5

Psychodynamic Therapy

OBJECTIVES

This chapter explains:

- *The psychoanalytic model of the mind as a set of distinct structures that sometimes conflict with each other.*
- *The unconscious mind and its role in the etiology of mental health problems.*
- *The mental structures of id, ego, and superego.*
- *The difference between mature and immature ego functioning.*
- *Object relations theory.*
- *The technique of interpretation, which produces insight.*
- *The capabilities and limitations of insight as an agent of change.*
- *The role of psychoeducation in dynamic therapy.*
- *How to provide corrective emotional experiences to clients.*

Case Example

Preemptive Strike

Jennifer's parents did not know whether they felt more sympathy or anger toward their 11-year-old (Caucasian) daughter. They described Jennifer as a bright, competent girl, but nothing made her happy, and she was usually in a bad mood, sometimes crying in response to minor frustrations. Jennifer had no close friends, and she frequently isolated herself in her room, where she watched TV and ate junk food. School came easily to her but, rather than contributing to an enjoyment of learning, this seemed to result in an arrogant attitude toward peers and disrespect for teachers who, she claimed, did not know more than she did. The parents described these problems as long-standing and were unable to locate their beginning at a particular point in time. The therapist, noting that depression in children sometimes manifests itself as irritability more than sad mood (see Chapter 14), made a diagnosis of persistent depressive disorder.

In her first session, Jennifer wasted no time before snickering at the therapist's unfashionable clothing and worn office furniture. She portrayed her behavior in school as justified given how boring and clueless the teachers were. She seemed to enjoy evading questions by turning the spotlight from herself back to the therapist. All attempts to examine her role in problems were met with derision (e.g., "Don't give me your analysis; you're just a Dr. Phil wannabe").

Psychoanalytic Theory

Psychodynamic therapy is a descendent of **psychoanalysis**, which was originated by Sigmund Freud and was the first form of psychotherapy. Modern versions of analysis are practiced today, but not widely, while dynamic therapy is a common form of treatment. Psychodynamic and psychoanalytic therapies are based on the same body of theory; the differences concern practice and technique. Analytic therapy involves four or five sessions a week, and dynamic therapy usually occurs once a week. Analytic treatment frequently takes several years. Dynamic therapy usually takes from several months to 1 year. In analysis, the client lies on a couch with the analyst seated behind her. In dynamic therapy, the clinician and client sit facing each other. (In both types of therapy, children are free to move around and play.)

The term **dynamic**, in "psychodynamic," refers to interactions between different parts or aspects of the mind. According to analytic theory, the mind is not a unified whole, and mental structures differ in their aims, content, and manner of operation. As a result, people often experience **internal conflict** (Fenichel, 1945; S. Freud, 1923, 1933; Hartmann, 1939/1958).

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Freud created a huge, sprawling theory, many of the tenets of which have been disproved during the last century. However, recent neuroscience research has produce deep-level information about brain functioning that conforms in some fundamental respects to the picture of the mind sketched by psychoanalysis. Westen (2005; Westen & Gabbard, 2002) reviewed psychological and neuroscientific research addressing psychoanalytic hypotheses and identified extensive support for some of the theory's most important postulates.

Perhaps the most important single conclusion of neuroscientific research is this: The mind is modular (Damasio, 1994; Debiec, Heller, Brozek, & LeDoux, 2014; LeDoux, 1998). In other words, the brain is not a single, homogenous entity but is composed of a number of modules or parts. The modules have different anatomical locations, functions, operating characteristics, and, to a considerable extent, *different agendas*. This is why it is possible for conflict to occur within the same brain.

Neuroscientists say that the brain is like a committee—and a fractious one at that, with members frequently arguing about the best course of action to take. When brains are viewed by CAT-scan, PET-scan, and fMRI machines, internal disputes are indicated by high rates of firing in the nerve tracts connecting the modules in conflict (Kehyayan, Best, Schmeing, Axmacher, & Kessler, 2013). There is even a certain brain structure (the anterior cingulate cortex) that functions like a mediator attempting to resolve conflicts between other modules. This neurophysiological account can help clients make sense of their experiences of ambivalence and competing impulses, which emerge as natural aspects

of the human condition. Statements taking the form, "Part of me wants X, but part of me wants Y" are not merely analogies—they can be literally true. What neuroscientists call the modular nature of the brain corresponds to what psychoanalysts call the dynamic nature of the mind.

The Core Idea: The Unconscious Mind

In the late 19th century, the scientific view was that "mind" is synonymous with consciousness. But then a young physician named Sigmund Freud, who had never heard of psychotherapy because there was no such thing, observed a demonstration of a new procedure called hypnosis (S. Freud, 1935). A woman was induced into a trance state, and she was given a posthypnotic suggestion that when the hypnotist said a certain word, she would get up from her chair and open a window in the room. The woman was brought out of her trance; the word was said; and the woman walked over and opened the window exactly as she was told to do. But this was not the most interesting aspect of the demonstration to Freud. He was more struck by what the woman said before she got up to open the window. Her verbalization was described as something like this:

> " … hmm, it's getting warm in here . . . . Boy, is it hot. It's stifling. I could really use some fresh air. Would you mind if I opened that window over there?"

There are two important truths revealed by this sequence of behavior: (1) People sometimes do things without knowing why, and (2) when this occurs, people generally construct plausible reasons for their actions, although these rationalizations have nothing to do with the real reason for their behavior (Fenichel, 1945; S. Freud, 1933, 1943). In this demonstration, the woman's behavior was under the control of her unconscious. However, her conscious mind did not generate thoughts like "I have no idea why I'm doing this" but, instead, generated reasonable (and irrelevant) justifications for the behavior. In the 100 years since Freud developed his theory, research has produced overwhelming evidence that much human cognition, emotion, and behavior are, indeed, controlled by unconscious processes (Damasio, 1994; Debiec et al., 2014; LeDoux, 1998).

Freud's ideas were met with derision by the scientific establishment of his time. The term "unconscious mind" was considered an oxymoron. The opposition was so vehement that the early analysts, in characteristic fashion, thought that people's resistance to the idea of the unconscious was based not on logic but on motivation and emotion. Freud (1943) placed this threat to humanity's collective self-esteem in the context of the history of science:

> Humanity has in the course of time had to endure from the hands of science two great outrages upon its naïve self-love. The first was when it realized that our earth was not the center of the universe, but only a tiny speck in a world-system of a magnitude hardly conceivable . . . . The second was when biological research robbed man of his peculiar privilege of having been specially created, and relegated him to a descent from the animal world, implying an ineradicable animal nature in him . . . . But man's craving for grandiosity is now suffering the third and most bitter blow from present-day psychological research, which is endeavoring to prove to the "ego" of each one of us that he is not even master in his own house, but that he must remain content with the veriest scraps of information about what is going on unconsciously in his own mind. (p. 252)

Most people in our culture seem to have assimilated the idea of the unconscious and no longer find it threatening or insulting. To me, this underlying layer makes the mind much more interesting and mysterious. Also, as will be discussed later, analytic theory does propose ways for people to come to know their unconscious minds, at least partially.

Mental operations are unconscious for several different reasons. Unconscious processing of physiological and sensory-motor information seems conducive to efficiency; we do not need to be conscious of these mechanisms. Many mental operations are unconscious because they occur automatically and the person has not taken the time to think about them; this is the understanding of unconscious schemas in cognitive therapy. Psychoanalytic theory posits an additional reason for mental contents to be unconscious: Some impulses, emotions, and memories are excluded from consciousness, or **repressed**, because awareness of them is too threatening or painful to be tolerated (A. Freud, 1946a; S. Freud, 1943; Hartmann, 1939/1958). Unconscious material of this type is considered the source of psychological dysfunction.

The anatomy and physiology of the brain are much, much more complicated than the words we non-neuroscientists use to describe the psychological phenomena that result. It is scientifically responsible to acknowledge that our language simplifies real phenomena, and then it is pragmatic to return to the metaphors that enable us to organize reality in a fashion that fulfills our purposes. Here, this means we should stipulate that the conscious and unconscious minds are not literally two places in the brain, one with the lights on and one with the lights off.

A more accurate description would state that the brain includes multiple neural networks that give rise to multiple networks of associations, which vary widely in the degree to which we are conscious of them, from complete awareness to no awareness, with everything in between (Westen, 2005; Westen & Gabbard, 2002). Frequently, we are conscious of the outputs of the networks (thoughts and feelings) without being aware of either the neural connections underlying the outputs or the learning histories responsible for the neural connections. For example, a man whose father frequently belittled him during childhood might find himself extremely anxious with his boss, and the man might not know why, or he might construct a plausible but irrelevant explanation. Sometimes the brain's networks of associations are consistent and coordinated with each other, but sometimes they operate semiautonomously and even produce contradictory cognitions and emotions, which may vary in their degree of conscious representation. As a result, the human mind is prone to conflict, and we do not always know why we feel and behave the way we do. This formulation can be referenced, in a quick and convenient way, by using the shorthand terms "conscious mind" and "unconscious mind."

Freud, working during Victorian times, repeatedly observed his clients repressing sexual and aggressive impulses. However, there are no rules about what feelings might be unacceptable to the conscious mind. Repression often operates against angry, selfish, and jealous feelings, memories of trauma, and sexual desires of which the person disapproves (e.g., homosexual impulses in homophobic individuals).

The difference between the conscious and unconscious minds is not simply that people are aware of the former and unaware of the latter (S. Freud, 1915/1957; Gray, 1994). These two aspects of mind have different properties, content, and ways of operating. The properties of consciousness require less explanation because this is the aspect of mind with which we are already familiar. Consciousness includes those feelings, thoughts, and memories that are acceptable to the individual. This material may be painful, but not to the point of being intolerable.

Cognitively, the conscious mind operates in a manner commensurate with the highest level of development that the individual has attained. In adults, the conscious mind involves adult thinking; in typical 9-year-olds, it involves thinking at this level of cognitive development, and so forth.

The nature of the unconscious mind requires more explanation, because it is not experienced directly. The unconscious includes emotions, cognitions, and memories that are threatening to the individual and that, therefore, have been repressed (Cabaniss, Cherry, Douglas, Graver, & Schwartz, 2013; Cramer, 2006; S. Freud, 1943). There seem to be two main reasons why this occurs: People sometimes cannot tolerate awareness of impulses and fantasies they find morally unacceptable, and people sometimes repress memories of experiences that were extremely painful. Repression can be total, as in amnesia for an event but, more often, it is partial. Frequently, people have some awareness of difficult emotions and painful memories but, as a result of repression, their awareness is incomplete.

According to analytic theory, the nature of cognitive development is dramatically different in the conscious and unconscious minds. The conscious mind becomes more logical and realistic as child development proceeds, but *the unconscious does not mature* (Dewald, 1971; S. Freud, 1957; Horowitz, 1998). Even in adults, its manner of operation remains that of a young child: Feelings are intense and poorly modulated; thinking is impressionistic, illogical, and dominated by emotion; there is little understanding of cause and effect; and there is a blurring of fantasy and reality. This difference between conscious and unconscious functioning is central to the analytic understanding of etiology and therapy.

