Psychotherapy Theory, Research, Practice, Training
2010, Vol. 47, No. 4, 570–585

0033-3204/10/$12.00 DOI: 10.1037/a0021179

THERAPISTS' VIEW OF THERAPEUTIC ACTION IN PSYCHOANALYTIC PSYCHOTHERAPY WITH YOUNG ADULTS

PETER LILLIENGREN AND ANDRZEJ WERBART
Stockholm University, and Stockholm County Council, Stockholm, Sweden

Studying experienced therapists' implicit theorizing may contribute to our understanding of what is helpful and what hinders treatment with particular patient populations. In this study, 16 therapists' views of curative factors, hindering factors, and outcome were explored in 22 interviews conducted at termination of individual psychoanalytic psychotherapy with young adults. Grounded theory methodology was used to construct a tentative model of therapeutic action based on the therapists' implicit knowledge. The results indicated that developing a close, safe and trusting relationship was viewed as the core curative factor in interaction with the patient making positive experiences outside the therapy setting and the therapist challenging and developing the patient's thinking about the self. The therapeutic process was experienced as a joint activity resulting in the patient becoming a subject and acquiring an increasing capacity to think and process problems. The patient's fear about close relationships was seen as hindering treatment and leading to core problems remaining. The model is discussed in relation to major theories of therapeutic action in the psychoanalytic discourse and previous research focusing on young adults' view of curative and hindering factors in psychotherapy. Implications for practice and further research are suggested.

Keywords: psychoanalytic psychotherapy, therapeutic action, young adults, curative and hindering factors, grounded theory

A number of authors have argued that experienced therapists develop private "working models" or "implicit theories," which more or less overlap with their explicit theoretical orientation in how to conduct therapy (e.g., Kottler, 1986; Najavits, 1997; Sandler, 1983; Schön, 1983; Shoben, 1962). Implicit theories are a mix of personal experiences, formal training, and professional reflections and may include the therapist's personal strategies of what to do during sessions or views about what processes are occurring in therapy. They also may include assumptions regarding what not to do in therapy and what hinders treatment. According to Sandler (1983), past development of explicit theories arose when weaknesses in available theories led to the grad-

Peter Lilliengren, Department of Psychology, Stockholm University, and Södermalm Psychiatric Outpatient Services, Stockholm County Council, Stockholm, Sweden; and Andrzej Werbart, Department of Psychology, Stockholm University, and Child and Adolescent Psychiatry, Stockholm County Council, Stockholm, Sweden.

This study was a part of the prospective, longitudinal Young Adult Psychotherapy Project conducted at the Institute of Psychotherapy, Stockholm County Council, and the Psychotherapy Section, Department of Clinical Neuroscience, Karolinska Institutet. The project was supported by grants from the Bank of Sweden, the Tercentenary Foundation (RJ 1999-0071), the Clas Groschinsky Memorial Fund (SF6 51), and the Centre for Health Care Science, Karolinska Institutet. The project has been approved by the Regional Research Ethics Committee at the Karolinska Institutet, and all participants have given their informed consent.

Correspondence regarding this article should be addressed to Andrzej Werbart, PhD, Department of Psychology, Stockholm University, SE-106 91 Stockholm, Sweden. E-mail: andrzej@werbart.se or andrzej.werbart@sll.se

ual elucidation of implicit or "private" theories to complement them. Thus, therapists' implicit theories may occasionally be superior to explicit theories for particular cases—yet surprisingly few studies have explored experienced therapists' views of therapeutic action (cf. McLeod, 1990).

By theories of therapeutic action we simply mean more or less elaborated ideas of "what works" (and what does not work, or impedes) psychotherapy. In the psychoanalytic discourse, two major lines of thought relate therapeutic action to either "insight" or "relational impact" (Kernberg, 2007). The first approach emphasizes reconstruction and interpretation, especially of the transference; the second approach emphasizes the experiential and transactional aspects of a new and better relationship. Many theoreticians have suggested that both factors interact to produce change (Fonagy & Kächele, 2009; Gabbard & Westen, 2003). However, we know very little about how explicit theories are conveyed to clinical practice and adopted to particular patient populations. Nor do we know which private theories experienced therapists develop. Following Sandler (1983), studying how therapists' think in practice may contribute to the development of formal theory and might be especially fruitful when it comes to specific patient populations in which theory is lacking or regarded as incomplete.

One such area concerns young adult patients, a population whose level of psychological distress is disturbingly increasing in the Western world (Evans, 2009; Grant & Potenza, 2009; Swedish Government Official Reports, 2006). From a psychoanalytic perspective, the developmental tasks of young adulthood involve separation from the family of origin and a consolidation of ego capacities necessary for life and career decisions. When this consolidation has been only partially or unevenly achieved, the individual might experience psychological symptoms and seek treatment (Adatto, 1980; Arnett, 2000, 2007; Emde, 1985). According to the clinical literature (e.g., Barnett, 1971; Escoll, 1987; Jacobs, 1988; Pearls, 2008; Perelberg, 1993), the developmental tasks of young adults may conflict with the process of therapy. Young adults are usually in a transient life situation, action oriented rather than reflective, still in the process of separation from internal parental figures and occupied by conflicts regarding dependency and intimacy. Thus, the psychoanalytic therapist has to affirm real-life activities and strivings for independence, regulate distance in the therapeutic relationship, and be more flexible with the therapeutic frames.

However, there are no empirically derived recommendations for adaptation of procedures when working with young adults, and no generally agreed on theory of therapeutic action in the psychoanalytic discourse. Empirical study of experienced clinicians' implicit theorizing may contribute to our knowledge about what is helpful and what hinders the therapeutic process in specific patient populations and eventually lead to a more comprehensive theory of therapeutic action for psychoanalytic psychotherapy in general.

The aim of the present study thus is to explore experienced therapists' views of curative factors, hindering factors, and outcome in psychoanalytic therapy with young adults and to construct a tentative model of therapeutic action based on experienced therapists' implicit knowledge. The specific research questions are: What in treatment contributed to change and what hindered change, according to the therapists' view? What kind of changes do the therapists perceive in the patients? How are these factors interrelated from the viewpoint of the therapists?

Because therapist implicit theorizing is mainly uncharted territory, a qualitative interview-based and discovery-oriented approach is appropriate (Kvale, 1996). Further, for analyzing data and creating a "bottom-up" model of therapeutic action (i.e., starting from experienced therapists' implicit knowledge) an inductive method, such as grounded theory, is considered the method of choice (Rennie, 2002; Strauss & Corbin, 1998).

Method

Procedures

This study was conducted as a part of the Young Adult Psychotherapy Project (YAPP), a naturalistic, prospective, and longitudinal study of young adults (age 18 to 25 years) in psychoanalytic psychotherapy. A total of 134 self-referred patients between 1998 and 2002 were included in YAPP, 92 enrolled in individual psychotherapy and 42 in group therapy. The patients were treated by 34 individual therapists working at the Institute of Psychotherapy in Stockholm, where subsidized psychotherapy is provided for people with various psychological problems. The overall design and outcome of YAPP has been

described in detail elsewhere (Philips, Wennberg, Werbart, & Schubert, 2006).

