EXAMPLE

P (In a bland voice) So I wentto Washington, spentthe day collecting the data thatI needed, and made the train back that night.

T (T is silently wondering IVhy this patient bores him. There is nothing wrong with What he is saying. Most patients give an account ofthe details oftheir daily life. He has been coming to treatmentforthree months, so he must be getting something out ofit.)

P Marjorie was there ...(He falls silent.)

T (Marjorie ... She was the one WIIo broke up with him last year. Maybe she is key to live feelings.) What was itlike to see her again?

P You remembered.

T A surprise?

P Yes. People don't.

T That must bother you.

P Notreally.I'm used to it.

T HOW did you get so used to it?

(Winces,the first shOW ofreal affectthe therapist has seen in a long time.)

(No longerfeeling bored, and suspecting that his reaction is related to the patient's CCRT pattern) There may be good reasons Why you got used to it.It would be ratherfrustrating to keep expecting people to remember What you have to say,ifthey never do.

P I'd say so.(His body posture relaxes ever so slightly.)

T (The therapistis glad to have found a way to understand the patient's bland way of presenting himself. He did not wantto mention it directly,feeling fairly certain thatthe patient WOuld be insulted if he did. He realizes that his own IVOrry about being rude had stopped him from looking more closely atthe issue. He then begins to considerthe patient's CCRT pattern.)

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

VIRORS (Wish)[implied and deeply buried] To be recognized,remembered
(Response of others)[anticipated] Notrecognized, notremembered
(Response of self) No emotionalreaction, no affect

The therapist could also considerthe patient's bland presentation as a defense against affect. The defense againstthe pain he IVOuld feelif he letin the disappointing response of others had become a defense against allfeeling.

Deepening the Exploration

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

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

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

By the later phase ofthe exploratory work,the patient has gained understanding ofthe past patterns in herlife and is no longer experiencing inner conflictthat stops herfrom functioning. She may continue to work through the remaining ways in Vトich old patterns may surface, as she gets ready to figure out new ways to cope. Wエth some patients that happens as a natural outgrowth ofthe process ofthe therapy. Others make active efforts to develop new coping strategies, nOIV thattheir energies are no longertied up in past patterns and conflicts.In this phase ofthe work,the patient may notice herself "freed up" in situations that used to be impossible for herto handle.

The Termination Phase

The end ofthe treatment comes when it comes. The best ending is an ending ofthe need fortreatment, Wトen the patientis engaged with herlife in ways thatfeel positive, withoutthe initial symptoms and turmoilthat brought herto treatmentin the first place. She should also have mastery other core themes, so that she no longerfalls back into the same problems once she has finished treatment. She should have developed new ways to cope, so that she feels that she can handle herlife.

In reality, people "get offthe train" oftreatment at different points. Some end due to symptom relief, some end due to difficulties in the treatment, or some stay untilthe deeperissues are resolved. Of course,there is really no such thing as being finished,if "finished" means having no problems and having complete confidence, but an end to a psychoanalytically based treatment should mean thatthe patient knows herself better, accepts herself and herfeelings, and is notfrightened of Wトat she willfind orfeelif she really tunes into herself. She should instead be in a place, psychically, Wトere the old demons have been tamed and no longer "spook" herin the present, and she is ready to move on.

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

echanisms of Psychotherapy

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

The Therapeutic Relationship

The Helping Alliance is pivotalto the therapeutic relationship.Itis the partnership between therapist and patient around the WOrk ofthe treatment. Some patients experience that alliance as going to a therapist IV ho gives them help (Helping Alliance 1), WLereas others experience it more as a partnership between patient and therapist(Helping Alliance 2). Research links both forms with a good outcome forthe treatment, provided itis a positive alliance, or one thatthe patientfeels offers help.

The Helping Alliance can be enhanced by the therapist's efforts to keep the channels of communication clear. This means actively listening to the patient so that she fee the therapistis a partnerin sharing herreal concerns.It also means noticing if problems occurin the alliance and seeking to address them.

