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Pragmatic Psychodynamic Psychotherapy – Bridging contemporary psychoanalytic clinical practice and evidence-based psychodynamic practice.

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Abstract

Pragmatic psychodynamic psychotherapy (PPP, Summers & Barber, 2009) describes the therapeutic principles and approaches found in many forms of manualized psychodynamic psychotherapies, which are being used in research studies with the aim of building an evidence-based psychodynamic practice. This article focuses on one such treatment, Supportive-Expressive psychotherapy (SEP, Luborsky 1984) which employs the Core Conflictual Relationship Theme method to formulate core interpersonal problems and treatment goals and identify therapeutic interventions. To illustrate SEP, we describe the 40 session treatment of a patient who met diagnostic criteria for several personality disorders. The case illustrates how complex ego-syntonic character pathology is expressed in CCRT terms and worked

through in the transference, gradually becoming ego-dystonic and amenable to modification. In this case, the patient became more aware of his interpersonal wishes and vulnerability. Although his anxiety increased somewhat, he had an improvement in psychosocial functioning.

The practice of psychoanalytic psychotherapy has been challenged and influenced by recent developments in the field. For the purposes of this paper, we will focus on the impact of manualized short-term psychodynamic psychotherapies (STPP), which are part of an attempt to develop a more evidence-based psychodynamic practice.

The creation of manualized psychotherapy treatments is predicated on the standardization of measures of treatment efficacy. Randomized clinical trials (RCT) are essential for evaluating the efficacy of psychodynamic therapy (Barber, 2009). To improve the quality of RCTs, clinical researchers were required to clarify and operationalize their concepts, and to identify disorder-specific techniques. All of these components have been

integrated into treatment manuals. Once a treatment was developed and employed, the need to assess the quality of its execution emerged, resulting in measures of adherence and competence in delivery of those interventions (Barber, Crits-Christoph, and Luborsky, 1996). A large number of STPP treatments have been developed. In an attempt to integrate psychodynamic theory, experience from psychotherapy training and clinical practice, and research data, Summers and Barber (2010) formulated what they call Pragmatic Psychodynamic Psychotherapy (PPP), which is an attempt to integrate common elements uniting these manualized short-term treatments (Summers and Barber, 2001). PPP offers guidelines for "tailoring" psychotherapy to a patient's strengths, limitations, and cognitive and emotional style. Rather than being a specific form of psychotherapy, PPP can be understood as an umbrella concept that encompasses a number of different STPP treatments.

The primary reason for the development of PPP treatments was to address the relative lack of evidence for the efficacy of psychoanalytic psychotherapies, when compared to Cognitive Behavioral therapies. As psychoanalysis as a scientific subject has largely disappeared from psychology departments in North America (Summers and Barber, 2010), a generation of clinicians is not being educated about psychoanalytic theory and practice. In most regional and national guidelines for the treatment of psychiatric disorders, psychoanalytically influenced treatments are, with some exceptions, rarely mentioned (Schachter and Kächele, 2011). When psychodynamic treatments are included as being evidence-based, the reference is to the kinds of psychodynamic therapies that we are including under the umbrella of the manualized pragmatic type.

The impact of research on the practice of dynamic psychotherapy: Pragmatic Psychodynamic Psychotherapy

There has been scientific and societal pressure on traditional psychoanalysis to change. Many of these developments and findings have highlighted the value of a more active stance from the therapist, compared to traditional psychoanalytic practice, and suggest a need for greater transparency in psychiatry in general, and psychoanalysis in particular. The importance of increased transparency in the therapeutic relationship has been emphasized in studies on the therapeutic alliance, which stress the benefits of lessening the hierarchy in the relationship between patient and therapist. Research on the therapeutic alliance (Muran and Barber, 2010) has also provided the field with active tools to observe, improve and restore the alliance.

Research demonstrating the importance to treatment outcome of educating and socializing the patient (Summers and Barber, 2010) has also had an impact on clinical practice. Socialization, or the process of clarifying the respective tasks of therapist and patient, contributes to strengthening the therapeutic alliance, which is the collaborative agreement and bond between therapist and patient. In response to these findings, dynamic therapists are increasingly disclosing more information about the treatment ahead of time, providing explicit information about how therapy works, what is expected of the patient, and what the patient can expect from the therapist. During the evaluation phase of treatment, all aspects of the frame are discussed, including how to deal with cancellations and the number of sessions.

Research has also brought about a greater awareness of the reality of trauma in our patients' lives, which has perhaps decreased the emphasis on internal fantasy in determining the impact of traumatic experience. In addition, there is greater emphasis on, and demand for, demonstrations of the efficacy of psychoanalytic psychotherapy.

Many practicing psychoanalysts have a direct experience of the effectiveness of their psychoanalytic practice, having often observed remarkable changes in their patients. There is evidence for the emotional and corrective effect of a precise and well-timed transference interpretation in both traditional and more recent psychodynamic practice (for example, Barber, et al., in press; Crits-Christoph, Cooper, and Luborsky, 1988; Owen and Hilsenroth, 2011). Taken together, the intensity of the clinical experience, the fact that many patients improve, and the development of a conviction about the uniqueness and effectiveness of psychoanalysis contribute to some analysts' reluctance to integrate evidence-based psychodynamic treatments or components of those treatments into traditional psychoanalytic practice. However, incorporating what we have learned from psychotherapy research may be important in improving the effectiveness of the treatment and the training of new psychoanalytically oriented psychotherapists.