The Treatments

The treatments were aimed at improving the patients' ability to manage developmental strains in young adulthood. The goals, duration, and frequency of psychotherapy were adjusted to the individual patient's needs and jointly formulated by the therapist and patient in a written contract at the start of therapy with an option to renegotiate. The therapists shared a psychoanalytical frame of reference despite working quite autonomously with varying preferences regarding theory and technique. All therapists met weekly in clinical teams in which treatment problems and clinical experiences were discussed. No manual was used.

Therapist Sample

The material for this study consisted of interviews with 16 therapists who treated 22 patients included in a previous study (Lilliengren & Werbart, 2005). The therapists were all senior, highly educated, and licensed specialists in psychoanalysis (seven) or psychoanalytic psychotherapy (nine) with extensive clinical experience and were engaged as instructors and supervisors in the Advanced Psychotherapy Training Program. The mean time in clinical practice after attaining their psychotherapy license was 11 years (range = 3 to 16, *SD* = 3.97). Four therapists were men and 12 were women, all of Scandinavian origin. As to their profession, two were physicians, seven were psychologists, and seven were social workers. Eleven therapists treated one patient each, four had two patients, and one had three patients. The interviews were conducted at termination of each individual therapy, thus providing 22 interview transcripts to analyze.

The Patients

The therapists treated 22 patients: three men (14%) and 19 women (86%). Their average age was 22.5 years (range = 19 to 25) at the start of therapy. Eight patients (36%) lived alone, five (23%) lived with their parents, and nine (41%) lived with a partner. None was married or had a child. The most common occupation was work, in 10 cases (45%) full-time, and in a further four in combination with studies (18%), followed by full-time study in eight cases (36%). None self-defined as unemployed. Sixteen patients (73%) were born in Sweden and had both parents of Swedish origin, a further two were born in Sweden with one parent having foreign origin (a Scandinavian country in one case and an Asian country in the other), and one additional patient was adopted as an infant from an Asian country by Swedish parents. Three patients were born abroad to non-Swedish parents (Scandinavia, Asia, and Latin America). In all, 17 patients (77%) had at least one parent with a university degree. Nine patients (41%) had previous outpatient or inpatient psychiatric contact (in four cases only on one occasion), and nine had previous psychotherapeutic contact.

Fourteen patients had at least one Axis I *Diagnostic and Statistical Manual of Mental Disease* diagnosis (4th ed., text revision, American Psychiatric Association, 2000): seven had a Mood Disorder (six with Major Depressive Disorder, one with Dysthymic Disorder), eight had an Anxiety Disorder (three with Anxiety Disorder Not Otherwise Specified (NOS) and one each with Panic Disorder with Agoraphobia, Social Phobia, Obsessive–Compulsive Disorder, Acute Stress Disorder, and Agoraphobia Without History of Panic), and two had an Adjustment Disorder. Seven patients (32%) had a personality disorder Axis II: one in Cluster A, two in Cluster B, and four with Personality Disorder NOS. Three patients had multiple Axis I diagnoses, and two had both Axis I and II diagnoses. The mean time in psychotherapy was 18.6 months (range = 7 to 32 months) with a frequency of one (12 cases) or two (10 cases) sessions weekly.

On the group level, the patients improved significantly on measures of symptoms and social functioning. The Global Symptom Index (GSI) of the Symptom Checklist–90 (Derogatis, 1994) decreased from a pretherapy level of 1.31 to 0.77 at termination, and the mean Global Assessment of Functioning (GAF; American Psychiatric Association, 2000) increased from a pretherapy level of 54.5 to 67.3 at termination. The 22 participants were deemed a representative sample of the entire YAPP patient group, as the demographic data and the pre- and posttherapy levels of self-reported and expert-rated symptoms and functioning were very close to the total percentages (Philips et al., 2006).

Interviews

The therapists were interviewed using the Private Theories Interview (PTI; Werbart & Levander, 2005, 2006). This semistructured, in-depth interview collects narratives on the following themes: problem formulations, ideas of background, ideas of cure, and descriptions of changes during and after therapy. It includes retrospective views about what in therapy contributed to change, what had been obstacles, and what could have been different. The informants were asked to elaborate their answers to these four main questions and to give concrete examples and illustrative episodes. The interviews were carried out by five psychologists trained in the PTI technique of "bracketing" their own understanding and to maintain an attitude resembling that of a social anthropologist rather than a clinician. The audiorecorded interviews lasted about 60 min and were transcribed verbatim.

Data Analysis

The interview transcripts were analyzed with basic grounded theory methodology, involving open, axial, and selective coding (Strauss & Corbin, 1998). A computer software interface known as ATLAS.ti (2000) was used in the coding process. In ATLAS.ti the links between transcripts, codes, categories, and memos are retained throughout the analysis making it possible to move back and forth between coding, elaborating the categories, writing memos, and building the conceptual model. The work process is described in detail below, and a graphical illustration of the coding process is provided in Figure 1.

Open coding. Each interview transcript was imported one at a time into ATLAS.ti and read, line by line. All sections and paragraphs reporting the therapist's reflections on the therapy process, perceived changes, helpful, or hindering treatment aspects were assigned open codes describing the content of the narrative. Code memos were written describing the properties and dimensions of each code in further detail as more statements were added to each code. The networking function of ATLAS.ti was continually used to sort codes that seemed closely related in meaning, theme, or content and to group codes into categories (e.g., code families).

Axial coding. As distinct categories emerged during open coding, a process of examining the

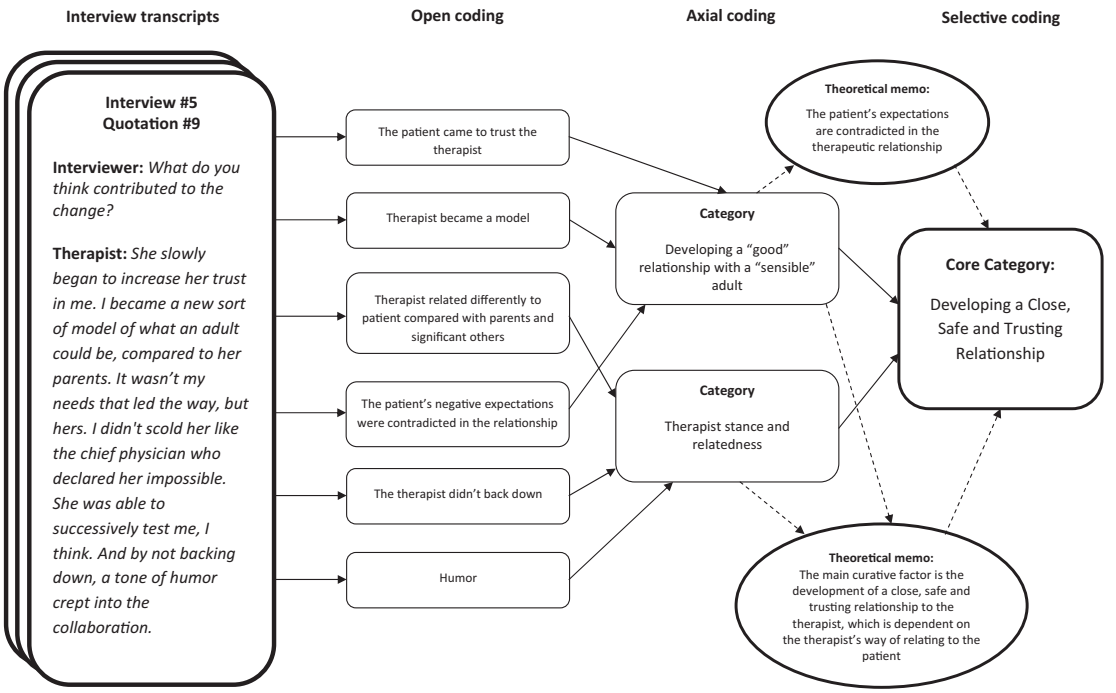

FIGURE 1. Data analysis: Steps from interview transcripts to core category.

relationship among the categories was initiated. The categories were compared with each other, revised and elaborated, and subthemes and relations were identified. In an effort to bracket prior knowledge, theoretical memos were written throughout the process, including notes on the coder's associations with established theoretical constructs. Questions about the relationships between categories were taken back to the original transcripts to explore the context in which the informants discussed their experiences. When 16 interview transcripts (one with each therapist) had been coded, the remaining six available transcripts were imported into ATLAS.ti and analyzed. No new codes, categories, or relations could be identified, that is, the open and axial coding process had reached the saturation point. The remaining six interviews were used to further deepen codes and categories.