A process ofrupture and repair can benefitthe alliance if misunderstandings or negative reactions have occurred. This process consists oftalking over W hat may have been problematic forthe patient, acknowledging any real difficulties that arose, and accepting the patient's feelings about W hatever WCnt W ong. Being able to look at a mishap withou brushing it away or overreacting can serve as a useful experience forthe patient. Safran & Muran (1996)found it actually to be beneficialto the treatment outcome, especially for patients with negative expectations ofrelationships.

EXAMPLE

P: (P cancelled the last session. She arrives atthis one just on time, and sits down.) So.

T: (Waits. She notes thatthe patientis focused on the a ll ofthe chair and looks annoyed.)

P: Nothing much to report. Work is busy. What else is new? A lot has happened, I guess.

T: (Wondering W y she is so evasive, and W ether something might be bothering her aboutthe therapy. Since she canceled the last session,there could be a reason for both.) YOu haven't been here in a few weeks,is thatright?

P: (Shrugs)

T: So Iimagine a lot has happened that you haven'ttalked about here.

P: As ifthat matters.

T: I getthe feeling I am pretty useless in yourlife right nOW.

P: (Shrugs again)

T: ButI do rememberjust a fCW weeks ago you talking about some really important things.I IVOnder W at happened in between? I must have done something, or said something,that made itfeel different here.

P: Done something.

T: OK, W at did I do?

Itturned outthat W atthe therapist did was to take a phone call during the patien session, something she ordinarily never does, but she had been worried about her own child, IV o was home sick. The therapist acknowledged that she had taken the call. She wondered ifthatfeltto the patientlike she was no longerinterested in her. After hearing the patient's feelings,the therapist apologized for causing the patientto feelthat she wasn'tinterested in her: "The last place you need to feelthatis here." After several sessions of WOrk on this rupture,repair began. The incident ended up helping the treatment, because the patient said that she had figured she would have quittherapy until the therapist admitted her mistake.It also led them to WOrk on the patient's transference expectations,through CCRT WOrk on her negative expectations of others and her own

defensive responses. AJld itled the therapistto reflect on the narrow bridge between her personal and professionallives.

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

T [illegible] Work

The exploratory, or expressive, WOrk ofthe treatmentis made up ofthe human process of dialogue in a protected place.Itis protected from intrusions by the "saving ofthe hour" forthe patient.Itis protected from the ears of others by the practice of confidentiality. AJld itis protected from having any agenda otherthan the patient's well-being by the nature ofthe therapeutic contract. The patient's part ofthe process in the expressive WOrk is to "say WLat comes to mind." The therapist's partis a sequence oflistening and responding, WHich gradually yields an understanding ofthe sources ofthe patient's problems.In psychoanalysis,the analyst's interpretations ofthe transference are pivotal.

Transference and the CCRT

The transference is the cornerstone concept of psychoanalysis.Itreflects the deep patterning of old experiences in relationships as they emerge in currentlife. Just as if someone had made footprints in the WOods and started looking for a path in the dark, people find themselves retracing their patterns ofrelating and responding withoutrealizing it. Itis not so easy to illuminate an unfamiliar path and walk a new way. Old paths wind through the shadows of habit and history. The analysis ofthe transference provides the lantern.

Even though volumes have been IVでitten aboutthe transference and its role in psychoanalysis,its inner workings may still seem mysterious. The Core Conflictual Relationship Theme method (CCRT) demystifies the concept by describing the different elements ofthe process. Each CCRT pattern is made up ofrepeated episodes, consisting ofthe patients wishes (W),responses from others, eitherreal or anticipated (RO), and responses from the self(RS). People tend to have either one or several central patterns, just as Freud described WトIen he first came up with the concept ofthe transference.In fact, Luborsky & Crits-Christoph (1998)found thatthe CCRT corresponded to the central defining characteristics that Freud gave forthe transference pattern. Thus the CCRT is an operational version ofthe transference.

