The *ego* orients the individual toward the external world and serves as a mediator between one's external and internal worlds. The *id* represents the organization of the instinctual pressures on the mind, basically the sexual and aggressive impulses. The *superego* is a split-off portion of the ego, a residue of the early history of the individual's moral training and a precipitate of the most important childhood identifications and ideal aspirations. Under ordinary circumstances, there is no sharp demarcation among these three major components of the mind. Intrapsychic conflict, however, highlights the differences and demarcations between them.

One of the major functions of the ego is to protect the mind from internal dangers and from the threat of a breakthrough into consciousness of unacceptable conflict-laden impulses. The difference between mental health and mental illness depends on how well the ego can succeed in this responsibility. In his monograph *Inhibitions, Symptoms and Anxiety* (1926), Freud pointed out that the key to the problem is the appearance of anxiety, perhaps the most common symptom of neurosis. Anxiety serves as a warning signal, alerting the ego to the danger of overwhelming anxiety or panic that may supervene if a repressed, unconscious wish emerges into consciousness. Once warned, the ego may utilize any of a wide array of defenses. This new view had far-reaching implications for both the theory and the practice of psychoanalysis.

Beyond Freud

Psychoanalysis has gone through many changes since Freud. The earlier defections by Adler and Jung have already been noted, but a serious split began within psychoanalysis even during Freud's lifetime. This grew out of the teaching and the influence of Melanie Klein in London, which eventually spawned what is known as the British school of psychoanalysis. Klein emphasized the importance of primitive fantasies of loss (the *depressive position*) and persecution (the *paranoid position*) in the pathogenesis of mental illness. Melanie Klein's influence is preeminent in England, many parts of Europe, and South America.

When Nazi persecution forced many of the outstanding European analysts to migrate to this country, the United States became, for a time, the world center of psychoanalysis. The leading figures in this movement were Heinz Hartmann, Ernest Kris, and Rudolph Loewenstein. These three collaborators tried to establish psychoanalysis as a general psychology. They did so by extending Hartmann's concepts of the adaptive function of the ego (Hartmann, 1939) and clarifying fundamental working hypotheses concerning the development of the psyche (Hartmann & Kris, 1945). Hartmann, in particular, emphasized the role of the transformation of the basic instinctual drives in a set of metapsychological propositions that have been largely abandoned in recent years. Closely related to the work of Hartmann, Kris, and Loewenstein were the efforts of Anna Freud, derived from studies of long-term child development. Her book *The Ego and the Mechanisms of Defense* became a classic.

For a while, issues concerning the development of the sense of self and personal identity were most prominent in the psychoanalytic literature. These were the focal point of works by D. W. Winnicott and John Bowlby in England and Edith Jacobson and Margaret Mahler in the United States. All of these studies underlined the importance of the child's early attachment to the mother and the emergence of the self as an independent entity.

Whereas Mahler emphasized the emergence of a sense of self through a process of separation and individuation, Winnicott emphasized the continuing influence of the psychological experience of the young child, where representations of the external world take the form of *transitional phenomena.* Winnicott's concept of the *transitional object* can be seen to this day, whenever a child carries around a teddy bear or baby blanket. These objects serve as concrete ways for the child to maintain a connection between herself and her attachments.

Current Status

Most people associate psychoanalysis with classical Freudian theory and techniques, without realizing how much the field has changed. As a result, psychoanalysis and psychodynamic therapies have been criticized for being irrelevant to today's culture, for being appropriate only to an elite group of highly educated patients, and for not being based on empirical findings. This view, however, is inaccurate. Psychoanalysis is a continually evolving field that has been revised and altered by psychoanalytic theorists and clinicians ever since its origin. This evolution began with Freud himself, who often rethought and substantially revised his own ideas.

Changing Clinical Concepts

In the century that has passed since Freud, psychoanalysts have developed different branches of psychoanalysis, including ego psychology, interpersonal theory, self-psychology, and various relational theories. In fact, there are so many differing theories that Wallerstein (1988) spoke of the need to recognize many psychoanalyses instead of just one. Perhaps the most significant differences within the field today concern the nature of the analyst's view of the treatment situation. The issue is often drawn in terms of whether psychoanalysis is a one-person or a two-person psychology. A "one-person" psychology focuses exclusively on the mental reactions of the patient, whereas a "two-person" psychology considers the treatment as emerging from the interaction between two individuals. The *relational* viewpoint takes the "two-person" perspective and emphasizes the mutuality within the therapeutic relationship (Aron, 1996).

A related issue is the question of the "blank screen." In classical analytic theory, the analyst was thought of as a "blank screen" onto which the patient might project his transference. In order to facilitate this process, the patient lies on the couch with the analyst behind her, out of sight. However, current thinkers have pointed out that "the blank screen is not blank." In other words, patients have reactions to an analyst who says very little and is out of sight, just as they have reactions to one who is visible and interactive.

The Interpersonal school of psychoanalysis, which began with Harry Stack Sullivan, introduced a view of the analyst as an active participant as well as observer in the therapeutic relationship. Sullivan believed that an individual cannot be meaningfully understood outside of her interpersonal and social context. He described a process of *selective inattention,* a variation on the concept of the unconscious, in which a person will actively exclude from awareness certain anxiety-producing aspects of her interpersonal experiences (Sullivan, 1953). Because she is missing this information, she may construct a distorted view of the world. He advocated conducting a *detailed inquiry* of troubled relationships in order to bring to light those aspects of which the patient has been unaware.

For interpersonalists the patient's feelings about the therapist may be reactions to the analyst's actual behavior and not merely manifestations of transference (Sullivan, 1954). A contemporary interpersonal analyst will attempt to be aware of the ways in which he may be contributing to the patient's view of him. But he will also try to notice his own experience during the session, attempting to recognize when he has been "transformed" by reacting to some aspect of the patient. Exploration of the therapist's reactions may then shed light on the nature of the patient's relationships in the rest of her life (Levensen, 1972). The analyst's own experience of the patient now becomes an invaluable source of clinical information.

