Examining the Therapeutic Relationship and Confronting Resistances in Psychodynamic Psychotherapy: A Certified Public Accountant Case

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ABSTRACT

Psychodynamic psychotherapy is effective for a variety of mental health symptoms. This form of psychotherapy uses patient self reflection and self examination, as well as the therapeutic relationship between the patient and psychiatrist, to explore maladaptive coping strategies and relationship patterns of the patient. A thorough understanding of *resistance* and the *core conflictual relationship theme* afford the psychiatrist the ability to facilitate this work. In this article, the composite case illustrates some of the psychodynamic psychotherapy techniques that can be employed in a psychotherapy case. In this example, the case is about a certified public accountant that came to treatment because of an acute stressor that put her career goals at risk. An acute episode or event can bring to light chronic and ongoing symptoms, which have had a remitting and relapsing course, and leave the patient unable to compensate on his or her own.

CASE PRESENTATION

(Composite case; not a real patient in treatent.) Ms. H was a 26-year-old single female accountant who initially presented with a chief concern of severe and debilitating anxiety over the previous two months. Ms. H reported increased worry, somatic complaints, autonomic instability, and extreme feelings of malaise and exhaustion. Her symptoms were especially intense in her occupational setting.

She decided to seek treatment after being accused of mishandling a client's financial records. She reported her anxiety increased prior to going to work when she would experience sensations of being "on fire," gastrointestinal distress, shortness of breath, tachycardia, and feelings of impending doom. She admitted also to becoming markedly less communicative and isolative so that those around her would not sense her discomfort. She was hypervigilant and preoccupied with the physiological expressions of her anxiety, as well as fixated on both the verbal and

nonverbal language of those around her. For example, she would experience diaphoresis and palpitations, and then panic as she assessed that others were cognizant of her plight. If she perceived any indication of ridicule or even recognition, her physiologic dysregulation would ensue. She reported that her symptoms had been present in a remitting and relapsing course over many years yet were subtle and manageable most of her life prior to this acute event; when presenting for psychotherapy she stated that the precipitating event put her "over the edge."

PRACTICE POINT: RECOGNIZING THE RESISTANCE

The process of change in psychotherapy is "set in motion not simply by the technical skill of the analyst, but by the fact that the analyst makes himself available for the development of a new 'object relationship' between the patient and the analyst."[1] The nature of the therapeutic relationship lends itself to imitating the ongoing struggle that the patient faces in interpersonal relationships outside the room. The psychiatrist may be tasked with confronting obstacles which, due to temperament, learned behavior, or emotional conflict, may impede the process of change. One primary obstacle to change is *resistance*. "Resistances serve three major psychodynamic functions: 1) they impede the uncovering of an unconscious conflict; 2) once a conflict is reactivated in psychotherapy, they interfere with the renunciation of unconscious wishes and fantasies associated with the conflict; and 3) they reflect the patient's general reluctance to experiment with new and more adaptive behavior."[2]

The initial task of the psychiatrist is to recognize the resistance. Resistance is part of the patient's characteristic mode of relating and can manifest itself in various forms of behavior.[3] Therefore, it is critically important to assess and formulate the central issue that is the fundamental meaning of the resistance. This can be accomplished by exploring the patterns of the patient's relationships with others and with the psychiatrist within the therapeutic relationship.[4]

The primary focus of psychodynamic psychotherapy is to reveal unconscious content of the patient's psyche that may be the basis of maladaptive functioning and resistance to change. See Table 1 for basic prinicples of psychodynamic psychotherapy. Psychodynamic psychotherapy relies heavily on the interpersonal relationship between the psychiatrist and the patient. Rather than utilizing a single system of intervention, psychodynamic work can be somewhat eclectic depending on the needs of the patient and style of the psychiatrist. If the patient is in crisis or experiencing acute or severe symptoms, the psychiatrist will focus on the patient's discomfort and will endeavor to de-escalate the acute symptoms first. When the patient is functioning at a higher level and when the therapeutic alliance is well established, the psychiatrist will assist the patient in acknowledging the existence of maladaptive functioning, while facilitating strategies for change.