In understanding the patient's CCRT,the therapistlooks forthe "convergence of spheres." Thatterm refers to the commonality in the CCRT themes in each ofthree fundamental areas ofthe patient's life: his currentrelationships, his pastrelationships, and the therapeutic relationship. Both the current and the pastrelationships are central relationships,typically with family members from the past and eitherfamily members or others WIIo are close to the patientin the present.

As the patient and therapist notice the ways in WトIich this pattern intrudes into the present,they become able to begin changing its impact.In clinical practice,itis important notto overload the patient with interpretations. Forthis reason,the therapist usually brings up one sphere at a time, an area related to the topic the patient has been talking about. As the treatment progresses,the patient may be ready to notice links between the spheres, once the pattern has become evident.

[illegible] pa
dy t

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I wished I could have walked out ofthe meeting, butI was stuck. YOu know hOW bad it WOuld have looked ifI had gotten out of my chair and knocked it over? (Laughs)Anyway,I was good and I satthere tillI saw someone else move his chair. The only problem is hOW 已抑 I going to stand this job, with all oftheir meetings?

HOW are you going to stand that stuck,trapped feeling?

Exactly. Oh, now that you say that,IrememberIfeltthat way in the lastjob.

When is it going to be over?

WTign willthere be a job thatisn't a trap?

you find me one? (Laughs)

Let's take a look at WhAat makes you feeltrapped. Maybe WC can figure it out hat way.

In this sequence,the patientis actively aware of his feeling state and realizes there is some pattern to it. The therapist picks up the patient's signs ofreadiness to l atthis pattern in the context ofthe job sphere, since thatis the patient's currentfocus. In supervision, his supervisor points outthatthe patient could develop those same feelings aboutthe therapy. After all, he is stuck in a room, sitting in a chair, having a me ing. The therapist decides to rememberthat possibility and to keep his ears open to see ifthattheme becomes active in the treatment.

Symptoms and the Symptom-Context Method

When a symptom appears in the course ofthe treatment,it gives the patient and therapist an opportunity to investigate its meaning. By taking a look atits context,they can begin to decode the symptom and find out WLatis making it erupt. The symptom can be thought of as a language forforces that are out ofthe patient's awareness, often an inne conflict. The context gives hints to IVhatit might mean. The contextincludes not only the events in the patient's life but also his feelings aboutthem.In a therapy session,th materialthe patient has just been talking aboutis the immediate context.

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

XAMPLE

It's happening again.... My throatfeels like it's closing up.(The patient had just been talking about early sexual abuse.)

What do you think aboutthat?

Wi(in a rasping voice) What he did to me.(Referring to a form of sexual abuse thatinvolved herthroat.)I can'ttalk.

This patient has been in treatmentlong enough that she can readily use the Symptom-Context method to understand her symptoms. She reached that pointthrough the gradual discovery that situations thattriggered feelings or memories ofthe abuse also caused bodily symptoms.

Transform

The goal ofthe expressive work is a kind of personaltransformation. By gaining an understanding of parts ofthe selfthat WCre previously at odds or out of awareness,the patient can WOrk out nCIV ways of handling her needs and herfeelings. This is a gradual process. As the patient gains self-understanding, she becomes more aware ofthe ways she has "been in her own way." She can begin to shift her expectations toward more positive ones and can find ways to go toward WLat she really wants,instead of defending herself against herfears. The maladaptive defense mechanisms that WCre operating before become less powerful. As described earlierin this chapter,research on the CCRT suggests this is the course of events in successfultreatment. Patients keep wishing for the same things they always wanted forthemselves, buttheir negative patterns ofresponses from others and self undergo change.

A E虻L Iお ATIONS

•• Who Can We Help?

Psychoanalysis functions both as a form of psychotherapy and as a conceptual system to understand how people function psychologically. As a foで皿 oftreatment, psychoanalytic therapies are particularly WCll suited forthe many patients VIIo have Vトat Sullivan termed "problems in living," Wトich include difficulties with WOrk and love. Often, people present with generalized patterns of behaviorthatinterfere with their conscious goals for happiness and success. Such difficulties are usually complex and lack an obvious cause, and a psychoanalytic approach helps discern the causes, often by tracing them to an unconscious conflict orrelational pattern. A man,for example, mightrepeatedly fallin love with and marry the same kind of WOman, although he knows from previous experience thatthese relationships will end disastrously. Or perhaps a WOman unconsciously arranges herlife so that any success at WOrk will be followed by an even greaterfailure.