This emphasis on the patient's real interaction with the analyst was a radical departure from the less involved stance of the classical analyst. It has led some analysts to let the patient sit up and look at them and to take a more interactive role in the treatment. The interpersonal view has strongly influenced many relational perspectives.

Psychodynamic Psychotherapy

Psychodynamic psychotherapy is the most commonly practiced form of psychoanalytic treatment. It is less intensive than psychoanalysis, and sessions are held one or two times each week; the patient is sitting up and facing the therapist. Training in psychodynamic therapy is offered in many psychology, psychiatry, and social work programs and can be conducted without formal advanced training at a psychoanalytic institute. Modifications in technique have enabled psychoanalytic concepts to be applied to new populations and settings. In supportive-expressive (SE) psychotherapy, the balance of supportive and expressive elements is calibrated to meet the needs of the patient. The level of psychological health or sickness of the patient is among the factors that help the therapist determine the appropriate balance of the treatment.

Incorporating Research and New Ideas

In recent years, psychoanalysts have incorporated ideas from other fields. Empirical findings from research literature in sexual trauma (Alpert, 1995), cognitive psychology (Bucci, 1997), mother-infant interactions (Beebe & Lachmann, 2002), attachment (Lyons-Ruth, 2003) and other areas have been integrated into psychoanalytic thinking. Ideas from feminist theory (Benjamin, 1988) have also informed and enriched the field of psychoanalysis. Nobel laureate Eric Kandel (2005) has examined psychoanalytic concepts through the lens of neuroscience, and Schore (2003) has brought together developmental, psychological, and neurological research findings to significantly advance this new field of neuropsychoanalysis. Schore suggests that much of what occurs in psychotherapy is a function of right-brain, or non-verbal and non-linear activity, which clearly suggests that the value of the talking cure goes beyond the actual talking itself. Finally, despite frequently voiced perceptions to the contrary, research on psychodynamic therapies and psychoanalytic concepts is actively pursued, with positive results. That research will be reviewed in the Evidence section of this chapter.

Psychodynamic Diagnostic Manual

In 2006, the first *Psychodynamic Diagnostic Manual (PDM)* was published. The PDM is a psychodynamic alternative to the *Diagnostic and Statistical Manual* (*DSM*), which is currently used for making psychiatric diagnoses (American Psychiatric Association, 2000). The *DSM* was conceived as a means for researchers and clinicians to have a common language for communicating about psychiatric disorders. It lists observable symptoms and characteristics for each diagnostic category but provides no conceptual framework for organizing the information.

In contrast, the *PDM* is based on a psychodynamic model of human functioning and integrates up-to-date information from the empirical literature on cognitive psychology, trauma, and attachment. For example, psychoanalytic research has revealed two distinct types of depression; one results from an overly self-critical personality, while the other stems from fears of abandonment and loss (Blatt, 2005).

Whereas the *DSM* emphasizes what is observable, the *PDM* describes the subjective experience of people who exhibit particular symptoms. For example, the subjective experience of anxiety is different for one who is neurotic ("I can't stand the fear; I need comfort"), one who is borderline ("My sense of self was hollow, like I didn't have a self"), and one who is psychotic ("They have been blowing poison gas through the keyhole. It's destroying me and obliterating my thoughts").

The *PDM* represents an extremely significant effort to provide a conceptual framework that meaningfully organizes what is known about the complexity of human psychological functioning.

Psychoanalytic Training

When psychoanalytic training began in this country, it was offered exclusively to physicians, but this is no longer the case. Today, admission to most psychoanalytic institutes requires that one first earn a Ph.D. or Psy.D. in clinical psychology or successfully complete a psychiatry residency. Institutes vary in their admission policies for clinical practitioners in social work. Whereas advanced training to be a psychoanalyst is extensive, training in psychoanalytic or psychodynamic psychotherapy is part of many graduate programs in psychology, psychiatry, or social work.

Psychoanalytic training generally consists of at least four years of course work, accompanied by closely supervised treatment of psychoanalytic patients who are in treatment at least three (and most often four to five) times per week for several years. A candidate is also required to undergo a personal analysis conducted by a senior psychoanalyst. This is an important part of the training; it provides an opportunity for candidates to learn firsthand what being an analytic patient, or *analysand,* is like and to observe a senior psychoanalyst at work. Even more important, a practicing psychoanalyst needs to know himself or herself well, since the work is deeply personal, and one's own emotional vulnerabilities and conflicts must be confronted and worked through if one is to be truly helpful to one's patients. For these reasons, some graduate programs recommend that students enter a personal psychoanalysis or psychoanalytically oriented therapy themselves.

Psychoanalytic Organizations

Much has changed in the organizational structure of psychoanalysis in recent years. The American Psychoanalytic Association (APsaA), founded in 1911, remains the largest of psychoanalytic societies in the United States, with 42 affiliate societies and 29 professional training programs. APsaA is part of the International Psychoanalytical Association, the largest worldwide psychoanalytic organization. The American Psychological Association's Division of Psychoanalysis lists 92 psychoanalytic training programs. Whereas many institutes have evolved from a Freudian framework, others, such as the William Alanson White Institute, have an interpersonal/relational orientation. The New York University Postdoctoral Program houses a range of theoretical orientations and encourages an exchange of ideas between them. Both the American Psychological Association (Division 39, Psychoanalysis) and the American Academy of Psychoanalysis are good resources for further information.