Psychodynamic psychotherapy can be effective for various depressive and anxiety disorders for the appropriate patient population.[5] A patient's suitability for psychodynamic psychotherapy is based on an imperative screening of ego strength. The level of ego strength can be deduced from a number of qualities derived from exploration of the potential for introspection, examining current relationships, and other important areas of psychological functioning. A strong observing ego and the capacity to form a supportive therapeutic relationship are considered selection criteria for psychodynamic psychotherapy.[6] See Table 2 for ego strength parameters for psychodynamic psychotherapy.

Several empirical studies support the effectiveness of psychodynamic psychotherapy. In a review and meta-analysis of the available empirical literature, Alberdi and Rosenbaum concluded that there is evidence that this form of treatment is beneficial for patients with unipolar depression, as well as for patient's with various anxiety disorders, including panic disorder, social phobia, generalized anxiety, and posttraumatic stress disorder.[8] Leichsenring reviewed the available empirical data on the effectiveness of both psychodynamic and psychoanalytic psychotherapies and concluded that short-term psychodynamic psychotherapy showed significant and large treatment effect sizes for both general psychiatric symptoms and target symptoms.[9,10] The effects were stable over time and actually increased at follow up.[9] Data on long-term psychodynamic psychotherapy "yielded significant, large, and stable with-in group effect sizes" in patients with target symptoms and personality functioning when compared to more brief forms of psychotherapy.[10] Ninety-six percent of patients with more complicated mental health issues who had undergone long-term treatment were judged to be better off than those in comparison groups.[10]

Possibly the most comprehensive review of literature regarding psychodynamic psychotherapy was performed by Shedler, who reviewed eight meta-analyses comprising 160 studies on psychodynamic psychotherapy, in addition to nine meta-analyses on alternate types of psychotherapy and various antidepressant medications.[11] The focus of Shedler's review was the "effect size," which quantifies change that each treatment type afforded. In general, for medical and psychological research, an effect size of 0.80 is considered large.[11] Shedler found that there was an effect size of 0.31 for commonly used antidepressant medications, while one major meta-analysis of psychodynamic psychotherapy, which included over 1,400 patients with various mental health issues, showed an effect size of 0.97 for patients who received once weekly psychotherapy for an average of less than one year. Interestingly, when effect size was re-measured nine

months or more after treatment ended, the effect size increased to 1.51, indicating that the patients continued to show improvement following termination of a course of psychodynamic psychotherapy.[11]

CASE PRESENTATION, CONTINUED

Ms. H described in more detail the allegations of mishandling a client's financial records and how this was affecting her. She described episodes of "freaking out," feeling scared, depressed, anxious, and "catastrophizing" the situation, fully expecting her professional career to end from this debacle. She became angry after learning that the accuser of this alleged wrong doing, Ms. H's direct supervisor, had already contacted the regional manager of the company. There subsequently was a formal meeting with the regional manager, and during this meeting the patient experienced a "panic attack," which consisted of shortness of breath and crying spells. She vehemently tried to convince the management that she had not knowingly mishandled the documents in question. The manager was receptive to Ms. H and a compromise was proposed, wherein Ms. H would have to pick up additional clients and would not be considered for a pay increase for the current fiscal year; if she agreed to these stipulations, her occupational record would remain unaffected by the alleged incident. Though this prevented Ms. H from losing her job in the immediate future, she still felt betrayed and taken advantage of by now having to take on extra clients, which had not been contracted earlier. In addition, this left her feeling alienated, "singled out and picked on." She also had concerns about the security of her position with the company moving forward.

Ms. H also had nearly daily contact with her supervisor, and this relationship remained tense and uncomfortable subsequent to the meeting, which created emotional upheaval for her on nearly a daily basis. She felt uncomfortable, and described feeling very transparent and exposed when she sensed others could see her distress. Her anxiety localized to her gastrointestinal system, and she experienced diarrhea, nausea, vomiting, and abdominal cramps. She dreaded going to work, and felt like people were "out to get me." She had a constant fear of another incident, which worsened when in close geographic proximity to her supervisor. She progressively became less interactive, less talkative, and more withdrawn at work. Her friends started to become concerned about her withdrawal from work-related social activities and inquired about the apparent increase in her workload. Ms. H went further in stating that she had not liked her supervisor from the day she met him, that she "just had this feeling" about him, and that she felt cheated that "someone with so little experience would dare incriminate me."