The conscious mind becomes more logical and realistic as child development proceeds, but the unconscious does not mature.

The Structure of the Mind: Id, Ego, and Superego

To organize its observations of psychological phenomena, analytic theory divides mental functions into a small number of categories. As with any theoretical system, there is a danger of taking the words too literally and thinking of them as concrete things; instead, analytic concepts should be viewed as patterns of mental phenomena.

Freud's (1923, 1943) **structural model** includes three main constructs, as summarized ahead:

- **Id:** the aspect of mind concerned with *what we want*
- **Superego:** the aspect of mind concerned with *what is right*
- **Ego:** the aspect of mind concerned with *what will work*, which includes resolving conflicts between the id and superego

According to analytic theory, most human behavior requires some type of collaboration between these three mental structures. Each aspect of mind is partly conscious and partly unconscious, depending on what has and has not been repressed.

Here is an example of the way the ego manages conflicts between the id and superego. Consider a 5-year-old girl who is enraged with her 2-year-old brother, most immediately because he has taken her favorite teddy bear and, more fundamentally, because he has taken so much of the parental attention that would otherwise be hers. Her conscious wish is to hit her brother so she can regain her bear. Her unconscious wish is to destroy her brother and thereby eliminate the root of the problem. But then come chilling, disturbing memories of the angry faces and harsh words she has received from her parents when she

hit the boy, followed by the thought that she does love her brother, and the nice thing to do would be to let him keep the bear. The older sister deliberates between her possible courses of action. Finally, she decides to offer her brother a stuffed dog in exchange for the teddy bear. Although analytic theory has a reputation for being far-fetched, it is about this type of ordinary conflict between what people want and what they believe to be right.

The popular understanding of the id as based on sexual desires oversimplifies Freud's concept. He did not use the word "sex" in this context; he used the word *Eros* (a figure in Greek mythology), which he defined as the desire for pleasure, affection, and connection with other people. Freud viewed Eros as our source of creative energy, and he saw scientific curiosity as a sublimated, sophisticated expression of Eros. He considered sex important not only because it involves pleasure but also because it is perhaps the most direct, intense form of the self's connection with the world outside the self.

The superego has two aspects: the conscience, which is concerned with right and wrong, and the ego-ideal, which represents the type of person one wants to be. The superego is the individual's repository of moral norms and ethical standards learned from parents, other authorities, religious traditions, and society in general. This mental structure is responsible for inhibiting the expression of impulses and motivating prosocial behavior. Harsh superego functioning causes guilt and anxiety, but insufficient conscience development results in actions that hurt other people, and the superego is absolutely necessary for group life and civilization (S. Freud, 1930/1962).

The ego is synonymous with cognition and adaptation; it is the aspect of mind that tries to figure things out and decide what to do (A. Freud, 1946a; S. Freud, 1923; Hartmann, 1939/1958). All perception, memory, reasoning, and planning—all efforts to know and adapt to the external world—are the province of the ego. The ego also has the vital function of mediating conflicts between the id and superego. The ego is *not* necessarily rational and realistic; when thinking is distorted, illogical, and even crazy, that is ego, too.

Because adaptive capabilities develop as children grow up, ego functioning can be characterized as immature or mature. Mature ego functioning involves the type of reasonable thinking and adaptive behavior that are familiar from everyday experience. Immature ego functioning involves thinking that is starkly irrational, unrealistic, and dominated by emotion (Dewald, 1971; Gilmore & Meersand, 2013). The good side of this way of thinking occurs in the lively, elaborate imaginations of young children. The downside of primitive ego functioning, or magical thinking, is that emotions overwhelm reason, and thinking is not constrained by a realistic sense of cause and effect. As a result of their immature ego functioning, young children may, for example, be terrified of monsters that do not exist and be frightened that their secret thoughts will hurt other people.

In older children and adults whose development is unimpaired, mature ego functioning occurs in the conscious mind, and immature ego functioning occurs in the unconscious. (In young children and psychotic adults, conscious ego functioning is immature.) Thus, most adults are conscious only of their adult thinking; most adolescents are conscious only of their adolescent level of cognition, and so forth. But in the unconscious minds of developmentally normal adults and older children alike, there are preserved remains of the disorganized wishes and fears of the person at much younger ages, as (ineffectively) managed by the immature ego of the individual at those ages.

Object Relations

The development of analytic theory did not stop with Freud. The most important ensuing development has been **object relations theory** (Cashdan, 1988; Greenberg & Mitchell, 1983; Kernberg, 1980). Object relations theory does not contradict the older structural model but complements and completes it. While the older theory focuses on conflicts between desires and moral standards, object relations theory emphasizes self-concept and relationships with other people as the foundation of personality.

The word *object*, here, means *other people*, as opposed to the self (as in subject versus object). An object relation has three components—namely, mental representations of:

1. The self.
2. Other people.
3. The relation between the two.

Object relations can be only roughly approximated by words because they exist as internal images, emotions, and experiences of relationships, not conscious thoughts. Nonetheless, we want to present examples to build an understanding of the concept, so here are some examples of object relations translated into words:

- I am valuable and lovable. Dad is caring and affectionate. I feel warm and happy in my relationship with Dad.
- I am unlovable and unimportant. Mom is busy and concerned with herself. In my relationship with Mom, I feel lonely, cold, and sad.
- I am clumsy and unskilled but funny and likeable. My big sister is condescending but good-hearted. If I clown around and don't try to gain her respect, she'll be nice to me.

Object relations are internal images or schemas of the self's relationships with other people, based on past experiences.

Object relations are internal images or schemas of the self's relationships with other people, based on past experiences. Because experiences are a joint function of external reality and inner interpretation, object relations are the product of both the behavior of other people and the individual's subjective (possibly inaccurate) perceptions of those behaviors.

Object relations structure and color people's interpersonal experiences by determining what is expected, desired, and feared (Glickauf-Hughes & Wells, 2006; Greenberg & Mitchell, 1983; Westen, 1991). These templates of relationships govern what people are primed to perceive and what they tend to miss. For example, neglected children sometimes cannot respond appropriately to nurturant caregiving because they have no internal script for this type of interaction, so they cannot recognize it for what it is. Object relations are similar to the schemas emphasized in cognitive therapy.

Object relations have behavioral implications because they govern people's sense of what is possible for them in the interpersonal world. These working models of relationships determine the individual's sense of what she has to offer, what other people want, and what she needs to do to connect successfully with others (Baldwin, 1992; Fraiberg, 1959/1992; Kernberg, 1980, 1993). For example, a child who sees herself as

unlovable and her caregivers as self-focused might feel that the only way she can achieve some closeness is by doing whatever she can to meet her caregivers' needs.

People do not have just one object relation; they have many. There may be different object relations for males, females, adults, children, and any other grouping that is salient to the person. To some extent, however, object relations *generalize* and show consistencies across relationships (Cashdan, 1988; Westen, 1991). People form stable concepts of the type of person they are, the typical nature of other people, and recurrent patterns in their interactions with others.

Psychoanalytic theory differs from the other major theoretical orientations by emphasizing the importance of early childhood. The theory is fundamentally historical in nature, viewing the past as a powerful influence on present personality and behavior (Bowlby, 1969; Gilmore & Meersand, 2013; Greenberg & Mitchell, 1983). The basic structures of the mind begin to develop in infancy, and our early experiences are particularly influential because they shape the deepest layers of our learning. As a result, the emotional and interpersonal experiences that laid down the foundations of our personalities were processed, at the time, by ego structures that were immature. This is why the mental functioning of adults contains buried elements of impressionistic, magical thinking and intense emotionality (which can be either positive or negative in valence).

Defense and Coping Mechanisms

Awareness of difficult realities can be painful. External realities hurt when they involve threats to well-being or negative feedback about the self. Internal realities hurt when we experience impulses or emotions that we wish we did not have. When the need to avoid anxiety outweighs the need for reality-based adaptation, people use **defense mechanisms** to avoid being conscious of some painful aspect of their internal or external world (Cramer, 2006; S. Freud, 1923; Klein, 1932).

Defenses represent the best the person has been able to do in her effort to pursue her desires while satisfying her conscience and her effort to see the world realistically while maintaining a sense that life is okay.

There are two important things to understand about defense mechanisms. First, they are relatively ineffective and maladaptive, because they distort the person's awareness of either the world or the self. However, defenses do accomplish something—otherwise, they would not be used. Defenses protect people from anxiety and pain. Thus, defenses represent the best the person has been able to do in her effort to pursue her desires while satisfying her conscience and her effort to see the world realistically while maintaining a sense that life is okay (Cabaniss et al., 2013; A. Freud, 1946a; Hartmann, 1939/1958).

Any unconscious mental operation that protects the individual from anxiety is a defense mechanism. Table 5.1 describes a number of common defenses.

These descriptions of defenses were originally based on clinical observations of clients, but experimental research has since documented many of these processes, including perceptual denial (Broadbent, 1977), projection (Newman, Duff, & Baumeister, 1997), and repression (Cooper, 1992). Some studies have examined sexual emotions. For example, Adams, Wright, and Lohr (1996) tested the psychoanalytic hypothesis that homophobia is a defense against unwanted homosexual impulses. They showed a film depicting homosexual activity to a sample of men who self-identified as heterosexual, and they assessed arousal in a direct fashion using a device that measures penile erection.

Table 5.1 Common Defense Mechanisms

Denial: The person refuses to acknowledge painful realities that are clearly evident. For example, a person who cannot get through a day without alcohol denies that he is addicted to the substance.

Repression: The person pushes painful experiences out of conscious memory, thus forgetting them. Related memories are often lost along with the trauma. For example, an adult survivor of child abuse has no memory of long periods during her childhood.

Devaluation: The person derogates someone or something that stimulates feelings of inadequacy or anxiety. One of Aesop's Fables provides an example: A fox, after unsuccessful attempts to get some grapes from a high vine, decides that the grapes were probably sour, anyway.

Displacement: Feelings toward one object are transferred to a different object. For instance, a woman says nothing while her boss yells at her but later, at home, she kicks her cat.

Projection: The person experiences his unacceptable feelings as located in another person, not himself. For instance, a child who is frightened by the prospect of his parents going away on vacation denies he is scared but insists that his baby sister is terrified and needs the parents to stay home.

Reaction formation: The individual copes with an unacceptable impulse by substituting the opposite feeling or behavior. For example, a jealous brother, resentful of his newborn sister, fawns over the baby and insists that he loves her more than anything.

Splitting: The individual separates and polarizes the positive and negative aspects of her experience in order to avoid the confusion and anxiety of ambivalence. For example, a child of divorced parents feels that his father never does anything wrong and his mother never does anything right.