Psychoanalytic Journals

Because so many theoretical orientations and professional disciplines now represent psychoanalysis, there are simply too many psychoanalytic journals to list them here. They include *The International Journal of Psychoanalysis, American Journal of Psychoanalysis, Contemporary Psychoanalysis* (interpersonal), *Psychoanalytic Dialogues* (relational), and *The International Journal of Psychoanalytic Self Psychology,* to name a few of the more popular ones reflecting the range of orientations. There are also journals on specific topics, such as *Gender and Psychoanalysis.*

PERSONALITY

Theory of Personality

Personality evolves out of the interaction between biological factors and the vicissitudes of experience. That interaction is influenced not only by the nature of the life events but also by the ways those experiences are absorbed and handled. Likewise, overall mood and attitudes toward life are affected by early experiences. "Basic mood" begins to develop during the first year of life, and "confident expectancy" is a mood state that can emerge after a happy first year in which the baby's needs are met.

Problems in early life may become embedded in personality through fixation or regression, hidden through defense mechanisms, or embodied through *enactment.* In *fixation,* aspects of the child's personality get stuck at the developmental moment in which a traumatic event or unresolved conflict occurred. For example, a young adult never leaves home, in spite of pressures from those around him to move out and move on. His parents were "always gone" when he was a child, leaving him with an array of nannies, and he became fixated on the home as a form of family connection. In *regression*, the child reverts to earlier forms of behavior in response to stress. Many parents are familiar with this phenomenon, since the birth of a baby typically causes the older sibling to regress. This is usually a temporary event, but in some cases a regression has more lasting effects. *Enactment* is a form of "action memory," in which memories of sequences of troublesome experience are replayed in action. A common example comes when parents find themselves disciplining a child in just the way their parents did, even though they thought they would do it differently.

Defense Mechanisms

Psychological defense mechanisms play a pivotal role in the structure of personality. The concept of a psychological defense had its beginning in Freud's writings, but it was his daughter Anna Freud who developed the concept. Whereas Freud paid a good deal of attention to the conflict between id and superego, Anna Freud brought the ego to the fore, delineating specific ego defenses and their important role in the development of the psyche. She observed in her clinical work with adults and children that there are specific types of defenses and that people tend to use them with some consistency. For example, one person might utilize her thinking ability to keep threatening feelings at bay by speaking about them in emotionally detached and abstract terms *(intellectualization),* whereas another might express unacceptable desires symbolically through a bodily symptom *(conversion* or *somatization).*

In many people, defenses are activated by stress, but they may have a full range of other ways of responding. Other people have what Wilhelm Reich (1949) called character armor, in which their defenses pervade how they act and respond. Even positive traits can serve as defenses. Anna Freud gives the example of a matchmaker who used altruism as a defense. All her energies went into other people's love lives, but she avoided experiencing her own needs and did not have a personal life of her own.

The ego psychologists, following Anna Freud's focus on the ego's defenses, shifted the focus to the ways people adapt to reality and showed how defensive style shapes their experience of themselves, others, and the world in general. For example, those with more histrionic personality styles tend to be impressionistic and intuitive, whereas those who are more obsessional are likely to be focused, goal-oriented, and conscientious (Shapiro, 1965).

Otto Kernberg (1975) investigated the character structure of patients in the "borderline" spectrum, so called because it was first considered as the area between

neurosis and psychosis. Borderline patients tend to use certain pathological defense mechanisms. The most common are *projection* (projecting one's own feelings onto another person) and *splitting* (seeing some people as all good and others as all bad, or alternately idealizing and devaluing the same person). Lyons-Ruth (2003) has shown how this type of personality structure may develop through certain forms of interaction between mothers and young children.

The types of defenses a person employs have implications for later mental and physical health. Vaillant (1977, 2002) conducted a large longitudinal study, in which he followed Harvard students from graduation until old age. He showed that the use of more mature defenses, such as sublimation (channeling one's impulses into positive, culturally desirable activities) and humor, as opposed to those that are less mature and pathological, such as projection, is highly predictive of both physical and mental health later in life.

Knowledge of the defensive and personality style of patients has useful clinical implications, as well. McWilliams (1994) has formulated very useful ways of assessing and treating people seeking psychoanalytic psychotherapy, based on their personality style and structure. For treating post-traumatic stress disorder and other stress-related problems, Horowitz (2001) delineated different treatment approaches found to be most effective, based on the particular defensive style.

Culture and Development

Erik Erikson, one of Freud's students, drew on his background in developmental psychology and anthropology, expanding Freud's theory of psychosexual development to include the effects of culture and society on psychological growth. Erikson (1963) postulated eight stages of psychosocial development from infancy to old age, in contrast to Freud's five stages of psychosexual development, which ended with childhood.

Each of Erikson's stages was based on a specific psychosocial conflict or crisis. The resolution of each crisis is associated with a particular psychosocial outcome that shapes the way the individual relates to other people and to society.

Erikson wrote a great deal about the ways in which our sense of identity develops throughout the life cycle, and he is best known for his formulation of the "identity crisis" of adolescence (Erikson, 1950). The period from 12 to 18 years (characterized in terms of the tension between identity and role confusion) is one in which an adolescent struggles to figure out who he is as a person in relation to his family, peers, and society. He then brings this sense of himself, however secure or confused, to his efforts to establish healthy and satisfying love relationships, which is the challenge of the next stage, in which the major psychosocial issue to be confronted is that of intimacy versus isolation.

Freud also believed that culture plays an important role in personality development, and for him, the superego is an internalization of the moral codes of family and society. However, Erikson believed that society's impact extends beyond its moral authority, and he placed great importance on the continual interaction between the person, culture, and family.

Early Relationships

Margaret Mahler saw the first three years of life as an unfolding process of *separation-individuation* (Mahler, Pine, & Bergman, 1975). She believed that the mother-infant relationship began with a state of oneness that she termed *symbiosis*. From there, the child gradually separates and forms her own sense of identity. In order to do so, she *internalizes* the relationship with the mother, giving her the ability to experience

a feeling of connection with her mother as she develops her own autonomy. Disturbances in the process give rise to lasting conflicts, with anxiety around separation and problems in establishing a secure identity.

