforting the bereaved. Supportive techniques range from nonspecific to highly specific. Nonspecific aspects of support include the structure and regularity provided by the weekly sessions, the therapist's availability and punctuality, and the therapist's conviction that the patient is capable of overcoming his or her pain and moving on meaningfully in life. The therapist need not convey this conviction in an overt statement, which may strike a patient as trite or stereotypical. Rather, the therapist expresses this conviction through tone of voice, respect for the patient's autonomy and natural healing process, and appreciation of the pain the patient is experiencing; that is, the therapist expresses the conviction through his or her entire stance toward the patient.

Specific supportive techniques include educating the patient about normal processes of grief and making suggestions that encourage greater activity in the world, increase social support, or encourage acts of kindness toward the self. Suggestions may be expressed in the form of questions, such

as, "How are you staying busy during the day?" "Do you have religious convictions or another belief system that provides some comfort?" "Have you considered volunteering or working to help fill your days?" and, "Have you treated yourself to anything special lately?" The therapist can also use supportive techniques as a form of "permission" for the patient to reengage in the world at a pace he or she chooses.

Use of Normalizing Interventions

Normalizing interventions communicate to the patient that the haunting, intense symptoms of grief are within the normal range of human experience and are understandable in light of the patient's loss. It is helpful to frame symptoms as attempts to cope with a major life stressor, rather than as reflecting "mental illness." For example, the therapist might say, "It's not surprising that you feel out of control in light of all you've been through."

Encourage Elaboration

Some patients, particularly those with histrionic or avoidant styles or those in a denial phase of grief, will give very few details in relating narratives. They may speak in a highly impressionistic or global manner (Shapiro, 1965) or prematurely sum up relationships, as if they have said all there is to say about the topic. These styles of self-presentation can be understood as attempts by the patient to modulate the expression of thoughts

and feelings. Often, although not always, the patient is unaware of the function his or her behavior is playing. The therapist can encourage elaboration by asking detailed questions about specific events or by asking for examples of patterns the patient identifies. Not infrequently, the impression that emerges from a detailed inquiry about a relationship sequence is quite different from the patient's original description.

To illustrate, one patient summed up his deceased father's problems by describing him as a "peacemaker" who tried to please too many people. When asked for specific examples, it emerged that the father was much more manipulative and cruel than one would infer from the descriptor "peacemaker." Sometimes patients will seem unable to communicate more details about relationships. They may repeatedly say, "I don't know," when asked open-ended questions. In these cases, the therapist can focus on the patient's lack of elaboration, perhaps expressing curiosity or puzzlement, since the relationship problems communicated earlier by the patient suggested that there was much to talk about. It may turn out that the patient's lack of elaboration is a response to overlearned family injunctions or taboos about certain topics.

Explore Dyselaboration

Some patients' use of language reveals how emotional content is

avoided. For example, a patient might refer to himself as "a little angry," "bothered," or "sort of mad" at his deceased father for belittling him in life. Exploring the meaning of these topic-avoiding verbalizations facilitates emotional expression in patients who are in a denial state of mourning. It also helps reveal warded-off concepts of self and other. One widower offhandedly referred to his former marriage as "the relationship." When the therapist pointed out this unusual form of reference, the patient became more aware of feeling emotionally distant from his wife.

Explore Behavioral Leakage

Behavioral leakage refers to indicators of over-controlled emotion. It is often observed only briefly. For example, when discussing a seemingly nonconflictual topic, a patient's face may suddenly redden, his or her eyes may briefly tear up, or there may be a transient flash of anger. Exploring behavioral leakage is particularly helpful for patients in denial states of mourning. The therapist does so by first calling the patient's attention to the behavior and inquiring whether the patient was aware of it. The therapist then invites the patient to explore the meaning of the leakage.

Name States of Mind and Schemas

Referring to patterns in a shorthand way enables both therapist and patient to identify them efficiently later. For example, one histrionic patient

referred to her style of frequent topic changes with the term "cliffhanger," indicating that she shifted a topic before bringing it to a conclusion. Later in the therapy, she and her therapist were both able to identify this pattern with this term. It is preferable if the shorthand term is first coined by the patient.

Explore Topic Flow

The patient's control of the topics discussed in therapy can be a means of understanding areas of conflict. For example, one patient with an obsessive-compulsive personality style rapidly changed topics. The therapist commented, "I've noticed today that each time we approach the topic of your mother's death, we quickly end up on a different topic. Have you noticed that?"

Facilitate Compassion for the Self

Grieving patients are often highly self-condemning and guilt-ridden. Many may be tormented with questions such as, "Why didn't I call him that last night in the hospital?" and, "Why wasn't I kinder?" The therapist's eliciting of narratives can bring these evaluative schemas of the self to the foreground. At such times, it is helpful to ask the patient whether he or she is able to find any compassion for the self in the midst of the self-condemnation. Such a question often surprises patients, who may not consider themselves "worthy" of compassion. Sometimes patients will answer, "No. I do not have

any compassion for myself. I don't deserve it." At this point, the therapist should avoid overt reassurances that the patient does, in fact, deserve compassion. Such a response may leave the patient feeling more criticized or helpless. A more productive tactic is to ask *why* the patient is unable to generate self-compassion, what prevents it, what its consequences might be, and what must happen for the patient to experience it. The therapist might also ask whether the deceased would be more forgiving of the patient, and what the deceased would think of the patient's self-condemnation. Finally, the therapist might consider whether the self-condemnation reflects an identification with past critics in the patient's life, perhaps including the deceased. Inquiries of this nature demonstrate an appreciation for the patient's value system and view of the self without endorsing them as adaptive. It also invites the patient to consider self-forgiveness and compassion as a worthwhile aim.

CASE EXAMPLE

Pamela Everett was a 25-year-old graduate student when she sought treatment for depression 18 months after her father died of heart disease. Ms. Everett's symptom presentation included insomnia, irritability, feeling "empty," recent weight gain, and crying spells that seemed to "come out of nowhere." She dated the onset of these symptoms to six months after her father's death, although she had had similar symptoms to a lesser extent prior

to his death. Ms. Everett reported that she felt unsupported by her boyfriend of three years and unable to discuss her thoughts and feelings about her father with him. Unable to sleep, Ms. Everett frequently leafed through photographs of her father late at night. Although she felt more connected to him through this activity, it always precipitated deep sobbing and feelings of abandonment and loneliness.

During the initial consultation, Ms. Everett discussed her relationship with her father and reviewed the circumstances of his death. She had great admiration for him but was also acutely aware of his limitations. She described him as an emotionally constrained, taciturn, and principled man. He seldom spoke about his feelings and took a highly guarded and superior stance toward others. He took great interest in his daughter's career choices, occasionally offering her advice, which she treasured. He advised her to pursue her dreams and not sacrifice them for either him or her mother, as he felt he had done for his parents. During her childhood, Ms. Everett idealized her father and felt much closer to him than to her mother. As an adolescent, she was shaken upon realizing that his belief system may have been based on irrational prejudice rather than logic. Ms. Everett recalled that her parents were coldly hostile toward each other but seldom argued openly. When in public, they became painfully shy. Early in her life, Ms. Everett was cast in the role of "family spokesperson." She became highly talkative and often the primary source of entertainment when adult friends of her parents visited.

Ms. Everett remained in regular contact with both her parents throughout her early adulthood.

The death of Ms. Everett's father was expected, coming after a long illness. Ms. Everett took an active role with her father's physicians during his last days. A week before he died, they told her that little could be done for him. Ms. Everett considered seeking an outside opinion, but her father died before she carried out her plan. Despite his terminal illness, Ms. Everett's father refused to discuss the possibility of death. This refusal played a significant role in Ms. Everett's last visit with her father. The two did not discuss the possibility of his death and the fact that this might be their last opportunity to talk. Ms. Everett said she "lacked the courage" to bring up the topic on her own. Instead, the two carried on a rather superficial conversation. As she was ready to leave, she wanted to tell her father she loved him but did not. The two rarely exchanged such words.

Although the death was expected, Ms. Everett felt unprepared when it came. She rapidly oscillated between overwhelming tears, pangs of guilt that she had not done enough for him, feelings of paralysis, and dutifully carrying out funeral arrangements and making necessary arrangements for her father's estate. In the face of these stressors, Ms. Everett took no time off from school except to attend the funeral. She settled back into her life after this initial "outcry" but gradually sank into a depression.

Ms. Everett and her therapist agreed to meet for once-a-week therapy on a time-unlimited basis. They set the following three goals: (1) to eliminate symptoms of depression, particularly insomnia, sad mood, and crying spells; (2) to improve understanding of her relationship with her father; and (3) to better understand and reduce current stresses with her boyfriend. The therapy lasted one year.

