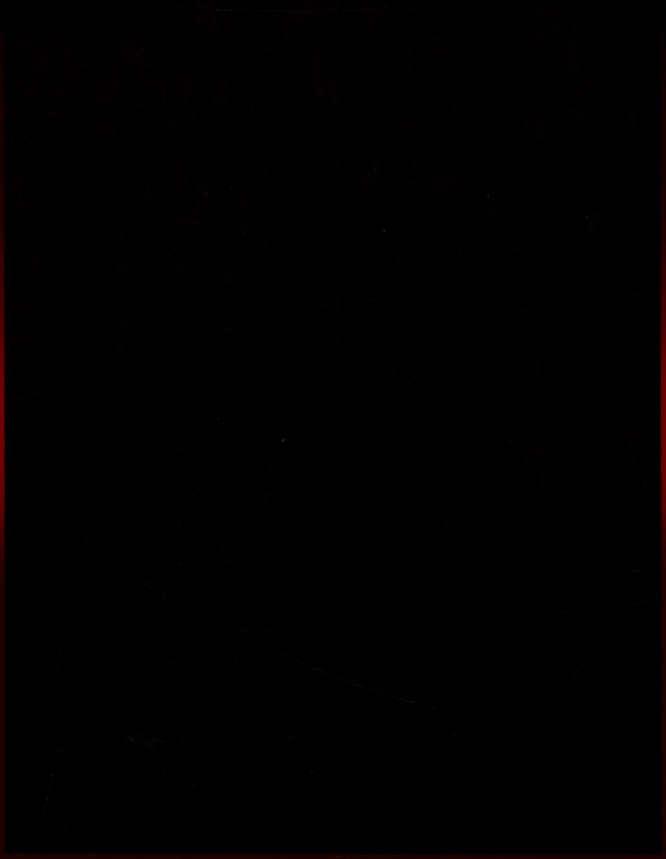
Psychodynamic Therapy

Conceptual and Empirical Foundations



Steven K. Huprich

PSYCHODYNAMIC THERAPY

Conceptual and Empirical Foundations

STEVEN K. HUPRICH

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Preface

One of the best experiences of my professional development was my training and experiences on my predoctoral internship at the State University of New York (SUNY) Health Science Center in Syracuse (now called Upstate Medical University). A major drawing point of the internship was the program's emphasis on psychodynamic training and the empirical support for psychoanalytic ideas and theory. The program's training director, Dr. Roger Greenberg, and his colleague, Dr. Seymour Fisher, had recently published an updated edition of their book, *Freud Scientifically Reappraised: Testing the Theories and Therapy* (Greenberg & Fisher, 1996).* My doctoral program had limited opportunities for exposure and training in psychodynamic theory and therapy, so the opportunity to train in Syracuse was very exciting.

My year-long instruction did not leave me disappointed. All of my supervisors and instructors had considerable experience and interest in psychodynamic psychotherapy and a strong respect for a broad and diverse orientation to psychoanalytic and psychodynamic theory. They also were highly invested in a scientific understanding of clinical psychology, which made for an intellectually stimulating work environment. One of the many influential instructors was Dr. Dennis Bogin, a local psychologist who taught and supervised at the internship, along with maintaining a successful private practice. Dr. Bogin was highly skilled in working with patients, especially those with long-standing character pathology. He could quickly formulate an understanding of their defensive structure, object relations, ego functioning, and the corresponding impairment in drive expression. For relatively inexperienced professionals, such as us interns, we were amazed with the

* The first volume is titled *The Scientific Credibility of Freud's Theories and Therapy* (Columbia University Press, New York, 1985).

precision with which he assessed and understood these patients and offered invaluable guidance in treating patients successfully.

From this experience, I found myself even more interested in the application of psychoanalytic and psychodynamic theory to clinical work. Over the past 9 years, I have maintained a clinical practice, along with supervising many doctoral students in their therapy and assessments of patients. My students, their patients, and my own patients have taught me much as they shared their inner-life experiences and the challenges they faced in their lives' journeys or in their experience of working with patients. Countless books, articles, and chapters, as well as fruitful consultation with psychoanalytic colleagues in Ann Arbor, Michigan, have all shaped my firm conviction that psychoanalytic and psychodynamic theory, broadly conceptualized, has more to offer clinicians and patients than the numerous other theories and approaches to psychotherapy that exist today. In fact, as I highlight in this book, psychoanalytic and psychodynamic ideas are found in many other theoretical and therapeutic models and offer a unified explanation for the mechanisms underlying much psychopathology and corresponding therapeutic change. Contrary to what is flagrantly misconstrued and taught as relic and historical artifact, Sigmund Freud's ideas and their evolution offer a comprehensive, very useful framework from which clinical psychology and psychiatry can benefit. As these ideas have been applied for over a century to improve the lives of real people, clinical science and practice can and will benefit from ongoing attention to this paradigm. *Time Magazine* (November 29, 1993) had a picture of Freud on its cover and asked the question, "Is Freud really dead?" The answer to that question is a resounding "no."

