EXAMPLE

P: (In a bland voice) So I went to Washington, spent the day collecting the data that I needed, and made the train back that night.
T: (T is silently wondering why this patient bores him. There is nothing wrong with what he is saying. Most patients give an account of the details of their daily life. He has been coming to treatment for three months, so he must be getting something out of it.)
P: Marjorie was there . . . (He falls silent.)
T: (Marjorie . . . She was the one who broke up with him last year. Maybe she is key to live feelings.) What was it like to see her again?
P: You remembered.
T: A surprise?
P: Yes. People don't.
T: That must bother you.
P: Not really. I'm used to it.
T: How did you get so used to it?
P: (Winces, the first show of real affect the therapist has seen in a long time.)
T: (No longer feeling bored, and suspecting that his reaction is related to the patient's CCRT pattern) There may be good reasons why you got used to it. It would be rather frustrating to keep expecting people to remember what you have to say, if they never do.
P: I'd say so. (His body posture relaxes ever so slightly.)
T: (The therapist is glad to have found a way to understand the patient's bland way of presenting himself. He did not want to mention it directly, feeling fairly certain that the patient would be insulted if he did. He realizes that his own worry about being rude had stopped him from looking more closely at the issue. He then begins to consider the patient's CCRT pattern.)

The therapist's countertransference response had let him know that something active had been missing. He took advantage of an opening in the patient's discourse to get to a "live issue." That allowed him to consider the patient's CCRT. In this case it would be

W: (Wish) [implied and deeply buried] To be recognized, remembered

RO: (Response of others) [anticipated] Not recognized, not remembered

RS: (Response of self) No emotional reaction, no affect

The therapist could also consider the patient's bland presentation as a defense against affect. The defense against the pain he would feel if he let in the disappointing response of others had become a defense against all feeling.

Deepening the Exploration

The expressive work deepens through the gradual emergence of patterns in the patient's problems. That includes patterns in relationships and in handling stresses and emotions. Unlike symptom-focused treatments, dynamic treatments start with the premise that any information can be useful in that process of discovery. Just as in mining for gold in a muddy stream, you don't know where the nuggets are until you find them.

In the middle phase of treatment, the patient and therapist gain a deeper understanding of what forces make for problems in the patient's life. That takes place by an examination of problems in relationships, through the understanding of the transference or CCRT pattern. The patient's emotions begin to make sense as their connections to

her past and present life become clear. The emergence of symptoms takes on new meaning once the links to the patient's inner conflicts are understood. The Symptom-Context method can help in that process.

By the later phase of the exploratory work, the patient has gained understanding of the past patterns in her life and is no longer experiencing inner conflict that stops her from functioning. She may continue to *work through* the remaining ways in which old patterns may surface, as she gets ready to figure out new ways to cope. With some patients that happens as a natural outgrowth of the process of the therapy. Others make active efforts to develop new coping strategies, now that their energies are no longer tied up in past patterns and conflicts. In this phase of the work, the patient may notice herself "freed up" in situations that used to be impossible for her to handle.

The Termination Phase

The end of the treatment comes when it comes. The best ending is an ending of the need for treatment, when the patient is engaged with her life in ways that feel positive, without the initial symptoms and turmoil that brought her to treatment in the first place. She should also have mastery of her core themes, so that she no longer falls back into the same problems once she has finished treatment. She should have developed new ways to cope, so that she feels that she can handle her life.

In reality, people "get off the train" of treatment at different points. Some end due to symptom relief, some end due to difficulties in the treatment, or some stay until the deeper issues are resolved. Of course, there is really no such thing as being finished, if "finished" means having no problems and having complete confidence, but an end to a psychoanalytically based treatment should mean that the patient knows herself better, accepts herself and her feelings, and is not frightened of what she will find or feel if she really tunes into herself. She should instead be in a place, psychically, where the old demons have been tamed and no longer "spook" her in the present, and she is ready to move on.

Termination is not as simple as setting a date to conclude treatment. It is a process instead, and considerable feeling comes up in ending therapy. Patients have typically become attached to their analysts, and there are many feelings about letting that person go. Old conflicts and symptoms may resurface as an expression of anxiety about stopping. However, these experiences should be brief and the patient should be able to get them back under control if she is really ready to end. It is important during this phase to explore any fantasies the patient has about how things will be after the analysis is over. That gives the patient and analyst a chance to share the patient's hopes and fears, as well as to give the patient greater confidence going forward. An "open door" policy is often useful as an ending stance. That means the therapy is a place the patient can return to if she ever has the need. In the meantime (which could be forever), she takes it with her.

Mechanisms of Psychotherapy

If someone listened through the walls to a psychodynamic treatment session, he would not be hearing "mechanisms." Instead, he would hear someone talking about his life, telling anecdotes, memories, feelings, and fears. He would hear the therapist's responses to those concerns—sometimes to the content, sometimes to the feelings, often to both. But those exchanges contain the treatment mechanisms, since the essential mechanism of psychotherapy is an interpersonal process. The two central elements of the treatment, the therapeutic relationship and the exploratory work, both contribute to their workings.

The Therapeutic Relationship

The Helping Alliance is pivotal to the therapeutic relationship. It is the partnership between therapist and patient around the work of the treatment. Some patients experience that alliance as going to a therapist who gives them help (Helping Alliance 1), whereas others experience it more as a partnership between patient and therapist (Helping Alliance 2). Research links both forms with a good outcome for the treatment, provided it is a positive alliance, or one that the patient feels offers help.

The Helping Alliance can be enhanced by the therapist's efforts to keep the channels of communication clear. This means actively listening to the patient so that she feels the therapist is a partner in sharing her real concerns. It also means noticing if problems occur in the alliance and seeking to address them.

A process of *rupture and repair* can benefit the alliance if misunderstandings or negative reactions have occurred. This process consists of talking over what may have been problematic for the patient, acknowledging any real difficulties that arose, and accepting the patient's feelings about whatever went wrong. Being able to look at a mishap without brushing it away or overreacting can serve as a useful experience for the patient. Safran & Muran (1996) found it actually to be beneficial to the treatment outcome, especially for patients with negative expectations of relationships.

EXAMPLE

P: (P cancelled the last session. She arrives at this one just on time, and sits down.) So.
T: (Waits. She notes that the patient is focused on the arm of the chair and looks annoyed.)
P: Nothing much to report. Work is busy. What else is new? A lot has happened, I guess.
T: (Wondering why she is so evasive, and whether something might be bothering her about the therapy. Since she canceled the last session, there could be a reason for both.) You haven't been here in a few weeks, is that right?
P: (Shrugs)
T: So I imagine a lot has happened that you haven't talked about here.
P: As if that matters.
T: I get the feeling I am pretty useless in your life right now.
P: (Shrugs again)
T: But I do remember just a few weeks ago you talking about some really important things. I wonder what happened in between? I must have done something, or said something, that made it feel different here.
P: Done something.
T: OK, what did I do?