Mahler's concept of symbiosis has been disproved by child development research, but the idea that the child internalizes the relationship with the mother is consistent with attachment theory on "inner working models" of relationships (Bowlby, 1988).

Over time, many psychoanalysts have moved toward orientations that place greater emphasis on the social and relational aspects of psychological functioning. Freud initially hypothesized that people are motivated by a quest for pleasure and gratification of certain basic drives, such that specific people become significant to a child because they satisfy his basic biological needs. A mother becomes important to a baby because she feeds him when he is hungry and thus becomes associated with the child's own gratification and pleasure. From the relational perspective, on the other hand, the primary motivation is the desire to be in a relationship with another person (Greenberg & Mitchell, 1983).

Object Relations

Fairbairn (1954) and others developed an idea that has come to be known as *object relations theory*. (He used the word *object* to mean a person who has great emotional significance to the child, having retained the term from Freud's earlier descriptions of caregiving adults as being "the objects of the drives," or those toward whom the drives are directed.) Fairbairn worked with abused children and observed that they remained extremely attached to parents who had severely abused them, suggesting they were looking to their parents for more than mere pleasure through need gratification. What is more, these children later sought out relationships characterized by the same abusive pattern as the earlier relationship.

Object relations theory concludes that human emotional life and relationships center around the unconscious mental images we hold of our earliest and most intense relationships, or *internalized object representations*. In order to avoid the terror of loss and abandonment, a child (or adult) will do whatever she can to maintain her connection to her early love objects. She might do so by seeking out others to whom she can relate in ways that match her internalized images of those who comprised her early emotional life; in this way, she recaptures the soothing feeling of connectedness. Object relations theory has helped psychoanalysts to understand better why people find themselves in relationships that appear to be maladaptive and self-destructive. It has been applied to a wide range of populations and situations and has provided particular insights into more serious and therapeutically challenging types of disturbances, such as borderline and narcissistic personalities (Kernberg, 1975). It has also led to a variety of other relational perspectives (Mitchell, 1988).

Numerous other psychoanalysts further elaborated on the early mother-infant relationship as it relates to personality development. One of these was Donald Winnicott (1965), who trained as a pediatrician before becoming a psychoanalyst. Winnicott (1965) believed that healthy emotional development requires a *good-enough mother* who provides a *holding environment* for her child with her consistent, loving presence. From this experience, the baby emerges with a sense of security and the ability to soothe herself during periods of stress and anxiety.

Self-Psychology

Heinz Kohut (1977) took a new look at a group of narcissistic patients for whom other formulations did not appear to apply. His was interested in those who presented with a

chronic state of emptiness, a lack of inner vitality, and an unstable sense of themselves and their self-worth, which was frequently masked by a more grandiose or expansive presentation. Kohut observed that these patients often reported a lack of "mirroring" experiences in their childhoods, such that they failed to receive support and admiration for what Kohut regarded as "healthy narcissism."

Young children frequently demand attention from adults by showing off and exaggerating their own power and abilities. A very young child might run around shouting, "Look at me, I'm the fastest runner in the world!" The parents of Kohut's patients, rather than mirroring the child's joy, typically responded with a lack of warmth and often with criticism or ridicule. Many of his patients also lacked an adult figure to safely idealize, something Kohut regarded as crucial to healthy development. In this self-psychological model, narcissistic disturbances result from environmental deficiencies rather than biological drives or psychological conflict.

Kohut found that psychoanalytic interpretations did not help narcissistic patients. Instead, he proposed offering empathy, mirroring, and support for positive self-esteem. In a well-known case of "Mr. Z," he used his empathic approach to reanalyze a patient who had not done well with traditional analytic techniques (Kohut, 1979).

Attachment and Personality Development

Psychodynamic theory and attachment theory have arrived at congruent views of personality development. Both regard early relationships as formative in the development of the child's emotional well-being and sense of self, and decades of attachment research supports this (Bowlby, 1969; 1988; Main, Kaplan, & Cassidy, 1985). Psychoanalysts are increasingly integrating these findings into their thinking. Lyons-Ruth (1991), for example, has proposed that Margaret Mahler's concept of *separation-individuation* be renamed "attachment-individuation." She points out that the child first develops an attachment to the parent and then *individuates* internalizing this relationship. Fonagy (2002) has demonstrated that the ability to *mentalize,* or mentally represent internal psychological states, develops from a secure early attachment relationship and is related to the later ability to regulate emotions and calm oneself during times of stress and anxiety. The intersection between attachment research and psychodynamic concepts continues to offer the potential for fresh thinking and discoveries.

Variety of Concepts

Defense Mechanisms

Freud first described defenses as the ego's struggle against painful or unendurable ideas or affects (Freud, 1894). He later shifted to using the word *repression* for that purpose, but the concept of defense returned in his later writings, and it has had staying power in the practice of psychodynamic forms of treatment.

Repression came to refer to the process of removing a painful memory or feeling from consciousness, whereas *defenses* came to mean the varied ways in which the ego keeps itself protected from painful thoughts and feelings, especially those experienced as dangerous. The danger often has less to do with active danger in the current world and more to do with a sense of "felt danger." The "felt danger" may have its origins in early, sometimes traumatic experience. For example, a child who was adopted from a

Russian orphanage at two years of age reacts to new people with ease. But he wriggles away from his adoptive mother. He has developed a defense that is easy to decode, since we know its history. He seems on the surface as if he is at ease with adults, but he defends against getting close, since he knows too well that people leave. Without such an obvious trail of documented history, patients discover their own "trail" in treatment, as a way to begin to undo early defenses.

The analysis of defense starts with noticing the defenses in operation. After becoming aware of their function, the patient can gradually look at the once intolerable content behind them. The therapist needs to respect that the content behind the "fence" of the defense may be difficult to tolerate and may even be part of a trail of memories to what was once a very painful experience. Here are some examples of prominent defenses:

In *projection,* the patient attributes unacceptable impulses or feelings of his own to another person (or agency). Angry, controlling, sexual, or jealous feelings are frequently projected onto others. Projection is the major mechanism of paranoia.

