Psychodynamic Psychotherapy

Introduction

An introduction to psychodynamic psychotherapy was given in the "Psychological Therapies" section. This section will cover psychodynamic psychotherapy in some more depth.

Basic Psychodynamic Concepts

Psychodynamic and psychoanalytic psychotherapies make use of a number of concepts regarding the characteristic workings of the mind under conditions of normality, neurosis, personality disorder and psychosomatic conditions.

Change and Development

Any human being at any time is in the process of change and development. This is most obvious in children and adolescents but is no less true of adults in middle and late life. As such their needs and expectations are changing both in material and relationship terms. Moreover within the range of life events, such as bereavement, the human reaction to these follows a more-or-less predictable course, unless interrupted by psychopathology.

Key Relationships and Transference

During the course of development, children establish complex relationships with key people, particularly parents, which include attachment and the meeting of a variety of needs which change over time. When such needs are not met or where the relationship is broken, the potential is there for the repetition, avoidance or idealisation of equivalent subsequent relationships through the phenomenon of transference.

The term transference refers to the unconscious influence of past learning of traumatic interpersonal relationships on present emotional responses, behaviour and relationships. This maladaptive learning stems from childhood experiences and interferes with normal relationship and decision-making.

"What are transferences? They are new editions or facsimiles of the impulses and fantasies which are aroused during the process of analysis; but they have this peculiarity, which is characteristic of their species, that they replace some earlier person by the person of the physician. To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment."

One of the objectives of psychotherapy is to enable the patient to recognise these previously unconscious distortions of interpersonal perception and to respond more appropriately to people in the future.

The ordinary, straightforward doctor-patient relationship is not of itself a transference relationship. It can, however, by its nature foster such relationships particularly where dependency is a predominant theme.

- a positive transference is one where the predominant emotion is in favour of the doctor.
- a negative transference is one where the predominant emotion is hostility to the doctor (assuming that in reality (s)he does not deserve it!).
- counter-transference is the doctor's transference feelings towards the patient and as such may be positive or negative.

An understanding of transference is therefore necessary not only to understand "academically" the neuroses and personality disorders but also the day-to-day vagaries of doctor-patient interaction.

Conflict and Anxiety

Anxiety arises through conflict between one or more "disturbing concerns" and one or more "reactive concerns".

Disturbing Concerns	Reactive Concerns
Wish for love	Fear of retaliation
Hostile urges	loss of control
Sexual wishes	exposure
Dependency	rejection
Competitiveness	failure
Autonomous striving	being destructive
	loss of love
	isolation
	abandonment
	Shame
	Guilt

Brief transient conflict produces acute anxiety until the conflict passes, is resolved or is modified by mental defences.

Chronic conflict brings about the longstanding deployment of defences which becomes part of a personality trait, e.g. obsessionality.

A Sense of Self

During the course of normal development, a person develops a sense of themselves as individuals capable of independent perception, thought and initiation of action. There is a sense of an integrated personality with congruent ideals and values linked to a sense of self-esteem. During the course of abnormal development the sense of self may be less soundly formed and become evident in clinical states, e.g. poor self-esteem in depressive states.

Unconscious Mental Mechanisms

Every human being is actively engaged in mental activity, much of it unconscious, directed to maintaining an emotional equilibrium in the face of impulses from within (e.g. aggression and sexuality) and emotional demands from others. Evidence for such unconscious activity is to be seen in the case of dreams and slips of the tongue which reveal more than is consciously intended.

In order to maintain this emotional homeostasis we employ, almost entirely unconsciously, a number of mental mechanisms - accordingly they are more obvious to our observant friends than to ourselves. Used in moderation these are essential to mental health. Overused they can become pathological because they impart a rigidity of thinking and relating which makes living more-or-less difficult. Certain other mental mechanisms (marked ✔ in the section on Defence Mechanisms) are more often implicated in psychopathology and often indicate greater anxiety which is being held back by more desperate and primitive defences.

Defence Mechanisms

✔ **Repression** - central to all the other mental mechanisms the defence mechanisms by which unacceptable impulses etc., are rendered unconscious. In normal people the repressed material finds expression in sublimation.

Sublimation - a process whereby primary emotions, sexuality and aggression are converted into and expressed in socially accepted terms, e.g. aggression sublimated into competitive sport.