Stress and Distress

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

Psychoanalytic treatments are beneficialforthose VIIo WOuld like to gain a deeper understanding oftheir problems. Those in the mental health professions often wish for a high level ofinsight and self-knowledge,in orderto be better able to help others with their difficulties. Because it can get atissues that are unconscious, psychoanalysis can also be quite helpfulto people Wトo feel generally troubled but do not knOW Wトy.

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Personality D

Psychoanalytic treatmentis probably the treatment of choice for personality problems and disorders. This is because psychoanalysts have developed sound theories and techniques to understand and treatthem, WHereas many other schools of psychotherapy have not. Such disorders are difficultto treat because, as the name suggests,they involve problems that pervade the patient's personality,ratherthan a specific symptom or condition. Personality disorders callforintensive,long-te阿 treatmentto address these issues at a deep level,including WOrk on the patient's defenses and underlying feelings.

Range of Applications

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

In supportive-expressive (SE) psychotherapy,the therapist balances two basic elements ofthe treatment,the supportive relationship and the expressive WOrk,in orderto meetthe needs ofthe patient.In that way the therapistis able to tailorthe treatmentto the level ofthe patient's pathology.

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

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

Child and Family Treatment

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

Play therapy is an application of dynamic concepts for children, based on Melanie Klein's conceptthat play is for children WLatfree association is for adults. Such therapy

pre

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

ume, gives an unparallel

Like otherforms of psychotherapy, dynamic therapies may be combined with the use of medication for symptoms that are too severe to respond to psychotherapy alone. That is often the case in a major depression or other major mood disorder. Medication does notreplace psychotherapy, and the two together are often more effective than either one alone. Understanding the meaning of symptoms and the psychologicalfunction they might serve is still an importanttask. Some dynamically oriented therapists combine tools such as relaxation and breathing techniques for addressing the immediate symptoms and the Symptom-Context method for understanding their meaning.

Treatment

Freud compared W二iting about psychoanalysis to explaining the game of chess.Itis easy to formulate the rules ofthe game,to describe the opening phases, and to discuss W卜at has to be done to bring a chess game to a close. But IVIIat happens in between is subjectto infinite variation. The same is true of psychoanalysis. Since every patient(and every therapist)is different, no two treatments are alike. Even so, dynamic treatments have inherent operating principles and treatmenttechniques that are notimmediately visible but are nevertheless at WOrk. The following case fragmentillustrates how they intermingle.

EXAMPLE

P:I have something I have been meaning to bring up ... Night...(Pt's voice is soft, and the therapistlistens closely. After several minutes the patient starts again.) Katie made the soccerteam.(Her voice is bright nOW.) Which is great, exceptfor allthe driving. The amount of miles I have put on that car...

T:(T is WOndering, W卜at happened to WHat she had been meaning to bring up? It seemed thatthe patient had abruptly shifted gears. She notices the pun in her thinking and decides to ask about exactly that.) YOu knOW,I 8円 still WOndering about IXHat you started the session with.It seemed like you shifted gears,just like the car.

P:(Smiles)I have an automatic. But you're right. So IVLat was I avoiding? (The patient has been in treatmentlong enough to knOW that avoiding has reasons.) Well, you're going to think, "She's a fat pig" ifItell you.

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

P:IIIel'l, maybe you WOn't, butI do.... OK, here's the thing. Jon (her husband) VII m goes to bed early. He goes upstairs at 9:00. because he's up at 5 to catch the train. A虹d there I れ山.Ijust gotthe kids to bed, with the W卜ole nightin front of me.I keep telling you I IVれnttime to myself, butthere itis, and WIIat do I do?