The focus on short term and efficacious treatment is not a recent development in psychoanalysis, as some early treatments of Freud and Breuer lasted only of a span of weeks or months (Breuer and Freud, 1895). Most famous is Freud's treatment of the composer Gustav Mahler, which was a one-session treatment that lasted four hours (Jones, 1955). Alexander and French strongly advocated the point of view that psychoanalytic treatment could be short yet effective (Alexander and French, 1946). This is consistent with manualized PPP, which chooses a focus and accordingly directs interventions more deliberately and actively than in open-ended traditional psychoanalytic treatment.

Among others, Summers & Barber (2010) have described how most forms of brief dynamic therapies emerged from traditional open-ended psychoanalytic technique and could be encompassed under the umbrella of PPP. In comparison with traditional psychoanalytic practice, the development and maintenance of the therapeutic relationship in PPP is less based

on abstinence and more active. Much more effort is put into identifying core psychodynamic problems earlier in treatment, and the development of a comprehensive case formulation is indispensable. This formulation is, in contrast to traditional psychoanalytic practice, shared with the patient at an early point in treatment and serves as a basis for collaborative goal setting. In traditional psychoanalytic practice, patients are assumed to change perception through self-awareness and may then try out new behavior. In PPP, behavior is viewed as having the power to change experience and affect intrapsychic conflicts and mental life. Therefore some forms of PPP encourage patients to try out new behaviors and experiences to achieve increased awareness, and increased awareness will consequently result in greater likelihood to try new behaviors. This two-way causality is a crucial aspect of PPP.

During the active evaluation phase in PPP, the therapist explores the core psychodynamic problem that the patient is suffering from, which informs the therapist about treatment goals, dilemmas in developing the therapeutic alliance, specific therapy techniques, and common transference and countertransference reactions. Summers and Barber (2010) suggested that most dynamic therapists focus on six core psychodynamic problems in PPP. These are depression, obsessionality, fear of abandonment, panic anxiety, low self-esteem, and trauma. For example, PPP (Summers and Barber, 2010) conceptualizes the depressive psychodynamic core problem as follows: The essential problem concerns loss and self-criticism; the key conflict involves abandonment and attachment threats, and conflict over aggression. The treatment goals would be to decrease vulnerability to abandonment fears, and to decrease self-punitive thoughts and behaviors. Specific therapeutic alliance issues are empathy, encouragement, and installation of hope, and education about depression. Typical resistances include overwhelming affects, hopelessness and passivity. Major technical strategies involve an initial phase of empathy, support, and encouragement of activities in areas that the patient identifies as important; a second phase of identification of key themes of

abandonment/loss, and conflict over resentment about losses; and finally a maintenance phase related to early recognition of increased conflict and plans for effective solutions. Typical transference reactions are feelings of abandonment, dependency, idealization and anger, while typical countertransference reactions include rescue fantasies and feeling incompetent and sucked dry.

SEP and CCRT

Luborsky's Supportive-Expressive Psychotherapy (SEP, 1984), which makes use of the Core Conflictual Relationship Theme (CCRT) method, is such a manualized evidence-based psychodynamic treatment. In our view, SEP is a form of specific PPP, and as such, we have chosen to focus on it in this paper. While maintaining a relatively firm base in psychoanalytic concepts and frames, SEP has some empirical evidence (Barber et al, 2012; Leichsenring, 2007) and is relatively easy for experienced clinicians to learn.

Relying on his experience at the Menninger Foundation and findings from the Menninger Foundation Psychotherapy Research Project, Luborsky (1984) posited that therapeutic interventions can be conceptualized as existing on a supportive-expressive continuum. A supportive relationship allows the patient to tolerate the expressive techniques of the treatment that are supposed to be the mainstay of psychoanalytically oriented psychotherapies (Luborsky, 1984). A specific example of a supportive intervention described in the SEP manual is that "the therapist conveyed a sense of respect for the patient's growing abilities to do by her/himself what the therapist is doing during the session (for example, patient asking him/herself questions". In SEP, an expressive intervention attempts to deal effectively with one facet of the core interpersonal problem and when appropriate relate it to one of the symptoms (Luborsky, 1984). The therapist's decision to emphasize the supportive vs. the expressive pole rests, in part, on the strength of the patients' personality organization.

SEP has been further developed through close cooperation of researchers involved in clinical practice, theoretical formulation and empirical testing (Barber, et al., 2000; Crits-Christoph, 1999; Luborsky and Crits-Christoph, 1998). SEP is one of few psychoanalytic treatments that have been found to be efficacious in two or more randomized controlled trials (Leichsenring, Beutel, and Leibing, 2007); however, it has never been evaluated by two independent groups for a specific disorder, as would be required by Division 12 criteria to define a well-established therapy.

The CCRT (Core Conflictual Relationship Theme), which is one component of the dynamic formulation, is aimed at capturing the core intrapsychic and interpersonal conflict that relates closely to the symptoms and maladaptive functioning of the patient and thus is employed to focus SEP treatment. A CCRT formulation has three components: the patient's wishes (W), the corresponding responses of others (RO), either feared or realistically anticipated, and the subsequent reactions, or responses, of the self to these ROs (RS). The CCRT is derived from a series of so-called relationship episodes (RE), which are specific interpersonal events told by the patient. REs are typically expressed spontaneously by the patient in during the first or evaluative phase of a treatment (Luborsky and Crits-Christoph, 1998). Naturally, those narratives occurred spontaneously during the course of psychotherapy. The therapist can encourage the patient to elaborate on the RE in order to make unspoken components of the CCRT more explicit. During treatment, the therapist often ask for further REs or for more details of each narrative (unpacking) concerning significant people in both the patient's history and their current life. The CCRT is derived from the most recurrent Wishes, ROs and RSs across REs. Following the early diagnostic phase of treatment, a preliminary CCRT is presented to the patient using his own words. This tentative CCRT, as well as a description of patient's interpersonal problems and symptoms, form the

basis for a discussion of the mutually agreeable goals of treatment. Generating a CCRT requires minimal psychoanalytic knowledge, and does not involve adherence to a specific psychoanalytic model.