It turned out that what the therapist did was to take a phone call during the patient's session, something she ordinarily never does, but she had been worried about her own child, who was home sick. The therapist acknowledged that she had taken the call. She wondered if that felt to the patient like she was no longer interested in her. After hearing the patient's feelings, the therapist apologized for causing the patient to feel that she wasn't interested in her: "The last place you need to feel that is here." After several sessions of work on this rupture, repair began. The incident ended up helping the treatment, because the patient said that she had figured she would have quit therapy until the therapist admitted her mistake. It also led them to work on the patient's transference expectations, through CCRT work on her negative expectations of others and her own

defensive responses. And it led the therapist to reflect on the narrow bridge between her personal and professional lives.

As we noted earlier, the therapist's empathy is another crucial aspect of the therapeutic relationship. Understanding the affect states that the patient goes through makes the partnership deeper. "Most experienced psychoanalysts will agree that in order to do effective psychotherapy, knowledge of psychoanalytic theory and an intellectual understanding of the patient are not sufficient. In order to help, one has to know a patient differently—emotionally" (Greenson, 1978, p. 147).

The Exploratory Work

The exploratory, or expressive, work of the treatment is made up of the human process of dialogue in a protected place. It is protected from intrusions by the "saving of the hour" for the patient. It is protected from the ears of others by the practice of confidentiality. And it is protected from having any agenda other than the patient's well-being by the nature of the therapeutic contract. The patient's part of the process in the expressive work is to "say what comes to mind." The therapist's part is a sequence of listening and responding, which gradually yields an understanding of the sources of the patient's problems. In psychoanalysis, the analyst's interpretations of the transference are pivotal.

Transference and the CCRT

The transference is the cornerstone concept of psychoanalysis. It reflects the deep patterning of old experiences in relationships as they emerge in current life. Just as if someone had made footprints in the woods and started looking for a path in the dark, people find themselves retracing their patterns of relating and responding without realizing it. It is not so easy to illuminate an unfamiliar path and walk a new way. Old paths wind through the shadows of habit and history. The analysis of the transference provides the lantern.

Even though volumes have been written about the transference and its role in psychoanalysis, its inner workings may still seem mysterious. The Core Conflictual Relationship Theme method (CCRT) demystifies the concept by describing the different elements of the process. Each CCRT pattern is made up of repeated episodes, consisting of the patient's wishes (W), responses from others, either real or anticipated (RO), and responses from the self (RS). People tend to have either one or several central patterns, just as Freud described when he first came up with the concept of the transference. In fact, Luborsky & Crits-Christoph (1998) found that the CCRT corresponded to the central defining characteristics that Freud gave for the transference pattern. Thus the CCRT is an operational version of the transference.

In understanding the patient's CCRT, the therapist looks for the "convergence of spheres." That term refers to the commonality in the CCRT themes in each of three fundamental areas of the patient's life: his current relationships, his past relationships, and the therapeutic relationship. Both the current and the past relationships are central relationships, typically with family members from the past and either family members or others who are close to the patient in the present.

As the patient and therapist notice the ways in which this pattern intrudes into the present, they become able to begin changing its impact. In clinical practice, it is important not to overload the patient with interpretations. For this reason, the therapist usually brings up one sphere at a time, an area related to the topic the patient has been talking about. As the treatment progresses, the patient may be ready to notice links between the spheres, once the pattern has become evident.

EXAMPLE

P: I wished I could have walked out of the meeting, but I was stuck. You know how bad it would have looked if I had gotten out of my chair and knocked it over? (Laughs) Anyway, I was good and I sat there till I saw someone else move his chair. The only problem is how am I going to stand this job, with all of their meetings?
T: How are you going to stand that stuck, trapped feeling?
P: Exactly. Oh, now that you say that, I remember I felt that way in the last job. When is it going to be over?
T: When will there be a job that isn't a trap?
P: Will you find me one? (Laughs)
T: Let's take a look at what makes you feel trapped. Maybe we can figure it out that way.

In this sequence, the patient is actively aware of his feeling state and realizes that there is some pattern to it. The therapist picks up the patient's signs of readiness to look at this pattern in the context of the job sphere, since that is the patient's current focus. In supervision, his supervisor points out that the patient could develop those same feelings about the therapy. After all, he is stuck in a room, sitting in a chair, having a meeting. The therapist decides to remember that possibility and to keep his ears open to see if that theme becomes active in the treatment.

Symptoms and the Symptom–Context Method

When a symptom appears in the course of the treatment, it gives the patient and therapist an opportunity to investigate its meaning. By taking a look at its context, they can begin to decode the symptom and find out what is making it erupt. The symptom can be thought of as a language for forces that are out of the patient's awareness, often an inner conflict. The context gives hints to what it might mean. The context includes not only the events in the patient's life but also his feelings about them. In a therapy session, the material the patient has just been talking about is the immediate context.

This method has a number of clinical uses. In instances of "momentary forgetting," in which the patient suddenly forgets what he is talking about, paying attention to the context helps the patient and therapist discover whether there was something emotionally disruptive that could have prompted the lapse of memory. A different kind of clinical use comes into play with patients whose symptoms are intrusive and frightening, as in anxiety disorders and post-traumatic stress disorder. Understanding the meaning of the symptom makes it less frightening, and the translation into words can begin to shift its form.

EXAMPLE

P: It's happening again. . . . My throat feels like it's closing up. (The patient had just been talking about early sexual abuse.)
T: What do you think about that?
P: (in a rasping voice) What he did to me. (Referring to a form of sexual abuse that involved her throat.) I can't talk.

This patient has been in treatment long enough that she can readily use the Symptom-Context method to understand her symptoms. She reached that point through the gradual discovery that situations that triggered feelings or memories of the abuse also caused bodily symptoms.

Transformation

The goal of the expressive work is a kind of personal transformation. By gaining an understanding of parts of the self that were previously at odds or out of awareness, the patient can work out new ways of handling her needs and her feelings. This is a gradual process. As the patient gains self-understanding, she becomes more aware of the ways she has "been in her own way." She can begin to shift her expectations toward more positive ones and can find ways to go toward what she really wants, instead of defending herself against her fears. The maladaptive defense mechanisms that were operating before become less powerful. As described earlier in this chapter, research on the CCRT suggests this is the course of events in successful treatment. Patients keep wishing for the same things they always wanted for themselves, but their negative patterns of responses from others and self undergo change.

APPLICATIONS

Who Can We Help?

Psychoanalysis functions both as a form of psychotherapy and as a conceptual system to understand how people function psychologically. As a form of treatment, psychoanalytic therapies are particularly well suited for the many patients who have what Sullivan termed "problems in living," which include difficulties with work and love. Often, people present with generalized patterns of behavior that interfere with their conscious goals for happiness and success. Such difficulties are usually complex and lack an obvious cause, and a psychoanalytic approach helps discern the causes, often by tracing them to an unconscious conflict or relational pattern. A man, for example, might repeatedly fall in love with and marry the same kind of woman, although he knows from previous experience that these relationships will end disastrously. Or perhaps a woman unconsciously arranges her life so that any success at work will be followed by an even greater failure.