T: What do you do?

le ni

P Nothing. Clean the kitchen counters. Leave the TV lOW, so I don't bother anyone. OK here itis. Eat.(Patientlooks embarrassed.)I ate an entire package of Oreos last night. The W卜ole package so I could throw the wrapping away and no one IVOuld know the difference.
T That must have been hard to talk about.
P Not as bad as Ithought.
T And you must be WOndering W卜atIthink.
P WellIreally don'tthink you WOuld judge me, but...I mean, W丘o wouldn't? Why WOuld anyone do something so stupid? I mean,I am trying to lose WCight. Good reason notto eatthat garbage.I should work on my writing ifI ever want to get anything published. Good reason notto waste my time.I have no time to myself during the day and finally the kids are in bed and Jon's up there too. You'd think I'd be happy aboutit.
T It sounds like you are really mad at yourself.
P I 8cm.
T And that you figure I WOuld judge you too.It's hard to getto the "why's" if you and I are both sitting in judgment, butI betthere are feelings hidden underthere.
P (Nods) Lonely
T (With empathy) Lonely.
P (Looks at T, and then back outthe window) Even though the house is full,it's empty.... YCah, OK,I'm trying to fillit up, but you can'tfillit with Oreos. (Looks at T, and they both smile.)...Is my time up?
T Actually, IVC have lo minutes left.
P Oh,that's so strange.I was sure it W包s over.
T Well,I WOnderifthere was something about WLat WC justtalked overthat made you feellike I'd be ready to getrid of you.
P You mean, having feelings?
T Having feelings like ...
P Lonely, mad thatI getleft with everything.
T And getleft?
P Yeah,that.(Her eyes startto tear.) When I married Jon IthoughtI was done with that. He is solid.
T But he goes to bed and leaves you, and gets up early and does it all over again.
P (Nods) And nOW are WC out oftime?

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

P I started doing it again@eating.I was doing better with it, and then this last week,I got back in my old habit, you knOW,the nightthing.
T I wonderif anything WCnt on this week that might have been difficult?
P No. Good things actually. Katie gotinto a summer program we wanted herto do. Jon got offered a promotion at work. Gotto buy some champagne.
T And yourlife?
P Yeah,thatis my life. Me and my Oreos.(Looks the therapistin the eye.) YOu knOW IV卜en I was a kid,it was the same thing. When I came home from school, no one W8s there, butthere was always food.
T What did you have to eatthen?
P Where'd always be something. Look in the refrigerator,look in the cupboard. Something. ButI wished WC'd have something really good.
T Like Oreos, by any chance?
P Now I'm throwing them away. My friend Aユdrea had allthatjunk in herlunch, and I wished I could have ittoo.

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

The nextthing to notice is the sequence ofthe session. The patient's emotional themes link her most spontaneous comments together. For example,just after she reveals emotionally laden material, she figures the session will be over. The sense thatthe session will be over comes from an innertheme, notfrom a realistic sense oftime. Talking about herfeeling of being lefttriggered the fearthat she WOuld be left by the therapist(by ending the session). Herresponse in this case was to become anxious.In the home sequences that she reports, she covers overthe feeling by eating.

The therapistis quick to note evasions in the patient's process. They could be thought of as a fo丘厠 of defense. Since the patient and therapist have WOrked with each otherfor 9 months,they have an easy rapport. The patient has also already learned through previous examples that she may be avoiding things with VトIch she doesn'tfeel comfortable. The patient and therapistfunctioned as partners in this exchange, discovering WLatis really behind changing the subject. Their Helping Alliance helped the patienttrustthe therapist WIIen dealing with a topic that was embarrassing to reveal. So did the therapist's analysis ofthe defense. When she made a joke aboutthe car changing gears, she was also pointing outthe patient's method of defense against difficultfeelings. When she commented that "no IVOnder" the patient WOuldn'ttalk about eating if the therapist WOuld think she was a "fat pig," she was pointing out one ofthe functions ofthe defense.