Table 12.3 summarizes the case formulation, which was constructed during the first weeks of therapy as relevant information emerged. I will refer to the formulation as I describe the "labeling schemas of self and other" step of the treatment.

During the early sessions, Ms. Everett presented herself primarily in one of two ways. First was as a sad and tearful mourner who was seeking comfort through disclosing her feelings. She complained that her boyfriend was not receptive to these feelings and "withheld" comfort. In turn, she withdrew from him. The therapy sessions seemed to serve as a substitute for the comfort she sought from her boyfriend. This relationship is depicted in Table 12.3 as a "problematic relationship schema" because it depicts Ms. Everett's primary presenting complaints. During these sessions, the therapist encouraged the expression of sadness and tears.

After the initial sessions, a brighter side of Ms. Everett came forth. She

presented herself as a responsible, healthy person who straightforwardly discussed problems with her boyfriend, particularly feelings of being controlled by him. She avoided talking about distressing states of mind and seemed motivated to give the impression that most of her relationship problems resided in her boyfriend. This relationship scenario is presented as an "adaptive relationship schema" in Table 12.3 because it was inferred to reflect an attempt to cope adaptively with an underlying wish-fear conflict, which at this point in the therapy was obscure.

A significant state of mind during these early sessions was revealed in a forced, compulsive quality to Ms. Everett's speech and a style of laughter that seemed designed to elicit laughter from the therapist. When the therapist commented on these observations, Ms. Everett became tearful and pointed out how important it was for her to maintain self-control. She linked her behavior to her efforts as a child to entertain her parents and others. A similarly noteworthy state occurred during the brief moments of silence Ms. Everett allowed during the therapy. At these times, she was seized with a sense of impending panic. She did not understand these feelings and fought strongly to ward them off.

In the next several sessions, Ms. Everett experienced increasing fears of panic and loss of emotional control. In a tearful session, she related feelings of "unforgivable" guilt because she had not followed through on getting a second

medical opinion on her father's condition. She castigated herself for lacking initiative and placing "false trust" in his physicians. Her therapist suggested that she might also feel that she had placed false trust in him, considering the intensity of her panicked states of mind. This interpretation precipitated a series of significant narratives during the following sessions. They involved themes of powerful manipulators who exploited innocent or not-so-innocent victims. Themes of greed and exploitation also emerged in these stories. In some stories, Ms. Everett played the role of manipulator; in others, she was the victim of others. Although the stories were not ostensibly about her father, the themes seemed to reflect an unconscious identification with him in two ways: as a powerfully cruel, emotionally sterile, and controlling person, but also as a weak and helpless man who feared others and felt inferior to them. These narratives are represented in Table 12.3 as "feared relationship schemas." These disclosures, along with Ms. Everett's complaints of emptiness and her efforts to focus the treatment on her boyfriend's problems, suggested a narcissistic personality style.

The narratives about other men led to disclosures about Ms. Everett relationship with her father. She tearfully related how he had suffered abuses at the hands of his parents. She related pride in his accomplishments but also seemed to share his sadness and disappointment that he had not accomplished more. His sullen, angry, and emotionally sterile side seemed to have a more human face after these narratives were told and discussed. The

"wished-for relationship schema" in Table 12.3 depicts Ms. Everett's major, childlike hopes for her relationship with her father. During these sessions, the therapist pointed out the roles that Ms. Everett cast herself and others into, as well as the relationship scenarios that played out between the "actors" of these roles.

After the significant schemas of self and other were presented, the therapy moved from the step of labeling schemas to that of learning their significance. The sessions increasingly focused on the relationship between Ms. Everett and her therapist. When he permitted periods of silence, Ms. Everett accused him of "withholding" help. She expressed fantasies that he was as manipulative and controlling as others in her life, including her father. In contrast, she saw herself as weak and out of control. At other times, Ms. Everett saw the therapist as a potential victim of her own seductive power. These themes were also expressed in the form of violations of the therapeutic frame. Ms. Everett canceled a number of sessions and requested changes in appointment times on short notice, all on ostensibly extra-therapeutic grounds. When these behaviors were framed in terms of deviations from the treatment contract, which specified weekly sessions, a deeper meaning emerged. Ms. Everett acknowledged that her canceled sessions were a test of whether the therapist would reject her. They also seemed to express Ms. Everett's strong motivation to control the therapist. Since she felt powerless to control him during the sessions, she expressed control by canceling

sessions.

After these "violations" were discussed, Ms. Everett resumed her earlier pattern of keeping her weekly appointments. The therapy moved more fully into a "learning schemas" phase. Ms. Everett gradually felt more comfortable in the therapy sessions and more assured that the therapist would not overstep his professional role. She felt more comfortable with silence and was not as compelled to fill all silences with talk. She discussed with pride that she was much better able to tolerate silences outside of the therapy sessions.

Further discussion about relationship difficulties ensued. It became clear to Ms. Everett that her relationship problems resembled those of her parents. She was at risk of having a similarly "paralyzed" relationship with her boyfriend. She made a commitment to being more assertive with him, to communicate more clearly, and to be more accepting of his "laid-back" lifestyle. His commitment to their relationship was reflected in his decision to enter psychotherapy.

Ms. Everett developed a more balanced image of her father. She expressed appreciation of his positive qualities, such as his intelligence and commitment to family. She was also more able to accept those qualities that she had criticized earlier, especially his difficulty with emotional expression. Ms. Everett began to struggle with the notion that forgiveness of self is

possible. She showed greater compassion and objectivity toward her own behavior at her father's death.

As Ms. Everett developed a stronger sense of self, as her relationships strengthened, and as she sustained a period of significantly reduced symptoms (including the absence of panic), she brought up the topic of termination. She and her therapist reviewed the past year's work. Ms. Everett expressed appreciation for minor qualities in the therapeutic interaction, for example, starting sessions on time. She felt increasingly secure in her capacity to form a close relationship that did not have the exploitive qualities of other relationships in her life. Although reporting increased satisfaction in her relationship with her boyfriend, she also recognized the need for further work. The topic of her father played a less central role in the sessions as she spoke more about current relationships and goals.

To summarize the case description, Ms. Everett developed a grief disorder following the death of her father. Her highly ambivalent relationship with him was complicated by a narcissistic personality style and concurrent relationship stressors. Prominent defenses were splitting, idealization, devaluation, omnipotence, and role reversal. The death of Ms. Everett's father activated feared latent schemas of the self as a helpless victim and as a powerful and merciless exploiter. These schemas seemed to develop out of Ms. Everett's intense frustrations and anger in not receiving the love she

needed from her father, whom she viewed as powerful but also as cripplingly flawed and vulnerable. The therapy focused on eliciting and reviewing Ms. Everett's repertoire of relationship schemas, including those that were most strongly warded off. The use of the patient's thoughts and feelings toward the therapist provided the opportunity for a here-and-now exploration of these conflicts. The establishment of an explicit therapeutic frame, and the therapist's stance of not taking sides, provided a context that permitted a fuller range of Ms. Everett's relationship schemas to emerge.

TRAINING

RTG is best taught with a manual guide (Horowitz, Marmar, Krupnick, Wilner, Kaltreider, & Wallerstein, 1984) in a format that permits close observation of the therapy process. A detailed review can be accomplished with videotape, audiotape, or process notes or through live supervision. Group supervision may be a more efficient form of training. Typically, one member's psychotherapy session is discussed during a single meeting. A close review of the session facilitates the observation of the effects of different types of interventions, unconscious meanings, the flow of the session, and shifts in a patient's state of mind and therapeutic responses to such shifts.

EMPIRICAL EVIDENCE FOR THE APPROACH

Surprisingly few controlled studies have been conducted assessing the efficacy of psychotherapy for the bereaved. Marmar, Horowitz, Weiss, Wilner, and Kaltreider (1988) compared time-limited (12 sessions) psychodynamic psychotherapy and mutual-help group treatment in a female conjugal bereavement sample. Women in both treatments experienced significant symptom reduction as well as improvement in social and work functioning. In a noncontrolled study of 52 bereaved patients treated in time-limited (12 sessions) psychodynamic psychotherapy, Horowitz, Marmar, Weiss et al. (1984) found statistically significant reductions of intrusive and avoidance symptoms, depression, and anxiety from pre-therapy to post-therapy status. In addition, subjects demonstrated a greater capacity for intimacy, although work capacity did not change. One of the more intriguing findings from this study was that exploratory actions on the part of the therapist were more suitable for highly motivated patients with a relatively stable sense of self and less suitable for patients with lower levels of motivation or a less stable sense of self. That is, therapist actions aimed at changing the patient's understanding of self-concepts in relationship to significant others involved in the bereavement were associated with better outcome only in the more highly functioning and motivated patients. Conversely, supportive actions were more predictive of a positive outcome in more poorly functioning patients. In their review of outcome studies of bereavement, Windholz, Marmar, and Horowitz (1985) conclude that psychotherapy "is of value in

selected cases but is only warranted for subjects who show either high manifest distress or potential for distress because of specific risk factors" (p. 445). Further controlled outcome studies are needed to better assess the efficacy of RTG.