Rationalisation - self-deceiving, apparently rational "explanations" for instinctual behaviour, e.g. schoolmasters invoking "discipline" to legitimise beating boys backsides.

Intellectualisation - excessive use of intellectual processes to avoid emotional expression and experience. Over-use leads to "cold" aloof schizoid personality formation.

✔ **Denial** - the denial of a painful experience or some unacceptable aspect of oneself. Commonly seen in the early phase of normal grief reactions. May continue for an unusual length of time when it is an expression of abnormal grief reaction.

✔ **Reaction formation** - means by which a repressed forbidden wish is expressed by its opposite e.g.: - voyeuristic urges expressed by anti-pornography militancy - a characteristic mechanism in obsessional neurosis though sometimes seen in other neurosis.

Displacement - displacing an affect or behaviour from one person to whom it would be appropriate, to another person or object. - e.g. mother scolds the child and the child breaks a doll because the child dare not attack the mother. - seen in delinquency.

✔ **Identification** - a defence whereby a person takes on large aspects of another's personality including symptomatology - seen clinically where a bereaved person presents with a virtually identical symptom pattern to the deceased's terminal illness - also seen as part of normal growing-up "hero-worship" - seen in hysterics who unconsciously mimic another's symptoms.

Avoidance - a defence whereby the person does not attempt to attain or compete lest he or she fail and feel humiliated - may be seen in its most obvious form in the social phobias, e.g. of school or of other social settings

✔ **Magic undoing** - a defence against unacceptable aggressive thoughts and comprises a mental or physical ritual to ward off the effects of that aggression - seen among "normals" in superstitious acts - commonly seen in obsessional-compulsive neuroses, e.g. Lady Macbeth-like handwashing

✔ **Projection** - the attribution of one's own feelings or wishes to someone else, e.g. to feel persecuted by a boss whereas the hostility is one's own - the basis of paranoid states and paranoid personality disorder

✔ **Dissociation** - a defensive process whereby two or more mental processes co-exist without becoming integrated - the basis of hysterical fugues and hysterical dual personalities

✔ **Conversion** - a mental mechanism in which an emotional response to a stress is converted into a physical symptom which symbolises the conflict - the basis of conversion hysteria

✔ **Regression** - a return to earlier childlike mental states also seen in normal people under stress, e.g. battle conditions and coronary care units.

The mental mechanisms marked ✔ have clear clinical implications.

It is one of the objectives of Psychotherapy to enable a person to be more aware of his/her characteristic maladaptive mechanisms and to change in the direction of a more adaptive use of mechanisms.

Individual Psychotherapy in General Psychiatry

By far the greater part of basic psychodynamically informed psychotherapy is carried out on an individual basis in the course of consultations. Such psychotherapy is often referred to as supportive psychotherapy and is integral to the care of all patients, in psychiatry particularly those with psychotic disorders such as schizophrenia and mood disorders.

Where appropriate such a psychotherapeutic approach can be modified as the patient's clinical state changes or particular problems or issues become evident. The options then might be:

Counselling - for specific problems such as housing or financial difficulties or for alcohol problems.

Behaviour therapy - to learn techniques to cope better with anxiety, phobias, compulsions.

Cognitive therapy - to learn alternative styles of understanding themselves in relation to others and to perception of self and own past and future.

Family sessions - to understand the family dynamics affecting recovery, to involve the family in ongoing treatment and to facilitate any necessary change in the way the family handles the tensions which may have caused or contributed to a family member's illness.

Marital sessions - similar objectives to family sessions but involving only the spouse and the patient.

Psychodynamic work - readily integrated into supportive psychotherapy, such a shift in emphasis can help a patient understand their symptoms, anxieties in a personal context. Such understanding itself allays anxiety because the patient has a better grasp of themselves and it also points the way to personal change to reduce relapse.

Group work - may occur in whole ward groups or specific group sessions.

Specific Psychotherapies

For many patients with life stress, neurotic or personality difficulties direct referral for psychotherapy is more appropriate for assessment and a decision as to the appropriate form of psychotherapy.

Individual Psychotherapy

In the case of psychotherapy the range of therapy varies from 10 sessions of 50 minutes on a weekly basis through to psychoanalysis, i.e., 3-5 sessions (50 minutes) per week for 2-5 years.