Participants who gave homophobic responses on a questionnaire exhibited arousal, and participants who did not express homophobia showed no arousal in response to the film. In a study of heterosexual feelings in women, Morokoff (1985) measured sexual guilt with a questionnaire and assessed physiological response to an erotic film using a device that measures genital arousal. Women high in sexual guilt *reported* less sexual excitement in response to the film but *exhibited* more physiological arousal. These studies seem to demonstrate the operation of denial and reaction formation as defenses against sexual impulses that are unacceptable to the superego, as in Hamlet's line, "Methinks he doth protest too much." There are few things as frightening as an unacceptable wish.

Maladaptive defenses account for much of the dysfunction in the world. However, because they perform the necessary function of protecting people from anxiety, defenses cannot simply be eliminated; they need to be replaced by something better.

That something is called **coping**. Like defenses, coping protects people from pain, but it accomplishes this without distorting reality (Gray, 1994; McWilliams, 2011). For example, a child grieving the death of a relative might *cope* by going to her mother for a hug, or she might *defend* against the grief by trying to convince herself that she did not really love the relative, anyway.

As mental operations whose purpose is adaptation, both coping and defense mechanisms are functions of the ego (A. Freud, 1946a; S. Freud, 1943; Hartmann, 1939/1958). Defenses are a product of immature ego functioning, and the mature ego formulates coping strategies. Defenses evolve unconsciously; no one realizes they are using a defense mechanism, or it would not work. Coping strategies are planned and utilized consciously.

What Causes Mental Health Problems?

The analytic understanding of etiology derives from the idea that the unconscious does not mature (Dewald, 1971; Fenichel, 1945; Freud, 1915/1957). When people repress painful experiences, their original understanding and response to those experiences are preserved and never revised in light of future learning—unless the material becomes conscious, and reprocessing can occur. People who repressed painful experiences when they were younger carry those experiences, and the meanings derived from them, in their original raw, disorganized, unrealistic form.

This would not be a problem if the contents of the unconscious were sealed there, hermetically, but they are not. Unconscious material affects people's functioning all the time, although (by definition) they are not aware of this influence. For example, people who were abused as children may experience anxiety in relationships that, in reality, are safe. When a person's reaction to a situation is strikingly inappropriate, that reaction may be based on old learning, preserved unconsciously, that is misapplied to the current reality (Cabaniss et al., 2013; Chethik, 2000; Greenberg & Mitchell, 1983). Such misapplication is similar to the behavioral concept of stimulus generalization presented in Chapter 2 but with the addition of a distinction between conscious and unconscious functioning.

Although unconscious processes affect conscious experiences, the reverse is not true. The conscious mind has no impact on unconscious material—unless that material becomes conscious. Without access, conscious thinking cannot reinterpret and reprocess repressed conflicts and trauma. It is as if these two aspects of mind are separated by a semipermeable membrane that can be crossed in one direction but not the other.

Unless there is severe psychopathology, the conscious ego functioning of older children, adolescents, and adults is relatively effective and mature. Nonetheless, these individuals sometimes experience mental health problems. Psychological disturbance in people who have the ego capabilities for effective functioning is called **neurosis** (Fenichel, 1945). Psychoanalysis was originally developed to treat this level of disturbance.

In neurosis, the person's mature ego has the capability to rethink and resolve old conflicts, but it cannot gain access to these conflicts because they are unconscious.

The development of maladjustment in people who are capable of mature ego functioning is something of a conundrum, because dysfunction generally results from the operation of defense mechanisms and other forms of *im*mature ego functioning (Dewald, 1971). The conundrum can be resolved by the idea that neurosis is a problem not of capability but of *access*. In neurosis, the person's mature ego has the capability to rethink and resolve old conflicts, but it cannot gain access to those conflicts because they are unconscious.

The explanation of mental health problems in individuals who do *not* possess high-level ego capabilities is simpler (although their treatment may be more difficult). For young children and seriously disturbed older clients who lack effective ego functioning, psychopathology is less a problem of access than of capability. For these individuals, gaining access to unconscious material will not lead to problem resolution unless there are additional forms of help.

The limited adaptive capabilities of children sometimes make ordinary stressors very difficult for them (Kernberg, Weiner, & Bardenstein, 2000; Klein, 1932). When faced with childhood challenges, such as desiring autonomy but being dependent, feeling small and weak in a dangerous world, feeling jealous of siblings, and experiencing anger toward parents, children sometimes terrify themselves with their misunderstandings and fantasies. If their adaptive tools are limited to primitive defense mechanisms, the result

could be the development of mental health problems in the context of a nice, normal family environment.

There are two forms of maladaptive superego functioning: The superego can be too harsh and strict, and the superego can be too lax (S. Freud, 1943; Gray, 1994). Generally, harsh superego functioning produces internalizing disorders, and weak superego functioning results in externalizing disorders.

Maladaptive object relations cause maladjustment by impairing interpersonal functioning (Bowlby, 1969; Kernberg, 1993; Westen, 1991). When internal models of relationships are imbued with a great deal of conflict and pain, and they have not been re-examined by the person's most mature thinking capabilities, these templates may distort the individual's perceptions and expectations of other people. As a result, the person has trouble seeing others for what they really are, he responds to new interactions as if they were old interactions, and his responses are frequently inappropriate.

Jennifer behaved as if interactions with authority figures were battles in which the winner would come out looking smart and the loser would end up feeling stupid. As a result, she experienced ordinary corrections of her behavior or schoolwork as insulting rebukes and was flooded with feelings of failure. She was unable to ask for help because doing so made her feel inadequate, and when someone noticed her need for help, she felt ashamed. Given this stance, therapy seemed like Jennifer's worst nightmare, because it was all about exploring her difficulties.

The Process of Therapy: Resistance

One of the distinctive characteristics of dynamic therapy is its focus on the process of therapy, especially obstacles to progress, and its emphasis on *using* these obstacles as opportunities to learn about client dynamics and create change. In this approach, therapy sessions are not simply occasions for clients to talk about their difficulties and to plan solutions; therapy is a setting in which client issues are manifested in real behavior, emotion, and interaction with the therapist. One example of this in vivo quality of dynamic therapy is the phenomenon of **resistance** (Dewald, 1982; S. Freud, 1943).

Freud discovered resistance as an obstacle that repeatedly blocked his progress. Often, his patients did not welcome his attempts to explore their inner worlds but, instead, resisted the process of therapy and the insights he offered. These patients avoided discussion of painful issues, wasted time on trivialities, and sometimes showed an especially direct form of resistance—being late or failing to show up for appointments.Resistance can be defined as the operation of unconscious defenses in the context of therapy (Cramer, 2006; Dewald, 1982; Horowitz, 1998). In other words, clients sometimes resist becoming aware of uncomfortable truths, even if doing so would improve their adaptation in the long run. An additional source of resistance is clients' fear of change. Even painful situations such as abusive relationships and social isolation may, on some level, involve a secure feeling of familiarity that people are afraid to move past.

Freud was frustrated by his clients' resistance, but eventually he realized that, if handled effectively, resistance can be a therapeutic opportunity. Because clients generally defend against the same issues, often using similar mechanisms, both within and outside therapy, resistance provides clinicians with an opportunity to see the client's defenses in operation. For example, Jennifer often tried to dismiss her therapist's feedback by behaving as if she were superior to him, and she also used this defense in her everyday environment.

The Process of Therapy: Transference

Transference occurs when the client has feelings about the therapist that are the result of his emotional dynamics and past experiences, not the present, external reality of the therapist herself (S. Freud, 1912/1958; Gill, 1982; Westen, 1988). In other words, the client transfers onto the therapist expectations and reactions that actually have to do with other people, often caregivers. The client's internal dynamics function like a lens that colors and sometimes distorts his experience of the counselor.

Transference can be a function of either learning or motivation. Clients' perceptions of therapists are influenced both by their general *expectations* of other people and by their unfulfilled *wishes* for relationships. For example, some neglected children avoid closeness with their therapists because they have learned that positive interpersonal connections do not last, and some neglected children cling to their therapists because they are desperate for nurturance. Learning-based and motivational processes may intermingle in the transference behavior of the same client.

Transference can be either positive or negative in emotional tone. In positive transferences, the client idealizes the therapist and has unrealistic hopes for a gratifying relationship with him. (A colleague of mine, who was raised by two psychodynamic clinicians, remembers a dinner-table conversation in which her father described a female client exclaiming about how charming, handsome, and charismatic he was. Her mother's response: "Now *that's* transference!")

In negative transferences, the client has disappointed, frustrated, or angry feelings toward the clinician. (I remember a very likeable 6-year-old boy who, for a period time, began every session by glowering at the floor and muttering, "I hate you, Shapiro.") There is no prognostic significance to whether the transference is positive or negative. From a dynamic viewpoint, the emotional twists, turns, ups, and downs of therapy are neither good nor bad but are all, equally, grist for the mill. Everything depends on how the material is handled.

Freud initially viewed transference, like resistance, as an obstacle to the progress of therapy. But once again he proved himself to be a master of an intellectual version of judo, turning what appeared to be a problem into an asset for the therapeutic process. Thanks to transference, the therapist does not learn about the client's interpersonal problems only by hearing reports of her experiences outside therapy; the counselor also *sees* these dynamics in action during sessions. Because object relations are manifested in the transference, these blueprints can be changed through work on the therapist-client relationship (Glickauf-Hughes & Wells, 2006; Greenberg & Mitchell; 1983; Kernberg, Yeomans, Clarkin, & Levy, 2008). The child might expect the therapist to treat him as other people have but, in therapy, these expectations will be disconfirmed, and the client will experience new forms of interaction and relationship.

Countertransference, the mirror image of transference, is the effects of the therapist's own issues and dynamics on his experience of the client (Gill, 1982; Schafer, 1983). In general, counselors should attend carefully to their internal responses to clients in a moment-to-moment way, because these reactions can be a sensitive form of information about subtle aspects of the client's functioning. The goal is for these responses to accurately register what the client presents, without being strongly influenced by the therapist's own issues. Countertransference interferes with counseling when it distorts the clinician's perceptions and responses to the client. It is the therapist's responsibility to distinguish between reactions attributable to the client's behavior and reactions deriving from his own dynamics, and it is his job to handle countertransference reactions internally, so they do not distort his work with the client.

Assessment and Case Formulation

Like other clinicians, dynamic therapists assess the child's conscious thoughts, emotions, behavior, and development. Dynamic assessment also focuses on the processes emphasized by the theory, including the client's wishes, fears, conscience, object relations, defense mechanisms, and coping strategies.

The assessment process in dynamic therapy is less straightforward and more interpretive than in the other approaches because the processes of interest are largely unconscious (Cabaniss, Cherry, Douglas & Schwartz, 2011; Chethik, 2000; Klein, 1932). If people could answer direct questions about their unconscious issues, these issues would not be unconscious. Nonetheless, unconscious dynamics are discoverable because they affect the surface of consciousness and behavior.

A psychodynamic counselor might put together observations of the child's play with puppets, his facial expression when he parted from his mother in the waiting room, an odd comment he made several weeks ago, and information about his history to formulate hypotheses about his unconscious conflicts, defense mechanisms, and object relations. Compared to other clinicians, dynamic therapists are willing to make inferences with a greater degree of speculation and a larger conceptual distance between observed behaviors and underlying processes.