REFERENCES

Abraham, K. (1948). A short study of the development of the libido, viewed in light of mental disorders. In E. Jones (Ed.), D. Bryan & A. Strachey (Trans.), *Selected papers on psychoanalysis* (pp. 418-501). London: Hogarth Press. (Original work published 1924)

Ball, J. F. (1977). Widow's grief: The impact of age and mode of death. *Omega,* 7, 307-333.

Benjamin, L. (1993). *Interpersonal diagnosis and treatment of personality disorders.* New York: Guilford Press.

Bock, E. W., & Webber, I. L. (1972). Suicide among the elderly: Isolating widowhood and mitigating alternatives. *Journal of Marriage and the Family*, 34, 24-31.

Bowlby, J. (1980). *Attachment and loss. Ill: Loss: Sadness and depression.* New York: Basic Books.

Carter, H., & Glick, P. (1976). *Marriage and divorce: A social and economic study.* Cambridge, MA: Harvard University Press.

Crenshaw, D. A. (1990). *Bereavement: Counseling the grieving throughout the life cycle.* New York: Continuum.

Deutsch, H. (1937). Absence of grief. *Psychoanalytic Quarterly*, 6, 12-22.

Engel, G. L. (1961). Is grief a disease? *Psychosomatic Medicine,* 23, 18-22.

Fenichel, O. (1945). *The psychoanalytic theory of neurosis.* New York: Norton.

Freud, S. (1957). Mourning and melancholy. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 243-258). London: Hogarth Press. (Original work published 1917)

Freud, S. (1962). Beyond the pleasure principle. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 18, pp. 1-68). London: Hogarth Press. (Original work published 1920)

Helsing, K. J., & Szklo, M. (1981). Mortality after bereavement. *American Journal of Epidemiology,* 114, 41-52.

Horowitz, M. J. (1986). *Stress response syndromes* (2nd ed.). Northvale, NJ: Jason Aronson.

Horowitz, M. J. (1987). *States of mind: Configurational analysis of individual psychology* (2nd ed.). New York: Plenum.

Horowitz, M. J. (1990). A model of mourning: Change in schemas of self and other. *Journal of the American Psychoanalytic Association*, 38, 297-324.

Horowitz, M. J. (1991). Person schemas. In M. J. Horowitz (Ed.), *Person schemas and maladaptive interpersonal patterns* (pp. 13-31). Chicago: University of Chicago Press.

Horowitz, M. J., Marmar, C., Krupnick, J., Wilner, N., Kaltreider, N., & Wallerstein, R. (1984). *Personality styles and brief psychotherapy.* New York: Basic Books.

Horowitz, M. J., Marmar, C., Weiss, D. S., DeWitt, K. N., & Rosenbaum, R. (1984). Brief psychotherapy of bereavement reactions: The relationship of process to outcome. *Archives of General Psychiatry*, 41, 438-448.

Horowitz, M., Stinson, C., Fridhandler, B., Milbrath, C., Redington, D., & Ewert, M. (1993). Pathological grief: An intensive case study. *Psychiatry,* 56, 356-374.

Horowitz, M. J., Wilner, N., Marmar, C., & Krupnick, J. (1980). Pathological grief and the activation of latent self-images. *American Journal of Psychiatry*, 137, 1157-1162.

Kernberg, O. (1975). *Borderline conditions and pathological narcissism.* New York: Jason Aronson.

Kernberg, O. (1984). *Severe personality disorders.* New Haven, CT: Yale University Press.

Kernberg, O. F., Selzer, M. A., Koenigsberg, H. W., Carr, A. C., & Appelbaum, A. H. (1989). *Psychodynamic psychotherapy of borderline patients.* New York: Basic Books.

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

Langs, R. (1981). *Resistances and interventions: The nature of therapeutic work.* Northvale, NJ: Jason Aronson.

Lindemann, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychiatry,* 101, 141-148.

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

Luborsky, L., & Crits-Christoph, P. (1990). *Understanding transference: The CCRT method.* New York: Basic Books.

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

Mann, J. (1973). *Time-limited psychotherapy.* Cambridge, MA: Harvard University Press.

Marmar, C. R., Horowitz, M. J., Weiss, D. S., Wilner, N. R., & Kaltreider, N. B. (1988). A controlled trial of brief psychotherapy and mutual-help group treatment of conjugal bereavement. *American Journal of Psychiatry,* 145, 203-209.

Middleton, W., Raphael, B., Martinek, N., & Misso, V. (1993). Pathological grief reactions. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 44-61). New York: Cambridge University Press.

Osterweis, M., Solomon, F., & Green, M. (Eds.) (1984). *Bereavement: Reactions, consequences, and care.* Washington, DC: National Academy Press.

Parkes, C. M. (1991). Attachment, bonding, and psychiatric problems after bereavement in adult life. In C. M. Parkes, J. Stevenson-Hinde, & P. Marris (Eds.), *Attachment across the*

life cycle (pp. 268-297). London: Tavistock/Routledge.

Parkes, C. M., & Weiss, R. S. (1983). *Recovery from bereavement.* New York: Basic Books.

Raphael, B. (1983). *The anatomy of bereavement.* New York: Basic Books.

Singer, J. L., & Salovey, P. (1991). Organized knowledge structures and personality. In M. J. Horowitz (Ed.), *Person schemas and maladaptive interpersonal patterns* (pp. 33-80). Chicago: University of Chicago Press.

Sanders, C. M. (1981). Comparison of younger and older spouses in bereavement outcome. *Omega,* 11, 217-232.

Sanders, C. M. (1993). Risk factors in bereavement outcome. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 255-267). New York: Cambridge University Press.

Segal, Z. V., & Blatt, S. J. (Eds.). (1993). *The self in emotional distress: Cognitive and psychodynamic perspectives.* New York: Guilford Press.

Shapiro, D. (1965). *Neurotic styles.* New York: Basic Books.

Stroebe, W., & Stroebe, M. S. (1987). *Bereavement and health: The psychological and physical consequences of partner loss.* New York: Cambridge University Press.

Tait, R., & Silver, R. C. (1989). Coming to terms with major negative life events. In J. S. Uleman & J. A. Bargh (Eds.), *Unintended thought* (pp. 351-382). New York: Guilford Press.

Vachon, M. L. S., Rogers, J., Lyall, W. A. L., Lancee, W. J., Sheldon, A. R., & Freeman, S. J. J. (1982). Predictors and correlates of adaptation to conjugal bereavement. *American Journal of Psychiatry,* 139, 998-1002.

Vachon, M. L. S., Sheldon, A. R., Lancee, W. J., Lyall, W. A. L., Rogers, J., & Freeman, S. J. J. (1982). Correlates of enduring stress patterns following bereavement: Social network, life situation, and personality. *Psychological Medicine,* 12, 783-788.

Wallerstein, R. S. (1986). *Forty-two lives in treatment: A study of psychoanalysis and psychotherapy.* New York: Guilford Press.

Windholz, M. J., Marmar, C. R., & Horowitz, M. J. (1985). A review of the research on conjugal bereavement: Impact on health and efficacy of intervention. *Comprehensive Psychiatry,* 26, 433-447.

Wortman, C. B., & Silver, R. C. (1989). The myths of coping with loss. *Journal of Clinical and Consulting Psychology,* 57, 349-357.

CHAPTER 13

Psychodynamic Psychotherapy with the HIV-Infected Client

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Most recent estimates by the Centers for Disease Control (CDC) indicate that there are 1 million individuals living in the United States infected with the human immune deficiency virus (HIV). This works out to a rate of 1 in 100 men and 1 in 800 women (CDC, personal communication, January 9, 1995). Of these, over 130,000 have the acquired immune deficiency syndrome (AIDS); since the onset of the AIDS epidemic, over 200,000 deaths have been attributed to AIDS. The current rate of disease is 18 per 100,000 nationwide, with rates varying from 121 to 0.6 depending on the state (CDC, 1993).

These figures are certainly relevant for the psychotherapist: most of these individuals suffer significant emotional distress during the course of the illness, and many seek therapy at some point. The psychodynamic psychotherapist may very well be called on to offer treatment. Likewise, the therapist may find himself or herself treating a client who during the course of treatment learns that he or she is infected with HIV.