Of course, the CCRT will not only manifest itself in relation to significant others, but also in relation to the therapist, which provides a direct opportunity for transference and countertransference clarifications and interpretations. The CCRT can be used to show the patient how his/her maladaptive patterns repeat themselves in significant relationships. The CCRT can also be conceptualized as an internalized psychological structure that influences not only the way patients think about themselves, but also their predominant needs in relations to other people, how these needs are expressed, and their way of adapting to either actual or feared responses from significant others. In this regard, the CCRT construct bears resemblance to the psychoanalytic concept of unconscious fantasy and the cognitive concept of schemas. The RSs are often the presenting symptoms that are connected to the patient's reason for seeking treatment. The goal of SEP is to guide patients in understanding that their symptoms are maladaptive solutions to their needs and feared reactions of others. When more adaptive ways of understanding and expressing needs or wishes are tried and the patient learns that feared ROs will not occur, their fantasies will be replaced by more realistic perceptions. Their symptoms will decrease, leading to generally better social adaptation.

CCRT and Diagnosis

Although it is likely that some CCRTs are typical for core psychodynamic problems and perhaps also for specific DSM-IV Personality Disorders, there is no evidence to support this seemingly reasonable a priori assumption. A typical depressive core psychodynamic problem will involve a wish to be loved, an RO of fearing rejection by others, and a RS of

feeling depressed and covertly angry. A typical CCRT formulation for fear of abandonment would be as follows: a wish to merge/be close (W); anticipating abandonment (RO); feeling abandoned and angry (RS). Finally, an example of a CCRT concerning obsessionality would be: a wish to be in control of emotions and impulses (W); a fear of being controlled by others (RO); feeling angry and anxious (RS). However, many patients who have other disorders could also present with these CCRTs.

Personality Disorders (PD) are diagnoses of character pathology formulated in psychiatric diagnostic terms (DSM-IV). It is possible to use an interpersonal perspective to derive typical CCRTs for PD patients (Vinnars and Barber, 2008). An avoidant PD patient, for example, often has a wish to be loved and accepted, and to share a sense of belonging or community. However, an anticipated response of others is that he/she will be rejected. This leads the patient to respond with social withdrawal, feeling that others find him/her unlikable, and feeling embarrassed, shy and insecure. An individual with more severe pathology, such as a narcissistic PD, could have a wish for support, admiration and entitlement to special rights from others. A typical RO for narcissistic pathology is, however, that others envy him/her and will insult him/her. This anticipated or experienced response from others will elicit an RO of making him/her treat others with contempt, unless they express admiration and will provide special privileges to him/her. In the therapeutic process, the narcissistic patient will presume that the therapist will admire and support him/her. When this does not take place, rage and disapproval will replace the earlier transference reactions, and there is a considerable risk that the patient will leave therapy at the first convenient occasion. Finally, a Cluster A diagnosis for a paranoid PD is likely to involve: a wish to feel secure by having others confirming and understanding him/her ; anticipating that others will attack, cause hurt or place blame ; triggering a high sensitive alertness and withdrawing in a hostile way or counterattacking (RS).

All of these diagnoses are relevant for the case that will now be presented to illustrate how psychotherapy using SEP can proceed with a fairly complex patient.

The case formulation

In the PPP model, the case formulation is an important step in establishing a collaborative bond with the patient, including mutually agreed upon treatment goals (Summers and Barber, 2010). The evaluation and socialization phase includes clarifying the goals of treatment and the tasks that are ahead, as well as formulating a personal or "tailor made" CCRT (again part of the dynamic formulation) that both therapist and patient feel captures the core problem.

Case formulations have a history in psychoanalytic practice. Although Freud concisely conceptualized his patients and described their conflicts, the purpose of his case formulations, a word he never used, seemed to be more educational than clinical (Summers and Barber, 2010). A precise case formulation can serve several purposes. It is a roadmap to integrate information in both a theoretical and practical clinical context to assure that the therapist has grasped the essentials of the patient's history and core problems. Additionally, it helps the therapist to avoid vagueness and ambiguity and to preserve a consistent way of thinking about the patient. In long-term open-ended psychoanalytic treatments, where the focus shifts depending on when different conflicts appear in therapy, and when the stance of the therapist is less directive, there is a greater potential for vagueness. For the patient, the core problem formulation that the therapist shares may be helpful in understanding the interventions that the therapist will make and their focus, thus establishing a working alliance that is especially important in the active and more directive format of PPP. For psychotherapy trainees, a case formulation is a tool to help develop clinical thinking. Of course, the case formulation is a

work in progress that continually needs to be discussed, reflected on, and modified during the treatment.

The four essential parts of a case formulation, demonstrated in the case below, are 1) a general summary of the case, 2) a review of the non-dynamic factors, 3) a description of the core psychodynamics, and 4) a prognostic assessment that identifies potential areas of resistance (Summers and Barber, 2010).

Case Illustration: Steven

Case formulation of Steven

The patient participated in a RCT for patients with any PD from the DSM-IV. Participants were randomized to either SEP or non-manualized community delivered psychodynamic treatment (Vinnars and Barber, 2008; Vinnars, et al., 2005). The time-limited SEP, which this patient received, was delivered once a week for up to 40 sessions.