It seems useful to engage in the complex, speculative process of dynamic assessment only when the more direct approaches of CBT and systems-oriented therapy fail to explain the client's difficulties. Sometimes, when you ask a young child why he is depressed, scared, or angry, the answer you get is not very helpful, at least not in a direct fashion. The child might say he is afraid a witch will fly through his bedroom window and eat him. Now what? You could ask what evidence he has for this fear—he has none, but he does not care; he is afraid of the witch anyway. Or, a child might say she is afraid her mother will hurt her physically, even though nothing like that has ever happened or been threatened. Immature ego functioning can produce emotional reactions that are divorced from external reality.

In situations like these, your best bet for assessment is probably to enter the child's world of magical, fantasy-based thinking and, for example, ask him to describe the witch, say where she comes from and why she is so mean, draw a picture of the witch, and engage in imaginative play about her with dolls and puppets. In time, this type of work might enable you to trace the fantasy fear back to its source. Such tracing generally leads away from the world of unrealistic fantasy to the much scarier world of real feelings in real relationships. Frequently, young children are not adept at answering direct questions about their emotional issues, but they are often remarkably eloquent in revealing complex paths from their life concerns to their mental health symptoms. The way to facilitate this revealing is to step back, provide the facilitative inquiry and reflection described in Chapter 1, and allow the child's dynamics to unfold.

With young children, this unfolding often occurs in the arena of play. Historically, dynamic therapists were the first to recognize that children's play is more than mere puttering around and sometimes expresses emotional issues and beliefs (Erikson, 1963; A. Freud, 1946b).

Questions to Ask

Psychodynamic clinicians assess the effects of past experiences on present functioning. When clients exhibit emotions or behaviors that do not seem attributable to the

immediate situation, which suggests that past learning is having an effect, these clinicians ask questions like:

- "I wonder where those feelings come from. Have you experienced anything like them before?"
- "Wow, you really had a strong reaction to that. Does it remind you of anything that's happened to you before?"

Questions about the child's responses to stress provide information about her coping and defense mechanisms. The clinician can ask parents versions of these questions to hear their perceptions of the child's ways of dealing with stress:

- "What do you do when you feel sad (mad, etc.)?"
- "When things go wrong for you, how do you deal with it? What do you do to try to feel better?"

Dynamic clinicians use their own, internal reactions to the client as a source of information about her functioning (Schafer, 1983; Summers & Barber, 2012). Jennifer's therapist frequently found himself feeling awkward and clumsy with this fast-talking, clever, arrogant client, and he viewed those feelings as information about how Jennifer often made other people feel. Then, he wondered what function this style of relating to others might have for Jennifer.

Therapists need a high level of self-awareness to know when their emotional responses provide information about the client and when these responses are more a function of their own issues. This type of introspective process might be articulated, internally, with words like the following:

"As Mary talks about her parents moving toward divorce, I feel my heart sinking, and I want to implore the parents not to tear this child's world apart. Why am I feeling this way? Is it because, despite her nothing-bothers-me talk, Mary is terrified by the prospect of her parents breaking up? Or are my feelings about my own parents' divorce intruding into my work with this client?"

Self-knowledge has always been considered vital to psychodynamic work, and there is an expectation that clinicians will receive their own therapy. When Freud, as the first analyst, formulated this idea, there was no one to analyze him but himself, so he conducted a formal self-analysis.

Patterns to Look For

Psychodynamic clinicians look for patterns in the client's presentation that connect with analytic theory and help to explain her difficulties. Dynamic clinicians view play, slips of the tongue, transference, resistance, use of language, and nonverbal behavior as

reflections of underlying mental structures and processes (Chethik, 2000; Kegerreis, 2010; McWilliams, 2011). They place their observations in the context of information about the child from outside therapy and then try to weave these data into a coherent picture that points toward strategies for helping her.

Compared to other theoretical approaches, the patterns of concern to dynamic therapy are generally less available to direct observation. Dynamic clinicians are interested in psychological phenomena that underlie the surface of behavior and the face value of verbalizations. Assessing these patterns might require complicated inferences, but the process begins with clinical data. Below, I describe three patterns of intermediate depth that lie between in-session behavioral observation and deep-level theoretical constructs.

Discrepancies, or incongruities, occur when client statements or behaviors are inconsistent with each other. For example, a child might insist that he is not anxious about his hockey games but, 3 weeks in a row, he complained of a stomachache on the day of a game and was unable to play. Jennifer claimed she did not care what her teachers thought of her. However, when criticized, she ruminated about the feedback for a long time, refuting the teacher's points but certainly seeming to care about them.

Omissions are noteworthy absences of thoughts or feelings that are "talked around" and never addressed directly. The expression "an elephant in the living room" captures this idea of an obvious but unmentionable issue. Dynamic therapists are interested in what clients do *not* talk about as well as what they do bring up. For example, a youth who has been mistreated but never expresses anger about it might harbor this feeling on some level but be anxious about revealing it.

Excesses are extreme behaviors or expressions of emotion; they are too much of something. For example, a child might become tearful and say, "You hate me" upon being told to play more carefully with a toy. When an emotion seems disproportionate to the event that occasioned it, the true source of that emotion is probably something other than the event. The source is usually an issue that is related to the event but is larger, more threatening, and more difficult to talk about.

When the therapist asked Jennifer what made her feel sad, she rolled her eyes and replied, "Stupid questions like that one." A response of this type does not seem to yield information about the cognitive or behavioral basis of the client's difficulties. From a dynamic perspective, however, this response may provide information about Jennifer's way of dealing with sadness and vulnerability: She avoided acknowledging such feelings and dealt with the threat of vulnerability by trying to turn the tables and make the clinician feel stupid. Further assessment suggested that Jennifer relied on the defenses of devaluation and projection. She was unable to tolerate her weaknesses and imperfections, and she dealt with the threat of personal inadequacy by projecting these qualities onto others and hating them there, as if to say, "*I'm* not bumbling and incompetent, *you* are."

Change Processes

Dynamic therapy pursues its goal of resolving mental health problems in a less direct manner than does CBT. Dynamic therapists not only focus on symptoms but also explore the client's overall development, relationships, and personality because they believe that symptoms arise from deep-level, internal processes.

The objectives of dynamic therapy include the following:

- Increased self-understanding
- Increased acceptance of feelings and wishes
- Replacement of (unconscious) defense mechanisms with (conscious) coping strategies
- Development of realistically complex and positive schemas for relationships between self and others

This chapter describes four change processes in dynamic therapy: Self-expression, insight, a certain type of psychoeducation, and corrective emotional experience. For three of these change agents, the discussion is consistent with mainstream dynamic theory. The discussion of psychoeducation departs somewhat from the traditional approach in a way that, I believe, adds to, rather than contradicts, conventional principles of dynamic therapy.

Facilitating the Expression of Material

One of Freud's (1933) earliest observations was that the act of listening carefully to clients often facilitated the expression of emotional issues underlying their problems, and self-expression, by itself, sometimes reduced clients' symptoms. In the psychodynamic literature, this change agent is called **ventilation** or **catharsis**.

Although based on a different theoretical framework, **emotion-focused therapy** (Greenberg, 2002; Greenberg & Pascual-Leone, 2006) makes extensive use of self-expression as a mechanism of change. Research with adult clients has found that when counselors facilitate the full, intense expression of emotion, particularly feelings that have been blocked from expression by fear or shame, clients often experience a sense of relief and completion. This sequence is conceptualized as a matter of "finishing unfinished business" (Greenberg & Malcolm, 2002). Outcome research reviewed by Greenberg (2002; Greenberg & Pascual-Leone, 2006) indicates that the result is often reduced symptomatology and enhanced relationships. Also, process research on psychodynamic therapy by Ablon, Levy, and Katzenstein (2006) found that outcomes correlate positively with client expression of emotions, especially dysphoric emotions.

Play is an important means of self-expression for young children. In addition to revealing thoughts and feelings, play is a mechanism of change, development, and self-healing through which children experiment with meanings, play out emotional scenarios, solve problems, and work through conflicts (Erikson, 1963; Russ, 2004). In children with mental health problems, defensive inhibitions and developmental blockages often constrain play. Therefore, one way therapists can help children is by supporting and facilitating their expressive play, as described in Chapter 1.

Interpretation and Insight

The core change agent in psychodynamic therapy is **insight** (Dewald, 1971; S. Freud, 1915/1957; Horowitz, 1998). Insight is an increase in self-understanding—specifically, new awareness of previously unconscious material. The central objective of dynamic therapy is *to make the unconscious conscious*. The theory predicts that if clients achieve sufficient insight, their symptoms will resolve.

Interpretation is the therapeutic technique that produces insight in clients. An interpretation is a statement by the therapist that brings an unconscious process to the client's attention (Gray, 1994; Summers & Barber, 2012; Weiner & Bornstein, 2009). Therapists take the lead in the technique of interpretation, figuring out some aspect of the client's unconscious functioning and then offering this new understanding to him. Interpretation involves more than reflection of feelings or meaning; it means telling the client something about herself that she did not know. Interpretations involve causal explanations of feelings, thoughts, behaviors, and symptoms. For example, one interpretation in Jennifer's therapy was that she sometimes tried to deal with her self-doubts by making other people feel the way she felt. If interpretations ring true and have explanatory value for clients, then insight occurs.

The fundamental question about dynamic therapeutic strategy is, why does insight help? The first part of the answer is that accurate self-knowledge is useful and valuable. When people do not know why they feel the way they feel or why they do the things they do, they feel confused and, sometimes, "crazy." Becoming aware of previously unconscious dynamics helps people feel that their emotions and behaviors do make sense, in an augmented version of validation, as described in the previous chapter's section on DBT. Also, accurate self-knowledge is a vital guide for personal planning, choices, and actions (Summers & Barber, 2012; Weiner & Bornstein, 2009). It is hard to know what to do unless we know ourselves.

But that is only the simple part of the story. The full answer to the question of why insight is helpful follows from the analytic understanding of neurosis as a problem not of limited capability but of inadequate access—specifically, access of the mature ego to the unconscious conflicts and misunderstandings responsible for dysfunction. In such situations, insight is the only change agent needed because once the person is able to think consciously about her previously unconscious conflicts, she will be able to resolve them.

Why are clients able to tolerate and utilize knowledge about themselves in therapy when, previously, this knowledge was so anxiety-producing that it had to be repressed? The explanation derives from the different levels of maturity that characterize conscious and unconscious functioning. Usually, when conflictual material is repressed, it is intolerably painful because the person's immature ego capabilities are unable to manage the material. After repression occurs, although years might go by, the unconscious material remains intolerable—but only to the immature aspect of the client's mind. The conscious, mature aspect of mind *would* be able to tolerate, rethink, and integrate the conflictual material—if it could gain access to it. The therapist's interpretations provide this access.

When the unconscious becomes conscious, the mature ego gains access to the problematic material, and it is more capable of managing problems in an effective manner than the immature ego had been.