This is an extremely complex disease, one fraught with uncertainty and unpredictability, a significant degree of mythology, profound stigmatization,

irrational fears, and cumulative losses. The therapist unfamiliar with the disease may feel overwhelmed by its many unknowns and great complexity, a feeling that may cause him or her to avoid treating these individuals. It is hoped that this chapter will help to clarify some of the issues relevant to the psychodynamic treatment of persons infected with HIV and provide some guidance in approaching this difficult and sensitive area.

HISTORY AND DEVELOPMENT

The causative agent in the disease is virulent and lethal, but easily transmitted only under very specific circumstances. Infection, which requires the entry of contaminated body fluids from one host into the body fluids of another, occurs almost exclusively from sexual intercourse without barriers, the transfusion of contaminated blood and blood products, or the injection of contaminated blood such as occurs with the sharing of needles during the intravenous injection of drugs.

Once the virus enters the body, the immune system begins to produce antibodies to it. It is these antibodies that are detected when an individual is tested for HIV infection. After entry into the body, the virus can remain dormant for many years and the individual can experience excellent health during this interval. However, at some point the individual will develop opportunistic infections or AIDS-related cancers that officially classify him or

her as having AIDS. These illnesses are treated with varying degrees of success by medications or radiation therapy, but the invariable outcome is death.

A measure of the status of the disease from the time of infection to death actually reflects the status of one part of the immune system, a subset of the T lymphocyte, or CD4+. The total count of these vulnerable cells falls as the virus multiplies and kills them. The lower the cell count, the greater the risk of developing an AIDS-defining diagnosis as the immune system becomes unable to ward off infection. Infection is most likely to occur when the count falls below 200 per mm (Fauci & Lane, 1994).

One of the issues in psychodynamic psychotherapy with HIV-infected individuals is the potentially long period between the time of diagnosis of HIV infection to the time of expression of the disease. In fact, long-term projections of disease progression show that AIDS may not manifest itself until 10-15 years after initial infection with HIV (Chaisson & Volberding, 1990). HIV infection is perhaps unique in this respect: other life-threatening illnesses usually express themselves at the time of diagnosis or within a relatively shorter period of time. Likewise, extraordinary measures are often taken in other illnesses to attempt to arrest the progression of the disease, which may be asymptomatic (e.g., surgery for carcinoma of the bowel). The individual with HIV infection is often left with an extended period without

treatment and in relative health during which to deal with his or her illness, especially when the diagnosis is made soon after the infection. In fact, earlier diagnosis is becoming more and more common.

Review of the Literature

Most literature on the topic of psychotherapy with HIV-infected individuals suggests a broad-based approach, recommends a combination of supportive and expressive modalities, and encourages the therapist to develop a practical but flexible approach (Winiarski, 1991; Jacobsberg & Perry, 1992). However, few monographs deal with specific aspects of psychodynamic psychotherapy of persons with HIV infection.

Adler and Beckett (1989) address briefly such issues as the potential stigmatization of the client by the therapist and fears the therapist may have concerning potential contamination and/or ostracization by his or her colleagues. They also address some of the ethical dilemmas faced by the therapist in dealing with certain acting-out behaviors and the role of denial, which can put others, particularly sexual partners, at risk. They point out that the life-threatening nature of the illness may facilitate the work of therapy and that a dynamic understanding of the client and his or her place in relationships and society can make the therapist's work easier.

Sadowy (1991) discusses in a case report some of the dilemmas she

faced as an analyst who found herself in close proximity to the death of her client. She discusses each dilemma only briefly, but she does address the transferential and countertransferential aspects of the role omnipotence plays in defending the client and therapist against helplessness. She explores the role of projection: AIDS becomes a defense against angry feelings and a way of explaining behaviors and fantasies at the same time that it is experienced by the client as a punishment for sexual feelings. The author also addresses the very important role of the therapist in providing a dynamic understanding of her client even when the client is no longer able to make himself or herself understood. This role includes providing a soothing companionship based on an understanding of the deeper meanings of events to the client.

Stevens and Muskin (1987) explore the psychodynamic origins of the frequent failure of the capacity for empathy for persons with HIV infection. They attribute this failure to the process of unconscious identification and externalization, which ultimately leads to an emotional distancing from the infected individual and ultimately stigmatization.

Cohen and Abramowitz (1990) discuss a self-psychological approach to clients with HIV disease. They feel that self-object theory helps to explain the connection between the social consequences and the intrapsychic effects of HIV. They explore some of the ways in which HIV precipitates a destabilizing

crisis for the self and disrupts self-object functions. They also point out that some behaviors that help to meet self-object needs may lead to transmission of the virus.

Because of the paucity of literature addressing psychodynamic therapy in HIV disease, we have looked to related fields for some guidance. Searles (1981), for example, elaborates on issues relevant to cancer patients that are equally applicable to HIV/AIDS patients. He points out that the therapist can help the client to separate out the realistic physical threat to life from the primitive, distorted perceptions that have been projected onto it by the client or by others. Searles suggests that the terrible anxiety that accompanies the knowledge of having cancer is related more to these unconsciously threatening psychological contents than to the actual external threat. It then becomes the work of therapy to discover the defensive functions that the fact of the illness, or at least the preoccupation with the fact of the illness, is serving in the client's psychological life. The author eloquently describes how cancer can come to be viewed as a curse or punishment for unconscious aggression or as representing "oral, devouring, basically infantile-omnipotent demandingness" (p. 173). Other relevant issues include helping the client to differentiate himself or herself from the disease; the therapist's and the client's mutual envy of the other's position; the therapist's withholding in defense against anticipated loss; the importance of the therapist's grief in helping the client to grieve; countertransferential fears of making the client

more vulnerable in the course of treatment; and the therapist's fears of losing ego boundaries and the role of the fear of contagion in relation to this.

A critical aspect of therapy with clients with HIV disease is working through existential issues related to death and dying. Yalom (1980) identifies four primary concerns—fear of death, freedom, isolation, and meaning—and provides a readily accessible framework for the dynamic working-through of these important issues.

There are also certain dynamic issues relevant to this specific client population. In most areas of Canada and the United States, the majority of clients are gay men (CDC, 1993; LCDC, 1994). Historically, psychiatry has viewed homosexuality as pathological (Lewes, 1988). Fortunately, the American Psychiatric Association has officially supported the removal of homosexuality as a diagnosis suggesting psychopathology (Stein, 1993), and an expanding literature (Isay, 1989; Gonsiorek, 1982; Hetrick & Stein, 1984; Oldman, Riba, & Tasman, 1993) that explores the problems of gay men from a psychodynamic perspective does so from the premise that homosexuality can be viewed as a variant of normal. Such a premise allows the problems of gay men to be approached in a much more helpful manner, allowing, for instance, exploration of the effects of stigmatization and marginalization on the evolving sense of self.

INCLUSION/EXCLUSION CRITERIA

The Clinic for HIV-Related Concerns in the Department of Psychiatry at Mount Sinai Hospital in Toronto was established in 1986 in an attempt to address some of the mental health needs of the HIV-infected population in the city. Since that time, the clinic has assessed over 2,000 individuals and provides approximately 100 hours of service per week. The psychotherapy done in the clinic is informed by psychodynamic theory. Therapy may take the form of crisis intervention, brief psychotherapy, or long-term, open-ended psychotherapy. Over the years of our involvement with this highly troubled population, we have come to appreciate the tremendous value of a psychodynamic approach to treatment.

By far the majority of clients referred to our clinic are gay men. This reflects the demographics of HIV infection in the city of Toronto and in Canada in general. Therefore, without meaning to diminish in any way the importance of HIV in the lives of women or other special populations infected with HIV, this chapter will focus on issues relevant to gay men.

Each client referred to our clinic undergoes a psychiatric assessment by a small multi-disciplinary team. A diagnosis is formulated on the basis of *DSM-IV* (APA, 1994); treatment is prescribed based on that diagnosis and the psychodynamic formulation. Symptoms of depression and anxiety are practically universal in this population; most are diagnosed with depressive

spectrum disorders or anxiety disorders.

Clients are selected for a psychodynamic therapy in the manner in which such treatment is usually prescribed (Langs, 1982; Hollender & Ford, 1990). However, we are probably prescribing it liberally, based on our experience that the knowledge of having HIV seems to act as a catalyst to the work of therapy, helps to break through resistance, and in general motivates the client to explore unresolved issues in his or her life. The motivating force of HIV is sometimes quite surprising, and we have had the impression that even clients with difficult borderline or narcissistic personalities are able to make impressive gains in shorter periods of time than might have been expected. Extrapolating from Searles (1981), it is possible that paranoid defenses are not as important to such individuals, who realize that life is foreshortened, and they can enter into the therapeutic relationship with less fear of being overwhelmed by it. These clients' motivation may also relate to the fact that a terminal illness such as AIDS legitimizes the dependent role and help-seeking behaviors, which can easily be turned into sanctioned activities, such as frequent visits to the doctor.