Stress and Distress

People with various symptoms of stress or distress, including depression, anxiety, or hypomania, are also well suited for a dynamic approach. A dynamic therapist attempts to understand a symptom in the context of the whole person. She takes into account biological and personality predispositions, past history, current circumstances, and unconscious and cultural meaning. A woman suffering from post-partum depression, for example, may have a genetic vulnerability, hormonal fluctuations, and stress and sleep deprivation, all of which contribute to a biological susceptibility to depression. A psychodynamic therapist would help her to explore the personal meaning of having her own baby to care for, looking at both her past and her present circumstances. Through this process, she may recognize the unconscious anxiety she has about her own unmet wish to be nurtured, which had been interfering with her ability to make an emotional connection with her baby. Once she has worked these feelings through, she will be able to form a positive bond with her child and to have more children without becoming depressed.

Psychoanalytic treatments are beneficial for those who would like to gain a deeper understanding of their problems. Those in the mental health professions often wish for a high level of insight and self-knowledge, in order to be better able to help others with their difficulties. Because it can get at issues that are unconscious, psychoanalysis can also be quite helpful to people who feel generally troubled but do not know why.

Personality Disorders

Psychoanalytic treatment is probably the treatment of choice for personality problems and disorders. This is because psychoanalysts have developed sound theories and techniques to understand and treat them, whereas many other schools of psychotherapy have not. Such disorders are difficult to treat because, as the name suggests, they involve problems that pervade the patient's personality, rather than a specific symptom or condition. Personality disorders call for intensive, long-term treatment to address these issues at a deep level, including work on the patient's defenses and underlying feelings.

Range of Applications

As a system for thinking about people and their problems, a psychodynamic model has a wide range of applications. Understanding the patient's personality structure helps the therapist decide which types of therapeutic interventions are likely to be most effective. The Psychodynamic Diagnostic Manual (PDM) (2006), a psychodynamically based system of classification of psychological difficulties, can be used in that process. Projective psychological tests can sometimes provide information about personality structure, areas of potential conflict, or the presence of a thought disorder.

In supportive-expressive (SE) psychotherapy, the therapist balances two basic elements of the treatment, the supportive relationship and the expressive work, in order to meet the needs of the patient. In that way the therapist is able to tailor the treatment to the level of the patient's pathology.

Psychoanalysis is now useful for many who might have at one time been deemed untreatable or "unanalyzable." Variations of psychoanalysis are currently being used to understand and effect change with a much wider spectrum of people and situations than ever before. Object relations theory, in particular, has widened enormously the scope of treatable conditions, making psychoanalysis useful for many more people and situations. Kernberg (1975), for example, has established an object relations approach to working with patients with personality disorders in the narcissistic and borderline spectrum.

Psychoanalytic formulations have been used to elucidate the dynamics of life in the inner city and their effect on psychological treatment (Altman, 2009). A relational approach has been found to be especially useful for people suffering from the long-term effects of chronic relational trauma, such as physical, emotional, or sexual abuse (Davies & Frawley, 1994). Other psychodynamic approaches to therapy have also been used to address the particular issues of gay men and lesbians, as well as older adults and the chronically medically ill (Greenberg, 2009).

Child and Family Treatment

Problems with a family can be addressed in various ways using a psychodynamic approach. A psychoanalytic perspective informs certain schools of family therapy, such as object relations couples therapy (Scharff & Scharff, 1997) and has been utilized in an integrative way by combining individual and family/couples approaches (Gerson, 2009; Wachtel & Wachtel, 1986). When couples or families work to discover the sources of their problems together, they often find that some of those problems have come about as a result of their own personal histories, conflicts, and vulnerabilities. Understanding those patterns together provides an opportunity to shift the present interactions away from the past paradigms.

Play therapy is an application of dynamic concepts for children, based on Melanie Klein's concept that play is for children what free association is for adults. Such therapy

gives the patient an uncensored opportunity to play out issues and express feelings in a way that causes no harm. Symbolic play allows children to express themes that might feel threatening in words. Parents can be thrown out the window, children can take over the house, animals can fight battles, and no one really gets hurt. Working with parents to help them with their relationships with their children can involve the application of dynamic theory. Either with the parents alone or with the parents and child together, the therapist can help separate the current parenting relationship from those in the parents' past. The work of Selma Fraiberg, excerpted in the *Case Studies in Psychotherapy* volume, gives an unparalleled example of that kind of work.

Combinations of Treatments

Like other forms of psychotherapy, dynamic therapies may be combined with the use of medication for symptoms that are too severe to respond to psychotherapy alone. That is often the case in a major depression or other major mood disorder. Medication does not replace psychotherapy, and the two together are often more effective than either one alone. Understanding the meaning of symptoms and the psychological function they might serve is still an important task. Some dynamically oriented therapists combine tools such as relaxation and breathing techniques for addressing the immediate symptoms and the Symptom-Context method for understanding their meaning.

Treatment

Freud compared writing about psychoanalysis to explaining the game of chess. It is easy to formulate the rules of the game, to describe the opening phases, and to discuss what has to be done to bring a chess game to a close. But what happens in between is subject to infinite variation. The same is true of psychoanalysis. Since every patient (and every therapist) is different, no two treatments are alike. Even so, dynamic treatments have inherent operating principles and treatment techniques that are not immediately visible but are nevertheless at work. The following case fragment illustrates how they intermingle.

EXAMPLE

P: I have something I have been meaning to bring up . . . Night . . . (Pt's voice is soft, and the therapist listens closely. After several minutes the patient starts again.) Katie made the soccer team. (Her voice is bright now.) Which is great, except for all the driving. The amount of miles I have put on that car . . .

T: (T is wondering, what happened to what she had been meaning to bring up? It seemed that the patient had abruptly shifted gears. She notices the pun in her thinking and decides to ask about exactly that.) You know, I am still wondering about what you started the session with. It seemed like you shifted gears, just like the car.

P: (Smiles) I have an automatic. But you're right. So what was I avoiding? (The patient has been in treatment long enough to know that avoiding has reasons.) Well, you're going to think, "She's a fat pig" if I tell you.

T: If I'm going to think that you're a fat pig, I can see why you stopped talking.

P: Well, maybe you won't, but I do. . . . OK, here's the thing. Jon (her husband) goes to bed early. He goes upstairs at 9:00, because he's up at 5 to catch the train. And there I am. I just got the kids to bed, with the whole night in front of me. I keep telling you I want time to myself, but there it is, and what do I do?

T: What do you do?