Selective coding. The aim of this process was to integrate and refine the emerging conceptual model based on the categories and their relationships. As the open and axial coding progressed, the networking function of ATLAS.ti was used to visually connect categories into diagrams outlining their relationships. Theoretical memos were examined for integrating ideas about the overall structure of the model. A core category was selected that explained the main curative process in the material while being related to all other main categories. Furthermore, several linking concepts, based on the codes that emerged during the axial coding, were used to describe processes taking place between the categories in the model. Finally, the conceptual model was assembled using graphical software tools.

Inviting the Participants

Once the main coding was completed, the interviewed therapists were invited to discuss the results. Four of the 16 therapists (two men and two women) participated (two failed to show up, seven had retired, three were deceased). The preliminary results were presented, and the therapists were asked to reflect if anything seemed odd or missing. The 1.5-hr long meeting was audiorecorded and field notes were integrated into the coding process. Overall, the therapists had little to add, and only minor changes were made in the descriptions of the categories and the conceptual model.

Owning Our Perspective

The main coding was carried out by the first author (a 35-year-old male psychologist working at a psychiatric outpatient clinic). At the time of the study he recently began postgraduate training in psychodynamic psychotherapy at Stockholm University. He has a special interest in psychotherapy integration and is a member of the Society for the Exploration of Psychotherapy Integration. During selective coding the second author (a senior male psychoanalyst, member of the International Psychoanalytical Association and the Society for Psychotherapy Research) reviewed all codes and theoretical memos and collaborated in refining the model. Differences in opinions were discussed in relation to data in the original transcripts until agreement was reached. On the basis of these audits the model was deemed grounded.

Results

The conceptual model is presented in Figure 2. The model consists of a core category with three subcategories, seven main categories, and seven linking concepts. Curative factors are represented as solid-line rectangles. The only hindering factor in the model is represented as a dashed-line rectangle. The model further includes four overlapping outcome categories, of which three are positive (represented as ellipses) and one negative (represented as a star). The linking concepts indicate a process that connects two or more categories and are placed in italics directly on the lines between categories. Dashed lines indicate a negative influence between categories, and direct lines indicate a positive influence. The categories and linking concepts are further elaborated below and illustrated by verbatim quotations from the interview transcripts (numbers in brackets in the headings below refer to the numbering system of the categories in Figure 2).

Developing a Close, Safe, and Trusting Relationship [1]

From the therapists' view, the core curative factor is the development of a special kind of relationship characterized by the patient gradually experiencing closeness, safety, and trust in relation to the therapist: "That we have somehow

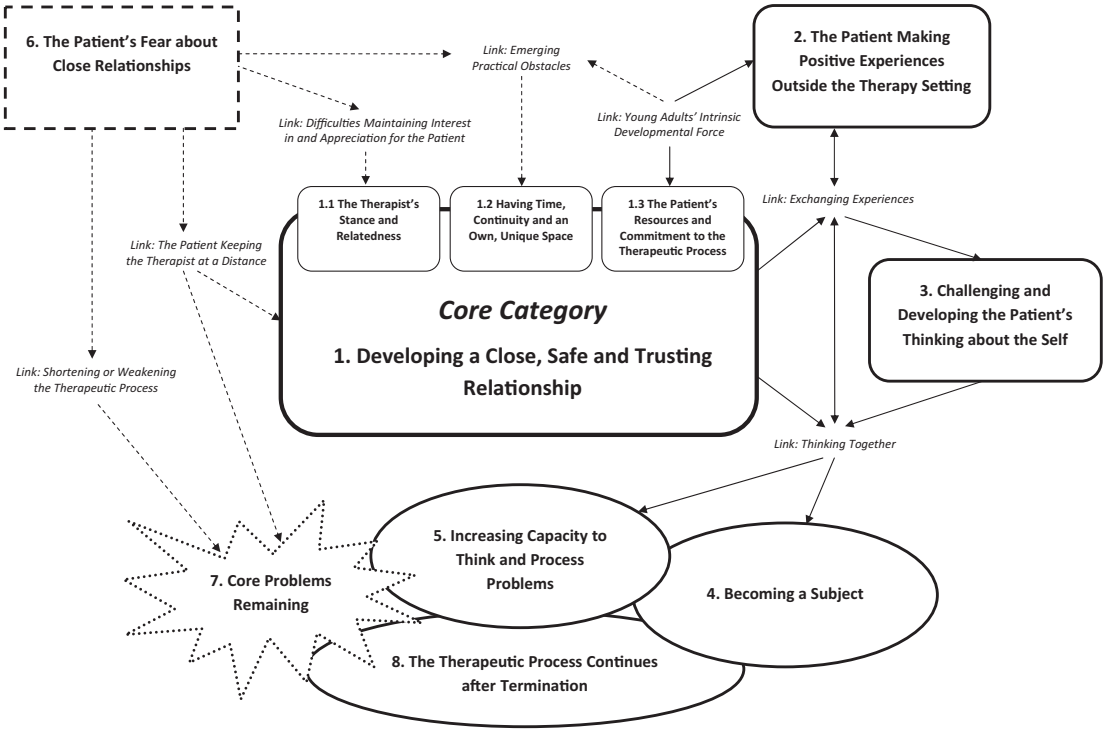

FIGURE 2. A tentative theoretical model of therapeutic action grounded in the therapists' views. Curative factors are indicated by solid line rectangles with rounded corners, the hindering factor by a dashed-line rectangle, positive outcome categories by ellipses, and negative outcome by a dashed-line star. The linking concepts are placed in italics directly on the lines between categories. Dashed lines indicate a negative influence between categories and direct lines indicate a positive influence.

developed a close relationship where she's developed trust in me."

As the patient becomes attached to the therapist, he or she is able to express feelings more openly and talk about difficult and painful subjects.

> It's about daring to connect, to begin trusting someone. To begin to feel that she can come here and open up about something that feels frightening and threatening to her . . . . It's about daring to be dependent and to permit closeness, of which she has had little positive experience.

When the patient dares to open up it creates an opportunity to test and revise inner conceptions of self and others. This can take place openly in dialogue with the therapist or implicitly in the interaction between the patient and therapist. From the therapists' view, it is central that the patients' negative expectations are contradicted in the relationship. What the patient believes will happen when he or she depends on the therapist, shows strong feelings or talks about sensitive topics—does not happen: "There's also a thread I perceive running though this therapy . . . that the things she believes will happen do not take place while discussing things with me."