In some cases, a clear focus for the therapy can be elaborated, and therapy ends when the issues involved have been addressed or when there is significant symptomatic improvement. In many other cases, the focus is less clear, and the therapy deals with the more open-ended issues of coping with

the diagnosis of a terminal illness and the existential issues involved, the pain of dealing with having a highly stigmatized illness, the shame associated with internalized homophobia, the isolation associated with other people's irrational fears of coming face to face with someone with HIV, and conflict over disclosure. Of course, the dynamic therapist quickly comes to realize that underlying the realities of the client's experience with HIV disease are conflictual patterns in interpersonal relating, unresolved intrapsychic conflicts, and a damaged sense of self.

DYNAMIC ISSUES IN HIV INFECTION

There are many dynamic issues encountered in the therapy of a patient with a life-threatening illness. The following section does not purport to explore all of them but focuses instead on certain issues that have been found to be particularly relevant in the treatment of HIV infection and AIDS.

Stigmatization

Perhaps the most pervasive, and one of the most insidious, is the issue of stigma. Stigmatization is the result of ascribing negative attributes and motives to individuals because they are associated with certain groups, a judgment that precludes the empathic understanding of the individual in any personal, sociopolitical, or sociocultural context. Clearly, gay men have been

stigmatized throughout history. From a psychodynamic perspective, stigmatization serves to distance the stigmatizer from feared elements of the self and society. The process also helps to protect the stigmatizer from the sense of his or her own vulnerability. In this context, the HIV-infected person suffers stigmatization as a result of society's fear of HIV, both as an infectious agent and as a metaphorical punishment for sexual feelings (Stevens & Muskin, 1987).

Homophobia is essentially a universal phenomenon, and it is well recognized that the fear of homosexuality is internalized by most, if not all, gay men. The resulting damage to a gay man's concept of self, sense of value, and capacity to have a compassionate relationship to himself is significant. Likewise, the internalization of "AIDS phobia" and stigmatization of those with HIV is practically universal. Intravenous drug users are stigmatized for what is commonly viewed as antisocial behavior. Likewise, women are often stigmatized owing to double standards applied to sexuality.

While the therapist must never dismiss the harsh realities associated with society's stigmatization of the gay man or any other person with HIV infection, it is important to keep in mind that a client's experience with stigmatization and its effects on him or her are highly individualized and determined by preexisting intrapsychic concepts of the self.

For example, Michael, an openly gay man who worked in the conservative environment of an accounting firm, reported that he rarely encountered overt homophobia or AIDS phobia. David, on the other hand, was a fairly "closeted" gay man who reported stigmatization at every turn. It became clear in the treatment of these two men that the difference lay in Michael's stronger sense of self and more trusting view of others, in contrast to David's highly vulnerable sense of self and rather paranoid attitude toward others. It is the work of therapy to help the client to explore issues beyond the realities of belonging to a stigmatized subculture and having a stigmatized disease—namely, the more important issues of the nature of the self and the resulting nature of his or her interpersonal relations.

Clearly, the therapist must remain vigilant for the emergence of transference in relation to stigmatization. Clients very often come to therapy expecting to encounter some form of stigmatization, whether they are gay men, intravenous drug users, or women with HIV.

The Metaphorical Meanings of Contagion

Another essentially universal phenomenon for therapy, and one closely associated with stigma, is the issue of contagion. We have seen that clients frequently view themselves as contaminated, dirty, and unlovable and as agents of death. The consequences of such self-perceptions include the

avoidance of telling others, isolation from others, and discomfort with sexual expression. Again, underneath such self-punitive views invariably lie attitudes and feelings about the self that antedate the knowledge of the infection. The therapy will uncover shame, guilt, mistrust, a sense of being unlovable, inadequacy, and other negative self-concepts. It is our clinical experience that the degree of shame and fear of rejection (and sometimes the degree of persistent emotional distress) that accompanies this disease is directly proportional to the intensity of these subconscious elements. AIDS is a very powerful metaphor. It becomes confirmation of the contaminated, unlovable self. It confirms the existence of an unsafe, hostile, and destructive environment. It is punishment for sinful behaviors, such as sexual expression, homosexuality, and behaviors that deviate from societal norms. It is confirmation of the fragility of ego boundaries and the threat of hostile, controlling intruders. In the transference, the client will project these issues onto the therapist, who must be vigilant for their emergence.

Rob is one client who illustrates how the projection of the self-concept of being unlovable creates an environment of mistrust and deception. He was desperate to enter into a long-term relationship and met a man with whom he quickly fell in love. Rob meticulously adhered to safer sex techniques, and it was not until the relationship had gone on for six months that he told his lover he was HIV-positive. His lover's reaction was a mixture of rage at the deception, extreme anxiety about his own health, fears for the future of the

relationship, and compassion for Rob's emotional state. Rob may have correctly assessed this particular lover as one who would have fled the relationship early on if Rob had not manipulated the situation so as to have his lover fall in love with him before he shared this essential bit of information. Rob's psychotherapy was itself associated with great resistance and withholding. He harbored profound unconscious fear of rejection by the therapist and defended himself through narcissistic grandiosity.

Dan, on the other hand, after careful exploration of his feelings about himself and the meanings of HIV in his life and to his subconscious world, gave up withholding the realities of his HIV status from potential sexual partners. To his surprise, he tolerated the occasional rejection he met. More surprising for him, however, was the fact that most of his partners appreciated his honesty and often accepted his sexual advances with equanimity. The impact was significant for Dan's self-esteem and sense of personal control, and his general anxiety and depression diminished significantly.

We have observed many cases in which persons infected with HIV have been able to enter into mutually satisfying and mature relationships, thus confirming for us that the issues of unlovability, isolation, and fears of being perceived as contaminated and dangerous are very much associated with individual dynamics, personality structure, and ego strengths.

Another consequence of a negative self-perception as contaminated and thus hateful is unnecessary isolation from potential sources of support. Ken suffered greatly from the isolation he felt after finding out he was infected with HIV. He felt he could tell no one, owing to his fears that he would be rejected, that contracts in his work as a freelance artist would dry up, that his friends would abandon him, and, most important to him, that his parents would either reject him or be so horribly burdened by his illness that they would suffer greatly and add to his pain. Unfortunately, Ken died from the complications of AIDS before we had time to explore in more depth his feelings about himself as a gay man and his feelings about his relationship with his parents throughout his life. Ken told his family about his illness one month before he died, when he was developing HIV encephalopathy and losing his capacity to communicate meaningfully. His parents entered therapy in the clinic after Ken's death and are struggling with their guilt for not having accepted Ken's homosexuality more fully and with the issue of what it means that Ken did not feel he could share his illness with them. Clearly, Ken's parents are representative of the many families who are deprived of the opportunity to provide love and support in this difficult time because of the projections originating from unresolved intrapsychic conflict around the narcissistic injury associated with being gay.

Greg provides another example of how HIV infection can be viewed as punishment. Greg was emotionally, physically, and sexually abused by his

father throughout his early childhood. He was continuously humiliated and placed in double-bind situations. The profound damage to his sense of self from these experiences set him on a course of self-destructive behaviors, including multiple substance abuse and promiscuous, compulsive sex. A voice from the deepest parts of himself tells him that he is undeserving of any good thing coming to him, and consequently, it is profoundly difficult for him to view HIV as anything but a natural consequence of his absolute worthlessness.

Helplessness and Control

HIV as intruder and the subsequent loss of control over one's life is a frequent theme of therapy. In this context, the issue of suicide figures prominently with these clients; it is most often associated with maintaining control over the course of life and avoiding a helpless, dependent position.

Clients often seek to regain a sense of mastery and control by attending to those areas of life in which this is still possible. For some, this means becoming extensively educated about the disease, investigating alternative treatments, or organizing one's will and funeral. However, the work of therapy also includes careful examination of the metaphorical meaning of the disease in an effort to separate out the fantasies associated with the virus from the practical realities. Most clients are able to work through their

defenses to some extent and deal with the underlying anxieties frequently associated with a profound sense of aloneness or vulnerability originating from a lifelong history of uncertain attachment.

Doug dealt with his sense of helplessness by employing his characteristic narcissistic defenses: projecting his rage toward all aspects of the medical profession, society at large, the community-based AIDS support services, and the gay community, all receiving equal wrath. He vigorously controlled his medical (and psychiatric) treatment. However, gentle interpretations as to the source of his rage helped him to temper his destructive impulses and eased the burden of his final days in the hospital for all those involved, including himself.

In the transference, the issue of control often emerges in relation to the perceived power of the therapist over the client and the client's sense that the therapist is withholding something from him or her.