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

W:(implied) To be close
RO: Leaves, does not stay close

from her childhood, in the present with her husband, and with the t
sible CCRT pattern looks like this:

The Symptom-Context method is at WOrk WトIen the patient and therapist examine the contextfor overeating.It gives them clues to the patient's feeling state. Another technique thatthe therapistfollows is responding to the patient's affect. She slows down the dialogue and makes time for empathy with the patient's feeling state.

The potentialfor change is suggested by the patient's positive response to the session and in her greater ease in moving into the materialthe second time. More work will be needed in orderto better understand the patient's feelings and their history. But VHat we have here is simply a fragment of a treatment, and itrepresents a good start.

The Psychoanalytic Situation

Shame,fear, pride, political correctness, social conformity@亡hese are among the forces that stand in the IVれy ofthe patient acknowledging her own truth. The psychoanalytic situation, in WLich nothing is the wrong thing to say, gradually undoes those layers ofinhibition. "The special conditions ofthe psychoanalytic situation are designed to promote the optimal unfolding ofthe patient s unconscious subjective life" (Rubin,1996. p. 24).

As the analystlistens to allthe layers ofthe patient s experience,the patient begins to do the same. Logic, consistency, and the other person's approval are notthe goals of

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

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

Evidence

People often think of psychoanalysis as a "dinosaur" among psychotherapeutic treatments, with a few stray fossils around and no science that could bring it back to life. That happens to be untrue. Not only is psychoanalysis actively practiced in a variety offorms, butthere has been ongoing psychodynamic research for decades. Research supports the efficacy of dynamic treatment and specifically supports the VOrkings ofits cornerstone principles. Although clinicalresearch does not suggestthat dynamic treatment yields more consistent success than otherforms of psychotherapy,it does confirm its effectiveness, and studies ofits WOrking mechanisms confirm its mostfundamental methods.

Psychotherapy Research

Psychotherapy research often focuses on WHich form oftherapy has the best outcomes, compared to otherforms. Researchers WHo have an allegiance to one particularform oftreatment often obtain results that supporttheirfavored approach. However, WHen psychotherapy studies are combined into meta-analyses,the results are different. Large-scale meta-analyses that aggregate data come up with two findings. The first, often ignored, may be more importantthan the second.

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

The second finding is that no one form oftherapy consistently outperforms the others. Differences that are too smallto be statistically significant are the noLJJ, es when the studies are corrected forthe effects ofthe researchers' allegiance (Luborsky et al.,1999). This has been called the "Dodo bird finding" after a story in Alice and Wonderland.In that story,the Dodo bird gives prizes to everyone WHo participated in a race, declaring that "everyone has WOn, and all shall have prizes."

Why is itthat everyone gets a prize, IVHen each runnerreally thinks he should be the winner? The mostlikely reason is that WCll-performed psychotherapies share some fundamentalfactors. Prominent among thC卸 is the Helping Alliance. Dynamic psychotherapies highlightthe importance ofthe alliance between patient and therapist, and othertreatments rely on the partnership between client and therapist, even ifitis not

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described as an aspect oftechnique. Whether explicit orimplicit,the Helping Alliance is key in moving the treatmentforward. Research also reveals thatthe therapist's empathy is also linked with positive treatment outcomes. Empathy is another aspect of psychodynamic technique that may be presentin otherforms oftreatment, Whether explicitly or not.

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

Evidence-Based Practice

In orderto gather clearer evidence on the effectiveness of differenttreatments, researchers have begun to establish empirically supported therapies (ESTs). By establishing precise guidelines forthe treatment and forthe type of disorder being treated, researchers intend to bring more objectivity to the studies comparing psychotherapies. However, pitfalls arise in relating the results ofthis approach to reallife. Most ESTs are brieftreatments, using specified techniques for specific disorders, with subjects IVHose problems fit with the criteria forthat disorder alone. This makes for a clean research design, butin reallife, people frequently have commingled problems, and those people are not eligible forthe studies (Westen, Novotny, & Thompson-Brenner, 2004).

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

Effective Psychotherapy

Seligman (1995) considered the question ofthe real-WOrld effects of psychotherapy in a simple way. He polled actual patients fortheirimpressions on a variety offactors. One ofthese factors was length oftreatment. The patients said they found longertreatments more effective than brief ones.