Summarizing statement. Steven is a 25 year old man who has abstained from drugs for a year after successful participation in the Minnesota twelve-step program. He is currently completing his high school diploma in an adult educational institution so that he can continue studying at a university level, but lacks a clear idea of what he will area he will focus on. In contrast to the USA, going to college/university is less common in Sweden. Steven lives in a small apartment in a low socio-economic immigrant area, and does not know what to do with his spare time. He attends AA meetings regularly to preserve his sobriety and perhaps also as a way to diminish his loneliness. He is obsessed with meeting and attempting to sexually seduce young women who often have some socio-economic problems, such as unemployment, living with their parents, or a lack of formal education. In the initial phase of the seduction process, he can show some personal interest in them, but he quickly loses interest once the seduction is done. Uncertain how to behave with "normal" people of a similar age, Steven easily feels embarrassed and shameful. He reports being rarely aware of

his own feelings and having difficulties engaging other people. He is a handsome and athletic young man, and in his spare time he trains teenagers in ballet dancing, something he did when he was a teenager. There are a few older, socially established and mature individuals that seem to care for him and that he trusts. A major traumatic family incident was the suicide of his alcohol dependent father when he was in his later teens.

Description of nondynamic factors. Steven meets the criteria for several PD diagnoses; avoidant, obsessive-compulsive, paranoid, narcissistic and antisocial. In addition he meets Axis I criteria for social and specific phobia. He grew up in a family with academically trained parents; his father was a lawyer with an alcohol addiction, his mother a teacher, and he has one sister. He remembers constant quarrels between his parents. Steven describes his father as a dominant and capricious person who only occasionally paid attention to him, but he gives a less precise description of his mother. In his early teens he started skipping classes at school, shoplifted and tried some drugs. After his father's suicide, Steven moved to a larger city to continue his drug abuse without being bothered by his mother, who seemed to care and worry for him. Until the age of twenty-three he was abusing cannabis and amphetamine but never injected any drugs. He was supported economically by older drug-addicted friends. He entered and completed the Minnesota program in a serious and unambivalent way. Entering treatment with us, he clearly states that he wants to change his pattern of seducing women, understand his relationship with his parents, and understand and accept himself and his past.

Psychodynamic explanation of central conflicts. Steven's core psychodynamic problem seems to be fear of abandonment. His central conflict revolves around attachment, because he is afraid that others will despise him once they discover who he really is, and for this reason he has an avoidant attachment pattern that may account for his avoidant PD diagnosis. He has a basic sense of insecurity, and his fear of being rejected activates feelings

of loneliness, anger, and despising and wanting to control others, as well as a narcissistic wish to be perfect.

Steven has very ambivalent feelings for his father and finds it difficult to identify with him. While he misses his father, he also admits to having wished for his father's death when he was younger, and recalls suffering from his father's verbal attacks. Examples of this are Steven's father's comments that Steven was worth nothing without an academic education and that if Steven ever became an addict, the father would kill him. If one hypothesizes that the father was unable to tolerate internal conflict stemming from contempt for his own dependency needs, it is possible that his verbal attacks on his son may have been a means of relieving his internal tension by projecting and acting out this repressed contempt. Steven may have internalized this conflict about dependency, adding to his ambivalence about his father and his fears of rejection. It is unclear how his father's suicide has influenced Steven, but a strong hypothesis is that it caused feelings of anger, shame and guilt that have been an obstacle for his independence and process of individuation.

On the other hand, his mother seemed to have provided a more secure attachment. At the end of the evaluation phase, Steven is able to describe his mother and his relationship with her in a more distinct and differentiated way, including that she cared for him, talked and wrote to him constantly during his periods of drug abuse, had several employments, and paid for language classes for him during his teens. At some point, he comments with considerable self-contempt, possibly in identification with his father, that all she had in return was a drunken drug-addict. However, he also adds that they have talked over this issue as an aspect of his drug treatment and that she has forgiven him. This relationship episode shows a capacity for reconciliation.

When Steven is in contact with non-ex-addicts he talks superficially about what he believes is considered "normal," but without any conception of how he appears in the eyes of

others. He is afraid of being exposed/seen as an ex-addict, which in his fantasies leads to his exclusion by others. Unable to understand what connects other people emotionally to each other, he talks about "normal" people's attachments with a sense of confusion. During his drug dependency, he looked for protection and support from older addicts who often perceived his sense of loneliness.

On the positive side, most of his angry and resentful feelings are kept on a fantasy level, and he does not act out aggression (other than in seductions) or violence, as one might suspect from the antisocial PD diagnosis. He is rather scared of both verbal and physical aggression in others, which seems to reinforce his view of himself as a coward. For example, he is afraid of being hurt by an addict friend serving time in prison, whose girlfriends Steven has fantasies of seducing, and whose revenge he perhaps unconsciously fears. A hypothesis is that this current fear originated in an older fear of his father acting out verbal aggression for competitive reasons. Steven's own tendency to act out is, however, expressed strongly in his relationships with young women. He seduces them, loses interest very quickly, and is rather proud of his capacity to be unfaithful. When he encounters women that he perceives as "normal" and that he would like to impress, he becomes confused, able only to identify a fear that they will despise him, rather than his own wishes. Understanding what causes this confusion and compulsive seduction is an important part of his treatment. One possibility is that he projects his own contempt toward the "normal" women and anticipates that they will have contempt for him. Another possibility is that he becomes threatened by his conflict about dependency needs, and fears he will be attacked for them, as he apparently was by his father.