The development of a close, safe, and trusting relationship was dependent on three factors that formed subcategories to the core category, specified below.

The therapist's stance and relatedness [1.1]. This subcategory was constructed from the therapists' view of how their way of relating contributed to the development of a close, safe, and trusting relationship. One recurrent theme was adopting a stance of genuine interest in the patient.

> I liked this girl. I thought it was pretty fun, even a bit exciting, every time she arrived and talked about what had happened, what she had thought about since the last session, and I believe that this has been a positive, contributing factor.

Closely connected to interest and engagement were reports of the therapists accepting thoughts and feelings that the patients had difficulty accepting in themselves. The therapists actively "gave permission" and "showed acceptance" for

feeling and thinking in ways previously perceived as forbidden by the patient: "I believe that one contributing factor has been the feeling that it's OK to feel some particular thing and one can live with it."

Another aspect of the therapists' stance was a readiness to be flexible with the boundaries of the therapy. They sometimes adjusted the contract to fit the needs of the patient, especially when patients signaled that they wanted to increase the number of sessions per week or extend the contract: "I believe that it took her a long time to trust me and that might have come about when she noticed that I understood that she was unhappy and I gave her the gift of continuing for another term."

In addition, the therapists found it important that the patient perceived them as confident, experienced, and stable persons, ready to listen and not backing down from difficult issues.

> I think I won confidence when I didn't back away from anything once she began talking about it, nor did I ever allow her the chance to flee from it. Even if she tried to talk about something else, I always made sure that we took up the topic, even at the final conversation. I believe that it was especially important that she saw that I was not afraid of it, but was instead ready to listen.

Another aspect of being a confident and stable therapist was to "keep one's cool" and not react in a retaliatory manner if the patient was critical toward the therapist or the treatment. It was important to not allow the patient to "destroy" the therapy by being aggressive and attacking the therapist.

> It was significant that I was present, listened, and remained sitting during her . . . rather strong attacks against me personally and the method, that I didn't declare that this had become pointless, or tell her to be quiet or some such thing; that I did not allow her to sabotage the therapy, as she was trying to do.

An overarching theme was that the therapists regarded their way of relating to the patient as markedly different from important figures in the past. The therapists showed engagement and interest in the patient, accepted difficult thoughts and feelings, were flexible in meeting the patients' needs for relatedness, did not retaliate in the face of criticism and were ready to listen and talk about difficult issues in ways that the therapists believed that no adult had ever related to the patient before: "It was in therapy that I think she met, in me, the first sensible adult in her life."

Having time, continuity, and an own, unique space [1.2]. In this subcategory the therapist's narratives indicated that time and continuity contributed to the development of trust and the patients daring to open up: "I believe the regularity and continuity has contributed to her daring to be dependent."

The narratives also suggested that it was important that the patient came to experience the therapy as "an own, unique space," an opportunity to "unload" with someone, and that the therapeutic relationship was associated with feelings of "exclusiveness": "I've thought that she has been given a space to talk about herself; that it has been her own space. There has been a place here for her to talk about things."

The patient's resources and commitment to the therapeutic process [1.3]. This subcategory emerged from the therapist's views of how the patients' resources and commitment to the therapeutic process contributed to the development of a close, safe, and trusting relationship. One aspect was the patients' aptitude and capacity to reflect as well as their general interest, curiosity, and positive expectations about therapy: "I feel she's a quite gifted girl, actually. I believe that she had a strong curiosity and desire to make use of this situation."

The therapists further emphasized the patients' commitment to the therapeutic process, the patients' courage to be honest and "open up," as well as having a genuine wish to understand themselves and a readiness to "make an effort" in the therapeutic process: "Her loyalty and commitment . . . . There is a striving toward honesty in her. A real striving toward honesty that I have appreciated and believe has greatly contributed . . . . That she has moved toward our relationship."

Linking Concept—Young Adults' Intrinsic Developmental Force

This concept links the patients' resources and commitment to the therapeutic process with the patients making positive experiences outside the therapy setting. The therapists described young adulthood as a period of restructuring identity, contributing positively to the patients' curiosity in themselves and motivation for engaging in therapy. Furthermore, the young adults are about to enter the adult world, which involves facing new situations and trying out different relationships, jobs, education, and so forth outside the therapy office. The therapists' narratives sug-

gested that they viewed this "developmental force" as intrinsic to being a young adult and as a positive contributor to the therapeutic process: "She is young, of course, so there is naturally a sort of forward-moving energy that is inherent in this inner developmental need."

However, this concept is also linked to Emerging Practical Obstacles indicating a potential negative influence. Because patients in this age group tend to be mobile, for example, changing jobs or moving away to study, this could sometimes lead to practical problems maintaining continuity in the relationship with the therapist: "She changed residence a lot at the beginning, living first with one person, then another. She did not have a fixed address. I think this went on throughout the first year, and I mentioned this to her as a problem."

The Patient Making Positive Experiences Outside the Therapy Setting [2]

A second curative factor emerged from the therapists' statements regarding the influence of the patients' activity outside the therapy office. The therapists mention several areas such as work, education, relationships, traveling, and so forth in which the new experiences affected their patients positively during the treatment period. Several therapists mentioned their patient took actions during therapy that led to an opportunity to challenge core problems and thereby gained experiences that contradicted negative beliefs about themselves.

When she began going to school, she discovered that she had hitherto untapped resources . . . and it was a great help to her. This has increased her self-confidence enormously. She has had very low self-confidence.

Challenging and Developing the Patient's Thinking About the Self [3]

The third curative factor concerned the therapist's interventions. One general aspect was that the interventions often targeted the patients' thinking. Several therapists mentioned this "cognitive" direction in their work explicitly: "I've tried to put interpretations on a cognitive level, or what could also be called an acceptable level. He has them as his own explanations."

A recurrent theme was challenging the patients' thinking about their own participation in their problems. The therapists often aimed at breaking the patients' passivity and victimized stance toward experiences in the past, problematic interactions in the present and life in general. The therapists generally described themselves as active and sometimes directly confrontational: "I believe I very quickly aimed to get her to own up to herself; that is to say, that she is a participant in both life and in whatever happens to her."

The therapists' also viewed their interventions as a way of creating new meaning or understanding. By labeling thoughts and feelings, making connections, pointing out patterns, and offering interpretations, the therapist helped the patient gain new and different perspectives on their problems. From the therapists' view, this new meaning had a "supportive" or "containing" function for the patient. In some cases a specific interpretation could lead to the patient feeling calmer or that a symptom completely disappeared: "His having received explanations, or hypotheses, if you will, had a calming effect on him."

Another theme concerned techniques the therapists omitted. Several therapists expressed that they had worked relatively less with transference interpretations than they normally would: "Generally, I'd say that I worked rather little with transference, what it's like to be sitting with a woman, what she thought about me and so on."

Linking Concepts—Exchanging Experiences and Thinking Together

Two linking concepts connect the three curative categories in the model. Exchanging experiences refers to the reciprocal exchange between the patients' activity, the therapeutic relationship and the therapists' interventions. As the patients talked about experiences outside the therapy setting, these experiences became "material" that could be elaborated by the therapist to reach further understanding.

Various events in his external world have . . . caused him to reflect and process. . . . But it is only once he begins to work with them during therapy that I feel he works constructively, so it's a combination of both life and therapy.