This type ofresearch is notthe WHole answer either, as Seligman would be quick to agree. However,this approach provides another way to look at psychotherapy using research thatis relevant and meaningful.

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

Evidence for Psychodynamic Concepts and Methods

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

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

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

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

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

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

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

Sprinters and Runners

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

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the effectiveness of psychotherapy, itis worth keeping in mind both the complexity of real people and their problems and the natural differences among forms oftreatment. The performance of psychodynamic therapies, like that ofthe long-distance runner, may be best measured overtime.

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

Psychotherapy in a Multicultural WOrld

Culture infuses all of our assumptions, and WHen considering theories of psychotherapy, itis alltoo easy to forgetthat both theorists and their patients are affected by culture. There is no such thing as culture-free thinking, any more than there is word-free language. Even within a culture, the name of a culture may nottellthe WHole story because of different subcultures that may be present. One person's experience may involve multiple experiences across different cultures and continents. AZother's cultural story may be a hybrid of differing beliefs and backgrounds within the same family. The potential for misunderstanding multiplies WLen a patient and therapist make assumptions about each other based on culturalfragments or stereotypes.

HOW can the search for understanding Stilltake place? HOV can a patient and analyst navigate a shared journey WHen they may not even know WHich ways they diverge or which assumptions they do not share? Altman (2009)refers to culture as the third force in the consulting room, proposing thatifthe analyst and patient are already working in a two-person psychology, issues ofrace, class, and culture create a third and critical elementin the relationship.

Cultural Assu[illegible] room, proposing t

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

While anthropologists criticized Freud's Totem &@ Taboo forits obsolete assumptions afterit was published in 1918. anthropology and psychoanalysis have since crossfertilized each other, with anthropologists delving into life histories and autobiography and psychoanalysis taking culture into account WHen studying differences in personality structure among non-Occidentalindividuals (Wittkower & Dubreuil,1976).

Research on Cultural Differences and Psychoanalytic Concep

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

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

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

cope wi Nonverbal Behavior

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

(Galanti, 200 Method and Cultural Meanings

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

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

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

Cultural differences can alertthe analystto areas that need to be explored in c

CASE E XAM E.L E

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

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A Psychoanalytic Session

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

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

"Ifeelrestrained by the city.I need the open fresh air;I have to stretch my legs.I'm sorry I gave up the house I had in the country.I have to get away from this city.Ireally can't afford to buy another house now, but atleastI'llfeel betterifIlook for one.

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

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

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

The factthat he suffered from claustrophobia Wれs a new finding in the analysis. The analyst noted to himselfthatthe patientfelt claustrophobic aboutthe analysis. The conditions ofthe analytic situation imposed by the analyst were experienced by the patient as confining.In addition,the analyst noted, again to himself,these ideas were coupled with the idea of being threatened and controlled by his mother.

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

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

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

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I don't even knOW hOIV old I was then, maybe 5 or 6 or perhaps 7. butI was definitely a child and I was frightened."

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

As the therapist helped him become aware ofthe persistent effects ofthese unconscious childhood conflicts,the patient would gain some insightinto the causes of his impotence and his stormy relations with WOmen, particularly his wife, as well as his inhibited personal and professionalinteractions with men. To this patient, having to keep a definite set of appointments with the analyst, having his car hemmed in between two other cars, being responsible to authorities, and getting stuck in elevators orin trains were all experienced as dangerous situations that evoked anxiety. Consciously, he experienced restrictions by rules and confinement within certain spaces. Unconsciously, he W8s thinking in terms of experiencing his penis inextricably trapped inside a woman's body. This is the essence ofthe neurotic process: persistent unconscious fantasies of childhoo impose a mental setthatresults in selective and idiosyncratic interpretations of events.