When the unconscious becomes conscious, the mature ego gains access to the problematic material, and it is more capable of managing problems in an effective manner than the immature ego had been. Insight makes it possible for the client's most rational, realistic, and adaptive thinking to be applied to his long-buried conflicts and misunderstandings for the first time. The person will rethink the old issues and develop more successful strategies for managing them. Defense mechanisms will be replaced by coping strategies. Neurotic symptoms will be replaced by conscious thoughts (S. Freud, 1933).

Dynamic Psychoeducation

I use the term **dynamic psychoeduction** to mean teaching the client about the emotional, relationship, and life issues involved in her difficulties. Psychoeducation is different from interpretation because, while interpretation increases the client's self-understanding, education also involves information about general human functioning. This is the one point in my presentation in which I diverge somewhat from mainstream psychodynamic formulations, although, as discussed later, past writings have included intimations of my recommendation of active, psychoeducational input from the therapist.

The traditional analytic formulation assumed that clients begin therapy with the ego capabilities they need to resolve their problems, once insight is achieved. Since the origination of the theory, some commentators have noted that young children and seriously disturbed older clients usually do *not* have the adaptive capabilities needed to resolve their conflicts, so that insight, by itself, is not a sufficient agent of change. Some authors have proposed that the healing power of play and self-expression, in the context of a supportive therapeutic relationship, is an important change agent in and of itself (Erikson, 1963; Gardner, 1993; Russ, 2004; Winnicott, 1971). However, it seems likely that there are clients for whom mirroring and empathy alone are not sufficient to engender adaptive thinking and coping. In my experience, clients who were not helped by dynamic therapy often complain that this treatment helped them understand their difficulties but did not resolve the problems. Also, the extensive research support for cognitive and psychoeducational interventions suggests that many clients benefit from active, substantive input from their therapists.

Discussions of this type of educative help are scattered in the psychodynamic literature, particularly in the area of supportive therapy (Dewald, 1994; Sugarman, 2003). In her later writings, Anna Freud (1968) expressed concerns about the limitations of insight as a change agent for children, and her work with clients included educative components that taught adaptive skills. Fonagy and Target (1998) proposed that seriously disturbed children often need direct help from their therapists to build ego capabilities. Some dynamic clinicians probably engage in the type of educative work I am recommending, but this form of intervention has received little systematic attention in the literature, and existing discussions have not produced well-articulated recommendations. Such recommendations could contribute to the repertoire of psychodynamic practice.

Counselors can help young children and older clients with limited ego strength to develop the life knowledge, understanding, and skills that clients with mature ego functioning have developed on their own.

Therapists can provide more than empathic reflection and insight. Counselors can help young children and older clients with limited ego strength to develop the life knowledge, understanding, and skills that clients with mature ego functioning have developed on their own. It seems likely that this work would be more effective if done in purposeful, targeted ways, not simply by trusting that an empathic relationship will somehow enable the child to develop the adaptive capabilities she needs but has lacked.

Insights concern the self. The strategy recommended here consists of teaching about life. These lessons generally involve basic, simple knowledge about human nature, relationships, moral values, and the way the world works. As one important example, guilt about angry, selfish, or sexual wishes seems to be an important etiological factor for some children. Two psychoeducational points address this etiology: (1) Wishes, impulses, and desires, in themselves, neither cause harm nor indicate that someone is a bad person,

and (2) all people sometimes experience wishes and impulses that, if acted upon, would be morally reprehensible. These points *are not insights* because they concern people and life in general, not the self. Clients who lack this type of knowledge are handicapped in their efforts to adapt, no matter how extensive their self-understanding might become.

Consider this analogy: Dysfunctional emotion and behavior are like the manifestations of a computer software program that does not work properly, and the unconscious is like the program code that governs what happens on the screen. People consciously experience what happens on their computer screen, but they are unaware of the software code responsible for these manifestations. Similarly, people consciously experience behavior, emotion, and symptoms but, ordinarily, they are not aware of the underlying mental structures that govern these phenomena. When things go well, there is no need to become aware either of software code or of unconscious issues, but to fix problems, we need to uncover and change the underlying, governing structures.

Insight reveals something analogous to the program code that controls what happens on a computer screen. If the user is a programmer, then once she becomes aware of the errors in the code, she will need no outside assistance to rewrite them correctly. If the client has mature ego capabilities, then once she becomes aware of her unconscious conflicts, she will need no outside assistance to resolve them. But if the computer user is not a programmer, discovering the errors in the code will not enable him to fix them. And if the client lacks mature ego capabilities, insight will not be enough, and he will need psychoeducational input from his therapist to reprogram the mental structures responsible for his maladjustment.

Insight helps the client make sense of her thoughts, emotions, and behaviors (e.g., "Oh, maybe that's why I feel this way"). Psychoeducation changes the client's picture of the self, other people, and possibilities, often by modifying beliefs concerning good and bad, so that new, more adaptive ways of functioning become apparent (e.g., "Oh, that's a new way to look at it").

As explained in Chapter 2 on behavior therapy, clients' misunderstandings sometimes begin with accurate interpretations of situations but end with overgeneralization of this learning. One important example occurs when children learn to cope with the expectations and demands of dysfunctional parents by developing ways of functioning that work comparatively well with these caregivers. When they take their adaptations to more normal settings, things go badly, because the child's caregivers are not accurately representative of people in general, and these relationships do not provide useful guidance about what generally works in relationships. In a sense, the root of the problem is a type of sampling error. When this is the case, the therapeutic objective is to replace *episodic* knowledge (memory of personal experiences) with *semantic* knowledge (general truths about life) as a basis for perceptions, emotions, and responses in the present.

In a nutshell, insight explains, and psychoeducation corrects. Insight is about why things are the way they are, and life education is about how they could be better. Dynamic therapy also includes a corrective factor that is not cognitive or educational in nature.

Corrective Emotional Experience

Dynamic therapy does not rely only on cognitive understanding and learning to achieve its objectives. Therapeutic *experiences* may be even more important as agents of change because they produce emotional learning and relearning.

Corrective emotional experience begins with the **holding environment** that the therapist creates for the child (Gardner, 1993; Winnicott, 1971). The holding environment is a remarkable setting, different from all other social contexts. The counselor is nondirective, so the child controls the activities and conversational topics. The counselor accepts the child unconditionally, which means that no matter what the child does, the therapist remains locked in her position of trying to understand and help. (Limits are set on dangerous behaviors, but limits are not inconsistent with acceptance.) The holding environment is a refuge where all thoughts, wishes, and fears, no matter how embarrassing they might be in other settings, can be voiced without eliciting disapproval. The counselor reserves only one prerogative: She comments on what the client says and does.

By modeling an accepting attitude toward the client's conflict-laden material and discussing this material in a calm, matter-of-fact way, the therapist detoxifies previously shameful issues (Chethik, 2000; Schafer, 1983). The client learns from experience that his fears and fantasies can be talked about—and, therefore, can be thought about. The child takes in the therapist's calm, constructive attitude toward wishes and emotions that, in the past, had seemed so threatening that they had to be repressed. Thus, the child develops self-acceptance by internalizing the counselor's acceptance of him.

Therapists provide corrective emotional experiences by demonstrating to the child that the interpersonal events she expects and fears will not occur in therapy.

In addition to providing a general atmosphere of empathy and acceptance, corrective emotional experiences should address the specific fears and interpersonal expectations that have impaired the client's functioning. Clinicians can accomplish this by bringing out the dynamics that clients expect will elicit negative reactions and then responding in a way that clearly disconfirms the unrealistic, fearful expectations. For example, the therapist would express heartfelt acceptance of vulnerable, needy aspects of the client if these were the issue, would explicitly express acceptance of angry feelings if these were the problem, and so forth. Therapists provide corrective emotional experiences by demonstrating to the child that the interpersonal events she expects and fears will not occur in therapy (Mallinckrodt, 2010).

From a behavioral perspective, these are counter-conditioning procedures (described in Chapters 2 and 13)—but, rather than targeting concrete fears like spiders or heights, this strategy targets abstract, initially unconscious fears concerning the self and relationships. From a dynamic perspective, this strategy addresses a root source of mental health problems because, if the client's emotions and wishes become tolerable to him, defense mechanisms will become unnecessary, and the etiological sequence will be undone at its origin.

Of course a therapist's acceptance cannot fully repair the emotional damage done to children by caregiver maltreatment, rejection, or disparagement. Nonetheless, corrective experiences show the child that another adult view of her and a different type of relationship are *possible*. Even if the client's caregivers are unable to provide a positive experience, the achievement of one relationship in which the child is fully known, accepted, and cared for may provide a template for similar interpersonal experiences in the future.

Outcome Research

The practice of psychodynamic therapy proceeded for many years without support from research, but recent years have seen a substantial accumulation of supportive evidence. Commentators have noted, however, that proponents of other theoretical orientations,

especially CBT, have been slow to assimilate the new findings, and outdated claims that dynamic therapy lacks empirical support continue to appear in the literature (Leichsenring, 2001; Shedler, 2011).

Keefe, McCarthy, Dinger, Zilcha-Mano, and Barber (2014) conducted a meta-analysis of psychodynamic therapy for anxiety disorders in adults. The obtained a medium/large effect size of .64 in comparisons with no-treatment controls. Effect sizes were non-significant for comparisons between dynamic therapy and alternative interventions. Meta-analytic reviews of dynamic therapy for depression in adults by de Maat, de Jonghe, Schoevers, and Dekker (2009) and de Maat et al. (2013) did not include control groups but examined within-client change at pre-treatment, post-treatment, and follow-up. These meta-analyses obtained large effect sizes at termination, and these effects were still larger in magnitude at follow-up. Shedler (2010, 2011) noted that many outcome studies of dynamic therapy have documented this type of "sleeper effect" in which the benefits continued to grow after therapy was completed, which is not generally the case for other types of interventions.

Research directly comparing the effects of dynamic therapy and alternative interventions is less plentiful and especially informative. Most of these studies were conducted with adult clients. Gerber et al. (2011) conducted a systematic review of RCTs that compared dynamic therapy with other empirically supported treatments (mostly CBT and also systems-oriented interventions). Of the 39 RCTs meeting their criteria for methodological quality, six showed dynamic treatment to be more effective, five showed dynamic therapy to be less effective, and 28 showed no difference between the therapies. In an RCT comparing treatments for adults with BPD, dynamic therapy produced benefits that equaled or exceeded those of DBT (Clarkin, Levy, Lensenweger, & Kernberg, 2007). Meta-analyses by Cuijpers, van Straten, Andersson, and van Oppen (2008) and by Leichsenring (2001) compared dynamic therapy and CBT for adults with depression. They found large effect sizes for both types of therapy, with no difference between the two. Similarly, a meta-analysis by Barber, Muran, McCarthy, and Keefe (2013) found no differences between CBT and dynamic therapy in outcomes for adults with anxiety disorders.