Treatment/CCRT formulation. Based on the RES, the therapist proposes the following CCRT when making a treatment agreement with Steven: I wish to be protected, to receive positive responses from others, and to be perfect (W); I believe that some others will take care

of me (RO), whereas others, usually younger or "normal" people, will despise me, criticize me, and think I am worthless (RO); I cannot be at the same level as others (RS), or meet the expectations of those that I rely on (RS), and I cannot do anything constructive with my life (RS). Steven responds with some interest to the W to receive positive responses and be perfect and the RS of not being able to find constructive solutions concerning his future, but is more detached regarding the issues of feeling worthless and not being able to meet the expectations of others.

In regard to constructing his future, Steven appears to have intelligence and ambition, although he had not used them until successfully entering the Minnesota program and pursuing psychotherapy. He is also disciplined in continuing his studies and working part-time to support himself. He seems to have adequate organizational skills, as is reflected in his high school studies and work as a ballet trainer.

Predicting responses to the therapeutic situation. With his narcissistically driven wish to be perfect, one would expect Steven to initially be more interested in finding the "right way" to be than in relating reciprocally to the therapist. His fear of being despised may lead him to feel criticized by whatever verbal interventions the therapist may make. Also, his avoidance may prevent him from coming in contact with his feelings. Because he is not open to the possibility of internal conflicts, he may be especially likely to disavow angry feelings towards the therapist that may arise when/if he feels inadequately taken care of and confirmed. A particular risk that needs to be considered in case of increased frustration is a possible drug relapse.

Concerning Steven's psychological capacity, it is unclear whether he will have the capability to formulate an internal conflict when the therapist points it out. Another critical issue is whether he has the capacity to trust the therapist and thus tolerate the anxiety and frustration that will inevitably arise during therapy. On the other hand, aiding the therapeutic

alliance, both his obsessional traits and his firm conscious decision to be as open and self-reflective as possible may help him to endure the expressive comments from the therapist.

The therapeutic process

At the opening phase of therapy, Steven is seemingly open and goal-oriented, revealing as much information as possible about himself. He readily tells of REs in which he does not appear in the most favorable light, and seems relatively genuine. After the second session, it gradually becomes clearer to the therapist that the flipside of this openness is that Steven does not leave space for interventions from the therapist. He does not react to the therapist's initially cautious interventions, but only pauses momentarily before continuing with his previous themes. The therapist tries to formulate tentative CCRTs from this observation, saying, "I have the feeling that you are expressing something like 'I wish to be as open and honest as possible in the sessions to receive help,' but then I also have the impression that you react to my comments as if they will not be useful to you". At this point, Steven appears confused and even a bit irritated, but tries to cover this reaction by putting up a neutral face.

Around the 5th session, without any active exploration from the therapist, Steven relates a RE that shows his internal conflict quite clearly. He goes to a large AA meeting situated in another major town during an extended weekend with a young woman who is not addicted to drugs but has relatives who are addicts. The relationship with the woman seems romantic, although Steven is very careful to point out that he holds back his sexual desires to allow time for them to get to know each other. Unfortunately, he has a negative experience at the AA meeting. As is expected in such meetings, he collects his courage and makes a personal statement concerning his efforts to maintain his sobriety and accept himself and his past (*W: to be a good person, to do the right thing*). However, the response to his speech from the other AA members present at the meeting is that he is not trustworthy because he knows

how to use words to make a good impression. In other words, the others doubted his sincerity (*RO: others despise me, attack me, put me down*).

The therapist believes there is a parallel process in the AA experience with the conflict that Steven is having in therapy. He has a wish to be open and frank and to receive help concerning how to be a good person, to be secure in relationships, and to gain a sense of social belonging. However, he seems to perceive the therapist's interventions as confusing and incomprehensible, and he becomes irritated and annoyed. Both the perceived attacks from others, including the therapist, and his reactive angry, resentful reactions, may prevent him from feeling socially accepted. The therapist is not yet clear about Steven's capacity to "hold" or digest such a transference formulation, or understand the idea of an internal conflict. Consequently, the therapist at this stage chooses to remain an observer and to keep his observations and reflections to himself.

Steven continues by describing how his weekend with the young woman ends. When he says good-bye to her, he expresses confusion as to the future of their relationship. The woman readily accepts Steven's statement that he cannot be faithful in a romantic relationship, saying she is willing to be involved with him anyway, which adds to Steven's confusion. The therapist identifies an actual RO that is not consistent with Steven's expected RO that others will reject him and despise him. Again the therapist chooses not to express his thoughts at this stage of therapy because he feels that the time is not ripe.

As therapy proceeds, Steven becomes increasingly emotionally engaged and recounts important material concerning his relationship with his father. Around the 8th session he states that he misses his father and wishes that he were alive, but he is also aware of his death wishes towards his father, who was often difficult with him, either attacking him verbally or simply ignoring him. The therapist sees this as a way of understanding the genetic origin of Steven's RO that others will attack and despise him, as in what happened at the AA meeting

(as described above). Steven's anger toward his father paved the way for strong guilt feelings when his father committed suicide. In the subsequent sessions, the therapist reacts to the fact that the young woman, with whom he had become involved, seems to have "disappeared" from the therapeutic agenda as far as Steven is concerned. Instead, Steven continues to talk superficially about his need for sexual conquests. When the therapist wonders about the absence of communication about the previously important relationship with the young woman, Steven acknowledges that he has lost both his romantic and sexual interest in her. It seems that this is not a conflict for him. The therapist suggests that jealousy and fear of abandonment (*RO*), two of Steven's core psychodynamic problems, prevent Steven from pursuing his appropriate wish to be involved in an intimate romantic relationship with a woman, and so he is retreating to his normal pattern of sexually seducing (*RS*), which seems like a less "dangerous" option. The therapist receives no reaction from Steven on this CCRT formulation.