P: Nothing. Clean the kitchen counters. Leave the TV low, so I don't bother anyone. OK here it is. Eat. (Patient looks embarrassed.) I ate an entire package of Oreos last night. The whole package so I could throw the wrapping away and no one would know the difference.
T: That must have been hard to talk about.
P: Not as bad as I thought.
T: And you must be wondering what I think.
P: Well I really don't think you would judge me, but . . . I mean, who wouldn't? Why would anyone do something so stupid? I mean, I am trying to lose weight. Good reason not to eat that garbage. I should work on my writing if I ever want to get anything published. Good reason not to waste my time. I have no time to myself during the day and finally the kids are in bed and Jon's up there too. You'd think I'd be happy about it.
T: It sounds like you are really mad at yourself.
P: I am.
T: And that you figure I would judge you too. It's hard to get to the "why's" if you and I are both sitting in judgment, but I bet there are feelings hidden under there.
P: (Nods) Lonely.
T: (With empathy) Lonely.
P: (Looks at T, and then back out the window) Even though the house is full, it's empty. . . . Yeah, OK, I'm trying to fill it up, but you can't fill it with Oreos. (Looks at T, and they both smile.) . . . Is my time up?
T: Actually, we have 10 minutes left.
P: Oh, that's so strange. I was sure it was over.
T: Well, I wonder if there was something about what we just talked over that made you feel like I'd be ready to get rid of you.
P: You mean, having feelings?
T: Having feelings like . . .
P: Lonely, mad that I get left with everything.
T: And get left?
P: Yeah, that. (Her eyes start to tear.) When I married Jon I thought I was done with that. He is solid.
T: But he goes to bed and leaves you, and gets up early and does it all over again.
P: (Nods) And now are we out of time?

This session gave the patient some relief. She told the therapist that she finally began writing again. But a month later the Oreos have returned.

P: I started doing it again—eating. I was doing better with it, and then this last week, I got back in my old habit, you know, the night thing.
T: I wonder if anything went on this week that might have been difficult?
P: No. Good things actually. Katie got into a summer program we wanted her to do. Jon got offered a promotion at work. Got to buy some champagne.
T: And your life?
P: Yeah, that is my life. Me and my Oreos. (Looks the therapist in the eye.) You know when I was a kid, it was the same thing. When I came home from school, no one was there, but there was always food.
T: What did you have to eat then?
P: There'd always be something. Look in the refrigerator, look in the cupboard. Something. But I wished we'd have something really good.
T: Like Oreos, by any chance?
P: Now I'm throwing them away. My friend Andrea had all that junk in her lunch, and I wished I could have it too.

In this sequence the symptom is *multidetermined.* As the session unfolds, more links between the patient's feelings, present and past, and the symptom come to light. That kind of layering is itself a psychoanalytic principle. As more layers of related feelings collect, they add to the pull of the symptom.

The next thing to notice is the *sequence* of the session. The patient's emotional themes link her most spontaneous comments together. For example, just after she reveals emotionally laden material, she figures the session will be over. The sense that the session will be over comes from an inner theme, not from a realistic sense of time. Talking about her feeling of being left triggered the fear that she would be left by the therapist (by ending the session). Her response in this case was to become anxious. In the home sequences that she reports, she covers over the feeling by eating.

The therapist is quick to note evasions in the patient's process. They could be thought of as a form of defense. Since the patient and therapist have worked with each other for 9 months, they have an easy rapport. The patient has also already learned through previous examples that she may be avoiding things with which she doesn't feel comfortable. The patient and therapist functioned as partners in this exchange, discovering what is really behind changing the subject. Their Helping Alliance helped the patient trust the therapist when dealing with a topic that was embarrassing to reveal. So did the therapist's *analysis of the defense.* When she made a joke about the car changing gears, she was also pointing out the patient's method of defense against difficult feelings. When she commented that "no wonder" the patient wouldn't talk about eating if the therapist would think she was a "fat pig," she was pointing out one of the functions of the defense.

A CCRT pattern is suggested, through the convergence of the responses described from her childhood, in the present with her husband, and with the therapist. The possible CCRT pattern looks like this:

W: (implied) To be close

RO: Leaves, does not stay close

RS: Eats, fills the space with a substitute; avoids feeling (in the early part of the session, she tends to avoid feelings, whereas later she becomes anxious instead. This is actually a sign of improvement since the anxiety is really underneath the avoidance and use of food).

The Symptom-Context method is at work when the patient and therapist examine the context for overeating. It gives them clues to the patient's feeling state. Another technique that the therapist follows is responding to the patient's affect. She slows down the dialogue and makes time for empathy with the patient's feeling state.

The potential for change is suggested by the patient's positive response to the session and in her greater ease in moving into the material the second time. More work will be needed in order to better understand the patient's feelings and their history. But what we have here is simply a fragment of a treatment, and it represents a good start.

The Psychoanalytic Situation

Shame, fear, pride, political correctness, social conformity—these are among the forces that stand in the way of the patient acknowledging her own truth. The *psychoanalytic situation,* in which nothing is the wrong thing to say, gradually undoes those layers of inhibition. "The special conditions of the psychoanalytic situation are designed to promote the optimal unfolding of the patient's unconscious subjective life" (Rubin, 1996, p. 24).

As the analyst listens to all the layers of the patient's experience, the patient begins to do the same. Logic, consistency, and the other person's approval are not the goals of

psychoanalytic discourse. It has its own logic, where the heart and the unconscious mind intermingle with the waking, rational self. As the patient comes to accept the varied parts of herself, a greater flexibility emerges.

As the transference is worked through, the patient may find that he can relate to others in new ways. The transference can be understood as a form of memory in which repetition in action replaces recollection of events. Once memory's voice is heard, its power to keep a patient repeating the same pathways weakens. Analysis of the transference helps the patient distinguish fantasy from reality, past from present. Analysis of transference helps the patient understand how he may have misperceived or misinterpreted. In place of the automatic ways in which he responded before, the patient becomes able to evaluate impulses and anxieties, rather than either acting on them or covering them over. Ironically, after making room in his consciousness for the illogical and irrational parts of the self, the patient is ready to make decisions on a more mature and realistic level.

Evidence

People often think of psychoanalysis as a "dinosaur" among psychotherapeutic treatments, with a few stray fossils around and no science that could bring it back to life. That happens to be untrue. Not only is psychoanalysis actively practiced in a variety of forms, but there has been ongoing psychodynamic research for decades. Research supports the efficacy of dynamic treatment and specifically supports the workings of its cornerstone principles. Although clinical research does not suggest that dynamic treatment yields more consistent success than other forms of psychotherapy, it does confirm its effectiveness, and studies of its working mechanisms confirm its most fundamental methods.