Patterns of relationships and recognizing the resistances. The patient paralleled this work experience to her problems with relationships, reporting that whenever conflict arose she became consumed with self blame, which resulted in increased anxiety. She further described that whenever she began a new endeavor/relationship her anxiety levels magnified.

When Ms. H's psychotherapy began, she was struggling with a long-distance relationship with a boyfriend living in another city. She reported ruminating on thoughts that he was cheating on her, though no concrete evidence existed for such a suspicion to be justified. She strongly disliked being yelled at, reprimanded, or treated poorly, but noticed a common pattern of being attracted to and involved with men who commonly did all of these things (i.e., cheating on her, abusing her physically and emotionally, and then dumping her). Historically, most of the men she dated she described as "emotionally unavailable," and "borderline." Furthermore, these men frequently came from allegedly abusive upbringings.

A main focus of Ms. H's complaints pertained to the intricacies of her previous long-distance relationships

TABLE 1. Basic principles of psychodynamic psychotherapy

- Much of mental life is unconscious.
- Childhood experiences in concert with genetic factors shape the adult.
- The patient's transference to the therapist is a primary source of understanding.
- The therapist's countertransference provides valuable understanding about what the patient induces in others.
- The patient's resistance to the therapy process is a major focus of the therapy.
- Symptoms and behaviors serve multiple functions and are determined by complex and often unconscious forces.
- A psychodynamic therapist assists the patient in achieving a sense of authenticity and uniqueness.

Gabbard, G. *Long-Term Psychodynamic Psychotherapy.* Washington, DC: American Psychiatric Press, Inc.; 2004:3.

TABLE 2. Ego strength parameters for a psychodynamic psychotherapy candidate

- The patient's capacity to tolerate frustration
- The patient's willingness to look at the more unpleasant aspects of oneself
- The patient's ability to handle stress imposed by an adverse environment
- The patient's employment history
- The patient's legal record
- The patient's use of alcohol or illicit drugs
- The quality of the patient's interpersonal relationships
- The patient's pattern of coping with stress
- The patient's reaction to loss
- The patient's relationships with prior psychotherapists

Hollender M, Ford C. *Dynamic Psychotherapy: An Introductory Approach.* Washington, DC: American Psychiatric Press, Inc.; 1990:30–33.

and her fear of their inevitable demise. Ms. H stated it was a "self-fulfilling prophecy" that people "used" her and subsequently ended the relationships. She reported that nearly all of the men she had dated had married soon after the termination of their relationship with her. She historically was attracted to men who were "psychologically tarnished," who had conflicted or distant relationships with their families, who were involved with numerous women simultaneously, or who were generally "needy" or "high maintenance" from a psychological standpoint. She admitted to being attracted to needy men, those who were dependent, who made her feel desired, "more holistic," and in general those who could distract her from her own insecurities.

Developmental antecedents. Ms. H's childhood and her relationship with her parents had been a subject matter very difficult for her to address in psychotherapy. She had only briefly touched on this aspect of her life, and remembered her mother saying when she was young that Ms. H was "the woman of the house," and that it was her responsibility to "take care of" her mother. She recalled feeling obligated to take on an authority role as a young child. Ms. H's father was allegedly physically abusive toward her mother and left the household when Ms. H was a child. Early on she described being full of anger, and utilized her anger as an avenue to deal with her emotions that were constantly in flux.

Emergence of resistance. During her initial sessions, Ms. H conducted herself in a hostile manner, demanding that the psychiatrist bestow insight from which she could benefit. She would bring in typed notes of her dialogue with men and read them aloud hoping for a magical interpretation from the psychiatrist, which she could then take back to the relationship and utilize. When her expectations went unmet or when inquiry was made as to her developmental upbringing, she became angry, degraded the psychiatrist, and then subsequently showed up late for sessions or did not come at all.

