INTRODUCTION

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Psychotherapy is a personal exchange between two people that has a beginning, middle, and end. The patient and therapist come together and form a connection that spins out an arc of emotion, experience and memory that neither could quite anticipate, and then they wind down and separate, hopefully with the patient feeling better and the therapist wiser.

This book is a collection of descriptions of psychotherapy written by psychotherapists who have been influenced by the conceptualization of psychodynamic therapy described in our first book, *Psychodynamic Therapy: A Guide to Evidence-Based Practice* (Summers & Barber, 2010). We present the reality of psychotherapy and focus on what is essential in driving a patient and therapist forward toward an active, energizing, and healthy interaction that results in change.

The raison d'être of this book is to counter the accumulated layers of sclerotic theory and outdated technique that weigh down the development of psychodynamic theory and praxis, and to contribute to the evolution of clinical conceptualizations and practices that are clear, succinct, structured, and based, as much as possible, on evidence. Our goals are to exemplify the model we previously articulated through detailed case histories, facilitate learning of our method, provide a tool for teaching and supervision, and help trainees get exposure to more cases.

The variety of therapy experiences illustrated here will help to explain the basic principles of the psychodynamic model, show their utility, and reveal some limitations. We start this volume with two chapters summarizing our conceptualization of contemporary psychodynamic theory and technique and follow with twelve case descriptions.

The emphasis on cases in this book comes from our experience in teaching about psychodynamic therapy and shows our commitment to using case histories as a learning tool. It takes quite a while for trainees to treat enough patients to really understand the psychodynamic model and its application, and to see the arc of treatment enough times to understand how to set it in motion. Teaching and training must explain the theory early and effectively, but it must also convey an intuitive, visceral grasp of how a treatment begins, does its magic, and ends.

Improving the pedagogy for any psychotherapy, but particularly for psychodynamic therapy, is especially timely for several reasons:

1. The evidence base for psychodynamic therapy has increasing heft (Barber, Muran, McCarthy, & Keefe, 2013), even though the field struggles against the powerful headwinds of research funding bias and medical economics.
2. The current generation of the mental health professionals is frequently not adequately exposed to and trained in pragmatic psychodynamic therapy techniques.
3. There is some cause for optimism about clinical opportunities for psychodynamic therapists in the future and for the reversal of the powerful trend away from this treatment.

PERSONAL REFLECTIONS

We were struck by many readers' reactions to *Psychodynamic Therapy: A Guide to Evidence-Based Practice*. They told us the book spoke to how they were trying to practice, and they recognized their worldview and sensibility in it—pragmatic and engaged, concerned with the scientific evidence base yet passionate about the importance of letting people tell and rework their stories, committed to patient empowerment and transparency, and relying on an active stance by the therapist.

Many trainees and early career therapists said the book influenced their thinking and identity as therapists, and this sparked their interest in exploring psychodynamic ideas and contributing to their evolution. We were, of course, excited by these developments and wanted to take the next step. We wanted to illustrate and refine the model. We asked younger colleagues and former trainees to present cases that would

reflect our psychodynamic model and that would serve as the scaffold for the fleshing out of these ideas. We selected cases that are typical of the problems and responses that therapists meet in real clinical settings.

Another experience contributed to the inspiration for this casebook. As a therapist in a randomized clinical trial comparing the efficacy of psychodynamic therapy versus cognitive-behavioral therapy versus applied relaxation therapy for panic disorder, one of us (RFS) had access to video recordings of a number of time-limited, complete psychotherapies with permission from the patients to use these records for teaching. One of the treatments (24 hours of recorded psychotherapy) was edited down to 90 minutes, comprising a series of 6- to 10-minute segments culled to illustrate the development, sweep, and resolution of the therapeutic encounter. Psychotherapy involves periods of quiescence and wandering reflection punctuated by moments of intense awareness, engagement and salience, and the resulting edited film certainly focused on these exciting moments, a bit like the TV series *In Treatment*.