Psychotherapy Research

Psychotherapy research often focuses on which form of therapy has the best outcomes, compared to other forms. Researchers who have an *allegiance* to one particular form of treatment often obtain results that support their favored approach. However, when psychotherapy studies are combined into meta-analyses, the results are different. Large-scale meta-analyses that aggregate data come up with two findings. The first, often ignored, may be more important than the second.

The first finding is that psychotherapy works. Two thirds to three quarters of patients in psychotherapy get better, a very high rate of success (Lambert & Bergin, 1994). The finding that good "talk therapy" helps the majority of patients is often overlooked in the wake of all the attention given to psychotropic medication. Supportive-expressive, or dynamic, psychotherapy is one of the forms of therapy that attain this level of success.

The second finding is that no one form of therapy consistently outperforms the others. Differences that are too small to be statistically significant are the norm, especially when the studies are corrected for the effects of the researchers' allegiance (Luborsky et al., 1999). This has been called the "Dodo bird finding" after a story in *Alice and Wonderland*. In that story, the Dodo bird gives prizes to everyone who participated in a race, declaring that "everyone has won, and all shall have prizes."

Why is it that everyone gets a prize, when each runner really thinks he should be the winner? The most likely reason is that well-performed psychotherapies share some fundamental factors. Prominent among them is the Helping Alliance. Dynamic psychotherapies highlight the importance of the alliance between patient and therapist, and other treatments rely on the partnership between client and therapist, even if it is not

described as an aspect of technique. Whether explicit or implicit, the Helping Alliance is key in moving the treatment forward. Research also reveals that the therapist's empathy is also linked with positive treatment outcomes. Empathy is another aspect of psychodynamic technique that may be present in other forms of treatment, whether explicitly or not.

Other shared characteristics include the structure and frame of the treatment and an explanatory system that the patient gradually masters. That does not mean there are no meaningful differences between forms of treatment. There are important differences, as you will see as you read the chapters of this book. However, meta-analyses suggest that the differences do not overpower the effect of psychotherapy itself. The Dodo bird's prize goes to those general ("g") factors that all good treatments share.

Evidence-Based Practice

In order to gather clearer evidence on the effectiveness of different treatments, researchers have begun to establish *empirically supported therapies* (ESTs). By establishing precise guidelines for the treatment and for the type of disorder being treated, researchers intend to bring more objectivity to the studies comparing psychotherapies. However, pitfalls arise in relating the results of this approach to real life. Most ESTs are brief treatments, using specified techniques for specific disorders, with subjects whose problems fit with the criteria for that disorder alone. This makes for a clean research design, but in real life, people frequently have commingled problems, and those people are not eligible for the studies (Westen, Novotny, & Thompson-Brenner, 2004).

The other real-life difference comes from the way psychotherapies are practiced. Whereas in studies of ESTs, the treatments follow "pure culture" methods, in reality good therapists adapt their treatment to the individual patient. In supportive-expressive therapy, that adjustment takes the form of balancing the supportive and expressive elements in accordance with the needs of the patient. Thomson-Brenner and Weston (described in Westen et al., 2004) found that therapists of different orientations tended to alter the degree of their activity in session, depending on the needs of the patient. Dynamic therapists reported using more structuring techniques (techniques associated with CBT) when dealing with emotionally constricted patients. And CBT therapists reported using interventions that explored relationship patterns (techniques associated with dynamic therapists) with emotionally deregulated clients. This means that in real life, the differences between forms of treatment are not always as clean as the differences suggested by EST research.

Effective Psychotherapy

Seligman (1995) considered the question of the real-world effects of psychotherapy in a simple way. He polled actual patients for their impressions on a variety of factors. One of these factors was length of treatment. The patients said they found longer treatments more effective than brief ones.

This type of research is not the whole answer either, as Seligman would be quick to agree. However, this approach provides another way to look at psychotherapy using research that is relevant and meaningful.

Dynamic psychotherapies aim to treat the whole person and the patterns of his problems. When specific symptoms alone are studied, the important forces in dynamic treatment may be overlooked. Dynamic concepts and methods are supported by research evidence, which has been found through different kinds of studies.

Evidence for Psychodynamic Concepts and Methods

The Transference. Evidence on the key psychoanalytic concept, the transference, has accumulated through research on the Core Conflictual Relationship Theme (CCRT) method (Luborsky & Crits-Christoph, 1998; Luborsky & Luborsky, 2006). The CCRT is an operational version of the transference that allows it to be studied in research on the process of psychotherapy. Here are some of the findings:

- The same CCRT pattern can be found in patients' narratives about different people.
- There is a parallel between the CCRT pattern with the therapist and with others.
- Interpretations of the CCRT are beneficial to the treatment when they clarify the habitual responses of self (RS) and other (RO).

The Unconscious Mind. Research in neuroscience has given the concept of unconscious processes scientific support through the study of implicit and explicit memory. The term *explicit memory* refers to the conscious retrieval of information, whereas *implicit memory* refers to memory that does not come to mind but is demonstrated through behavior (Westen, 1999). Implicit memory would be the kind of memory linked to transference patterns that are demonstrated through behavior in new relationships. Another form of memory, *associative memory,* links a network of things by their similarities. That process is akin to one tracked in dynamic inquiry into unconscious meanings, such as when the therapist follows the train of thought by its nonlogical, emotional links.

Schore has studied the role of early relationships in early brain development. He notes that the processing of emotional understanding of the right hemisphere precedes verbal understanding. Schore hypothesizes that "the implicit self-system of the right brain that evolves in preverbal stages of development represents the biological substrate of the dynamic unconscious" (Schore, 2005, pp. 830–831).

Finding Meaning in Symptoms. The meanings of a symptom can be found through the Symptom-Context method, which tracks the connection of a symptom to its context (Luborsky, 1998; Luborsky & Luborsky, 2006). The researcher compares samples of material from psychotherapy that contain a psychological symptom with samples of material that do not. This method has yielded three notable findings:

- The symptom emerges after a state of helplessness.
- Feelings of hopelessness, lack of control, and helplessness are linked to symptoms.
- The context for a symptom is significantly different from the context for a nonsymptom.

The Role of the Past in the Present. The belief that past relationship problems persist into the present is basic to psychoanalysis. Attachment research on the intergenerational transmission of attachment patterns (Main, Kaplan, & Cassidy, 1985) validates that hypothesis. Attachment researchers have also validated Bowlby's concept that "inner working models" of relationships develop through attachment experience and affect the child's sense of security and functioning in relationships.

Sprinters and Runners

What would happen if someone decided to discover which were better, sprinters or long-distance runners? One of each type might be stopped after a quarter of a mile and tested for their heart rate and how rapidly they covered the distance. Would the winner really be the winner, or simply the one who best fit the research design? In order to study

the effectiveness of psychotherapy, it is worth keeping in mind both the complexity of real people and their problems *and* the natural differences among forms of treatment. The performance of psychodynamic therapies, like that of the long-distance runner, may be best measured over time.