Research on the mediation of treatment effects in dynamic therapy for adults has produced extensive support for the hypothesized mechanisms of change (Crits-Christoph, Connolly Gibbons, & Mukherjee, 2013). Studies by Kivlighan et al. (2000), Connolly Gibbons et al. (2009), and Kallestad et al. (2010) found that dynamic therapy helped clients achieve insight (i.e., self-understanding) and that increases in insight predicted ensuing reductions in symptoms. The Connolly Gibbons and Kallestad studies found that dynamic therapy produced larger increases in insight than did cognitive or supportive therapy. Several studies found that dynamic therapy reduced client reliance on rigid, primitive defenses, and that improvements in defensive functioning predicted subsequence decreases in symptomatology (Bond & Perry, 2004; Johansen, Krebs, Svartberg, Stiles, & Holen, 2011; Kramer, Despland, Michel, Drapeau, & de Roten, 2010). In studies by Blatt, Stayner, Auerbach, and Behrends (1996) and by Vermote et al. (2010), dynamic therapy produced improvement in the quality of clients' object relations, and this improvement was associated with reduction of symptomatology.

Research that goes beyond "brand names" by directly measuring therapeutic techniques has produced evidence supporting two psychodynamic strategies: interpretation of transference and interpretation of defense (Ablon & Jones, 1998; Jones & Pulos, 1993). Regardless of whether they believed themselves to be doing dynamic therapy or CBT, the counselors

who produced the best outcomes focused more on transference phenomena and defensive avoidance of emotions, compared to less effective counselors.

Abbass, Rabung, Leichsenring, Refseth, and Midgley (2013) performed a meta-analysis of 11 studies ($n = 655$) examining short-term dynamic therapy for children and adolescents with a variety of diagnoses, including depression, anxiety, anorexia, and BPD. Most of the comparisons were to active, bona fide treatments, and these comparisons did not yield significant differences, which is a common finding in outcome research. Within-group analysis of clients receiving dynamic therapy produced a large effect size of 1.07, which increased in magnitude from termination to follow-up ($g = .24$).

A Brazilian study of children aged 6–11 years with a no-treatment control obtained a medium/large effect size of .70 (Deakin & Nunes, 2009). In an Australian study of adolescents with serious mental illness by Tonge, Pullen, Hughes, and Beafoy (2009), psychoanalytic therapy produced larger reductions in overall symptomatology and social problems, compared to a TAU control. An Italian study comparing short-term dynamic therapy to a TAU control found that both groups demonstrated improvement in the study's first 6 months but, at a 2-year follow-up, 65% of the control group and only 34% of the dynamic therapy group still exhibited clinically significant disturbance (Muratori, Picchi, Bruni, Patarnello, & Romagnoli, 2003; Muratori et al., 2002).

Several studies have examined differences between diagnostic groups of young people in their response to dynamic therapy. A large retrospective chart review ($n = 763$) by Fonagy and Target (1996) found that children with internalizing disorders were more likely to complete treatment and to achieve clinically reliable improvement than were children with disruptive behavior problems. In the Italian research cited earlier (Muratori et al., 2002, 2003), internalizing problems were more responsive to treatment than externalizing problems, and outcomes were better for children with "pure" emotional disorders, compared to children who also exhibited behavior problems.

The Therapist's Style

Dynamic therapists generally have a reflective, inquisitive style, with a calm curiosity about all human experiences. Although traditional analysts had a neutral style that precluded expression of their own emotions, modern dynamic therapists make careful exceptions to this rule. In the current understanding of "neutrality," the therapist is fully and equally accepting of all of the client's impulses, emotions, thoughts, and all aspects of self. However, this does not preclude the expression of human responses to the client's experiences (Kegerreis, 2010; Kernberg et al., 2000). Important examples include the expression of compassion when the client is suffering, gladness when the client achieves progress or a victory, and respectful appreciation of efforts or qualities that the client has undervalued because of low self-esteem.

Beneath all the complexities of its theory and technique, the dynamic approach is distinguished by a certain attitude toward mental life. When psychoanalysis began at the end of the 19th century, the prevailing attitude toward mental life in the Western world could be described as judgmental and moralistic. When individuals examined their thoughts and feelings, the main question was whether their mental contents were good or bad. This orientation still seems common today. In contrast, the psychodynamic orientation toward the mind is analytical and naturalistic. When therapists guide clients in examining their thoughts and feelings, the questions are about how they operate and interact, why they

evolved the way they did, and whether they are working to produce a good life for the client. This viewpoint permits moral judgments about actions, but internal life is viewed as a natural phenomenon, like chemistry or physics, which operates according to scientific principles, so moral judgments are inapplicable. Just as engineers use principles of physics to build bridges and physicians use principles of biology to treat disease, counselors use principles of psychology to achieve therapeutic goals.

In the psychodynamic viewpoint, people do not choose their impulses and desires, which come into our minds unbidden. Since the flux of mental life is governed mostly by dynamic interactions between subdivisions of the mind that follow mysterious rules and occur unconsciously, it makes no sense to hold people responsible for their wishes and emotions. Also, desires and thoughts, by themselves, cannot hurt others. The core psychodynamic observation is that all people, including very nice ones, frequently have wishes and fantasies that conflict with morality. In contrast to some religious traditions, in dynamic therapy there is no such thing as a sin in thought, because attempting to judge and prohibit mental contents seems to be a fruitless endeavor.

The psychodynamic insight is that mental life is most effectively managed not by simple, forceful efforts to judge and forbid unwanted impulses but by an accepting attitude, self-understanding, and sophisticated self-management strategies.

The psychodynamic insight is that mental life is most effectively managed not by simple, forceful efforts to judge and forbid unwanted impulses but by an accepting attitude, self-understanding, and sophisticated self-management strategies. This scientific, artful approach to mental life seems more effective than a crude, moralistic approach. This attitude toward mental life has been absorbed by the mental health field in general, but it is epitomized by the dynamic approach, which deserves credit for originating this view.

Facilitating Expression of Material

The first objective of dynamic therapy is to bring out the client's issues so they can be reprocessed in the treatment setting. At this stage, the main technique is reflection of feelings and meanings, as described in Chapter 1. The therapist connects with the child on the surface of what he does and says, and then the therapist inquires further, drawing out the emotional themes implied by the child's self-expression. For example, if a child said her father was out of town on business, the clinician might ask whether she misses him. If the child said yes, the counselor might explore further. Was she mad at her father for leaving? Did his leaving have anything to do with her? Was she scared something might happen to him? Or did the child simply miss her dad, with nothing more to it?

Dynamic therapists view the play of young children as a symbolic language, and they try to decode these metaphors in order to understand the child's experiences and mental structures (Gardner, 1993; Russ, 2004; Winnicott, 1971). Dolls, animals, and action figures may represent different elements of the child's internal world, including wishes, fears, possible solutions to problems, and images of self and others. Erikson (1963) proposed that children's play is an early form of the human ability to create model situations in which planning and experimentation can be done in a hypothetical, representational form, and dynamic therapists take children's play seriously, in a sense.

The way to work with play is to relax your reality-oriented set and enter the child's world. Children know their play materials are not really people and animals, but they talk and act as if these symbolic materials *were* real—and you should, too, because playing

along communicates understanding and facilitates the emergence of material. This process is like the "suspension of disbelief" that happens when we are drawn into works of fiction or theatre, and we have emotional responses to them even though we know the events are not real.

Reflections of feeling and meaning should not merely echo the client's words and actions but should organize her self-expression and bring out implications that are only hinted at, thus moving the client forward in his conscious processing of emotional issues—for example:

- "The boy tiger is little, but he's so fierce and strong that he scares his father away and does whatever he wants!"
- "It's scary for the rabbit in the woods. All the other animals are bigger, and they're mean. Is there anybody in the woods who might help the rabbit?"

The task of facilitating self-expression with older children and adolescents operates by the same principles, except that talk replaces play as the main mode of communication. Therapists facilitate the emergence of material by connecting with the client's verbalized concerns, demonstrating that therapy is a place where anything and everything can be discussed, and gently pushing toward recognition of patterns and themes that recur or are associated with strong emotions.

Interpretation and Insight

Interpretations link an unconscious process—a defense, wish, fear, memory, or misunderstanding—to the client's conscious experience.

Interpretations link an unconscious process—a defense, wish, fear, memory, or misunderstanding—with the client's conscious experience (Cabaniss et al., 2011; S. Freud, 1915/1957; Hartmann, 1939/1958). This core tool of dynamic intervention makes connections between different aspects of the client's life, including internal processes, in-session events, recurring feelings, past history, current relationships, and presenting problems. Interpretations are causal explanations; they attempt to explain *why* the client feels, thinks, or behaves in some way—for example:

- "Maybe you ran out of the room because you were afraid to hear what the teacher was going to say."
- "Do you think the crying and sadness might be your way of punishing yourself for hurting Mom?"

The achievement of insight is sometimes signaled by an "aha experience," but insights are usually achieved in an incremental manner, with therapist statements gradually increasing the client's level of self-understanding until a point of full insight is reached

(Cabaniss et al., 2011; Summers & Barber, 2010). Insight-oriented work should begin at the surface of the client's conscious self-understanding and then work down into progressively deeper layers of unconscious material.

Weiner and Bornstein (2009) recommend that therapists employ a sequence of three steps to process each new unit of therapeutic material. The steps are: (1) clarification, (2) confrontation, and (3) interpretation.

Clarification, a simple verbal behavior, means asking questions about client statements or behaviors to ascertain what the child meant by his words or actions. The most basic clarification statements are, "Tell me more about that," and "Explain what you mean by _____." Clarification also involves asking for behavioral specification (e.g., "What do your teachers do when they are being 'stupid'?"). Clarification can be applied to the client's play to bring out its meanings (e.g., "Why is the rabbit hiding?").

Confrontation, in dynamic therapy, does not have the aggressive connotation this word has in everyday language. This technique does not involve criticizing or opposing the client. Confrontation means drawing the client's attention to some inconsistency or contradiction within her own beliefs, emotions, and behaviors. Confrontations typically follow the formula of:

> "On one hand, you say or do _____, but on the other hand, you say or do _____; how do you put those two things together?"

In confrontation, the therapist connects two pieces of data that the client has not thought to consider in juxtaposition. The two elements are inconsistent with each other, but the client has not noticed this, so the therapist reflects both elements in one statement—for example:

- "You're telling me you're sorry about putting toothpaste on your sister's pillow, but I can't help noticing a smile on your face. I wonder if you actually enjoyed annoying her but don't want to admit it."
- "You're saying you had a good time with your aunt, but it doesn't seem like you want to tell me about it, and you're scribbling awfully hard with that crayon."

The client's new awareness of these inconsistencies alerts him that something confusing is going on. We hope for reactions of puzzlement and curiosity, because these set the stage for new learning.

In the next, final step, interpretations offer explanations of the mystery. We need to be gentle in doing this, because there is a danger of interpretations coming across as presumptuous or intrusive to the client. Interpretations should be offered in a tentative manner rather than with certainty, using stems such as, "I wonder if," or "Could it be that … " (Weiner & Bornstein, 2009). When my interpretations take several sentences to present, I sometimes preface them with requests like, "Could I run something by you?", and I offer permission to disagree by saying, "Now tell me if I'm getting this wrong."