Obsessional thinking and *compulsive rituals* are defenses against unacceptable thoughts or unbearable feelings. Rather than allowing the individual to feel worried about the potential consequence of an aggressive thought, or overwhelmed by an anxiety-provoking one, obsessional thinking shifts the focus to small details that can be cognitively controlled. Compulsive rituals have a similar function, reducing anxiety through behavior.

Denial is the refusal to accept external reality when it is too threatening, and may involve "the reversal of real facts into their opposites" (A. Freud, 1966, p. 93). Young children exhibit harmless denial when they use the "magical thinking" of childhood, but it becomes a serious problem if this defense mechanism survives beyond childhood. It is frequently associated with alcohol or drug dependence, where acknowledging the related problems would mean facing the addiction.

Avoidance is a much more common mechanism than denial. It involves withdrawing from the experience of "psychic pain" or anxiety. However, in doing so, the patient also avoids the entire situation that caused the perception of emotional pain.

Primary and Secondary Process Thinking

Primary process thinking is nonlogical thinking. It is the language of the dream, of creative processes, and of the unconscious. The connections between thoughts have to do with images, memories, and emotion, rather than rational thinking. *Secondary process* thinking is logical, verbal thinking. These modes of thinking have been linked to the different modes of processing of the left and right hemispheres of the brain (Erdelyi, 1985).

Dream Interpretation

Freud considered the dream to be "the royal road to the unconscious" and *The Interpretation of Dreams* to be his greatest achievement. He believed that to understand his theory of dreams is to understand psychoanalysis.

Following the method Freud developed to interpret dreams, the dreamer holds the key to its meanings. Unlike Jungian analysis, psychoanalytic dream interpretation does not tend to attach preset meanings to dream symbols. Instead, the dreamer's associations, or thoughts about each dream image, serve as clues to understanding the dream. When the dreamer comes up with associations to the dream elements, they offer links between the dream image and its meaning to the dreamer.

The *manifest content* of the dream is the overt dream story, and the *latent content* consists of its underlying meanings. *Day residue,* or images that come from events of the day, may make their way into the dream. The interpretation of the dream emerges by listening to the dream and the dreamer's associations to elements of it, while seeking the deep thematic links between them. Understanding the language of the dream gives the analyst the ability to make sense out of what might sound like nonsense to others.

Although some aspects of Freud's thoughts on dreaming (such as the idea that the dream is the guardian of sleep) have not withstood the test of science, his insights into the language of the dream still open doors to the "royal road." The language of the dream consists of the use of nonlogical forms of expression, including condensation, [personal] symbolism, allusions, and displacement.

Here is an example of some of these mechanisms at work in a dream:

DREAM: "I dreamt about a flower. I was the flower and I was the picker."

BACKGROUND: The patient, a young woman of 20, had recently had an abortion. Her first thought about the flower was that it was a daisy. Her association to a daisy was "he loves me, he loves me not," which made her think of her boyfriend (an allusion), who would not commit to their relationship. Then she thought of picking off the petals. This was a symbolic reference to the abortion, as "taking off" the flower. When asked for her association to picking the flower, her eyes became misty with tears. The dream condensed her feelings and thoughts about the abortion into one moving image.

Freud believed that these mechanisms disguised hidden wishes and that interpreting the dream reversed the censorship created through these forms of disguise. Psychodynamic therapists now are likely to consider the dream as a symbolic representation of whatever is essential to the patient, in dream language. Whether the dream is considered as a product of censorship or as a different form of processing during sleep, understanding the language of dreams can still take the dreamer down the royal road to personal discovery.

Clinical-Research Concepts

Psychotherapy researchers have developed methods that allow for the study of psychotherapy process and outcome. The methods highlighted here have both clinical and research uses. Their clinical use is as procedures in the practice of supportive-expressive (SE) psychotherapy. They may also be used in other forms of treatment.

The Core Conflictual Relationship Theme Method (CCRT). The CCRT is a method to examine the inner workings of the patient's relationship patterns. It serves as an operational version of the transference (Luborsky & Luborsky, 2006). The therapist listens for repeating patterns in the stories the patient tells about encounters with others ("relationship episodes"), including responses to the therapist. The pattern is termed *conflictual* because the responses are most often at odds with what the patient really wants for himself.

Each CCRT pattern is composed of these three elements:

1. The wish (W), either stated or implied
2. The response of others, either real or anticipated (RO)
3. The response of self (RS)

Common wishes include the wishes to be loved, to be respected, and to be accepted. Here are some examples of CCRT material as it appears in session:

CCRT Example 1

P: I am getting behind in my work. It's driving me crazy. Every time she passes by my desk it gets so dragged out that I have no time to myself. If this keeps up, my manager is going to get wind of it.

W (implied): To be respected

RO: Takes over; doesn't consider patient's needs

RS: Feels trapped

CCRT Example 2

P: (Stares blankly for a few minutes, and then speaks) Nothing much to say (in a monotone). Rob is in L.A., and there is no point calling. He is much too busy meeting this one and that one to want to talk.

W (implied): To be cared for

RO (anticipated): Indifference, not caring

RS: Give up, get depressed

The CCRT is not decoded by one example alone. It comprises repeating episodes that bring the conflictual theme to light. The wish (W), response of other (RO), and response of self (RS) can be thought of as three strands of a rope that have become intertwined. The first task of the CCRT method is to notice the strands at work. That starts the action of the second aspect of the method, which involves disentangling the strands so that new forms of responses can begin. In fact, research suggests that is just what happens in successful SE psychotherapy. The patient's wishes remain the same, but the responses of others and self show some change (Luborsky & Crits-Christoph, 1998). In other words, the patient still wants what he wants for himself, but he no longer has such negative expectations of others or so many self-defeating responses from himself.