The REs that Steven describes are increasingly laden with anxiety and persecutory fears, as is his affect during the sessions. He talks about frightening recurring dreams in which his imprisoned older male friend attempts to kill Steven because he is so hurtful to women, and also because the friend suspects that Steven is having sex with his girlfriend. Steven acknowledges to the therapist an interest in his friend's girlfriend. At that moment, he seems to become preoccupied with the video camera in the room, and the therapist senses a vague paranoid fear. The therapist hypothesizes that as the content of the material involves opportunities for others, such as his friend, to despise him and even get back at him, Steven's fear of retribution is expressed in a fear of surveillance in the session. The therapist chooses to make an interpretation referring to the content of the previous session when Steven talked about his father: he wonders if a link between Steven wishing his father dead and having his friend of out the way in order to seduce his girlfriend activates the paranoid fear in his

dreams. For the first time, Steven acknowledges the therapist's intervention, saying that he always believed that his wish for his father's death contributed to his father's suicide.

In the 10th to 12 th sessions, one has the impression that the therapist, probably stimulated by Steven's positive reaction to the intervention concerning his father, is moving forward too rapidly expecting Steven to use a reflective capacity that is not yet available to him. During this period, the therapist is increasingly driven to be overly active, expressing CCRT formulations that sometimes seem premature. His interventions become long-winded, and the impression is that the therapist may have a complementary countertransference reaction of "I feel unappreciated by him; I feel manipulated by him," leading to interventions that may be regarded as intrusive by the patient. This has been described as not uncommon in therapists treating narcissistic patients (Dimaggio and Stiles, 2007). Steven is responding to this increased activity from the therapist by being emotionally distant, narrating REs, but in a detached manner.

During the same period the therapist becomes exceedingly worried about Steven's actual physical safety. He has on several occasions seduced young women, some of them virgins, who are part of an ethnic subculture known for both conservative moral values and violence. Steven claims, not without pride, that the men from this group want to stop him. Accounts of obsessional sexual activities are also taking more time in therapy as Christmas break approaches, and the therapist is starting to wonder if Steven's sexual activities can be conceived of as a defense against the loneliness that he may feel.

Following the recognition of his countertransference, the therapist tries to alter his interventions and to focus more on Steven's wishes of belonging, his ROs of being hurt, and his RSs of sadness. At some point, Steven admits to having angry, resentful feelings towards the therapist because of what he understands as intrusive comments. As he acknowledges these feelings, his detachment seems to loosen up. He gives several examples of how

confused he feels, seeing other people who have control over their lives that he cannot himself achieve, and he openly admits to envying these people.

Between the 20th and 30th sessions, Steven become more conscious of and open about his anxiety. He cannot handle relations to "normal" people of his own age, and shares his frustration with the therapist. Steven also demonstrates a trusting attitude vis-à-vis the therapist, which is a new development of the therapeutic alliance. His irritation with the therapist is gradually decreasing. Steven wonders about the possibility of having several sessions a week, or extended sessions.

At this stage, obviously less frustrated, the therapist arrives at CCRT formulations intended to capture the contradictory parts of the patient's self. He proposes that Steven has wishes for support, belonging, and intimacy in a normal relationship, but experiences a frightening RO about being rejected and regarded as perverse if he lets another person become emotionally important to him. This leads him to become simultaneously confused, withdrawn, and cold inside. Steven shows a strong interest in this formulation and describes a sensation that his thoughts and feelings are completely separated from each other. For the first time in therapy, he is able to experience and describe these contradictory affective states. This can be considered as a therapeutic advancement; however, the conscious experience of contradictory affective states also increases Steven's anxiety.

In a subsequent RE during the 28th session, Steven describes how he is actually able to identify and contain his anxiety and thoughts of rejection and abandonment. He has met a young woman, a former ballet pupil of his, in a coffee bar. The woman approaches him and talks with interest and enthusiasm with him. Steven manages to talk in a relatively relaxed manner with her, while internally acknowledging to himself how scared he is of being rejected and looked down upon if he openly shows interest in her. During this period, a shift also occurs in Steven's feelings and behavior. He appears more thoughtful, often silent in the

beginning of sessions, and has stopped talking excessively. The therapist construes this as a way for Steven to get in contact with his feelings without rejecting them and to find ways of trusting the therapist.

In the following session, the 29th, a major therapy crisis emerges as Steven's core psychodynamic problem of abandonment appears to be acted out in the transference. Steven reports a high level of anxiety in connection with his schoolwork. It is clear that he has often overslept and arrived late to school, and the headmaster has recently warned him that he may not receive grades at the approaching end of the semester. The headmaster is sorry about this, as Steven is doing well in school. Once again, the therapist feels that a parallel process is appearing, since termination of therapy is rapidly approaching, a fact that Steven on a manifest level does not yet seem to acknowledge. It seems to the therapist that the issue must inevitably be addressed, so he asks about Steven's thoughts and feelings regarding termination of psychotherapy. Much to his surprise, Steven does not show any worry or strong feelings concerning termination. The therapist chooses to be prudent and to await further indications on the topic.

In the following session (30th) it becomes clear why Steven has been unconcerned about termination. He tells the therapist that he expects therapy to continue beyond the 40th session since it is going so well and he needs it. The therapist is quite surprised and points out gently but firmly that this is not a correct perception, although he can understand Steven's wish to continue. He states that therapy will end at session 40, i.e., there will be ten more therapy sessions. The therapist does not feel comfortable with this intervention, having been rather prematurely pushed into it. Steven looks totally paralyzed and ashamed and claims that he cannot think at all. He looks intently at the video camera (*RO – to be rejected, hurt and embarrassed*).