Therapists need words with which to talk about the different, semiautonomous aspects of mind that interact within clients. Terms like "parts of you" and "sides of you" fulfill this function—for example:

- "Right now, I'm seeing a side of you that's small and scared and wants to stay close to Mom, but I know that last week, at the playground, there was another side of you that's strong and confident and wants to go off on your own."
- "It seems like there's a part of you that wants to blow school off and have fun, but there's another part that wants to learn things and succeed, and you haven't yet found a way for those two parts to work together."

Interpretations of resistance and transference can be particularly awkward for clients because, like Freud before he reinterpreted these obstacles as opportunities, clients sometimes feel they have been caught doing something wrong. To make it clear that this is not the case, I sometimes say, "I'm glad this came up, because it's important for us to talk about."

The most basic interpretation of resistance may be, "It seems like you don't want to talk about this." Many interpretations of resistance follow the formula of:

1. "It seems like when I bring up _____ (e.g., your sister, anger), you usually _____ (e.g., stop talking, change the subject)."

Here are two examples of transference interpretations:

1. "Jennifer, you treat me as if I just don't get it, so you're not going to try to explain things to me. What's good about that for you? Does it mean you won't have to worry about anything I say?"
2. "Jason, you seem so concerned about saying something wrong or 'stupid,' like I might judge you for that. Has it ever been this way for you with someone? If you didn't say things just right, they'd make you feel dumb?"

Here are two examples of interpretations of defense mechanisms:

1. "You're really good at forgetting about times you got in trouble, so it's like those things never happened. Your mind erases everything; it's like you have a *mind eraser* for when you do something bad."
2. "I think sometimes you get so mad at your brother that it scares you, and you try to deal with that by bending over backward to be extra, sugary sweet."

Here are two examples of interpretations related to object relations:

1. "Your dad used to promise he'd come visit every weekend, but he usually didn't keep his promise. Could that be one of the reasons why you don't trust people to come through for you?"
2. "Do you feel like the only way to make friends is by doing kids favors and giving them things, like no one will like you unless you do that?"

The increase in self-understanding produced by interpretations may reduce clients' confusion about their experiences. It is a good feeling to realize that one's emotions and reactions make sense. On the other hand, clients often feel some discomfort on hearing interpretations, because these statements generally involve anxiety-producing material and they usually imply a problem with some aspect of the client's functioning (Horowitz, 1998; Weiner & Bornstein, 2009).

Clients sometimes disagree with interpretations. There is an old analytic view that such disagreement constitutes resistance and so supports, rather than weakens, the validity of the interpretation. This may be true sometimes, but it is also possible that the client disagrees with an interpretation because it is inaccurate. The view that the client's disagreement actually proves the therapist is right puts the client in a bind and probably comes across as smug. Usually, it is more useful to consider the possibility that the interpretation was inaccurate.

Insight, as a one-time occurrence, usually does not produce much change. The clinician's initial statement of an interpretation is only the first step in her use of this information. In the process called **working through**, the therapist helps the client *apply* an insight to the variety of experiences and behaviors to which the insight pertains (Cabaniss et al., 2013; S. Freud, 1943). For example, a teen might have an insight such as, "The reason I don't trust people is that my dad physically abused me when I was little." Simply stating this idea would be unlikely to increase the youth's trust in other people. Constructive application of the insight would involve the adolescent remembering and discussing the abuse experiences, other aspects of his relationship with his father, and the experiences with other people that he now realizes might have been affected by the abuse.

Important dynamics manifest themselves in multiple contexts, possibly including resistance, transference, play, fantasy, and a variety of experiences and relationships. When clients discern the response patterns occurring in multiple contexts, and they learn to recognize them *as they occur*, they become able to disrupt their previously habitual responses.

Jennifer's therapist interpreted similar dynamics in his client's functioning with a range of adult authority figures, especially teachers, coaches, and the therapist himself. Authority figures stimulated self-doubts in Jennifer because she knew these adults would be evaluating her. Over time, she learned how her fear of failure caused her to launch preemptive strikes against authority figures in order to put them on the defensive and take the spotlight off her. She also came to realize that the accusations of inadequacy she experienced as coming from others actually originated in her own nagging sense of deficiency. One source of Jennifer's troubled self-concept seemed to be her vacillation between two opposite images of herself: one as powerful and special, and one as a pitiful failure. This dichotomous experience of herself made Jennifer intolerant of her imperfections because any perception of weakness hurled her into an experience of shame.

Once the old, symptomatic ways of operating have been revealed and understood by the client, he is on the road to change, but he has not arrived at his destination until better ways of living have been developed. In the next phase of change, the client learns to substitute new, effective, consciously planned responses for the old, maladaptive, unconsciously driven ones.

Dynamic Psychoeducation

Insight is a lot, but sometimes it is not enough. For example, a child might learn that her low self-esteem is caused by her mother's derogating, rejecting behavior. Understanding the reasons for her low self-esteem would lead to improved self-concept if, but only if, the client has the ego capabilities necessary for reconstructing a positive self-image. Many clients lack such capabilities, in which case something more is needed, and that something is active, substantive input from their therapist.

Insight and psychoeducation should be tightly related, because insight tells counselors what the content of education should be. The sequence should generally be: first insight, then psychoeducation.

When insight reveals a mistaken interpretation that contributes to the client's disturbance, and she lacks the knowledge to correct the misinterpretation by herself, life education can fill this gap by providing valid information. Often, the key to this work is providing an *alternative explanation* of a painful reality. For example, one client achieved the insight that her persistent feelings of being "unimportant" and "small" (despite much academic and social success) stemmed from her father's persistent abuse of drugs despite her entreaties to stop for her sake. This insight was an important step in her therapy; it helped her understand her current feelings of insignificance. However, the insight did not refute her belief in her unimportance because she continued to view her father's continuing drug abuse as convincing evidence of this belief. ("Obviously I'm not important enough for him to make himself stop.") Her self-esteem did not improve until the counselor provided an alternative explanation of her father's drug abuse—namely, an explanation of the causes and consequences of addiction.

Sometimes the client's original, valid learning occurred in the past and is misapplied to the present, and sometimes the valid learning occurs in the family and is misapplied to the larger environment. In both cases, the child has drawn reasonable conclusions from interactions that are not representative of most relationships, so his valid learning becomes maladaptive when it is extended past the domain in which it was acquired. Insight pertains to the reasonable nature of the child's original inferences, and psychoeducation corrects the overgeneralization of this learning, so semantic knowledge overrides episodic knowledge as a basis for emotions and behavior in the present. Here is an example of the insight-education sequence:

> "You've always known that, if you want to get your dad's respect, you've got to be that tough kid who is always ready to push back and fight. You learned this way of operating because it worked better than anything else, at least as far as your father was concerned. But the problem is, it's not working in school, and it's messing up your life there.
>
> Your dad's right that it's important to stand up for yourself, but there's a different way of doing that in school. Your father doesn't make the rules in your school—the teachers do, so if you want to do well there, you've got to win at their game. I think you could learn to do this, if you wanted to."

As discussed in Chapter 2, Behavior Therapy, the boundary between dynamic therapy and CBT sometimes blurs when we carefully consider the fabric of therapeutic action, because both theories are concerned with the misapplication and overgeneralization of learning (Dollard & Miller, 1950; Wachtel, 1977). Psychodynamic therapy is distinctive in its emphasis on the unconscious. The foregoing therapist statement was psychodynamic to the extent that the client had been unaware of the connection between his relationship with his father and his aggressive behavior in school.

Because the immature ego is emotion-driven and impressionistic, the life lessons clients need sometimes seem so elementary and obvious that we look past them and do not realize these ideas need to be stated explicitly. Dynamic therapists are alert to primitive cognitions with a degree of irrationality that goes beyond the type of thinking error of concern to CBT. For example, a boy whose father had died of cancer was tormented by images of him crying in pain. The key insight for this client was the realization that, on some level, he felt like his father's suffering was still occurring. The life lesson he needed was a statement of the obvious: When the counselor said the father's suffering was over now, and he was no longer dying because he was dead, the child's empathic agony ceased.

Dynamic therapy hinges on a certain attitude toward emotions and wishes, and psychoeducation socializes clients into this attitude. Therapists help clients develop a constructive attitude toward mental life in which they accept their emotions, examine them without judgment, and make conscious decisions about which ones to express and how to manage the impulses that should not be directly translated into behavior. One client, when asked what had been most helpful to her in therapy, replied, "Learning that the way I felt was okay."

There are innumerable occasions when clients disclose difficult material and then say something like, "It's probably wrong to feel this way," "It might be bad to have this thought," or "I really shouldn't want that." At these times, the psychodynamic attitude toward internal life can be engendered by using words like the following:

- "Well, you're guilty of being human."
- "No one can help what they think; ideas and feelings just pop into our minds."
- "I don't know about 'bad,' but we could look into where that feeling comes from and maybe we'll learn something."
- "Feelings and thoughts don't make people good or bad; that depends on what people do."
- "You criticize yourself for having this wish, which you can't help, but you don't give yourself credit for disapproving and trying to control the wish, which *is* up to you."

Insight-oriented work with internalizing clients often reveals a harsh, punitive superego (S. Freud, 1915/1957, 1943). When this occurs, I sometimes metaphorically describe the client's current conscience as being like a slave-driver with a whip, and I offer an alternative image of a gentler, more effective superego by describing a kind grandparent who helps his grandchild understand her difficulties and do better at being the kind of person she wants to be.

Sometimes (older) clients need to understand the rudiments of object relations theory and how that theory might apply to them. Here is an example:

> "When kids are little, they have no way to know who and what they are—whether they are cute or ugly, lovable or annoying, good or bad. Little kids learn about themselves by seeing how their parents treat them. It's like parents hold up a mirror, and kids see what they are in that mirror. So if parents treat their kids like they're wonderful, that's what the kids figure they are, and if parents treat their kids like they're a pain, kids come to feel like they're not worth much.
>
> There can be a big problem with this: What if the parents are unhappy and angry so much of the time that it gets in the way of their seeing good things in their child? If that happened, when the kid looked in the mirror, he'd feel like he was seeing the truth about himself, but what he'd really be seeing would be his parents' unhappiness and anger.
>
> I know you've always had this feeling that you're just not good enough. But the question is, does this feeling come from reality or psychology? Does the feeling come from the reality of who you are or from that mirror your parents held up? What we see in those mirrors really sticks with us, but it's not fair, because of something very simple that is often hard for kids to believe: Their parents can be wrong."