The Symptom-Context Method. The Symptom-Context method offers a way to decode the meanings of symptoms that can be used both in clinical and research situations. Instead of considering the symptom as having a life of its own, this method provides a way to examine why the symptom emerges.

Just as clinicians look for the "triggers" for depression or problems of abrupt onset, the Symptom-Context method looks at the "material" surrounding the symptom—that is, the emotional and verbal responses of the patient. When this approach is used as a research method, the researcher blocks off the segment of the session before and after the appearance of the symptom (its nodal point). That segment is compared to other, non-symptom segments of the same length (its control nodal point).

In treatment, the Symptom-Context method gives the patient and therapist a way to make sense out of what was once a mysterious, disturbing event. Its power begins to diminish once the context gives clues to its meaning. This is particularly useful for patients with anxiety disorders, PTSD, or stress-related physical symptoms.

An Example of the Symptom-Context Method

P: In the car coming over here, I started getting a headache. . . . I think it was because of what we've been talking about. You know, him. . . . And my sister wants me to drive her all the way to Staten Island to visit him.

Context: The patient has been talking about her father, who singled her out for berating during her childhood. She has been working on the issue in therapy long enough to suspect that the headache is a manifestation of the conflict in her head, between the pressure to see her father, and her anger against him.

The Helping Alliance Methods. The Helping Alliance is the partnership between the patient and the therapist around the work of the treatment. In clinical writings, it has been referred to as the therapeutic, or working, alliance. The Helping Alliance methods include scales and questionnaires designed to be used in research to track the state of the Helping Alliance.

Two kinds of Helping Alliance were found through factor analysis of clinical research material. The first kind, called Helping Alliance 1, is an alliance in which the patient feels that the therapist is there to help her. In other words, she feels that the therapist is doing his job and is on her side. The second kind, Helping Alliance 2, is an alliance in which the patient feels like a partner in the therapy process. He sees working together as a way to move his recovery forward. Both forms of alliance are linked with a successful treatment outcome in psychotherapy research.

In SE psychotherapy, two different therapeutic tools are important in the development of the Helping Alliance. The first is the therapist's empathy for the patient's experience. Research shows that a strong Helping Alliance early in the treatment is linked to the therapist's empathy, both of which are predictors of a good outcome for the therapy. The second is the process of examining problems that occur within the treatment, acknowledging anything that the therapist may have done that has bothered the patient, and setting about to clarify the problem. That is referred to as *rupture and repair,* a process that initial research suggests is beneficial to the treatment (Safrin et al., 2001).

PSYCHOTHERAPY

Theory of Psychotherapy

As a form of therapy, psychoanalysis brings the "whole person" to the couch, including his problems, stresses, memories, dreams, fantasies, and feelings, in order to discover the inner sources of his problems. The psychoanalytic process begins as the patient opens up, so that previously unknown parts of the self can be owned and recognized.

During the patient's free associations, the analyst starts to hear patterns in the midst of the stories the patient tells and begins to pick up the emotional "hot spots" in the patient's life. At the same time, the patient may begin to convey his difficulties through the ways he reacts to the analyst. The convergence of these streams of information forms the basis of the transference. This gives the analyst and patient a chance to work on repeating patterns while they are active in the treatment. The analyst also listens for sources of inner conflict that may be linked to symptoms or life problems. Change comes through the process of reworking old patterns so that the patient can become freer to respond in new ways.

The therapeutic relationship itself is the other central change agent. Greenson (1967) and Zetzel (1970) pointed out how an alliance between therapist and patient is beneficial to the treatment. Whereas in psychoanalysis the treatment relationship develops through the intensity of the treatment, in psychodynamic psychotherapy a strong working alliance is actively encouraged. Current psychoanalytic thinking emphasizes the importance of the emotional communication between patient and therapist as a way to gain information and create connection.

Change in Psychodynamic Psychotherapy

What makes for change in dynamic psychotherapy? The theories about what matters in treatment have their origins in the central principles of psychoanalysis. Change is seen as a gradual process of (1) opening up to self-discovery, (2) discovering patterns of relating and perceiving that stand in the way of current functioning, (3) finding ways to disentangle the influences of the past from the present, and (4) finding new ways to cope. The first (1) objective is achieved through free association on the part of the patient and the "evenly hovering" attention of the analyst. The next (2) objective refers to the analysis of the transference or, in SE psychotherapy, the examination of the CCRT. The third (3) objective involves the gradual discovery of the sources of pain, through memories and through the unwelcome reminders that may come via symptoms and behavior in relationships. The final phase (4) is achieved by working through the changes from the preceding steps and developing an increasing ability to use the working alliance with the therapist as a backdrop for a new sense of emotional competence.

Psychoanalysis and Psychodynamic Treatment

Although psychoanalysis is the subject of a vast amount of writing, psychodynamic treatment is more frequently used in practice. Psychodynamic treatment began in order to shorten and simplify the lengthy process of psychoanalysis. It remains popular for the same practical reasons. Supportive-expressive (SE) psychotherapy was developed in order to add clarity to the clinical process. It works from central dynamic principles and includes the use of clinical-research methods in the treatment.

Gains in psychoanalysis and in dynamic psychotherapy derive from two sources: the therapeutic relationship and the exploration of the patient's problems. In supportive-expressive (SE) psychotherapy, the relationship and the structure of the treatment serve as the basis for the supportive aspect of the treatment. Exploration of the patient's problems, using the CCRT and the Symptom-Context methods as tools, constitutes the expressive aspect.

Table 2.1 illustrates the ways in which the psychoanalytic principles emerge in treatment. The term *psychodynamic psychotherapies* here refers to both psychoanalysis and dynamic psychotherapy, since both make use of the same fundamentals in their treatments.