The opportunity to write this book was rather serendipitous. During a phone call to former Lawrence Erlbaum and Associates editor Steven Rutter, I was asked if I knew of anyone with interests in psychodynamic theory. I indicated that I did, and Steve presented the opportunity to write this textbook. He indicated that his market research led him to identify a real need for a book on psychodynamic therapy that (1) demonstrates that psychodynamic ideas are very much alive and utilized in clinical work today; (2) highlights how there is strong empirical support for psychodynamic theory and therapy; and (3) exemplifies how psychodynamic therapy is related to other approaches to psychotherapy. Without hesitation, Steve offered me the opportunity to write the book, and it did not take any work

on his part to my agreeing to undertake the task. Once Erlbaum Publishers was sold to Taylor & Francis, I had the opportunity to work with George Zimmar, who was helpful and supportive of the task I had begun earlier and could now finish with him.

In preparation for writing this book, there are numerous people who have been helpful and influential: Harvey Falit, MD, and the Michigan Psychoanalytic Institute; John Porcerelli, PhD; James Hansell; PhD; V. Barry Dauphin, PhD; Robert Cohen, PhD; Michael Shulman, PhD; Joshua Ehrlich, PhD; Julie Jaffee Nagel, PhD; J. Stuart Ablon, PhD; Jack and Kerry Kelly Novick, PhDs; Richard Summers, MD and the Residency Education Subcommittee of the University and Medical Education Committee of the American Psychoanalytic Association; Mark Solms, PhD; and John Knapp, PhD and Eastern Michigan University's Faculty Research Fellowship Award for Spring–Summer 2007. I also am appreciative of the American Psychoanalytic Association's Reading List that was prepared by Robin Renders, PhD, and Lisa Mellman, MD, which proved to be a useful reference tool. One of my research assistants at Eastern Michigan, Ann Wilson, deserves a lot of credit, too, for her enthusiastic and prompt attention to my requests for copying and obtaining articles and book chapters.

Finally, I want to recognize the unwavering and remarkable love and support provided by the love of my life—my wife, Donna. Although she occasionally joked about my having the summer "off from work" while I was writing this book, she offered me her genuine support, encouragement, and praise for the task of writing a book such as this throughout a 4-month period. I truly am grateful to have a wonderful wife and life situation that has allowed me to do something that I love as much as this.

Contents

1

Introduction

Patients enter psychotherapy for a host of reasons, and, with few exceptions, almost all who seek treatment do so because they cannot find a way to solve their psychological problems. In other words, they are blocked from knowing or understanding something about themselves in a different way from that which they currently do. They come to treatment believing that such knowledge or insight would allow them to be more satisfied or to live in a more gratifying or satisfying way.

It also is not uncommon to hear many patients say, "I know that I should not feel this way," or "This obviously is bad for me," yet they are unable to make the kinds of changes that ultimately would reduce their suffering and increase their sense of well-being. Other individuals may not be aware that what they are thinking, feeling, or experiencing or what is motivating them is problematic. For instance, the man who is successful yet is despised by his coworkers may refuse to consider the possibility that his needs for control and his perfectionism are what alienate him from them. He may well believe that his lifelong work ethic, attention to detail, and "Midwestern values" that were instilled in him and his siblings account for his success and that it is others who need to adapt to him, not vice versa. But, as he becomes more depressed over the lack of friends in his life, he may attempt to ingratiate himself to others by taking them out to lunch or buying them a drink after work, which only increases their sense that he is trying to control or manipulate how they feel. He may have the same attitude in his social life, which he may find dissatisfying for much of the same reasons.