Omnipotence

In the first interviews with these clients, the therapist frequently encounters the hope that the therapist and the therapy will have some positive impact on maintenance of health and ultimately on longevity. There is a widely held belief in this client group that stress reduction, avoidance of depressed mood, and a generally optimistic approach to life will preserve

health. Therefore, psychotherapy is often viewed as an important adjunct to medical treatment. Rescue fantasies and belief in the therapist's omnipotence thus figure prominently early on. Careful exploration of the individual's hopes and expectations uncovers the dynamic issues associated with the tremendous fears of abandonment and existential aloneness.

Meaning and Fear of Death

Fear of death is essentially a universal phenomenon, and we all learn defenses against the anxiety associated with our mortality. These anxieties and associated defenses often inhibit our ability to life to its fullest extent. Obviously, the diagnosis of a terminal illness confronts our denial and presents the opportunity to work through the defenses, address the anxiety, and ultimately find a richer way of living.

This process runs parallel with questions about meaning in life. Meaning figures prominently in the psychotherapy of the gay man with HIV disease, for the search for meaning is complicated by repeated experiences of rejection, isolation, and marginalization, which lead to internalization of a punitive view of the self.

Aloneness

Stigmatization, contagion, control, omnipotence, fear of death, and

meaning as dynamic issues relevant to the treatment of clients with HIV disease all have common elements. I believe that ultimately, much of the work involved in the therapy with these individuals centers on exploration of the profound sense of aloneness awakened by this disease. Our experience has demonstrated that this is of particular concern in the treatment of gay men. Most tell us that they were aware of their difference, even from a sexual perspective, at a very early age. Many recall alienation and isolation within their families, with consequent deficits in early nurturing relationships. Profound loss is also experienced during adolescence through failure to connect with peers; these individuals are also frequently victims of scapegoating. Persisting into adult life is marginalization, stigmatization, and persistent devaluation. Various defenses are called into play to deal with these reactions, and the individual copes as best he can. However, the appearance of HIV in his life takes on meaning that serves to confirm the internalized belief that he is unlovable and bad, and he feels the profound aloneness originating from childhood but hidden by his defenses.

Successful therapy frequently involves an exploration of the individual's experiences with rejection and isolation, a working-through of those elements that have been internalized, and paying careful attention to the transference, in which the therapist is seen as another potential abuser and abandoner of his or her vulnerable client.

Countertransference Issues

As might be expected, countertransference in the therapy with these clients can be particularly intense.

Stigmatization is a practically universal phenomenon, and the therapist must carefully explore his or her attitudes and preconceived notions about the group from which the client comes.

Unrealistic fears of contagion are extremely common among even medically knowledgeable therapists. The therapist must deal with these fears, as well as his or her own relationship to the metaphorical meaning of HIV.

The therapist frequently encounters his or her own sense of helplessness and hopelessness in the face of an illness that inevitably leads to death. The therapist must adjust his or her notions of success in therapy, particularly in therapy cut short by overwhelming illness and death.

The therapist inevitably comes to deal with his or her own fear of death and deals with barriers to empathic relationships with clients whose illness confronts the therapist's denial. Likewise, the therapist may need to deal with his or her relationship to aloneness, particularly in dealing with a disease as isolating as HIV infection.

Identification is an important countertransference issue. As suggested

above, we can easily become personally involved in a client's struggle with existential issues. We can find that working with terminally ill and dying clients from our own age group arouses difficult feelings; we can find it difficult to treat clients from the same age group as our children; and some therapists find it easy to identify with marginalized individuals. The possibility of over-identification with the client may be of particular importance for the gay therapist or the HIV-positive therapist. Unless the therapist understands clearly the inherent dangers in such situations, he or she may find it difficult to maintain boundaries with the necessary degree of objectivity.

Sometimes the therapist is faced with the ethical dilemma of having to deal with a client who presents a risk to others. The most common scenario is that of the individual who continues to seek sexual contacts without telling sexual partners that he or she is HIV-positive or has AIDS. The ethical dilemma may vary depending on whether the individual practices safer sex. It is essential that the therapist take the opportunity to understand the motives of the client in such situations. In the worst-case scenario, an individual is deliberately attempting to infect others through unsafe sex practices as an expression of rage. In such situations, the dilemma is perhaps less complicated: in the clear interest of protecting the public, the therapist can report the individual to local public health authorities. More commonly, however, the motives are less destructive and the behaviors less risky, as

suggested in the case of Rob described earlier.

The therapist must obviously attend to the countertransference evoked by such situations and seek to understand the role that his or her own personal morality, homophobia, AIDS phobia, or anger plays in the therapy and in understanding the individual. As suggested earlier, this issue, like all others, provides the opportunity for further dynamic understanding of the individual.

The question frequently arises as to the legal responsibility of the therapist in this context. It is important that the therapist explore this issue with his or her professional organization and to be aware of specific pertinent laws within his or her state or province. Clearly, the need to protect the public interest must be balanced against the need to preserve confidentiality.

TREATMENT GOALS

Goals of treatment with this client population vary with the individual and his or her issues and capacity for change. In general, however, the therapist hopes to achieve some symptom alleviation, to effect some change in the underlying intrapsychic conflict, to help the individual understand the meaning of the disease in his or her life, and to sort out the associations and projections from the realities of the disease. As mentioned, we frequently find that significant changes come about, not by addressing HIV directly, but by

focusing on interpersonal relationships, the view of the self, or apparently unrelated subconscious conflicts. This change in the individual translates into a different way of coping with the disease. It is tempting to advise caution in approaching the limitations of working with such a complicated client population, but in our experience, many of these clients are capable of significant degrees of success in working in a dynamic psychotherapy.

THEORY OF CHANGE

It has been the experience of the therapists in our clinic that this client population is, in general, quite capable of significant working-through of dynamic issues, despite the complexity of the issues involved. We hypothesize that the diagnosis of HIV has the power to motivate the individual to seek change in patterns of relating to the self or others, to work through defenses and anxieties associated with conflict, and to grapple with unconscious conflict. The individual experiences a sense of urgency that may manifest itself as a wish to find meaning in life, a wish to control emotional symptoms in order to enjoy time that is left, a wish to work through old feelings associated with past hurtful experiences, or to finally connect in meaningful relationships. Thus, the client is motivated to work on issues in a way that a physically healthy person who does not feel the urgency of time may not be. As mentioned, we have at times been quite surprised by the capacities of clients with fairly fragile personalities to make significant gains. Again, we

hypothesize that HIV acts with an overriding catalyzing effect on the individual, facilitating attachment and the development of a therapeutic alliance. In many cases, the therapist is treating an individual with HIV some years before the expression of the disease, and there is often sufficient time to deal with issues in a reasonable way.

TECHNIQUES

The usual techniques of a dynamic therapy apply for this psychotherapy (Langs, 1982; Hollender & Ford, 1990). However, therapy with HIV-infected clients is complicated by a number of factors. First is the aforementioned unpredictability and irregular course of the disease. It is characterized by the sudden onset of often bizarre, frightening, life-threatening illnesses that may lead to death or may be followed by long periods of relatively good health. We feel that any therapist who undertakes a psychotherapy with these individuals must be familiar with the medical aspects of the disease and be prepared to work in a flexible manner. The therapist may need to rapidly shift focus as the disease progresses, or regresses.

Our therapists have had to address the important issue of boundaries and the implications of changing the venue of therapy, entering the intimacy of the home environment, cleaning up vomit, urine, or feces during a home visit, involving family members and caregivers in sessions, and attending at

the deaths, funerals, and memorial services of clients. Obviously, it is important to ensure that boundaries are not loosened to the extent that over-identification with the client and a wish to be too gratifying occurs. It is possible to interfere with important work in the last stages of life if boundaries are loosened inappropriately.

On the other hand, boundaries can be too rigid if the therapist resists entering into the client's experience because of the painful issues involved for both the client and the therapist. Sadowy (1991) makes the observation that even if the client becomes unable to speak, the therapist can still use dynamic understanding of the client to his or her benefit by anticipating the meaning of events that are occurring. We have had the experience that extending the dynamic understanding of the client into other venues has been helpful for both the clients and their caregivers, as illustrated in the following examples.

Phil was seen in weekly psychotherapy for two years. We explored in depth his sense of vulnerability related to having been adopted, to having lost his adoptive father to cancer when he was seven years old, and to having had to cope with being gay. HIV was clearly a motivating force in bringing him to therapy but was not a primary focus in the therapy until he developed a large Kaposi's sarcoma lesion on his face after the first year of therapy. A prominent theme was highlighted by this event: his fragile sense of his lovability and his compulsion to attend to the needs of others in order to feel

he deserved their love. He developed great skill in covering his facial lesions with makeup and wearing clothes that hid his progressive weight loss. He also went to great lengths to reassure friends and work associates that any changes they observed in him were insignificant. He was consciously making an effort to avoid upsetting others and to avoid the guilt of having to burden them with his illness.