This video was used to teach psychiatry residents and other trainees at the University of Pennsylvania and around the world. Students and clinicians watching the film reflected on the aerial view of the arc of the psychotherapy provided by the edited sequence, and appreciated the sped-up experience of learning about what happens over the entire course of treatment. Gaining this experience usually requires a much greater expenditure of time. We hope exposure to these case histories will provide the same type of "big-picture" educational experience for our readers that viewing the edited psychotherapy did for our trainees.

Many psychiatrist and psychologist colleagues with diverse practices came forward with an interest in contributing case histories. We regard each of the contributors to this collection as talented and skillful, and are pleased to be able to illustrate their work. They have taken a risk, as all authors do, in displaying their work, and taken additional risk in providing their self-reflections and assessments of the treatments. We believe honest self-reflection and sharing help to refine and develop one's craft. Our chapter authors, we believe, give an important gift in sharing their personal observations.

The cases presented in this book come from a variety of settings (e.g., training clinics, private practice) and include patients with a range of function. Because our model relies heavily on the notion of the core psychodynamic problem and the critical importance of identifying the problem early in treatment as a basis for active collaboration between patient and therapist, we include cases that illustrate all six of the core problems we have described—depression, obsessionality, fear of abandonment, low self-esteem, panic anxiety, and trauma. While change strategies and transference–countertransference enactments are fully

discussed in the cases, it is really the recognition of the core problem and the striking of a therapeutic alliance around work on that problem that moves the therapy from the beginning to the end and takes its place as a fundamental anchor of our model.

Some of the cases are much more specifically connected to the model, while others are consistent with it but have other important theoretical and practical influences. The cases are naturalistic in the sense that they reflect clinical work designed and implemented by a mental health professional in settings where the patient has considerable freedom to choose the goals, type, and technique of therapy.

A NEW WAY OF LEARNING ABOUT PSYCHODYNAMIC THERAPY

Learning psychotherapy has been likened to other kinds of complex skill acquisition. The Dreyfus brothers' model, which has broad acceptance in business as well as medical education settings (Dreyfus & Dreyfus, 1980), identifies consecutive stages of skill acquisition, including novice, competent, and expert levels. These levels reflect sequential accumulation of skills, knowledge, and their application. Thus, learning psychotherapy entails many steps and hours of training to develop the necessary expertise to treat patients.

We suggest that psychodynamic therapy education and training have traditionally been robust and effective for those therapists who are already interested and have a reasonable knowledge base. But the early phases of learning, including initial exposure, early practice of technique, and the development of an initial synthesis and style, have been left to nature. The techniques for teaching novice skills and facilitating movement toward competence have not been as fully developed and attended to as the methods for further development of experienced psychodynamic therapists. This is a gap we want to bridge with this book.

Indeed, we believe that learning about psychodynamic therapy requires three elements: (1) *framework*—a clear and concise model; (2) *feeling*—an experiential immersion in what happens in therapy, including a big-picture appreciation of the arc of treatment; and (3) *freedom*—the opportunity to practice in a safe, nonjudgmental setting with lots of feedback and the opportunity to explore, experience, make mistakes, and reflect. We see this casebook as a contribution to the "feeling" part of the learning experience—it will allow you, the reader, to dive into twelve psychotherapeutic encounters. You will be exposed to the struggles of twelve patients, the formulation of their core psychodynamic problems, and the techniques for translating all of that information and experience

into a focused treatment that leads to change and, ultimately, the end of therapy. The summary of our pragmatic psychodynamic model in Chapters 1 and 2 will prepare you for that.

The process of identifying with mentors and supervisors, and combining and transforming the lessons from their behavior and approach into one's own unique synthesis, is a lifelong process. In tough clinical situations, many of us find ourselves reflecting on what our analysts, our therapists, or particular favorite supervisors and valued colleagues would have said if they had had to deal with what we are now facing. Or what we imagine they would have said! Reading the cases here provides an opportunity to add to that process. You will consider the sensibility, tone, decisions, and strategies of each therapist and can incorporate those features that resonate with you into your own work.