In virtually all patients, it also is the case that there is an element of interpersonal relatedness that becomes part of the focus of treatment. Ask any therapist, and she or he will likely state that it is difficult, if not impossible, to separate how a person's reasons for being

in psychotherapy are not related in some way to the person's interpersonal relationships. Interpersonal relatedness evokes emotional states, ideas, wishes, fantasies, desires, and impulses to act (or not act) toward another person or group of people. Psychological difficulties do not occur in isolation, although the suffering that many patients experience makes it seem as if they are alone, as if they cannot be understood, or that their unhappiness may be representative of a more severe problem. Additionally, if their problems are brought more to the surface, many patients fear that they would be disliked, disapproved of, shunned, humiliated, or rejected rather than helped with their pain. For instance, if a married man's fantasies of being sexually involved with another man were to be made known, they may lead to feelings of disgust and a possible separation or divorce from his wife. Thus, even in those problems that seem most private or hard to experience, how the problem interfaces with other people in the patient's life takes on salience and meaning.

Good therapists know that effective therapy is based on a theory of personality and psychopathology that has substantial explanatory power and applicability to people's lives. Without theory driving the applied action of therapy, treatment often proceeds in a haphazard way. In this situation, therapy can be ineffective and potentially harmful to the patient. Now over 100 years old, psychoanalytic and psychodynamic theories have stood the test of time. They have considerable explanatory power and applicability, even in a climate in which brief and (empirically supported) treatments are preferred. It is the focus of this text to review psychoanalytic and psychodynamic theories and their application to various kinds of psychotherapy.

So, to begin to understand psychoanalytic and psychodynamic therapy and the theory it is based on, it might be helpful to examine some case studies and to review the major tenets of psychoanalytic theory to see their therapeutic applications, after which I discuss them in the context of psychodynamic theory, hoping to draw attention to what has become a very effective and highly relevant approach to clinical work.

The Case of Mr. Shelby

Mr. Shelby was a 19-year-old high school dropout who worked for his family's restaurant. He was referred by his parents, with whom he

lived, because they believed he needed help with the severe bouts of panic that had come upon him about 8 months earlier for no apparent reason. Though he was legally an adult and responsible for his own treatment, he came to see the psychologist only with his parents and at their insistence. In the first session, the therapist learned from his parents that Mr. Shelby was rather quiet as a child, one who seemed to keep to himself often. His interactions with his family were generally good, and even as he entered into his teenage years he tended to favor playing with cousins who were in preschool or just entering the primary grades. Mr. Shelby had few friends in school, though as he aged, the friends he made had interests in computer games. These games had aggressive and violent themes, in which characters were killed; however, they could be "resurrected" through a spell cast upon them by another character in the game. As a child, Mr. Shelby was not particularly violent, although on one occasion when he was 12 he became so angry with his parents that he broke a lamp. Neither his parents nor he could recall why he became so upset, yet he was punished, which all remembered as having a strong effect on curtailing his behavior. At the time therapy began, Mr. Shelby showed very little affect, except for some disdain toward his parents, particularly his loquacious and domineering mother, who had made him come to see a psychologist.

Mr. Shelby stated that he dropped out of high school when he was 17 because he did not like it. Later, it was learned that Mr. Shelby was becoming very anxious at school and did not want to be there for fear of how he might behave (e.g., getting anxious, red in the face). His parents conceded to his wish, and shortly thereafter Mr. Shelby began working at the restaurant, initially clearing tables but then starting to work as a waiter. His parents stated that he did well with customers, despite some initial anxiety.

About 1 year before, Mr. Shelby's favorite uncle had died suddenly. He attended the funeral but said he did not cry. Two months after the uncle's death, Mr. Shelby was leaving his home to go to work when he became very anxious. He felt faint and had many symptoms of panic disorder. Upon getting into his car, he felt nauseated, vomited, and felt unable to go to work. These symptoms happened several times and generalized once to when he was going to a movie with a friend. Over the past few months, the symptoms had subsided somewhat, but Mr. Shelby continued to have anxious feelings and was highly concerned about leaving the house.

The Case of Ms. Murdock

Ms. Murdock was a highly successful 43-year-old businesswoman who came to therapy after suddenly breaking up with her long-term male partner (David) of 6 years. Ms. Murdock was rather sad, lacked energy, and could not seem to get over David's sudden departure from their home. Several years prior, she had been married to another man, Nathan, for about 3 years. The marriage ended after they seemed to "grow apart." Again, this relationship was hard for her to get over. She described Nathan as needing much support and reassurance, particularly when others did not appreciate his hard work. David was unlike Nathan in that he was outgoing and free-spirited and liked to be the "life of the party." Particularly upsetting in her relationship with David was his capricious spending and gambling. Ms. Murdock reported that David spent thousands of dollars on goods and products that he wanted and had lost about $2500 in gambling over the past 6 years.

Ms. Murdock had a hard time identifying what went wrong with David. She did not appreciate his spending habits but did not think it affected how she felt toward him. More often, she speculated that she must have done something to annoy him and worried what this might be. At times, her ruminations about the separation woke her up in the middle of the night, leading to notable sleep deprivation.