For the first time, Steven misses the subsequent session without canceling it. He cannot explain why he did not cancel the session. The therapist proposes that Steven was actually taking the active role in the RO of "others abandon and reject me" and subjecting the therapist to the same feeling of rejection. Steven accepts the content of this interpretation and is capable of working with it. He explains that he had enjoyed fantasizing about the therapist worrying that he had killed himself or gotten lost in drug addiction. This leads to a further exploration and understanding of the events of Steven's father's suicide, and of Steven's experience of it as a relief to him at the time it happened.

After the usual month-long Swedish summer vacation, Steven has relapsed and is in a treatment home when he returns to therapy (session 35). He has arranged this by himself, rather than trying to involve the therapist and disrupting the therapist's vacation, although most likely the relapse is related to his anxiety about terminating therapy. This behavior could also be conceived of as pushing away the therapist: I'll deal with this on my own, now that you soon will be abandoning me anyway. In order to help Steven address his fear of abandonment and avoid further drug relapses, the therapist uses the remaining sessions to actively focus on the psychological meaning of the termination. In supervision, the therapist confesses to having some feelings of guilt over not foreseeing the possible consequence of Steven's feelings of being abandoned.

Steven manages to attend all remaining sessions in spite of high levels of anxiety. In one of the last sessions, he talks about an encounter with his mother, who has seldom been "present" in therapy. She had told him that she easily understood how his addiction and his recent relapse had to do with his feelings of loneliness and despair. Talking about his mother, Steven is deeply touched, especially concerning his insight that she is much wiser than he had anticipated, and that the two of them have an affiliation that he did not expect. The therapist chooses not to comment on his own thoughts while listening to Steven. He believes that

Steven is actually acknowledging that he intends to keep the therapist as an internal valuable object, in spite of the frustration that the therapist has subjected him to by maintaining the frame of termination. Since up until this moment, the mother had been rather absent in therapy as an important object, the event may show that accepting the emotional importance of an object has become less anxiety-provoking for Steven than it was at the beginning of treatment.

Assessment at Termination

At termination of treatment, Steven only received two PD diagnoses: histrionic and narcissistic. After another 2.5 years, a follow-up evaluation was made and Steven again received several PD diagnoses: dependent, paranoid, narcissistic and borderline (antisocial does not return). Despite the persistence of these diagnoses, his overall level of functioning (Global Assessment of Functioning, GAF) showed increasing improvement throughout the assessments and his total number of PD criterion was lower at both termination and follow-up. Interestingly, his self-rated level of psychiatric symptoms had increased, whereas on all other self-report measures his pathology had decreased (Table 1). Understanding this complicated outcome necessitates some discussion.

Although the termination outcome measures still show personality and symptom pathology, the impression taken from the psychotherapy process is that Steven has become more open and less obsessive, and certainly more aware of his pathological traits. This is demonstrated by results of the Inventory of Interpersonal Problems (IIP, Horowitz et al). At intake, Steven reported his highest interpersonal problems as being too cold, too socially avoidant, and too submissive, whereas independent raters evaluated his main interpersonal problems as being too dominant, too vindictive, and too cold. Steven's self-rating at intake can be understood as a denial or unawareness of his narcissistic traits. However, at

termination his self-rated interpersonal profile was similar to the clinical ratings made at intake, that is, dominant, vindictive, and cold, and his level of overall interpersonal distress had diminished. In this instance, increased awareness of his interpersonal functioning was associated with decreased distress. The increased symptoms shown on the SCL-90 may indicate that since the detachment between thoughts and feelings had disappeared, and his internal conflicts were conscious for him, his anxiety had also increased. This event can be conceptualized as a structural improvement in his pathology. Last but not least, he had also remained clean from drugs during the whole follow-up period.

Perhaps most psychodynamic clinicians would regret that a patient with such severe personality pathology was not offered extended psychotherapy with the same therapist as an ideal option. From a purely symptom oriented perspective, one could also argue that in some respects Steven even deteriorated, considering his increased levels of anxiety. However, working through his abandonment and rejection fears in the context of the transference may have been an important factor in his overall improvement. Steven accepted the termination in agreement with the study conditions, and gained insight, at the expense of increased anxiety, but with an increased overall level of functioning. The experience of keeping to the agreement and managing it in spite of severe difficulties may have helped to develop a new structure for Steven that he could generalize to other difficult situations in which his fear of abandonment would be activated. Coping with termination may also have increased his self-esteem and self-respect. At follow-up, Steven had taken up university studies, although he had still not chosen a direction of study.

An unexpected follow-up fact was revealed around 10 years after termination when Steven made a short phone call to the therapist recounting that he had just finished several years of specialist university training for a specific profession. He also mentioned that he had

had a long-term love relationship for several years during this period, although it had now ended.