The Purpose of the Psychoanalytic Method

Why make the unconscious conscious? Why talk about the past? The psychoanalytic stereotype is that of patients spending dozens of years of talking to the ceiling and getting nowhere. Aimless analysis may sometimes occur, but that is not the intent of the method, nor is it likely in a well-conducted treatment. Let's look at the theoretical

TABLE 2.1 **Application of Psychoanalytic Principles to Treatment**

Psychoanalytic Principle	Psychodynamic Psychotherapies	SE Psychotherapy
Allow a positive regard for the analyst as a base for the treatment.	Develop a working alliance.	Apply Helping Alliance methods.
Understand the transference. Unconscious conflict results in symptoms.	Analyze the transference. Explore conflicts that may be connected to symptoms.	Apply CCRT methods. Apply Symptom-Context method.

reasons for the psychoanalytic method. (The psychodynamic and clinical-research methods applicable to each of these points are given in parentheses.)

1. *To uncover the inner problems that had been disguised as symptoms.* Just as replacing a garden hose does not solve a problem in water quality, in psychodynamic psychotherapies, the goal is to resolve the problem at its source. In order to understand the meanings expressed in the symptom, the treatment allows in all kinds of material that might at first appear to be random and unrelated. The thematic and emotional links become apparent only after enough "emotional data" have been collected. An "emotional understanding" of the meaning and function of the symptom should prevent *symptom substitution,* in which a different symptom emerges that expresses the same inner problem, and should help reduce the likelihood that the same symptom will continue to recur. {Expressive work; Symptom-Context method.}

2. *To become integrated.* In intrapsychic, or internal, conflict, the parts of the self are at odds with each other. For example, one part may hold the belief in high achievement, while the other part may feel burdened and resentful of work. In conflict, one part sabotages the other, as in the student who never makes it to class. In "working through the conflict" the student may come to know the part of himself that feels resentful and may give that part a chance to speak in session, rather than through behavior. The next task is to find solutions in life that work for both parts of the self. That may take the form of no longer holding on to old feelings that carried pain or frustration, so that what once was at impasse becomes possible. Or it might take the form of a different kind of adaptation, as in the student who decides to spend a semester in Alaska instead of in class. {Free association; working through; CCRT}

3. *To uncover the sources of past pain that may be embedded in the present, causing ripples, or at times whirlpools, of the past in the present.* Perhaps the most powerful reason to take the time to consider what may lie behind symptoms and problems in living is the power of the past to find its way into the present. Selma Fraiberg (1987) tells poignant stories of her work with mothers who had been neglected or abused themselves as children. Their own babies began life in a form of repetition of that neglect, because the mothers could not respond to their babies' cries. Through her work with the mothers and their memories, Fraiberg and her colleagues helped two generations at once, separating the past from the present by first allowing past pain to be understood and then focusing on the present, new baby. An except from the one of these cases, "Ghosts in the Nursery," is included in Case Studies in Psychotherapy, the companion book to this text. {Early memories; therapist's empathy; Symptom-Context method}

4. *To discover what stands in the way of taking appropriate actions for the self.* Even the best plans sometimes go nowhere because other forces within the patient stand in her way. For example, a patient spent several sessions outlining her plan to apply to business school and then develop her own business. But she then canceled her next session and did not return the therapist's phone calls. When she finally showed up, weeks later, she and the therapist discovered that she had expected the therapist to hold her to a plan she was not ready to follow. In fact, the people who would have been behind her plan were not even there. They were her parents as she remembered them from childhood, always planning for her, especially her mother. The therapeutic work needed to back up, and take a look at the transference, so that the patient could become free to make her own choices. The CCRT offered them a way to examine the anticipated responses of others (RO) as well as her own response (RS). {Transference; CCRT}

The sources of change in dynamic treatment are summarized in Table 2.2.

Psychoanalytic Variations

Although the fundamentals of the theory of psychotherapy are shared by most therapists working in a psychodynamic tradition, the emphasis on one element or another varies considerably. For example, classical psychoanalysts focus most on the exploratory work, with the analysis of the transference as the crux of the work. Self-psychologists focus on the nature of the therapeutic relationship, using empathy, rather than understanding, as a prime tool. Relational analysts focus on what gets conveyed through the relationship forged between patient and analyst. The diversity in viewpoints makes a refreshing change from the early days of psychoanalysis (Orfanos, 2006).

However, underneath the differences, a common set of principles continues to operate. In addition to the fundamentals mentioned above, there is the importance of individual differences and the view of the treatment as an opportunity to help the patient rediscover himself. The patient's unique story is the topic of the treatment, with its previously hidden parts as sources of both pain and potential. The dynamics to understand are not a theory to fit to the patient. Instead, they are principles that can guide the therapist's ways of understanding the patient, once enough clinical material has emerged.

Process of Psychotherapy

Psychoanalytically oriented psychotherapy is an unfolding interpersonal process aimed at both discovery and recovery. It is shaped by the personality and problems of the patient, the nature of the therapeutic relationship, and the pathway discovered by patient and therapist as most fitting for the patient. It moves through a series of stages that do not have a time line, except in time-limited versions of dynamic treatment. Instead, the stages are paced by the process and progress of the treatment.

Phases of Dynamic Psychotherapy

Just like a book, the phases of dynamic psychotherapy can be divided in three: the beginning, or *opening phase;* the middle, which consists of the major work of the treatment, including *working through* the basic themes; and the end, commonly called the *termination phase.* Whereas the beginning and the end are defined by their place in the treatment, the middle phase is defined more by the nature of the processes and progress that take place. Consequently, the opening and termination phases will be discussed here as such, and the work of the treatment will be described in terms of the elements that go into the treatment.

The Opening Phase. The opening phase begins before the door opens. What made the patient decide to come into treatment at this time? How hard was it to make the decision? Has she ever been in treatment before? How "bad off" is she? Are there symptoms that might be dangerous to her well-being? Does she have clear goals, or is she "here because she's here"? The therapist will be interested in all of these questions, but he will not want to bombard the patient with them. He will want to set a tone and a pace that allow the patient to begin to get comfortable being in therapy and telling her story.