Research suggests that symptom relief may be achieved through several "well-performing" therapies. But psychoanalysis was never about symptom relief alone. Patients go into all forms of treatment because of symptoms that are troubling them, and they should get relief from those symptoms. But dynamic psychotherapies offer something else as well: a changed sense of self that is no longer stuck in old patterns.

Psychotherapy in a Multicultural World

Culture infuses all of our assumptions, and when considering theories of psychotherapy, it is all too easy to forget that both theorists and their patients are affected by culture. There is no such thing as culture-free thinking, any more than there is word-free language. Even within a culture, the name of a culture may not tell the whole story because of different subcultures that may be present. One person's experience may involve multiple experiences across different cultures and continents. Another's cultural story may be a hybrid of differing beliefs and backgrounds within the same family. The potential for misunderstanding multiplies when a patient and therapist make assumptions about each other based on cultural fragments or stereotypes.

How can the search for understanding still take place? How can a patient and analyst navigate a shared journey when they may not even know which ways they diverge or which assumptions they do not share? Altman (2009) refers to culture as the third force in the consulting room, proposing that if the analyst and patient are already working in a two-person psychology, issues of race, class, and culture create a third and critical element in the relationship.

Cultural Assumptions of Psychoanalysis

In the early days of psychoanalysis, questions of cultural differences were not considered important. On the contrary, Freud sought to create a psychology that applied to a "universal man" (Davidson, 1988). Did his own cultural assumptions limit his theories? Rendon (1993) wrote, " . . . psychoanalysis has been ethnocentric. It has been practiced mostly by and for certain ethnic groups and sectors of society" (p. 120). That bias has been challenged by feminist writers (Benjamin, 1988; Chodorow, 1989). Chodorow (1999) analyzed the ways that personal beliefs about culture and gender, along with unconscious fantasies, influence subjective experience. Altman (2009) considers the ways race and class influence the developing self while challenging the assumptions often ascribed to "blackness" and "whiteness." Leary (1995) points out that race and ethnicity are frequently taboo topics, all too often left unexplored.

While anthropologists criticized Freud's *Totem & Taboo* for its obsolete assumptions after it was published in 1918, anthropology and psychoanalysis have since cross-fertilized each other, with anthropologists delving into life histories and autobiography and psychoanalysts taking culture into account when studying differences in personality structure among non-Occidental individuals (Wittkower & Dubreuil, 1976).

Research on Cultural Differences and Psychoanalytic Concepts

The mid to late 20th century brought collaboration between psychoanalysts and anthropologists, which led to a mingling of theories and perspectives (Mead, 1957). Utilizing data from the Human Relations Area Files (HRAF), a collection of all known

ethnographic data, psychological anthropologists (Whiting & Child, 1953; Whiting & Whiting, 1975) studied Freudian theory across cultures, showing the influence of early socialization experiences on personality development. Herdt and Stoller (1990), an anthropologist and a psychoanalyst, respectively, studied gender identity and eroticism cross-culturally.

Tori and Bilmes (2002) studied psychological defenses in Thailand in order to see whether this concept was only relevant in Western countries. These investigators found evidence that the Thai population studied utilized ego-defense mechanisms, although there were differences in which defenses were most common there as compared to the United States. However, despite these differences, the fundamental concept still proved useful in understanding how individuals in different cultures cope with emotions.

Differences in Nonverbal Behavior

Differences in the interpretation of nonverbal behavior can lead to misunderstanding in treatment. While direct eye contact typically connotes honesty and connection to most people in the United States, it has different meanings in other cultures. For example, in Asian cultures, looking away may be a signal of respect to someone of a higher status (Galanti, 2004). Likewise, the psychoanalytic use of the couch and expectations about speaking your mind may mean very different things in different cultures. Cultural differences add a layer of meaning to the basic structure of a treatment.

The Psychoanalytic Method and Cultural Meanings

The psychoanalytic method of inquiry can be used to uncover some of the ways divergent cultural influences may influence both patient and treatment, including the complex effects of dislocation and adaptation to another culture. ". . . In our pluralistic society, conflict and symptomatology are often the products of two or three generational disparities in cultural values" (Davidson, 1998, p. 88).

Recent writings on treatment with patients from diverging backgrounds identify the ways that experiences of loss and dislocation may be hidden in a patient's problems, along with the value of working that through.

Immigration from one country to another is a complex and multifaceted psychosocial process with significant and lasting effects on an individual's identity. Leaving one's country involves profound losses. Often one has to give up familiar food, native music, unquestioned social customs, and even one's language. The new country offers strange-tasting food, new songs, different political concerns, unfamiliar language, obscure festivals, unknown heroes, psychically unearned history, and a visually unfamiliar landscape. However, alongside the various losses is a renewed opportunity for psychic growth and alteration. (Akhtar, 1995, p. 1051)

Cultural differences can alert the analyst to areas that need to be explored in therapy.

CASE EXAMPLE

This case example illustrates the application of a classical psychoanalytic approach to a pivotal session in the treatment. The same session would be handled somewhat differently by therapists representing other psychoanalytic perspectives. In order to clarify some of the differences, the case description will be followed by the view of a relational analyst and the view informed by the use of the CCRT.

A Psychoanalytic Session

The patient was a middle-aged businessman whose marriage had been marked by repeated strife and quarrels. His sexual potency had been tenuous. At times he suffered from premature ejaculation. At the beginning of one session, he began to complain about having to return to treatment after a long holiday weekend. He said, "I'm not so sure I'm glad to be back in treatment even though I didn't enjoy my visit to my parents. I feel I just have to be free." He then continued with a description of his visit home, which he said had been depressing. His mother was bossy, aggressive, manipulative, as always. He felt sorry for his father. At least in the summertime, the father could retreat to the garden and work with the flowers, but the mother watched over him like a hawk. "She has such a sharp tongue and a cruel mouth. Each time I see my father he seems to be getting smaller and smaller; pretty soon he will disappear and there will be nothing left of him. She does that to people. I always feel that she is hovering over me ready to swoop down on me. She has me intimidated just like my wife."

The patient continued, "I was furious this morning. When I came to get my car, I found that someone had parked in a way that hemmed it in. It took a long time and lots of work to get my car out. I was very anxious, and perspiration was pouring down the back of my neck.

"I feel restrained by the city. I need the open fresh air; I have to stretch my legs. I'm sorry I gave up the house I had in the country. I have to get away from this city. I really can't afford to buy another house now, but at least I'll feel better if I look for one.

"If only business were better, I could maneuver more easily. I hate the feeling of being stuck in an office from 9 until 5. My friend Bob had the right idea—he arranged for early retirement. Now he's free to come and go as he pleases. He travels, he has no boss, no board of directors to answer to. I love my work but it imposes too many restrictions on me. I can't help it, I'm ambitious. What can I do?"

At this point, the therapist called to the patient's attention the fact that throughout the material, in many different ways, the patient was describing how he feared confinement, that he had a sense of being trapped.