One of the fundamental dilemmas of life is that investing in new relationships is risky because, the more one likes or loves someone, the more painful rejection and loss are. Three groups who often experience this dilemma in a particularly acute way are foster children, children adopted after infancy, and adolescents who are beginning to date. The safest option might seem to be avoiding all closeness, but this is not a solution—it is a defense mechanism. The adaptive response is to get to know people gradually while assessing their trustworthiness and interest in a relationship, and to let feelings build as the relationship grows. Ascertaining the trustworthiness of other people is both difficult and important, so counselors should offer clients guidance in making these assessments. Of course, our ability to make these judgments is not infallible, but the issue is not our fallibility but whether our input could contribute to the client's capabilities.

When clients fail to recognize the *costs* of their maladaptive behaviors, dynamically oriented psychoeducation can help them understand what they are losing as a result of their accustomed way of operating—for example:

> "People have let you down so many times, you're at the point of saying to *hell* with them. Starting to trust someone is scary, because that's when you can really get hurt. But it's a problem, because you're pushing away good things along with the bad."

Careful thinking about the specific life lessons and skills needed by a client may lead the dynamic therapist to CBT. For example, a child might use maladaptive defense mechanisms to control his anger because he is afraid that, if he allows himself to feel this emotion, his behavior might go out of control. Achieving insight into this dynamic, by itself, will not

solve the problem, because there would still be a danger of loss of control. Once insight has revealed the youth's defenses, providing him with anger management training (described in Chapter 12, Aggression) might make those defenses unnecessary. Thus, once the unconscious cause of a symptom is discovered, the therapist's job is to help the client solve the problem that the defense mechanism was originated to solve.

Sometimes, individuals other than the therapist are in the best position to supply the child with the input she needs. When misunderstandings concern family members, it is often useful to move from individual therapy to a parent counseling or family therapy modality (A. Freud, 1946b, 1968).

The central life lesson for Jennifer concerned the nature of human adequacy and inadequacy. Her dichotomous schema needed to evolve into a more complex, calibrated understanding so that failures would not threaten her sense of adequacy. Therefore, the clinician portrayed both Jennifer and people in general as complicated, evolving mixtures of strengths and weaknesses. With this more fluid, flexible view of people, Jennifer came to see herself as a work in progress. Failure no longer seemed like a catastrophe, and Jennifer no longer needed to strike out at others to protect her self-esteem.

Corrective Emotional Experience

Both insight into the self and education about life are cognitively based change processes. Most clients also need interpersonal/emotional experiences to resolve their difficulties. By making skillful use of the therapeutic relationship, counselors can create interpersonal experiences that counter and refute maladaptive lessons about self and others that the client learned in the past (Gardner, 1993; Kernberg, 1980, 1993; Kernberg et al., 2008; Mallinckrodt, 2010; Summers & Barber, 2012).

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Corrective emotional experiences begin with the therapist's own view of the child, proceed to the counselor's communication of this view, and conclude with the child's internalization of the therapist's view of her. Your view of the client becomes a therapeutic experience when it is translated into the way you smile, make eye contact, listen, and speak to her. The metamessage underlying these interactions should be something along the lines of, "I know you don't like parts of yourself, and I also know you are a good kid, and when you understand yourself better, you'll know this, too." Sometimes, stating this message in words might feel awkward or too intense for the child, but at other times, direct statements are the strongest means of getting the message across.

Children with internalizing dysfunction usually need comforting experiences in which they learn that they are okay the way they are. These experiences often involve a two-part sequence. First, the therapist learns of something the child feels guilty or ashamed about. The child might disclose this material, the parent might report it, or the therapist might infer the material from the client's in-session behavior. Regardless of the information source, clients often fear that the therapist will reject them once he realizes how weird, pitiful, or awful they are. Corrective emotional experience occurs when the counselor addresses the shame-associated revelation with the same constructive, helpful spirit he

has maintained from the beginning. This exposure-based intervention has the potential to modify harsh superego functioning and make defenses unnecessary.

The therapist's task in implementing this strategy is to be unmistakably clear in expressing two things: full understanding of the shameful or anxiety-producing material, and full acceptance of the child. Neither component, without the other, will produce the needed experience. Generic, nonspecific acceptance does not result in corrective emotional experience. Clients will perceive your acceptance as meaningful only if they believe you know the worst about them and still accept them fully.

One way to begin disconfirming client expectations of disapproval is to respond to new and difficult material with our usual exploratory type of comment:

- "That sounds really important."
- "This sounds like hard stuff."
- "Tell me more about this so I can understand it better."

Providing corrective emotional experiences centrally involves work with the transference. This work often involves the following sequence of six steps. (For the first four steps, illustrative material is included.)

1. Reflection: "You seem afraid that I'll look down on you for feeling this way."
2. Present-oriented inquiry: "Why would I look down on you for this?"
3. Historical inquiry: "Has that happened? Has someone looked down on you for this type of thing?"
4. Therapist provision of realistic feedback to disconfirm transference: "The fact is, I'm not looking down on you at all. What's going on in my mind is that I see how painful this is for you and I'm wondering where that comes from."
5. An interpretation linking past experiences to the client's currently distorted perception of the therapist.
6. Strong disconfirmation of the client's misperception, including a reinterpretation of the client's experience and a statement of the therapist's actual perception of that experience. See ahead.

When maladaptive expectations of relationships are entrenched, they are difficult to disconfirm. With these clients, disconfirmations need to be unmistakably clear and emphatic to break through and produce change. These youth need strong statements that not only deny a negative view of them but also affirm a positive view, and precisely regarding the aspects of self about which they feel most insecure, guilty, and/or ashamed. To accomplish this objective, therapists must provide more than general compliments; they need to articulate specific, insightful appreciation of the client's qualities and strivings—for example:

"Sometimes you wish your big brother would fail at something, because everyone thinks he's perfect and no one seems impressed with what you do. I think it hurts you to have that wish, and you feel guilty and ashamed about it. But I really respect that, even though you can't help feeling jealous and angry, you care about right and wrong, and you care about your brother. It takes character to confront this head-on and try to do better with it."

Insight-Based Child Management

Especially with young children, therapists sometimes make use of their insights into the child's functioning without sharing these insights with the young client, in a strategy I call **insight-based child management**. Counselors can use their understanding of the child as a basis for planning experiences to address her difficulties without increasing the youngster's self-understanding at all.

Insight-based child management can be conducted both by therapists, during sessions, and by parents, at home. In both settings, one important example of this strategy consists of reassuring the child's fears without verbalizing them. When children express anxieties in an indirect fashion through play or fantasy, therapists have a choice between offering an interpretation or bypassing the realm of cognitive understanding to directly allay the fear. For example, if a child's play expressed a fear of being rejected or abandoned by the therapist, the counselor could interpret the connection between this play behavior and the child's real concerns, or the counselor could leave this connection aside and make a reassuring statement about the secure nature of the therapeutic relationship.

As an example of insight-based child management implemented at home, if a counselor ascertained that a client's disturbance derived from his fear that his mother's imminent remarriage might disrupt their relationship, the counselor could pass this information on to the mother, and she could convey to the client, in actions as well as words, that their bond will remain strong in the new family arrangement. If the anxiety at the root of the client's disturbance were allayed, his disturbance might resolve without him ever achieving insight into its genesis.

Summary

Psychodynamic therapy is based on a model of the mind as a set of distinct, semiautonomous structures that interact with each other, usually in a coordinated fashion but, sometimes, with conflict. Much mental activity occurs unconsciously, and people are sometimes unaware of their internal conflicts because their most threatening emotions, impulses, and memories are repressed.

Freud's original model postulated three mental structures: the id, ego, and superego. Since Freud, object relations theorists have proposed a view of personality as composed of internal representations of the self, others, and relationships between the two. Generally, these mental structures are partly conscious and partly unconscious, depending largely on the extent of repression that has occurred.

Outcome research on dynamic therapy lagged far behind research on CBT for many years, but it has begun catching up. There is now considerable evidence that for treatment of internalizing problems, dynamic therapy is similar in effectiveness to CBT and other EBPs. Dynamic therapy does not usually seem to be an effective treatment for externalizing problems.

The psychodynamic understanding of etiology begins with the postulate that the unconscious mind does not mature, and the contents of the unconscious do not change with time and experience. As a result, when conflictual emotions or traumatic experiences are repressed, they remain as threatening, confusing, and unresolved as they were at the time the repression occurred, even if, in ensuing years, the person develops ego capabilities that could resolve the issues.

In this formulation, people are most controlled by what they do *not* know about themselves. Therefore, one fundamental strategy of dynamic treatment is to make the unconscious conscious. When insight is achieved, the client's mature ego gains access to the previously unconscious material and develops more adaptive ways to manage these conflicts and issues.

According to analytic theory, clients' wishes, fears, and object relations are manifested in their experience and behavior during sessions. Defense mechanisms are manifested as resistance to the process of counseling. Emotions and expectations concerning relationships with other people are played out in the transference. Thus, intrapsychic phenomena are translated into interpersonal form. Although these processes might appear to disrupt the smooth flow of counseling, they actually represent valuable therapeutic opportunities, if handled effectively.

Dynamic therapy is conducted in a nondirective, unstructured manner so the client's characteristic patterns of thought, emotion, and behavior are free to emerge. The process of engendering insight is an incremental one; therapists usually do not surprise clients with revelations but gradually increase their self-understanding by offering interpretations of moderate depth and applying these realizations to the details of the youth's experience.

Insight is a lot but, especially for young and seriously disturbed clients, it might not be enough. Psychoeducation is an additional type of help that seems necessary when the client's most mature, conscious level of ego functioning is not capable of resolving her difficulties even when it gains full access to them. Counselors can assist these clients by helping them understand difficult issues and providing guidance in effective coping.

In addition to these cognitively oriented strategies, dynamic therapists use their relationships with clients to create emotional experiences that address the conflicts, misunderstandings, and maladaptive learning that have contributed to the youth's mental health problems. The purpose of these corrective experiences might be to demonstrate that the hurtful relationships the youth has had in the past are not accurate depictions of the types of relationships he could have in the future. Dynamic therapy attends to the youth's history, but its purpose in doing so is to sever maladaptive connections between the past and present, so the client is freed from the harmful effects of his history as he moves into his future.

Case Study

Jennifer was not pleased when the therapist confronted her arrogant stance toward others, but over time there was a decrease in her anxiety about performance as she developed a more resilient image of herself. With a less catastrophic view of failure, she became open to the idea that no one—neither she nor the adult in charge—had to be viewed as deficient when something went wrong. When self-doubts occurred, her lashing out was replaced by problem solving and twinges of anxiety that she learned to tolerate and manage.

The corrective emotional experience Jennifer needed from her therapist was enactment of a balanced, moderate view of her. The counselor was not extremely impressed, intimidated, or disgusted with Jennifer, but consistently viewed her as a good kid who was confused and having trouble with life. One of Jennifer's scripted self-statements (from the cognitive portion of her therapy) was "What's so bad about being a regular kid?"

As Jennifer's self-perceptions became more balanced and stable, she was able to give up the aggressive, attacking stance that had served as a cover for her feelings of vulnerability. Jennifer had fought her war with adults to protect herself from painful feelings of inadequacy. Once she learned to moderate and manage her self-perceptions, there was nothing left to fight about.