The therapy focused on his sense of vulnerability and feeling that his value to others was measured by what he could do for them and how little of a burden he could be. Gradually, as he developed insight and was able to address these issues, he was able to tell people of the true nature of his illness and was surprised to find that support and love came to him more or less unconditionally. He eventually abandoned the makeup and was less obsessive in his dress. Consequently, we were able to deal more directly with his feelings about his impending death. After approximately two years of therapy, Phil became homebound due to pain in his legs from extensive Kaposi's sarcoma lesions. Therapy continued in his bedroom on a weekly basis for some months. The proximity of death naturally moved the therapy toward more existential issues, but we continued to explore his discomfort with the role of having to receive help and his anxiety about not having the energy to entertain visitors. Ongoing attention to these issues facilitated the implementation of home care and visiting nurses, a more relaxed attitude toward his friends' visits, and also the change in venue of the therapy. (When

presented with the option of my coming into his home as his health deteriorated, he had been terrified by the prospect, for much the same reason.)

As he continued to decline, he developed a secondary infection in his leg and became delirious. The themes of his psychosis were perfectly within the context of the issues we had dealt with in the therapy. Although Phil's interactions with visitors were consistently pleasant, he developed delusions that he angered them with his behavior. He believed that some people actually became physically abusive, including his lover, whom he believed to have struck him on several occasions. Phil naturally assumed all blame for this, feeling that others "abused" him because he was such a tremendous burden. While interpretation was, of course, unhelpful to Phil at this point, his lover found the dynamic understanding of the themes immensely helpful and was able to view the situation with a little more objectivity.

Max was treated in a psychodynamically informed supportive psychotherapy for approximately two years before he became home-bound owing to progressive weakness associated with wasting syndrome. He had a paranoid personality; while interpretation of his projections was often unhelpful, he seemed to value the therapeutic relationship, and the transference was largely free of paranoid projections. I took this as a reflection of his need to preserve some links with an empathic relationship in

the face of his deteriorating health, even though virtually all his other relationships had been influenced by his defenses. As his health deteriorated, he was, of course, pressed into the position of accepting increasingly intimate care from his family and from strangers, such as those from a visiting hospice service. Attention to the dynamic meaning associated with my visits to his apartment, I believe, helped to preserve his contact with the real elements of his relationships. For example, he was upset during one visit that I had declined a glass of juice at the previous visit; he had assumed I did so because I feared catching HIV from him. We talked about his fears, and he seemed reassured. On other occasions, it was necessary to deal with the implications of cleaning up spilled urine and holding his basin for him while he vomited. The easing of boundaries in situations such as this may very well have precipitated angry, paranoid feelings in this individual, but I believe that the relationship we had established, with its honesty and respect for his person and self for who he was, helped to preclude such feelings. Likewise, in meetings with his family and caregivers, who were often angered and distressed by his rage and rejection, the sharing of a dynamic understanding of his behaviors helped them to develop tolerance and to strategize to provide him with optimal care.

Naturally in these situations the therapist must have the client's consent for discussion of his or her intrapsychic world, but I have found that invariably the client not only can understand the importance of such

discussion but experiences relief from the knowledge that people understand him or her in this way.

Some attention has been given to the possibility of formally adapting short-term models of psychotherapy to this client population. Our therapists have felt uncomfortable with anxiety-provoking methods, such as those outlined by Sifneos (1992), given the nature of the issues we are dealing with. It could be that Mann's (1973) model is applicable, given its focus on anxiety related to termination, but again, our concern is that we may be dealing with issues beyond the scope of that form of therapy.

However, the concept of developing a focus is applicable, and these clients are often able to participate in this process and generate a clear focus for the therapy. Common foci are fears about disclosure, unresolved interpersonal difficulties, and barriers to intimacy. Luborsky's (1984) supportive-expressive method of brief psychotherapy holds promise, and we have recently begun to explore its utility with these clients.

In any event, we have been impressed by our clients' capacity to work effectively with a focus. Our practice in many cases has been, in fact, to develop a focus with a patient, work on that issue toward resolution, and terminate the therapy, making further therapy available at a later date to work on other issues as they become important for the client. Clients for

whom this practice works are obviously those who can tolerate adhering to a focus; these are usually individuals who fit the criteria for candidacy for short-term psychotherapy, as set out in the literature on the subject (Crits-Christoph & Barber, 1991).

Most, if not all, models of brief psychodynamic psychotherapy explore in varying degrees of depth the issues of transference and countertransference reactions to termination. While there is real concern for not wanting to harm a person facing death, we speculate that formally dealing with termination in a brief psychotherapy can be an immensely helpful experience. It can provide a sense of mastery and competency with respect to separation. In so doing, the therapist would have to confront his or her own death anxiety and other countertransference issues, such as fears of being perceived as cruel and rejecting and personal fears of abandonment and aloneness. Our therapists generally apply an "open-door policy": a client is told that, while the therapy is formally terminating, he or she may return at a later date to take up other issues. At this point in the evaluation of our approach to these clients, this appears to be the most appropriate intervention, primarily because HIV disease is a disease of continuum that ultimately leads to death. New issues inevitably arise or previously treated issues become increasingly complex as the disease progresses, and a return to therapy can be most appropriate.

Clients taken on in long-term therapy are those who require more

support or are unable to focus, owing either to difficulty with affect regulation or personality structure. Likewise, ill clients are rarely if ever terminated in their therapy.

CASE EXAMPLE

Following is a summary of a psychotherapy with a man who presented to the clinic with a request for help dealing with feelings he was having about his HIV diagnosis.

History

Mark was a 50-year-old gay man who presented with a major depressive syndrome and concomitant panic disorder that seemed to start shortly after moving in with a lover of four months. The depression and anxiety had progressively worsened over the eight months prior to presentation. Mark had been diagnosed HIV-positive three years prior to presentation, and his latest CD4+ cell count of 310 indicated that his disease was progressing, although it was not yet in a critical stage.

Mark was born while his father was overseas with the armed forces, and he felt that he was probably illegitimate. His father was absent for the first three years of his life, and during this time he was raised by his grandmother, whom he remembered as acting dutifully toward him rather than with love.

He had very little memory of his mother from this time. Mark's father returned home when he was three, divorced his mother, and put Mark and Mark's one-year-old brother in the care of Children's Aid. Apparently his grandmother had wanted to keep the children, but his father would not permit this, and Mark remembered a traumatic separation from her. Between the ages of six and fifteen, Mark was placed in three separate foster homes. In one, he was neglected and physically abused, and in the others he received little emotional nurturing.

Between ages 15 and 20, he lived with a maternal aunt. After successfully completing high school, he obtained a good job and went through a rapid series of promotions. He said that at age 20 he had everything he could hope for and was quite comfortable financially. He remained close to his aunt until she died when he was 33. He had since had little contact with any of his family: "It's as though the whole family died when she died."

He married in his early twenties and was happy for the first three years, until his wife had an affair and he left her and his two-and-a-half-year-old daughter. Mark had been aware that his brother was homosexual and began accompanying him to gay bars, although he did not identify himself as homosexual at the time. He found that he enjoyed the attention of men and began to enjoy sex with them, but he believed that it was not possible for men to love each other. He had two brief relationships but terminated both of

them because he felt he was hurting his partners with his lack of commitment.

He decided to go back to his wife, out of a sense of pity for her, he said. He reported being content for the following year and enjoying his daughter, who was six years old at the time. However, he precipitously left the marriage when he learned that his wife was five months pregnant and had not told him. He viewed her not telling him as a breach of trust and a lack of commitment. He had never seen either his wife or daughter since.

At this point, Mark believed he could no longer trust women and returned to a homosexual lifestyle. Over the years, he was in and out of relationships with men. When he developed feelings of love, he responded by leaving. His longest relationship lasted four years. He reported that he had not found men any more trustworthy than women but felt he had been able to exercise more control over men. He left his last relationship three years prior to the assessment after discovering that he had HIV. At that point, he made up his mind that he would give up on relationships altogether.

One year prior to presentation, he met John. Mark tried very hard to resist a relationship with him but came to care for John a great deal. After four months, the two decided to move in together. At the time of assessment, Mark described John as honest, and paradoxically, he said that he trusted him

implicitly. He felt that John was totally committed to him and would be available when Mark needed him, even as his health deteriorated. However, Mark worried about the burden that he would become for John and at a more preconscious level worried that he did not deserve John. Sex was a major area of difficulty for them. Mark consciously experienced this difficulty as a fear of infecting John, even though he was fully aware of ways they could make love while absolutely minimizing the risk to John.

The Treatment

Mark clearly identified HIV as giving him a sense of urgency and was also highly motivated by the intensity of his depression and anxiety. Given the degree of his symptomatology, it was decided to treat him with a combination of lorazepam and trimipramine, which provided moderate results with maximally tolerated doses.