The patient responded, "I do get symptoms of claustrophobia from time to time. They're mild, just a slight anxiety. I begin to feel perspiration at the back of my neck. It happens when the elevator stops between floors or when a train gets stuck between stations. I begin to worry about how I'll get out."

The fact that he suffered from claustrophobia was a new finding in the analysis. The analyst noted to himself that the patient felt claustrophobic about the analysis. The conditions of the analytic situation imposed by the analyst were experienced by the patient as confining. In addition, the analyst noted, again to himself, these ideas were coupled with the idea of being threatened and controlled by his mother.

The patient continued, "You know, I have the same feeling about starting an affair with Mrs. X. She wants to and I guess I want to also. Getting involved is easy. It's getting uninvolved that concerns me. How do you get out of an affair once you're in it?"

In this material, the patient associates being trapped in a confined space with being trapped in the analysis and with being trapped in an affair with a woman.

The patient continued, "I'm really chicken. It's a wonder I was ever able to have relations at all or get married. No wonder I didn't have intercourse until I was in my twenties. My mother was always after me, 'Be careful about getting involved with girls; they'll get you in trouble. They'll be after you for your money. If you have sex with them, you can pick up a disease. Be careful when you go to public toilets; you can get an infection,' etc. She made it all sound dangerous. You can get hurt from this; you can get hurt from that. It reminds me of the time I saw two dogs having intercourse. They were stuck together and couldn't separate—the male dog was yelping and screaming in pain.

I don't even know how old I was then, maybe 5 or 6 or perhaps 7, but I was definitely a child and I was frightened."

At this point, the analyst suggest that the patient's fear of being trapped in an enclosed space is the conscious derivative of an unconscious fantasy in which he imagines that if he enters the woman's body with his penis, it will get stuck; he will not be able to extricate it; he may lose it. The criteria he used in making this interpretation are the sequential arrangement of the material, the repetition of the same or analogous themes, and the convergence of the different elements into one common hypothesis that encompasses the data—namely, an unconscious fantasy of danger to the penis once it enters a woman's body. The goal of this interpretation is to move toward what must have been an unconscious fantasy of childhood, that of having relations with his mother, and a concomitant fear, growing out of the threatening nature of her personality, that in any attempt to enter her she would swoop down upon him. In this case, there was a threat of danger associated with these wishes—namely, a fantasy that within the woman's body there lurked a representation of the rival father who would destroy the little boy or his penis as it entered the enclosure of the mother's body.

As the therapist helped him become aware of the persistent effects of these unconscious childhood conflicts, the patient would gain some insight into the causes of his impotence and his stormy relations with women, particularly his wife, as well as his inhibited personal and professional interactions with men. To this patient, having to keep a definite set of appointments with the analyst, having his car hemmed in between two other cars, being responsible to authorities, and getting stuck in elevators or in trains were all experienced as dangerous situations that evoked anxiety. Consciously, he experienced restrictions by rules and confinement within certain spaces. Unconsciously, he was thinking in terms of experiencing his penis inextricably trapped inside a woman's body. This is the essence of the neurotic process: persistent unconscious fantasies of childhood impose a mental set that results in selective and idiosyncratic interpretations of events.

Drive Theory versus Relational Theory

The analyst in this case (Jacob Arlow) looks through the lens of drive theory. He sees the patient's problems as having originated in the psychosexual anxieties of Oedipal conflict. The patient's repressed sexual and aggressive impulses are behind his symptoms. Rather than succumb to these urges, he develops a symptom, claustrophobia, to represent the conflict symbolically, enabling him to simultaneously repress and express the impulse. This analyst sees his role as an objective observer who interprets the patient's experience in order to make conscious what had previously been unconscious. In so doing, he works within a "one-person model," offering insights that give the patient a deep-level understanding of his problems.

A relational analyst would see the same material as an intersection of reality with long-standing relational patterns. She would be more likely to focus her responses on the ways the relationship patterns were activated in the present, by spending time on the patient's feelings about the treatment. For example, when the patient talked about not wanting to come back to analysis after the weekend, she would have inquired about those feelings, "shining a flashlight" on what the patient was experiencing with her. She would have had an interest in the patient's early relationships as memories to explore, using them to understand the patient's past and current feelings, rather than interpreting them in accordance with Oedipal theory. She would have tried to "get a feel" for the patient's early world by empathizing with what was frustrating in his early experiences.

She would be working from a two-person model, in which she is participant as well as observer. Her focus would be on the patient's relationships, past and present.

Looking Through the Lens of the CCRT

In looking at the session through the lens of the CCRT, the *convergence of spheres* becomes apparent. The patient describes the same themes in his relationship with his mother, his work, the analyst, and his wife. That convergence makes it a good time for the patient and analyst to look at the pattern. The fact that the theme is reflected in the session itself means that the patient's feelings about the analyst need to be further explored. Considering the session in that way makes it seem to be a pivotal session, just as it did to the treating analyst. However, what seems pivotal is the convergence of the CCRT pattern, not the Oedipal material.

The CCRT pattern conveyed by this patient would be

W: (Implied) To be free, independent

RO: Controlling; trapping

RS: Get angry; get anxious; get impotent

The patient's perception of the mother as controlling seems like an important driving force in his conflictual pattern. The patient's symptoms, impotence and claustrophobia, both seem to be expressions of the CCRT pattern. The patient's impotence appears to be linked to his perception of (female) others as controlling, and while his own response is to feel angry and trapped. The patient's claustrophobia also seems symbolically related to his CCRT pattern, since the symptom involves the fear of being trapped. The Symptom-Context method could be used to determine the context of that symptom, including feelings, thoughts, and events that precede it.

We noted, when we traced themes in this psychoanalytic session, that for this patient, having to keep a definite set of appointments with the analyst, having his car hemmed in between two other cars, being responsible to authorities, and getting stuck in elevators or in trains were all experienced as dangerous situations that evoked anxiety. Whether seen through the lens of classical or relational analysis, or through the CCRT, the pattern in the transference is key in the process. The differing techniques use different language and approaches to help the patient come to terms with its impact.

SUMMARY

Psychoanalysis began as a way to explain and treat human behavior that did not follow the laws of logic. What made people remain in states of psychic pain, with physical symptoms that had no apparent cause? From his early use of hypnotic techniques with patients who were then called hysterics, Freud began to develop a way to treat the conditions of psychic distress. Both his theories and technique evolved along with his clinical experience. As he discovered that psychological cures were often not as simple as recovering memories and regaining health, he noticed resistances within his patients that he began to explore. Theories of defense and of inner conflict as a source of symptoms evolved from there. He postulated an unconscious mind as the keeper of early patterns of relating, otherwise known as the transference.