PRACTICE POINT: MANAGING THE RESISTANCE

Once the patient is engaged in the psychotherapy, the psychiatrist facilitates an increase in awareness of ineffective coping strategies. These strategies may have served a purpose during developmental years but are no longer relevant. For example, in the case of Ms. H, she would often deem herself unworthy of care or affection and, therefore, would unconsciously create situations that would prevent her from becoming vulnerable or intimate. This would come in the form of denigrating others to elevate her and bolster her own defenses. By pointing out this aggression, the patient may gradually learn that he or she is masking underlying fears of inadequacy. In this case, over time, Ms. H learned to tolerate her own limitations, and she no longer generalized her world to fit her exaggerated projections. Slowly her pattern of resistances diminished and she became progressively less anxious.

The psychiatrist's initial temptation may be to fall back or retreat when the patient seems unable to tolerate the distress of affectively charged relationship issues. When working with a patient who is apprehensive about relationships, the psychiatrist may over-identify with this apprehension. However, if apprehension is then modeled by the psychiatrist, the patient may become more apprehensive rather than less so. It is a safe assumption to expect that the patient will seek comfort measures, such as withdrawal or even anger, when he or she is challenged to bear emotionally laden content. It is necessary for the psychiatrist to increase the patient's awareness of his or her defenses against this by commenting on it when the time is right. This may then pique the curiosity of the patient to work further.

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CASE PRESENTATION, CONTINUED

It was brought to Ms. H's attention that seeking treatment in the midst of a significant acute stressor superimposed on long-standing anxiety was to be commended, albeit an extremely challenging undertaking.

Psychiatrist: You seem uneasy coming here and discussing your personal matters.

Patient: How would you feel? You don't get how hard this is for me right now. I was really getting settled in at work and then this happened. I really feel like my future is over before it even started. Nothing good ever goes my way. These types of things always happen to me. I've been coming here weekly and I'm not getting anything out of this. You're supposed to be making me feel better.

Psychiatrist: You have many expectations coming here, and it sounds like you want to get the most out of this experience. You're placing a great deal of pressure on yourself to succeed, and it sounds like you're in a great deal of emotional pain. I imagine this is a struggle for you, and I give you credit for seeking treatment at this time.

In addition, the therapeutic alliance was strengthened and facilitated by acknowledging the intensity of the anxiety during exploration of these issues. With tact, it was also articulated by the psychiatrist that this was collaborative

work that was ultimately deemed by the patient to be supportive.

Psychiatrist: I've noticed when you start discussing the problems that led you to psychotherapy and how they make you feel, you sometimes change the topic or become silent.
Patient: Really? I hadn't noticed. That's interesting because my ex use to tell me he knew nothing about me because every time I'd begin to talk about details of my upbringing I'd get angry for no apparent reason or simply stop communicating.
Psychiatrist: Tell me more about that.
Patient: I don't know. Maybe it's an effort to protect myself?
Psychiatrist: What do you feel you may be protecting yourself from?
Patient: Perhaps the pain related to some of things that happened in the past.
Psychiatrist: Tell me more about what that pain is like for you.
Patient: It makes me feel scared inside. I start to get butterflies, and my stomach gets queasy. My heart races and I sometimes feel like I can't catch my breath.
Psychiatrist: It sounds frightening and I can tell you've really been struggling. I now have a better appreciation for how debilitating this has been for you. You sharing these intimate details about who you are and how you feel will help us work toward our goals here in the room.

Over time, the patient learned to respect the consistency, safety, and nature of the working relationship.

PRACTICE POINT: CORE CONFLICTUAL RELATIONSHIP THEME

Lester Luborsky developed the construct of the Core Conflictual Relationship Theme (CCRT).[12] CCRT is a method used to formulate the patient's "unconscious plan." Reference is made to Freud's concept of "the patient's perception of certain types of danger situations evoked in relation to people (Freud [1926] 1959), and involvement of remembered helplessness associated with anxiety."[4]

When compared to other interpretations and forms of dynamic psychotherapy, Luborsky emphasizes a more exploratory, less-educative, and interpretive approach, and incorporates object relations theory or interpersonal theory. The goal is to improve interpersonal functioning with less distinct focus on making the unconscious conscious.[12] When developing the CCRT, Luborsky noted where there was *repetition* in the patient's narrations of relationship patterns and problems. He devised CCRT as a system to guide the clinical judgment of the psychiatrist regarding the patient's central relationship patterns. Through studying and analyzing videotapes of patient sessions, he categorized patient descriptions of relationships, or "patient narratives," based on 1) the patient's main wishes, needs, or intentions toward the other person in the narrative; 2) the responses of the other person, either positive or negative; and 3) the patient's responses of the self, either positive or negative.[12] The types of descriptions that occurred with the highest frequency could subsequently be identified and ultimately the psychiatrist could formulate the CCRT.