Psychoanalysis and dynamic psychotherapy differ in certain respects during the first phase. A notable difference is that analysts typically wait for the patient to tell her story, rather than asking many questions. Whether or not questions are explicitly posed, the therapist will want to understand

- Why the patient is seeking treatment at this time
- What kinds of triggers to the current problems seem to be present
- How troubled the patient appears to be (psychological health-sickness)

The therapist takes cues from the patient right from the start. Thus some patients will be able to talk over their reasons for coming into treatment in an organized way, whereas others convey their reasons by their level of distress and difficulty talking. The therapy begins where the patient is.

The introductory phase typically lasts for several sessions. Some therapists use the first three sessions to get an initial sense of the patient and her problems and to go over treatment goals together. Others begin without a formal procedure, trusting that the process will unfold organically. In SE psychotherapy, some form of evaluation, however informal, takes place during the first several sessions. The therapist seeks to get a sense of the patient's psychological well-being in order to consider what form of treatment will be in her best interest. Related decisions include the frequency of the treatment, as well as the balance of supportive and expressive elements. If the initial assessment raises concerns about psychotic process, drug abuse, or severe depression, it also is the responsibility of the therapist to refer the patient for a psychiatric evaluation. Psychological testing may be used to better understand a patient's cognitive and psychological problems.

The practical arrangements of the treatment need to be made during the introductory phase. Those include establishing the frequency of the sessions, agreeing on the fee, and communicating any policies the therapist has regarding missed or canceled appointments.

In psychoanalysis, particularly classical analysis, the patient moves from sitting up to lying on the couch either after a few sessions or when she is ready. In dynamic psychotherapy, the patient remains sitting up, facing the therapist. Psychoanalysis typically takes place three to five times a week, whereas psychotherapy sessions typically occur either once or twice a week. This reflects a difference in the process between the two forms of treatment. In psychoanalysis, the patient goes through what has been called a *transference neurosis*. That is, she replays her core relationship problems in the analysis, and they are resolved by working through their action in the treatment. Frequent sessions intensify that process. In dynamic psychotherapy, work on the transference also takes place, but it is less likely to be replayed in the same way. The CCRT offers a tool for uncovering its action in SE psychotherapy.

The Helping Alliance begins in the opening phase, through the partnership forged between patient and therapist around beginning the treatment. An early positive Helping Alliance correlates with positive results in treatment, according to psychotherapy research studies. This does not mean that a therapy is doomed if the patient starts with mistrust and misgivings, but it does mean that forging a good connection is an auspicious start.

The Elements of the Treatment

The two central elements of the treatment are the therapeutic relationship and the exploration of the patient's problems. The balance of these two elements varies by the form of dynamic treatment being practiced and, more important, by the needs of the patient. In SE psychotherapy, the amount of supportiveness and the amount of expressiveness are tailored to the needs and pathology of the patient. In other words, a patient who is more psychologically fragile will need more support from the therapist than one who functions well in daily life. Some patients respond more to the empathy and the feeling of connection; others respond more to the quest for self-discovery that happens through expressive work. The guide to the right balance of these elements is the patient.

The Supportive Relationship. In SE psychotherapy, the supportive relationship includes all elements of the therapeutic relationship that offer sources of human connection

and structural support to the patient. These elements include the Helping Alliance, the therapist's empathy, the structure of the treatment contract, and attention to the realities of the patient's life. Although many people think of "support" as a lesser element, something either to avoid or to fall back on when nothing else works, empirical studies link support with a positive outcome of the treatment (Orlinsky, Graw, & Parks, 1994).

In all dynamic treatments, the therapeutic relationship is considered a source of the therapeutic action. The therapist's empathy sets the stage for connection. "One begins to empathize with the patient as soon as one goes to open the door, even before seeing him" (Greenson, 1978, p. 158). Empathy connects the therapist and patient to a level of the patient's experience that may not be expressed in words. Since patients often come to therapy when they find themselves in the midst of different kinds of negative emotion, it is encouraging for them to find that the therapist can get the "feel" of their lives.

Example

P sits in her chair in a way that makes her look as if the chair is her skin. She is not moving. The therapist sits very still, finding that she has quieted herself to be in tune with the patient's slow rhythm. Time passes. The therapist watches the patient's face.

P: Tomorrow is another day.
T: (Nods)
P: You don't know what it's like to get up in the morning, look around the room, and see . . . (She begins to get teary.)
T: (Hands her the tissues)
P: Thanks.
T: (Nods)

The patient is trying to come to terms with the end of her marriage. There are no words the therapist can offer her right now that are as useful as her presence. The patient needs someone to *be with* her feelings.

The Expressive Work

The expressive work is a gradual process of making sense of the patient's problems, in the context of the whole person. Before forming any hypotheses about the problems, the therapist needs to deepen her sense of the patient by tuning her ear to listen for all the levels of communication that take place. Freud called this "evenly hovering attention"; instead of preselecting what matters, the therapist listens to everything the patient brings. Luborsky & Luborsky (2006) refer to this process as *open listening,* and Rubin (1996) likens this form of listening to Buddhist meditation, in which the focus is not the content but a state of being.

Meanwhile, the patient is asked to "say what comes to mind," a suggestion that different patients use in different ways. Some want to begin at the beginning and start with their memories and earlier problems. Some begin with today—with whatever events and thoughts come to mind. Some stay problem focused and select those situations that cause stress. In that way the treatment belongs to the patient, and he is shaping it as his own by the nature of the concerns he brings.

It is not only what the patient says that helps the therapist develop an understanding of the patient, but also how he conveys himself. That includes his tone of voice, *affect* (emotional tone), and behavior. Many current analysts consider their countertransference reactions as possible sources of information as well.