I decided to treat Mark with a brief psychotherapy utilizing Luborsky's (1984) supportive-expressive method and the core conflictual relationship theme (CCRT). I was aware that in many ways Mark was not an exceptional candidate for brief psychotherapy, but he was able to fairly rapidly develop a focus for the therapy and was very motivated for the work. This particular technique seemed well suited to his therapy given its relationship themes.

In this method, the focus develops from a formulation that is generated

from a series of anecdotes from the client's interactions with others, referred to as relationship episodes. The therapist explores with the client the wish associated with these relationships. Consideration is then given to how the client expects the other to respond (response of other). Finally, the response of self is generated based on how the client expects to respond to the anticipated response of other. This formulation, which is referred to as the core conflictual relationship theme, becomes the focus of the therapy, and anecdotes, unconscious material, and transference are interpreted in this context.

It was hypothesized that Mark's anxiety was associated with unconscious fears reactivated by his developing intimacy with John. Given the serious nature of his repeated early abandonment experiences, Mark had come to expect that he would always be abandoned by anyone for whom he cared. Therefore, it felt safer for him to abandon the other before he himself could be hurt. This feeling seemed operative both times he left his wife, particularly the second time, and in his succession of homosexual relationships.

The CCRT developed for the therapy was as follows:

Wish: To be in a relationship in which he could feel safe

Response of other: To abandon him

Response of self: To leave the relationship

Mark accepted the CCRT as the focus for the therapy and settled into the contracted 16 sessions. He readily generated relationship episodes, which were interpreted in the context of this theme, and he quickly developed insight into the origins of his anxiety. His comfort with John increased significantly, and he had many fewer episodes of panic, although he was not able to resume a comfortable sexual relationship with John. It seemed that sex made him too vulnerable, that it was too intimate to enter into with ease. Clearly, he also experienced his infection as a metaphor for his contaminated, unlovable self.

It was obvious from the outset that the transference involved in termination would further evoke anxiety related to the theme of abandonment. Mark resisted exploration of his feelings about termination. He denied that termination had much significance for him and expressed relief at the idea of being able to have one less doctor to see. Without having fully explored the termination issues, the therapy ended at the contracted time. When he returned in follow-up several months later, it was obvious that he had continued to explore relationships utilizing the insight he had gained in the therapy. One of his most impressive gains was the development of a mutually satisfying sexual relationship with John. However, he was distressed by a recent exacerbation of anxiety, which we were able to understand as

related to returning to the intimacy of the therapeutic relationship and the unexplored unconscious fears associated with it. He was engaged in an additional brief course of therapy in an attempt to further elaborate these issues, and his anxiety level decreased markedly. During this time he reunited with his brother, whom he had been estranged from for eight years over an objectively minor breach of trust. The brothers developed a very close bond that persisted despite several significant conflicts that Mark realized would in the past have precipitated his leaving the relationship. In each case, Mark was able to evaluate his feelings in relation to the CCRT and preserve the relationship.

Case Summary

This case illustrates several points: (1) the potential for overcoming barriers to intimacy in the face of the existential crisis associated with the profound aloneness accompanying HIV disease; (2) the role HIV plays in bringing a person to therapy to deal with issues that become pressing in the face of terminal illness; (3) the facilitating effect of HIV in helping a person attach and engage in the therapy; (4) the catalyzing effect of HIV on the therapy; (5) the potential for doing good work in the face of a complex set of circumstances, including the dynamics associated with repeated abandonment in critical developmental periods, the dynamics associated with homosexuality and the presence of a life-threatening illness associated with

profound stigma; and (6) the value of approaching the crisis of HIV from the perspective of unresolved intrapsychic conflict.

TRAINING

A psychodynamic approach to the client with HIV disease naturally requires familiarity with the principles and techniques of dynamic therapy. However, given the complexity of the disease, its unpredictable course, and it's devastating effects, the therapist must also have a basic understanding of the disease itself. It is most helpful to have a good working relationship with the medical doctors treating the individual. Supervision from therapists with experience treating these clients is helpful to those taking these clients on for the first time, as is ongoing discussion with peers who provide similar treatment.

EMPIRICAL EVIDENCE FOR THE APPROACH

I am not aware of research addressing the psychodynamic treatment of individuals with HIV disease. The Clinic for HIV-Related Concerns continues to explore the relevant issues, particularly the applicability of brief forms of dynamic therapy, and we have recently begun planning for preliminary research into practical applications of brief models of psychotherapy with our client population.

REFERENCES

Adler, G., & Beckett, A. (1989). Psychotherapy of the patient with an FIIV infection: Some ethical and therapeutic dilemmas. *Psychosomatics,* 30, 203-208.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.) *(DSM-IV).* Washington, DC: American Psychiatric Association.

Centers for Disease Control. (1993). *HIV/AIDS surveillance report,* (vol. 5, No. 3). Atlanta, GA: Centers for Disease Control.

Chaisson, R. E., & Volberding, P. V. (1990). Clinical manifestations of HIV infection. In G. Mandell, R. G. Douglas, & J. E. Bennett (Eds.), *Principles and practice of infectious diseases* (3rd ed.) (pp. 1059-1092). New York: Churchill Livingstone.

Cohen, J., & Abramowitz, S. (1990). AIDS attacks the self: A self-psychological exploration of the psychodynamic consequences of AIDS. In A. Goldberg (Ed.), *The realities of transference: Progress in self-psychology* (Vol. 6, pp. 157-172). Hillsdale, NJ: Analytic Press.

Crits-Christoph, P., & Barber, J. P. (Eds.). (1991). *Handbook of short-term dynamic psychotherapy.* New York: Basic Books.

Fauci, A. S., & Lane, H. C. (1994). Human immunodeficiency virus (HIV) disease: AIDS and related disorders. In K. J. Isselbasher, E. Braunwald, J. Wilson, J. B. Martin, A. S. Fauci, & D. L. Kasper (Eds.), *Harrison's principles of internal medicine* (13th ed.) (pp. 1566-1618). New York: McGraw-Hill.

Gonsiorek, J. C. (Ed.). (1982). *Homosexuality and psychotherapy: A practitioner's handbook of affirmative models.* New York: Haworth Press.

Hetrick, E. S., & Stein, T. S. (Eds.). (1984). *Innovations in psychotherapy with homosexuals.* Washington, DC: American Psychiatric Press.

Hollender, M. H., & Ford, C. V. (1990). *Dynamic psychotherapy: An introductory approach.* Washington, DC: American Psychiatric Press.

Isay, R. A. (1989). *Being homosexual: Gay men and their development.* New York: Farrar, Straus, & Giroux.

Jacobsberg, L. B., & Perry, S. (1992). Psychiatric disturbances. In D. A. White & J. W. M. Gold (Eds.), *The medical clinics of North America: Medical management of AIDS patients* (Vol. 76, No. 1, pp. 99-106). Philadelphia: W. B. Saunders.

Laboratory Centre for Disease Control (LCDC). (1994, April). *Quarterly surveillance update: AIDS in Canada.* Ottawa: Health Canada.

Langs, R. (1982). *Psychotherapy: A basic text.* New York: Jason Aronson.

Lewes, K. (1988). *The psychoanalytic theory of male homosexuality.* New York: Simon & Schuster.

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

Mann, J. (1973). *Time-limited psychotherapy.* Cambridge, MA: Harvard University Press.

Oldman, J. M., Riba, M. B., & Tasman, A. (Eds.). (1993). *Review of psychiatry* (Vol. 12). Washington, DC: American Psychiatric Press.

Sadowy, D. (1991). Is there a role for the psychoanalytic psychotherapist with a patient dying with AIDS? *Psychoanalytic Review,* 78, 199-207.

Searles, H. F. (1981). Psychoanalytic therapy with cancer patients: Some speculations. In J. Goldberg (Ed.), *Psychotherapeutic treatment of cancer patients* (pp. 167-181). New York: Free Press.

Sifneos, P. E. (1992). *Short-term anxiety-provoking psychotherapy: A treatment manual.* New York: Basic Books.

Stein, T. S. (1993). Overview of new developments in understanding homosexuality. In J. M. Oldman, M. B. Riba, & A. Tasman (Eds.), *Review of psychiatry* (Vol. 12, pp. 9-40). Washington, DC: American Psychiatric Press.

Stevens, L. A., & Muskin, P. R. (1987). Techniques for reversing the failure of empathy towards AIDS patients. *Journal of the American Academy of Psychoanalysis,* 15, 539-551.

Winiarski, M. G. (1991). *AIDS-related psychotherapy.* New York: Pergamon Press.

Yalom, I. D., (1980). *Existential psychotherapy.* New York: Basic Books.

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