Menninger's Triad. The concept of a central theme is also emphasized in Menninger's Triad, in which the central theme is attended to in three spheres: 1) current relationship of the patient and therapist in the treatment, 2) current relationships outside of treatment, and 3) past relationships, particularly one's first sustainable attachments.[13] The first sphere has the greatest potential for therapeutic impact because it is played out in the "here and now."[14] By assessing and articulating the central theme, the ground work is laid to help the patient see patterns of interpersonal functioning as they relate to past experiences and relationships. When this pattern is then repeated within the therapeutic relationship, a concrete example is available for the patient and psychiatrist to dissect and improve.

CASE PRESENTATION, CONTINUED

CCRT. Ms. H was raised in an environment void of an empathic father figure, in that her own father allegedly physically abused her mother and left the family abruptly when Ms. H was very young. The patient's mother relied on Ms. H to fill the gap left by an abusive and then absent husband. As an adult, Ms. H found herself seeking out volatile, harmful relationships and being attracted to emotionally unavailable and demanding men, who in turn, would treat her poorly and would sooner or later reject her in some way. This left her hypervigilant about the way in which she navigated her current relationships, and caused her to second guess her emotional states, conduct, and demeanor.

The precipitating event leading her to psychotherapy was the work-related allegation, which also left her feeling betrayed, exposed, and extremely vulnerable. This experience caused Ms. H to manifest a variety of similar symptoms, including elevated anxiety, somatic complaints, and a learned helplessness that she expressed in anger and self-loathing statements.

Exploring the resistance. Psychotherapy with Ms. H was increased from once to twice weekly in an effort to further decrease her anxiety, as well as to allow for more time to navigate through the myriad of resistances and defenses. After agreeing to this arrangement, she immediately returned to showing up late, and commented on feeling "under a microscope" during sessions. She shifted her thought processes quickly, and would go to great lengths to avoid placing herself in a vulnerable position. She verbalized a fear of coming to appointments and was specifically afraid of "not having anything to say." Exploration revealed she was concerned that she would allow the psychiatrist to see her "flaws" and she correlated this same feeling to her professional work setting and her fear that she was inadequate because she had a learning disorder. Her most

recent arguments with her boyfriend frequently revolved around the theme that she felt "not good enough."

PRACTICE POINT: UNDERSTANDING "AGENCY OF SELF"

A patient's manifest (overt) memories of helpless feelings during childhood carry with them an unconscious wish to be his or her own person.[15] This inner conflict generates anxiety, against which the patient defends and which subsequently creates resistance. This patient defends against efforts at self agency (called "grandiosity") and its associated anxiety, by experiencing "shame." For example, when Ms. H received recognition from the psychiatrist on the work she was doing, the patient quickly recanted the accomplishment and became fidgety and restless. This could be interpreted to her as follows:

Psychiatrist: While there's a strong part of you that desires affirmation and respect, nonetheless you feel too unworthy for such affection and recognition.

Repetition of such interventions by the psychiatrist over time will help in quieting both the patient's defenses and resistances and allow her to experience less anxiety and to "stay in the moment" for increasingly longer periods during the therapy session, so that positive change can be facilitated.

CONCLUSION

Much can be uncovered and understood by bearing witness to a patient's testimony (i.e., listening), facilitating the patient's feeling of being valued, and then gradually allowing the patient to understand what has been driving his or her egodystonic behavior. Through examining the patient's resistances to change and unmasking unconscious conflicts and patterns, the psychiatrist identifies maladaptive patterns that can be brought into the patient's awareness, which builds insight, and promotes growth and change.[16]

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