Within that range, perhaps two-thirds of cases would be seen once weekly for 6-18 months. The setting would be that of the therapist and patient both seated in normal face-to-face style engaged in conversation with therapist using a non-directive technique, but employing transference interpretation.

Group Psychotherapy

Psychodynamic/psychoanalytical is often practised in a group setting - 6-8 patients with usually two therapists, meeting once per week for 1½ hours for a period usually of 18 months to 2 years generally on an outpatient basis. The style is again non-directive with the focus being on both transference and group verbal interaction interpretations.

Marital Therapy

Psychodynamic understanding can be applied to marital problems with the "patients" being either one or both partners in the marriage. Usually both partners are seen together by two co-therapists at approximately fortnightly intervals for an average of 6-10 sessions of 1-1½ hours.

Psychosexual therapy often is based on a combination of psychotherapy styles focused on the psychosexual problem of the patient or couple.

Family Therapy

Usually involves psychodynamic techniques applied to the natural group of the family - whether 2 or 3 generations. Most frequently used in Child and Family Psychiatry units.

Cognitive Analytic Therapy

Brief (12-20 sessions) therapy focused on target problem using elements of cognitive therapy and psychoanalysis.

Indications for Psychotherapy

By definition the indications for psychodynamic supportive psychotherapy are limitless but special attention may be drawn to:

- Bereavement reactions
- Reactions to illness in the patient or family
- Abortions - spontaneous or "therapeutic"
- Drinking problems

The indications and contra-indications for psychodynamic/psychoanalytic psychotherapy are much more specific, though as in any medical decision there has to be a judgement as to the relative weighting of any given feature.

Indications	Contra-indications
Neurotic disorder	Psychotic disorder
Psychosomatic disorders (some)	
Psychopathic personality	Mild to moderate personality disorder
Wanting to change both symptomatically and in personality function	Wanting doctor to just magic away disorder the symptoms
Capacity for sustained work	Impulsive - poor control e.g. frequent suicide attempts
Reasonably verbal and intelligent	Paranoid traits
Capacity for relating	Life-long entrenched attitude of pessimism
Generally supportive relationships	A fixed, impossible social setup
Some past indications of success	

The greater the weighting of positive indicators relative to contra-indicators the more likely is there to be a successful outcome to therapy.

A more comprehensive guide to referral is given later which gives some indication as to when preference might be given to a psychodynamic, a cognitive/ behavioural or a psychiatric referral.

Outcome of Psychotherapy

Accumulating research evidence is showing that appropriately selected patients treated by relevant variants of Psychotherapy administered by properly trained therapists with innately therapeutic personalities produce results considerably better than "spontaneous remission" rates as measured by indices of symptom relief, social adjustment (rated by self and peers) and better personality functioning.

A Guide to Psychotherapy Referral

Which therapy?

A	Long-term dynamic psychotherapy/psychoanalysis
B	Short-term dynamic psychotherapy
C	Short-term behavioural/cognitive therapy
D	Group therapy
E	Family therapy
F	Marital therapy
G	Crisis intervention
H	Crisis support
I	Psychiatric treatment
J	Long-term supportive therapy

What condition?

Longstanding mild/moderate personality disorder	A,B,D,J
Interpersonal problems	A,B,C,D
Neurotic symptomatology	A,B,C,D
Psychosomatic symptomatology (some)	A,B,C,D
Psychotic symptomatology	C,I
Actively psychotic	I
Transient stress-related disturbance	G,H,E,F
Marital problems	F,G,H

Which patient?

Reasonably intact, coping personality	A,B,C,D,G
Average or above average intelligence	A,B,C,D,G
Some past indicators of success	A,B,C,D,G
Psychologically-minded	A,B,D,G
Chaotic, non-coping person	E,F,H,I,J
Psychopathic/impulsive/frequent overdoses	H,I
Withdrawn, schizoid person	H,J
Paranoid, hostile, suspicious person	H,I,J

With what objectives?

To understand self and life problems in order to find better solutions	A,B,C,D,E,F
Motivated to make personal changes	A,B,D
To learn better coping strategies	C
To "get better" symptomatically only	C,I
To get over present crisis and cope as usual	G,H
To maintain nurturing relationship	J