Evidence for the efficacy of SEP

A review from 2007 (Leichsenring and Leibing, 2007) found five RCTs in which SE therapy had been used for different psychiatric disorders, namely: opiate dependence (Woody, et al., 1990), cocaine dependence (Crits-Christoph, et al., 1999), bulimia nervosa (Garner, et al., 1993), personality disorders (Vinnars, et al., 2005) and generalized anxiety disorder (Crits-Christoph, et al., 2005). However, most of these RCT's involve comparison to other effective therapies rather than placebo. In the RCT for opiate addiction, SEP plus drug counseling and cognitive-behavioral therapy (CBT) plus drug counseling were equally effective, and both were superior to drug counseling alone (Woody et al., 1990). For SEP, the pre-post effect size was .97, for CBT .81, and for individual drug counseling alone .07. When subgroups were compared, patients with high symptom severity made considerable progress when they received either SE therapy together with drug counseling or CBT with drug counseling (Woody et al., 1984). In an additional study for opiate dependence, the efficacy of SE therapy was further confirmed (Woody, et al., 1995). In this study, SE therapy in combination with drug counseling was superior to drug counseling alone. However, in a later multicenter RCT for cocaine dependence (Crits-Christoph et al., 1999), SE therapy and CBT each combined with group drug counseling were equally effective, but both were inferior to individual drug counseling. One may conclude that in this sample of cocaine dependent patients who had a relatively low level of psychiatric severity besides the drug dependence, drug counseling was very effective.

In terms of studies other than treatment for substance dependence, when SE therapy was compared to CBT in the treatment of bulimia nervosa, both psychotherapies were found to be equally effective (Garner et al., 1993). In an RCT for psychiatric patients with any

personality disorder from the DSM-IV, SE therapy was compared to community-delivered psychodynamic treatment (Vinnars et al., 2005), which was carried out by clinically experienced clinicians. In the study, both treatments were equally effective with regard to personality disorder severity and psychiatric symptoms, and the general level of psychosocial function also increased significantly. However, at the one year follow-up, SE patients made significantly fewer visits to the psychiatric outpatient clinic compared to patients who had received community-delivered treatment.

Crits-Christoph et al. (2005) conducted a randomized controlled feasibility study of generalized anxiety disorder comparing SE therapy with supportive treatment. The SE treatment was found to be equally effective to the control treatment regarding continuous measures of anxiety. However, the number of patients in the study was fairly small and the study did not contain enough power to detect possible further differences between treatments. Barber, Barrett, Gallop, Rynn and Rickels (Barber, et al., 2012) just reported the results of an NIMH funded RCT comparing SEP vs. Pharmacotherapy vs. Placebo (n=156) for the treatment of major depressive disorder. In that trial, patients in the pharmacotherapy arm who did not respond to medication after eight weeks were switched to another medication (sertraline followed by venlafaxine), and patients in the placebo condition were switched to another placebo if not responsive at eight weeks. Results at sixteen weeks indicated that although patients improved significantly in all conditions, no difference between the three treatments groups emerged even when focusing the analysis on the subgroup of more severely depressed patients. In light of the large number of minority patients and men in that sample, Barber et al, (2012) examined the role of gender and minority status and found a significant interaction. Subsequent analyses indicated that for white men, placebo was more effective than medication or SEP. For minority men, however, SEP was significantly more effective than pharmacotherapy and placebo. For minority women, no difference between the

treatment groups was found. Finally, for white women, they found the expected results that pharamacotherapy and SEP were more effective than placebo. While those findings require replication, they point out to the possibility that no treatment works equally well with all subgroups of patients with a specific psychiatric disorder.

In conclusion, altogether at least eight RCTs using SEP for different specific psychiatric disorders have been conducted. According to the criteria put forward by Division 12 of the American Psychological Association (Chambless & Hollon, 1998) for the definition of empirically supported therapies, at least two RCTs for a specific psychiatric disorder, conducted by independent research groups, have to be available in order for a treatment to be considered empirically supported. Thus, SEP has not yet met this criterion. For the different psychiatric conditions mentioned, further RCTs need to be conducted. Since SE treatment manuals for several disorders (Leichsenring, Beutel, and Leibing, 2007) now exist, such RCTs are highly feasible and desirable.

Several of these studies have tested hypotheses other than the efficacy of SE therapy; for example, the accuracy of the therapist's interpretation of the patient's CCRT has been shown to be a significant predictor of patient outcome (Crits-Christoph and Connolly, 1999; Crits-Christoph, Cooper, and Luborsky, 1988; Luborsky, McLellan, et al., 1985; Luborsky, Barber, and Crits-Christoph, 1990). There is also important evidence that the competent delivery of expressive interventions in SEP, as rated by independent expert clinicians listening to recorded sessions, predicts good outcome (Barber, Crits-Christoph, and Luborsky, 1996) (Barber et al., 1996). There is also some evidence that the strength of the therapeutic alliance as reported by patients early in treatment predicts subsequent change in symptoms among depressed patients (Barber, et al., 2000).

All in all, there are considerable arguments in favor of using SE therapy in further randomized trials to empirically evaluate an important psychodynamic treatment. SE therapy

may also be valuable in the training of psychodynamic therapists. The treatment has considerably more practical, structured aspects that many other psychodynamic treatments, without losing complexity and nuance. This structure is especially provided by the CCRT method, which is an easy to learn tool to be used by the therapist to identify unconscious levels of pathology. Many psychotherapy novices have problems supporting the active listening stance of psychodynamic therapy while also elaborating on the personal narrative of the patient, and find the more direct manuals of CBT comparatively less difficult. For them, the CCRT can supply a structure to "lean on" while developing their psychotherapeutic capabilities.

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Table 1.
Outcome at termination and follow-up.

	Intake	Termination	Follow-up
Number of positive criterion for each PD diagnosis.	Avoidant (4) Obsessional (4) Paranoid (4) Narcissistic (7) Antisocial (5)	Histrionic (6) Narcissistic (5)	Dependent (5) Paranoid (5) Narcissistic (7) Borderline (5)
Total PD criterion	44	33	36
SCL-90	1.22	1.54	1.50
GAF	53	58	65
Average IIP	1.84	.84	