Drive Theory versus Relational Theory

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

A relational analyst would see the same material as an intersection ofreality wit long-standing relational patterns. She would be more likely to focus herresponses on the Ways the relationship patterns WCre activated in the present, by spending time on t patient's feelings aboutthe treatment. For example, WHen the patienttalked about not wanting to come back to analysis afterthe WCekend, she WOuld have inquired aboutthose feelings, "shining a flashlight" on WhIatthe patient Was experiencing with her. She WOu have had an interestin the patient's early relationships as memories to explore, using thCcm to understand the patient's past and currentfeelings,ratherthan interpreting them in accordance with Oedipaltheory. She would have tried to "get a feel" forthe patient's early WOrld by empathizing with WhIat was frustrating in his early experiences.

She WOuld be WOrking from a two-person model,in WHich she is participant as WCll as observer. Herfocus would be on the patient's relationships, past and present.

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Looking Through the Lens ofthe CCRT

In looking atthe session through the lens ofthe CCRT,the convergence of spheres becomes apparent. The patient describes the same themes in his relationship with his mother, his WOrk,the analyst, and his wife. That convergence makes it a good time for the patient and analystto look atthe pattern. The factthatthe theme is reflected in the session itself means thatthe patient's feelings aboutthe analyst need to be further explored. Considering the session in that way makes it seCJ\ to be a pivotal session,just as it did to the treating analyst. However, WIIat seems pivotalis the convergence ofthe CCRT pattern, notthe Oedipal material.

The CCRT pattern conveyed by this patient WOuld be

CCRT pattern, not the Oedipa

The CCRT pattern convey

RS: Get angry; get anxious; getimpotent

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

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

SUMMARY

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

Since Freud, psychoanalytic ideas and forms oftreatment have continued to evolve in different ways.In the century since his early discoveries,they have beer alternately challenged,followed,rejected, and expanded. The classical psychoanalytic tr dition has stayed the closestto Freud's originalideas, W hereas othertheorists and practitioners have made changes in focus and technique. These include the ego psychologists, self-psychologists,the objectrelations school, and the currentinterpersonal and relational analysts. Psychoanalytic concepts have been evaluated through clinicalresea- h,through

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

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

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

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Anna Freud has one ofthe finest and clearest writing styles in psychoanalysis. The Ego and the Mechanisms of Defense is an established classic forits lucidity in portraying theoreticalimplications ofthe structuraltheory and their application to problems oftechnique.In a relatively small volume, the author offers a definitive presentation of the psychoanalytic concept of conflict,the functioning of the anxiety signal, and the many ways in which the ego attempts to establish defenses. The sections on the origin of the superego, identity, and the transformations in adolescence present a clear picture of how the child becomes an adult.

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

GreenbergJ. R., & Mitchell, S. A.(1983). Objectrelations in psychoanalytic theory. Cambridge, MA: Harvard University Press.
This landmark book contrasts drive theory and the relational model,in terms oftheory and history. The latter paradigm follows from the British objectrelations theorists who believe that an innate need to maintain relationships is what motivates human behavior and that early relational patterns remain active throughoutlife.

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

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

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The third of a trilogy,this volume builds on Mcwilhams's previous books on psychoanalytic diagnosis and case formulations. She discusses in a sophisticated but accessible way the essential aspects of psychodynamic therapy.

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Selma Fraiberg takes the psychoanalytic concept ofthe role ofthe pastin the presentinto the lives of neglected infants. The mothers in these case studies could notrespond to their own babies until Fraiberg and her colleagues responded to their own, previously forgotten memories of being neglected themselves. That opened up the potential forthe mothers to heartheir own real babies. Fraiberg offers a moving account ofthe ways two generations can be helped at once.

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

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

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

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

Winnicott, D. W (1972). Fragment of an analysis.In P. L. Giovacchini(Ed.), Tactics and technique in psychoanalytic therapy (Pp. 429-491). New YOrk: Science House.

Winnicott's approach to psychoanalytic theory and practice represented an importantturning pointin psychoanalysis. This case reportillustrates his special approach, which emphasizes the influence ofinterpersonal interactions and feelings. Winnicott's technical precepts have had a strong and lasting effect on psychoanalytic practice