Ms. Murdock had a strong network of friends and a mother who was generally supportive and understanding. Her father, however, had grown increasingly negative and bitter toward her, which stood in contrast to the almost idealized role that he had toward her as a child. Their relationship had changed at the time Ms. Murdock entered high school when her father had lost his job due to a layoff. He was unable to find meaningful employment after that and had become sullen, isolated, and negative toward his family.

Basic Psychodynamic Ideas

Psychoanalytic and psychodynamic theory has been and is primed to address the very issues that lead patients to seek treatment. In one of the most comprehensive and well-researched review papers on the legacy of Sigmund Freud, Westen (1998, pp. 334–335) highlighted

five major postulates that define contemporary psychodynamic theory, which are easy to see in the cases presented herein:

1. Much of mental life—including thoughts, feelings, and motives—is unconscious, which means that people can behave in ways or can develop symptoms that are inexplicable to themselves.
2. Mental processes, including affective and motivational processes, operate in parallel so that, toward the same person or situation, individuals can have conflicting feelings that motivate them in opposing ways and often lead to compromise solutions.
3. Stable personality patterns begin to form in childhood, and childhood experiences play an important role in personality development, particularly in shaping the ways people form later social relationships.
4. Mental representations of the self, others, and relationships guide people's interactions with others and influence the way they become psychologically symptomatic.
5. Personality development involves not only learning to regulate sexual and aggressive feelings but also moving from an immature, socially dependent state to a mature, interdependent state.

Mr. Shelby and Ms. Murdock each experienced distress, for which they had little realization of why it occurred and how to manage it (point 1). The origin of their symptoms resided in that part of their minds that was not accessible to them, namely, the unconscious mind. Not only were the symptoms unconscious, but so were many other aspects of each patient's life. Mr. Shelby could not account for why he enjoyed playing violent video games so much. Yet it seemed to be associated with ways he managed his angry and aggressive feelings. In Ms. Murdock's case, she was not aware of the extent to which she had become involved with partners who were highly self-focused and for whom their own self-interests were essentially supported at her expense. She also was not aware of the way her frustration with them ultimately was directed toward herself, leading to feelings of guilt and consequential depression.

Both patients had adopted a compromise solution (or compromise formation as it is called in psychoanalytic terminology) for managing their distress (point 2). Mr. Shelby developed severe panic symptoms, which were associated with two opposing feelings: (1) frustration toward his parents for pushing him to become more independent; and (2) fear of losing them someday. His conflicted feelings of hate

and fear of loss led him to experience anxiety and panic that led him to physically expel the conflict from his body. In this way, he was able to avoid facing the conflict directly. Ms. Murdock had been successful at blocking out of awareness her angry feelings toward her selfish partners by acting as if things were all right. When angry feelings began to surface, she asked herself what she might have been doing that led to problems in the relationship. And when each partner eventually left because of their own self-focused needs that could not be met by Ms. Murdock's patient and kind support, Ms. Murdock became very depressed and self-critical.

Both cases also show how personality patterns developed in early life continued to exist in adulthood (point 3). Mr. Shelby was a rather quiet and introverted child. Except for the time he broke a lamp, he caused very few problems for his parents. As he grew older, he continued to identify mostly with younger children, who were dependent on adult figures to care for them and to protect them from the troubles and challenges of life's experiences. This was a safer world, which in early childhood is characterized by naiveté about the dangers that exist and in which magical solutions still seem possible. Indeed, as Mr. Shelby became a young man, he continued to return to the electronic world, where dangers lurk but protection and care are available. It came as no surprise that he had no interest in leaving his parents' home and had few, if any, ideas about what his future would look like.

Ms. Murdock shared a mutually strong attachment with her father as a child. She was idealized and received much love and support from an attentive and adoring father. Like Mr. Shelby, she appeared to have a normal development and reasonable success in school, yet when her father experienced a traumatic job loss and an inability to be a good caregiver his attention to her waned. She was puzzled by his evolving distance but seemed to have few negative feelings toward him, instead feeling occasional guilt and bewilderment at his absence. Thus, when men to whom she was close as an adult left her, she responded with similar disbelief and confusion.

Closely related to these longstanding personality patterns is point 4, which describes the mental representations and templates individuals develop of others. Such templates, or object relations as they are described in psychodynamic theory, involve thoughts, feelings, and desires that are developed about oneself, others, and relationships. Mr. Shelby had very little to say about himself; he