Furthermore, the patients' experience of the relationship with the therapist and the therapeutic process became important experiences in themselves leading to the patient daring to try out new situations outside the therapy office: "She now dares to be more open with her colleagues, initi-

ating contact. She dares to apply what she met here."

Thinking together embraces the therapists' experience of the therapeutic process and suggests that they felt a sense of "togetherness," in which the close, safe, and trusting relationship developed in parallel with the active exploration of the patient's experiences. From the therapists' view, this joint process led to the development of the patients' own capacity to think: "I don't think we worked in any particular way other than that we just thought and tried to think together. . . . I believe that this has helped to jump-start her own thinking abilities."

The therapists' narratives suggested that they further believe that this joint process has "left traces" when the patients identified themselves with the therapist's way of thinking and relating. The therapist became a new and "good object" that differed from the patients' inner representations of their parents and a better model of what it means to be an adult: "I have been straightforward and direct in a way that is evidently quite different from what she is used to."

Becoming a Subject [4]

The therapists' narratives suggested that the therapy had helped the patients establish themselves as "subjects" in the interpersonal world. One theme in this category was the therapists' experience that the patients became more open in relation to others and able to talk about their own inner world of thoughts, feelings, and values. At the same time the patients also developed clearer boundaries and handled conflicts more directly when needed. Further, the therapists felt that the patients reached a more healthy balance between dependence and independence, which was associated with improvements in the patients' ongoing relationships with friends, coworkers, and so forth.

She worked very hard during therapy to try to find her own voice, to try to be her own subject. It's become apparent in all of her relationships, particularly with her boyfriend . . . she has truly striven more to maintain her autonomy in such a close relationship.

Another important aspect of becoming a subject was changes in relation to the patients' parents. The therapists felt that the patients had increased the "psychological distance" from their parents and gradually reached their own values and goals in life. This was associated with problems in relation to the parents becoming less pronounced.

I believe that she has been able to find her own style, her own life, and has created considerable distance from both parents. She's done this internally . . . . I think it is pretty nice that she has even been able to accept that her father is as he is and that she cannot reform him.

A further theme was positive changes in the patients' view of themselves. The therapists' impression was that many patients gained greater acceptance of themselves and greater trust in their own abilities. The patients are depicted as being more confident and pleased with themselves, taking better care of themselves, making less destructive choices, standing up for their values, and taking greater responsibility for themselves, and their own issues.

She was flourishing. She said that she had found tools for taking better care of herself and not prioritising everyone else. She is taking care of her inner child, which is something we discussed a lot. I feel we separated in a way I found quite satisfying.

Increasing Capacity To Think and Process Problems [5]

According to the therapists' view, thinking together in the context of the therapeutic relationship promoted a "holding capacity" that made the patient better able to reflect and process problems rather than act out destructively: "I think that words have a very containing capacity . . . . So I believe that she has received an increased ability to contain herself, to reflect instead of merely reacting."

This category includes narratives that indicated that the patients had become more aware of themselves and their problems, or had gained "insight," and that the therapist observed that the patient's symptoms decreased. As the patients gain more self-knowledge in the therapeutic process, their problems become clearer, identifiable as they emerged, and "thinkable." The patients can use their increased capacity to think and process to try out new ways of relating, which leads to symptom reduction.

The problems have been made visible. They can be thought through. They can be lifted out of the diffuse and anxious and defined instead as emotions, oversensitivity, and sensibilities; in other words, defined as aspects of her ego and linked to the understanding she has in her own baggage that she has to carry throughout life.

The Patient's Fear About Close Relationships [6]

Practically all of the therapists' narratives concerning hindering aspects in therapy had to do with the patients' fears about establishing a close relationship with the therapist and engaging in the therapeutic process. For example, the fear could concern feeling dependent in relation to the therapists: "I believe it is somewhat . . . difficult for her to be a patient. To be dependent on someone. To be the one who needs."

Another recurrent theme was that therapists perceived some patients as afraid to "go deeply" into their own experiences. Further narratives suggested that some patients had difficulties in trusting the therapist as a benevolent person or had difficulties discussing their fantasies concerning the therapist and/or the therapeutic relationship: "There has been a fear of getting close to me on a deeper or emotional level, to dare explore what I was sitting there and thinking about her and to generally dare have fantasies about me."

Some narratives indicated that the therapist tried to discuss how the patients' fears hindered the treatment process. Other narratives suggested that the therapists sometimes deliberately avoided bringing the patients' fears into focus because there would not be enough time to work through them before the termination of the therapy.

I've thought that I should have challenged her more; interpreted her fear or anxiety about approaching me and having thoughts about me. It may possibly have worked and paid off. I may have regrets now, but a satisfactory termination is always a sort of balancing act; to not enter into a process that should have required continuing a few more years.

Linking Concept—Emerging Practical Obstacles

The therapists described several pathways on which the patients' fears of close relationships hindered the therapeutic process, illustrated by several linking concepts in the model. One way was related to practical obstacles emerging during treatment. For example, some patients had difficulties making room for the therapy sessions in their life, canceled sessions due to their work or school situation, or repeatedly missed sessions due to sickness, which had a negative influence on the continuity of the therapeutic relationship.

She was absent a lot during therapy, thus I have to say that it was hard to have any depth. At least this showed itself on the manifest level in that she found it very difficult to get away from her new job. There were training courses and business trips, and then she was often ill.

Some narratives suggest that the therapists tended to interpret practical obstacles as having to do with patients' fear of closeness with the therapist or commitment to therapy. Other narratives indicate, as mentioned previously, that practical obstacles where related to the patients' development as young adults.

Linking Concept—Difficulties Maintaining Interest and Appreciation for the Patient

The therapists' narratives suggested that the patients' fears of closeness had a negative influence on the therapists' stance and relatedness. The patients' distancing sometimes evoked difficult feelings or "countertransference," such as feelings of irritation and tiredness. The therapists experienced that they had to "struggle and work hard" to maintain an interest in and appreciation for the patient and to keep their stance: "I felt dragged into some pit and sometimes had to work my way back out in order to feel able to contribute something back. There were powerful forces here under the surface."

Some narratives suggested that the therapists' reaction was brought up in therapy and that it could promote the therapeutic process.

I sometimes grew rather tired of her, because she babbled and was superficial and guarded herself behind a mass of words . . . . Initially, she was extremely superficial and defensive, but later she was able to relate how scared to death she was. . . . So I think we did some good work together, both she and I.

Linking Concept—Keeping the Therapist at a Distance

The therapists perceived that some patients used irony or direct criticism as a way of keeping the therapist away. Other patients talked in a distancing tone or "used words as a barrier" in relation to the therapist. This could lead to the therapist feeling "left out" and having trouble getting a clear picture of the problems the patients were struggling with.

She kept me a bit at arm's length. You could say that, although it did get better and better. She showed a bit of irony . . . . I have a feeling that there was quite a lot I never got to know.

Linking Concept—Shortening or Weakening the Therapeutic Process

In some cases the therapy became too short or too low intensity, according to the therapists. This was typically due to the patient deciding to terminate the therapy or rejecting the therapist's suggestion that they should increase the frequency of sessions. A recurrent theme is therapist belief that some patients could have benefited from longer treatment, but their need to keep a distance prevented this.

I believe that she would actually benefit from longer therapy, but I do not think she is currently ready for it. I would be happy to hear that she was willing to continue. But I do not think that she is . . . she has been keeping me a bit at arm's length.