Since Freud, psychoanalytic ideas and forms of treatment have continued to evolve in different ways. In the century since his early discoveries, they have been alternately challenged, followed, rejected, and expanded. The classical psychoanalytic tradition has stayed the closest to Freud's original ideas, whereas other theorists and practitioners have made changes in focus and technique. These include the ego psychologists, self-psychologists, the object relations school, and the current interpersonal and relational analysts. Psychoanalytic concepts have been evaluated through clinical research, through

methods that give operational status to their inner workings, notably the CCRT and the Symptom-Context method.

Psychodynamic treatments make use of two basic elements of cure: the therapeutic relationship and exploratory work. Varied forms of treatment have evolved from the psychoanalytic core. They include both forms of psychoanalysis and dynamic psychotherapy, including supportive-expressive (SE) psychotherapy, which expands the range of patients who can be treated through a dynamic approach. Pivotal to all the forms of treatment are the fundamental psychodynamic beliefs in the power of old patterns of relationships to "trip the system" of current relationships, and the power of unconscious aspects of the self to appear in the form of symptoms.

One of Freud's seminal contributions to the history of psychology was his insight that there is more to us as human beings than what is on the surface, and that we can hide things about ourselves, even from ourselves. That is as true today as it was a century ago. Psychodynamic treatment continues to offer a way for patients to make sense of their own behavior and develop a clearer personal path. Psychoanalytic thinking continues to evolve by engaging in new ideas and clinical research. But perhaps most important of all, it is enriched by the source that sparked its origins: the patient.

ANNOTATED BIBLIOGRAPHY

The following books are recommended for those who want to learn more about psychoanalysis as theory and practice.

Freud, A. (1966). *The ego and the mechanisms of defense. The writings of Anna Freud* (Vol. 2). New York: International Universities Press. [Originally published in 1936.]
Anna Freud has one of the finest and clearest writing styles in psychoanalysis. *The Ego and the Mechanisms of Defense* is an established classic for its lucidity in portraying the theoretical implications of the structural theory and its application to problems of technique. In a relatively small volume, the author offers a definitive presentation of the psychoanalytic concept of conflict, the functioning of the anxiety signal, and the many ways in which the ego attempts to establish defenses. The sections on the origin of the superego, identity, and the transformations in adolescence present a clear picture of how the child becomes an adult.

Freud, S. (1915–1917). *Introductory lectures on psychoanalysis.* London: Hogarth Press.
These lectures make up Volumes 15 and 16 of *The Complete Psychological Works of Sigmund Freud.* The books are based on a set of lectures Freud gave at the University of Vienna. His lectures are a model of lucidity, clarity, and organization. Introducing a new and complicated field of knowledge, Freud develops his thesis step by step, beginning with simple, acceptable, common-sense concepts, and advancing his argument consistently until the new and startling ideas that he was to place before his audience seemed like the inevitable and logical consequences of each individual's own reflection. *Introductory Lectures on Psychoanalysis* offers the easiest and most direct approach to the understanding of psychoanalysis.

Greenberg, J. R., & Mitchell, S. A. (1983). *Object relations in psychoanalytic theory.* Cambridge, MA: Harvard University Press.
This landmark book contrasts drive theory and the relational model, in terms of theory and history. The latter paradigm follows from the British object relations theorists who believe that an innate need to maintain relationships is what motivates human behavior and that early relational patterns remain active throughout life.

Greenson, R. (1967). *The technique and practice of psychoanalysis.* New York: International Universities Press.
This book offers a clearly written introduction to psychoanalytic theory and technique. The psychoanalytic essentials of free association, the transference, and resistance are explained, as is the working alliance. The author gives clinical examples that demonstrate the psychoanalytic method and describes the "skills required of a psychoanalyst." Greenson has a rare capacity to make complex concepts clear.

Luborsky, L. & Luborsky, E. (2006). *Research and psychotherapy: The vital link.* Lanham, MD: Jason Aronson.
This book does three things. It brings clinical experience and research together in one volume, showing how the two can enrich each other. It introduces Luborsky's innovative methods, which can be used both in the practice of psychotherapy and as research tools. Finally, it offers a clear, stepwise introduction to the practice of supportive-expressive (SE) psychotherapy, a form of psychodynamic therapy.

McWilliams, N. (2005). *Psychoanalytic psychotherapy: A practitioner's guide.* New York: Guilford.
The third of a trilogy, this volume builds on McWilliams's previous books on psychoanalytic diagnosis and case formulations. She discusses in a sophisticated but accessible way the essential aspects of psychodynamic therapy.

CASE READINGS

Arlow, J. A. (1976). Communication and character: A clinical study of a man raised by deaf-mute parents. *Psychoanalytic Study of the Child, 31,* 139–163.

The adaptive capacities of the individual, even under difficult environmental circumstances, are illustrated in this well-documented case of a person raised by deaf-mute parents. In many respects, overcoming real hardships and conquering shame contributed to the character development of this person.

Fraiberg, S. (1987) Ghosts in the nursery: A psychoanalytic approach to problems with impaired infant-mother relationships. In L. Fraiberg (Ed.), *Selected Writings of Selma Fraiberg* (pp. 100–136). Columbus, OH: Ohio State University Press.

Selma Fraiberg takes the psychoanalytic concept of the role of the past in the present into the lives of neglected infants. The mothers in these case studies could not respond to their own babies until Fraiberg and her colleagues responded to their own, previously forgotten memories of being neglected themselves. That opened up the potential for the mothers to hear their own real babies. Fraiberg offers a moving account of the ways two generations can be helped at once.

Freud, S. (1963). The rat man. In S. Freud, *Three case histories.* New York: Crowell-Collier.

The case of the "rat man" was a landmark in Freud's developing theory of psychoanalysis. In precise, clinical reporting, Freud outlined the role of the primary process, magical thinking, ambivalence, and anal fixation in the structure of an obsessive-compulsive neurosis. Although in his later writings Freud expanded his clinical theory and metapsychology, this case report is a prime example of how Freud used clinical observation to develop his ideas and shed light on previously obscure problems.

Grossmark, R. (2009). The case of Pamela. *Psychoanalytic Dialogues, 19(1),* 22–30. [Reprinted in D. Wedding and R. J. Corsini (Eds.). (2010). *Case studies in psychotherapy* (6th ed.). Belmont, CA: Brooks/Cole.]

A vivid rendering of a psychoanalytic treatment conducted from a relational perspective. A woman unconsciously reenacts her traumatic experiences in her relationship with her analyst, who uses his own countertransference to better understand his patient's inner world.

Winnicott, D. W. (1972). Fragment of an analysis. In P. L. Giovacchini, *Tactics and technique in psychoanalytic therapy* (pp. 455–493). New York: Science House.

Winnicott's approach to psychoanalytic theory and practice represented an important turning point in psychoanalysis. This case report illustrates his special approach, which emphasizes the influence of interpersonal interactions and feelings. Winnicott's technical precepts have had a strong and lasting effect on psychoanalytic practice.