Core Problems Remaining [7]

This category emerged from the therapists' narratives about less satisfying outcomes. None of the therapists believed that therapy had any negative consequences for any patient, but some acknowledged that core problems remained largely unchanged. In these cases the therapists reflected that the patients had retained their "character structure," including characterological defenses, certain symptoms, or difficulties in affect or self regulation. Typically, however, there is ambivalence in these narratives. In parallel to recognition of unchanged problems, there is also a conviction that "something has changed": "The problems are still there, even though some progress has been made during this time. She still has poor self-confidence and performance anxiety."

When the therapists felt that something has changed, even though the core problems remained, they tended to emphasize that the patients have become "more aware" of themselves and their problems. Furthermore, the increased awareness has lead to the problems being more "nuanced" or "shifting."

She still has some compulsive thoughts and even some behaviors. She is very much aware of these and realizes that she ties her feelings into her actions . . . . These remain, and she is very aware of it, but it's faded in comparison with before.

A recurrent theme was also the therapists' conviction that some of the patients would have needed a longer or intensified treatment to further improve and for changes to become stable and lasting.

I wish that she would have stayed in therapy a bit longer, that we could have worked through these new skills in another way. Had we done that, I would feel more secure that these would last.

The Therapeutic Process Continues After Termination [8]

This last category indicates that, from the therapists' view, the therapeutic process did not really end with the last session. After termination the patient continues to process problems as he or she goes on with "life itself." A recurrent theme in this category is the therapists' belief that the patients are "on the right track" or "better equipped" after therapy, but that some issues remain. These issues typically involve challenges that the therapists suppose the patient needs to face and that cannot be solved in the therapy office.

Then I remember that this is a young person. There is a lot that she needs to face out in reality . . . . I believe the therapy has built a base for her questioning and going onward. . . . To continue the work begun here.

Discussion

Advantages and Limitations of the Method Employed

Although qualitative methodology has the advantage of being close to the individual narrative, it is more open to researcher subjectivity. This is reduced through "bracketing" of existing theory and one's own values (Elliott, Fischer, & Rennie, 1999; Malterud, 2001) and through carefully following formalized qualitative methodology, such as grounded theory. Owing to the overall design of the YAPP, however, some deviations from strict grounded theory methodology had to be accepted. The semistructured interview manual was constructed in advance, and interviewers other than the researchers themselves were trained to conduct the interviews. This potentially limited researcher sensitivity to the data. Further, there was no continuous sampling to deepen categories by conducting new interviews, as recommended by Strauss and Corbin (1998). However, the 22 available interviews contained enough data to reach a saturation point in the analysis (Rennie, Phillips, & Quartaro, 1988). To deepen the categories, as well as to validate the results and reduce researcher subjectivity, feedback from four informants was integrated in the coding process.

The 16 therapists were all highly trained clinicians with extensive experience in treating young adults with psychoanalytic psychotherapy. However, all the therapists worked at the same workplace and were involved in the same research project. Furthermore, information about the therapists' official theoretical orientation is lacking. This limits the model's "explanatory power" (e.g., the ability to explain phenomena and processes likely to occur in the situation studied, as experienced by the participants involved) concerning how other therapists in other countries or cultures experience working with young adults. On the other hand the therapist sample represented expert clinicians with some range of theoretical and technical preferences within the psychoanalytic frame. It could be argued that their implicit knowledge, as made explicit in the conceptual model, can be applied across a variety of similar settings.

Main Findings in Relation to Psychoanalytic Theories of Change

The core curative factor from the therapists' view was the development of a close, safe, and trusting relationship enabling the patient to gradually open up and talk about dangerous or forbidden thoughts and feelings. This provided an opportunity to discover, test, and revise inner representations of self and others in the interaction with the therapist. The therapists stressed the importance of the patient's negative expectations, dictated by past experiences, being contradicted in the relationship with the therapist. The relationship thus became a new experience, which was regarded as curative in itself.

The idea that therapeutic action takes place in the interaction between the patient and the therapist has a long tradition in psychoanalytic discourse. Often a developmental metaphor is used in which the therapeutic relationship is viewed as recreating a parent–child relationship with the aim to repair deficits (Mayes & Spencer, 1994). Traditional examples of theories following this line involve the creation of a "new-object relationship" (Bibring, 1937), corrective emotional experience (Alexander, 1946), introjection of the therapist's containing function (Rosenfeld, 1972), and self-object internalization (Kohut, 1984). Recent attempts to understand therapeutic action also come from research on child development that highlights the establishment of an attachment relationship and the mutual regulation of affective experience (Bowlby, 1988; Schore, 2003; Stern et al., 1998). According to Wallin (2007, p. 2), psychotherapy is the "transformation of self through relationship" in which the patient's attachment to the therapist is foundational because it supplies the secure base necessary for exploration, development, and change. In this study, the informants' implicit ideas of therapeutic action seem close to this view.

From the therapists' view the development of a close, safe, and trusting relationship was dependent on their stance and relatedness. This involved an attitude of genuine interest and acceptance, being flexible with the boundaries of the therapy, and being perceived as a confident, stable adult ready to listen and talk about difficult or painful issues, and who does not retaliate or abandon if the patient is critical. One interpretation is that the therapists stressed the impact of the "real relationship" (Greenson & Wexler, 1969) rather than the development and resolution of a "transference neurosis" (Gill, 1954). In fact, there were few references to interpretation of the transference, often emphasized in the psychoanalytic literature as a curative agent. Rather, when transference work was discussed in the interviews, it was typically brought up as something the informant did not work with as much as usual. According to Jacobs (1988) young adults might not want to be caught up in transference feelings that pull them back in time in threatening ways. It is possible that the therapists noticed this aversion and avoided transference interpretations. Another possibility is that the model reflects an implicit theory that emphasizes the therapist being a trustworthy attachment figure who relates in a new way to the troubled young adult coming to therapy with a history of bad experiences in attachment relationships.

The results further indicate that the development of a curative relationship needs time and continuity and is dependent on the patient's resources and commitment to the therapeutic process. We find it interesting that the informants seem to experience some ambivalence concerning the patients being young adults in this regard. The "intrinsic developmental force" of young adulthood is viewed as a positive motivational factor, but the young adults' mobility and activity also places strains on the continuity of therapy. When practical obstacles emerged, the therapists' implicit theory might lead them to interpret these

as resistance and fears of closeness or as an expression of the patients' natural development as young adults.

In addition to the development of the therapeutic relationship, the model includes two other curative factors: Patients making positive experiences outside of therapy, and the therapists' efforts at developing the patients' thinking about the self. Further, the therapists stressed the continuous exchange of experiences between the therapeutic relationship, the patients' daily life, and the therapists' interventions. This was experienced as thinking together and could be interpreted as an implicit description of working through, a concept that has been given surprisingly little attention in the psychoanalytic literature (Fonagy & Kächele, 2009). Some classical psychoanalytic theorists, including Freud (1914), emphasized the working through of repetitions that evolve in the transference. In this study the therapists stressed the here-and-now and orientation toward reality and the future rather than toward stimulating regression to activate unconscious developmental arrests in the therapeutic relationship. The therapists' implicit theory of therapeutic action seems to combine extratransference interpretations with a corrective therapeutic relationship and testing of newly acquired capacities in the real world. This is also in line with recent relational theorizing (e.g., Frank, 1999) challenging the traditional tendency to equate all action with acting out. However, there is also evidence of ambivalence in this regard, represented in the model by the link between the intrinsic developmental force and practical obstacles. Sometimes, the actions taken by patients are interpreted as an indication of acting out, which interferes with the establishment of a curative relationship.

Turning to the therapists' view of outcome, the model states that the process of thinking together changes the patients' characteristic way of relating to self and others. The category becoming a subject corresponds to the psychoanalytic concept of structural change and indicates a resolution of the developmental crisis around identity versus role confusion described by Erikson (1959, 1968). Becoming a subject is a broader concept, however, involving the development of a more positive self-image, increased self-acceptance, and a capacity for self-care (Benjamin, 2003), as well as a sense of personal agency and responsibility (Schafer, 1983). Further, it involves an increased psychological distance from inner parents, and an improved ability to invest in close relationships managing the dialectics of self-definition and relatedness (Blatt, 2008). This was mainly achieved, according to the therapists' view, through the patient's identification with the therapist's benevolent stance and mature relatedness, which differs from the patient's internalized parents. This indicates a possible implicit idealization of the therapist as a new object and overvaluation of the real relationship.

From the therapists' view, the process of thinking together also increased the young adults' capacity to think and process problems. The therapists' narratives often contained direct reference to established psychoanalytic concepts such as developing a containing function, holding capacity, or ego-strength. We find it interesting that this category also included narratives referring to insight, which is generally considered to be the primary mode of the therapeutic action in psychoanalytic psychotherapy (Fonagy & Kächele, 2009). In the therapists' view, however, insight was mainly viewed as an outcome variable rather than a curative factor in itself. The therapists' implicit notion is thus more in accordance with the relational, intersubjective view of insight "as a product of the therapeutic collaboration that emerges organically in both patient and therapist after an authentic and reliable relationship is established between them" (Messer & McWilliams, 2007, p. 16). This view is also evident in the therapists' narratives concerning less satisfying outcomes. Here, the therapists noted that the patient might have gained some insight in therapy but that their core problems remained unchanged because there was no establishment of a close, safe, and trusting relationship.

Main Findings in Relation to Patients' View

In a previous study, young adults' view of curative and hindering factors in psychoanalytic psychotherapy was explored with similar methodology (Lilliengren & Werbart, 2005). The starting point was the same actual therapies as in the present study. In general, the results greatly overlap when it comes to curative factors in therapy. The model based on the patients' view indicated that talking about oneself, having a special place and relationship, and exploring together with the therapist were perceived as cur-

ative factors leading to therapeutic impacts such as new relational experiences and expanding self-awareness. Thus, the patients and therapists both stressed the importance of establishing a special kind of relationship enabling the patients to talk openly about their inner experiences. Furthermore, both viewed the therapeutic relationship as a curative experience in itself and valued the joint process of working together to expand the patients' self-understanding and self-definition.

However, when it comes to hindering factors in therapy, there is an interesting divergence between the two studies. In the model based on the patients' view, patients typically experienced the therapists' relative passivity as hindering and wanted more direction, guidance, and focus on between-session activities. In addition, disappointed patients typically considered changing therapist or treatment modality (e.g., switching to Cognitive–Behavioral Therapy or medication). In the present study the therapists regarded the patients' avoidance of closeness with the therapist as the main hindering factor, in some cases leading to a blocked therapeutic process. Typically, the therapists regarded longer or more intense treatment as a solution. Of course, switching treatment is sometimes warranted, and more time or intensity in therapy might lead to a resolution. However, when comparing the models it seems sadly obvious that therapists and patients occasionally became caught in a "vicious circle" (Wachtel, 1997) of "blaming the other" for nonprogress in therapy. More important, both parties have their own, often incompatible, implicit theories regarding what the problem in therapy is and what is needed to change it.

Conclusions and Implications

The analysis of experienced therapists' view of therapeutic action in psychoanalytic psychotherapy with young adults resulted in a complex model reflecting a general relational point of view in the psychoanalytic discourse. The model places the development of a close, safe, and trusting "real" attachment relationship at the heart of change. There is an emphasis on new experiences, both in the context of the therapeutic relationship and in the patients' life outside the therapy setting. Also, cognitive elaboration aimed at developing the patients' thinking about the self is emphasized, whereas transference interpretations are generally toned down. The model further suggests a future- and reality-oriented approach, working in the here-and-now, to strengthen the young adults' active participation in their life. The therapeutic process is experienced as a joint activity resulting in the patient becoming a subject and requiring an increased capacity to think and process problems. One implication for further research is that the nature of the young adults' attachment to the therapist might be an important mediator enabling the therapeutic process to unfold.

Accordingly, the model also suggests that young adult patients' fears of closeness might hinder the therapeutic process. Because the establishment of an attachment relationship is considered the core curative agent, it is logical that patients having difficulties in this regard might present a special challenge for the therapist. However, the developmental phase of young adulthood might itself interfere with this process, requiring more flexibility than usual on the therapist's part. Considering that young adulthood involves a general striving toward individuation, entering a close relationship with an adult roughly in the same age group as one's parents might evoke considerable stress. Avoidance of closeness and dependency might be a natural tendency in young adulthood and should not automatically be interpreted as avoidance of the therapeutic work.

The notion of the patients' fears of closeness hindering the treatment should also be interpreted with caution when it comes to direction of causality. Comparing the therapists-based model with young adult patients' views indicates that therapists and patients might sometimes become caught in a vicious circle, blaming each other when therapeutic hopes are not met. A clinical implication of this is that therapists need to be wary of their own reactions when experiencing that a young adult patient is keeping a distance in the therapeutic relationship. Distancing might signal that some aspects of the therapeutic collaboration need exploration. Our results indicate that both therapists and patients have their own ideas as to the problem and its possible solution; however, their ideas are mostly incompatible. Therapists may need to address the patient's fear of closeness, but also to reflect on their own contribution to the coconstruction of hindrances and actively invite the patient's perspective to foster a collaborative therapeutic relationship.

References

ADATTO, C. P. (1980). Late adolescence to early adulthood. In S. G. Greenspan & G. H. Pollock (Eds.), *The course of life: Psychoanalytic contributions towards understanding personality development: Vol. 2. Latency, adolescence and youth.* (pp. 463–476). Adelphi, MD: NIMH, Mental Health Study Center.

ALEXANDER, F. (1946). The principle of corrective emotional experience. In F. Alexander & T. M. French (Eds.), *Psychoanalytic therapy: Principles and applications* (pp. 66–70). New York, NY: Roland Press.

American Psychological Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

ARNETT, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist, 55,* 469–480.

ARNETT, J. J. (2007). Suffering, selfish, slackers? Myths and reality about emerging adults. *Journal of Youth and Adolescence, 36,* 23–29.

ATLAS.TI. (2000). The knowledge workbench 4.2 [Computer software]. Berlin, Germany: Scientific Software Development.

BARNETT, J. (1971). Dependency conflicts in the young adult. *Psychoanalytic Review, 58,* 111–125.

BENJAMIN, L. S. (2003). *Interpersonal diagnosis and treatment of personality disorders* (2nd ed.). New York, NY: Guilford Press.

BIBRING, E. (1937). On the theory of the results of psychoanalysis. *International Journal of Psychoanalysis, 18,* 170–189.

BLATT, S. J. (2008). *Polarities of experience: Relatedness and self-definition in personality development, psychopathology, and the therapeutic process.* Washington, DC: American Psychological Association.

BOWLBY, J. (1988). *A secure base: Clinical applications of attachment theory.* London, England: Routledge.

DEROGATIS, L. R. (1994). *Symptom checklist–90–R: Administration, scoring and procedures manual* (3rd ed., revised). Minneapolis, MN: National Computer Systems.

ELLIOTT, R., FISCHER, C. T., & RENNIE, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38,* 215–229.

EMDE, R. N. (1985). From adolescence to midlife: Remodeling the structure of adult development. *Journal of the American Psychoanalytic Association, 33,* 59–112.

ERIKSON, E. H. (1959). *Identity and the life cycle.* New York, NY: International Universities Press.

ERIKSON, E. H. (1968). *Identity: Youth and crisis.* New York, NY: Norton.

ESCOLL, P. J. (1987). Psychoanalysis of young adults: An overview. *Psychoanalytic Inquiry, 7,* 5–30.

EVANS, M. E. (2009). Prevention of mental, emotional, and behavioural disorders in youth: The Institute of Medicine Report and implications for nursing. *Journal of Child and Adolescent Psychiatric Nursing, 22,* 154–159.

FONAGY, P., & KACHELE, H. (2009). Psychoanalysis and other long term dynamic psychotherapies. In M. G. Gelder, J. J. Lopez-Ibor, & N. Andreasen (Eds.), *New Oxford textbook of psychiatry* (2nd ed., Vol. 2, pp. 1337–1349). Oxford, England: Oxford University Press.

FRANK, K. A. (1999). *Psychoanalytic participation: Action, interaction and integration.* Hillsdale, NJ: Analytic Press.

FREUD, S. (1914). Remembering, repeating, and working through. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 145–156). London, England: Hogarth Press.

GABBARD, G. O., & WESTEN, D. (2003). Rethinking therapeutic action. *International Journal of Psychoanalysis, 84,* 823–841.

GILL, M. M. (1954). Psychoanalysis and exploratory psychotherapy. *Journal of the American Psychoanalytic Association, 2,* 771–797.

GRANT, J. E., & POTENZA, M. N. (2009). *Young adult mental health.* New York, NY: Oxford University Press.

GREENSON, R. R., & WEXLER, M. (1969). The nontransference relationship in the psychoanalytic situation. *International Journal of Psychoanalysis, 50,* 27–39.

JACOBS, T. J. (1988). Notes on the therapeutic process: Working with the young adult. In A. Rothstein (Ed.), *How does treatment help? On the modes of therapeutic action of psychoanalytic psychotherapy*. (pp. 61–80). Madison, CT: International University Press.

KERNBERG, O. F. (2007). The therapeutic action of psychoanalysis: Controversies and challenges. *Psychoanalytic Quarterly, 76,* 1689–1723.

KOHUT, H. (1984). *How does analysis cure?* Chicago, IL: University of Chicago Press.

KOTTLER, J. (1986). *On being a therapist.* San Francisco, CA: Jossey-Bass.

KVALE, S. (1996). *Interviews: An introduction to qualitative research interviewing.* Thousand Oaks, CA: Sage.

LILLIENGREN, P., & WERBART, A. (2005). A model of therapeutic action grounded in the patients' view of curative and hindering factors in psychoanalytic psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 42,* 324–339.

MALTERUD, K. (2001). Qualitative research: Standards, challenges, and guidelines. *Lancet, 358,* 483–488.

MAYES, L. C., & SPENCER, D. P. (1994). Understanding therapeutic action in the analytic situation: A second look at the developmental metaphor. *Journal of the American Psychoanalytic Association, 42,* 789–817.

MCLEOD, J. (1990). The practitioner's experience of counselling and psychotherapy: A review of the research literature. In D. Mearns & W. Dryden, (Eds.), *Experiences of counselling in action* (pp. 66–79). London, England: Sage.

MESSER, S. B., & MCWILLIAMS, N. (2007). Insight in psychodynamic therapy: Theory and assessment. In L. G. Castonguay & C. E. Hill (Eds.), *Insight in psychotherapy* (pp. 9–29). Washington, DC: American Psychological Association.

NAJAVITS, L. M. (1997). Psychotherapists' implicit theories of psychotherapy. *Journal of Psychotherapy Integration, 7,* 1–16.

PEARLS, E. (2008). *Psychotherapy with adolescent girls and young women.* New York, NY: Guilford Press.

PERELBERG, R. J. (1993). The psychoanalytic treatment of young adults as a rite of passage: Discussion of the

conference. *Bulletin of the Anna Freud Centre, 16,* 95–103.

PHILIPS, B., WENNBERG, P., WERBART, A., & SCHUBERT, J. (2006). Young adults in psychoanalytic psychotherapy: Patient characteristics and therapy outcome. *Psychology and Psychotherapy, 79,* 89–106.

RENNIE, D. L. (2002). Experiencing psychotherapy: Grounded theory studies. In R. C. Page, J. F. Weiss, & Lietaer, G. (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 117–144). Washington, DC: American Psychological Association.

RENNIE, D. L., PHILLIPS, J. R., & QUARTARO, G. K. (1988). Grounded theory: A promising approach to conceptualization in psychology? *Canadian Psychology, 29,* 139–150.

ROSENFELD, H. (1972). A critical appreciation of James Strachey's paper on the nature of the therapeutic action of psychoanalysis. *International Journal of Psychoanalysis, 53,* 455–461.

SANDLER, J. (1983). Reflections on some relations between psychoanalytic concepts and psychoanalytic practice. *International Journal of Psychoanalysis, 64,* 35–45.

SCHAFER, R. (1983). *The analytic attitude.* London, England: Hogarth Press.

SCHÖN, D. (1983). *The reflective practitioner: How professionals think in action.* New York, NY: Basic Books.

SCHORE, A. N. (2003). *Affect regulation and the repair of the self.* New York, NY: Norton.

SHOBEN, E. J. (1962). The counselor's theory as a personal trait. *Personnel and Guidance Journal, 40,* 617–621.

STERN, D. N., SANDER, L. W., NAHUM, J. P., HARRISON, A. M., LYONS-RUTH, K., MORGAN, A. C., . . . TRONICK, E. Z. (1998). Non-interpretive mechanisms in psychoanalytic therapy. The "something more" than interpretation. *International Journal of Psychoanalysis, 79,* 903–921.

STRAUSS, A., & CORBIN, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). London, England: Sage.

Swedish Government Official Reports. (2006). *Ungdomar, stress och psykisk ohälsa: Analyser och förslag till åtgärder* [Young people, stress and mental ill-health: Analysis and action proposal]. [Rep. No. SOU 2006:77]. Stockholm, Sweden: Fritzes.

WACHTEL, P. L. (1997). *Psychoanalysis, behavior therapy and the relational world.* Washington, DC: American Psychological Association.

WALLIN, D. J. (2007). *Attachment in psychotherapy.* New York, NY: Guilford Press.

WERBART, A., & LEVANDER, S. (2005). Understanding the incomprehensible: Private theories of first-episode psychotic patients and their therapists. *Bulletin of the Menninger Clinic, 69,* 103–136.

WERBART, A., & LEVANDER, S. (2006). Two sets of private theories in analysands and their analysts: Utopian versus attainable cures. *Psychoanalytic Psychology, 23, 108–*27.