Written cases have advantages over videotaped sessions. They protect privacy much better, and are a more processed mode of presentation than video. The author can highlight the essential themes and experiences and create a picture that emphasizes the figure in relation to the background, just like an artist's rendering brings out realities a photograph cannot. Despite these obvious advantages, we are all aware that a written case is clearly a production of the therapist and reflects to some degree his or her needs, biases, strengths, and limitations. We introduce each case with a few paragraphs of observations in italics about some important aspects of the treatment and make relevant connections with our model.

Maintaining confidentiality is essential to therapy. Most cases presented in this book are confidential in that all of the identifiable personal information has been changed to protect the privacy of the patients. Some cases are fictionalized by combining the stories of several real patients so that the material makes psychological and psychotherapeutic sense but does not actually reflect the history of a particular person. Most stick close to the real experience with the patient although important details are changed and disguised to protect privacy, and informed consent was provided.

HOW TO READ THE CASES

Each case is written in a relatively standard format, with a chief complaint and presenting problem, history, psychodynamic formulation, course of treatment, termination, and assessment of progress. But that's where the similarities end!

We each found that an essential part of our own learning as psychotherapists took place while reading. One reads about a patient's history

and life experiences, arrayed over a timeline, notices patterns repeating and changing, and sees a therapist straining to understand, characterize, communicate, and facilitate. Reading other people's cases is a rich opportunity to self-reflect and understand more fully one's own clinical experiences. This may involve remembering complicated and confusing experiences with patients and seeing them in a new light with a deeper awareness of one's own feelings or an increased empathic understanding of the patient.

We hope you will be able to tap into this self-reflective reading and learning experience and see it for the refreshing, invigorating, although sometimes anxious, experience that it is. Let your mind wander, notice the moments in the stories you return to and the things you struggle with, and consider your own identity and style as a therapist.

On a less ethereal level, we encourage you to ask a number of questions of each case to help you read actively. You may want to stop for a minute or two in the midst of a chapter to consider them to help keep your reading fresh and open.

• What is the essential story? What are the key aspects of the patient's history and why did the patient seek treatment? What happened over the course of therapy and what kind of change occurred in the patient and in the relationship with the therapist?

• What did it feel like to be the patient? What was his or her everyday experience, the particular type of suffering and discontent? When was the patient particularly vulnerable and compromised and what were his or her strengths? How well did you feel like you could understand the patient's subjective experience? Did you feel the therapist was able to?

• What was it like to be the therapist? What was interesting and exciting, and what was anxiety-producing, frustrating, or confusing? Can you imagine yourself in the therapist's shoes?

• What did you think of the therapist's conceptualization of the core psychodynamic problem? How different were the patient's and therapist's understanding and did these views converge as the treatment went on?

• How did the therapeutic alliance develop? Can you identify the components of the alliance—goal, task, and bond? What do you learn from the therapist's decisions about handling the obstacles to the alliance? Can you see the difference between the therapeutic alliance and the positive feeling shared by the patient and therapist? Can you distinguish between the therapeutic alliance and the transference and countertransference reactions?

• How did the patient change? Do you think there was a substantial change or an incremental one? Was it a change in how the patient feels, sees the world, or behaves? Was the amount of change reasonable for this patient? Did you expect more or less?

• Was the treatment, and the arc of the interaction between therapist and patient, predictable? As you read, are you forming hypotheses about what will happen next, and are your hypotheses accurate? Does the core problem formulation help in your predictions?

• How did reading the case stimulate your own introspection, either about being a therapist or a patient? Did the case authors' self-observations help you be more self-aware and honest in your own reflections?

• Did the therapist adhere closely to the model we have proposed, and was there a clear application of these ideas and techniques? Are there other important influences on the therapist that are apparent and how did that change the treatment?

It is our hope that these questions, which we should ask of ourselves every day in our clinical work, will help keep you in an active and critical (in the constructive sense of the word!) stance as you read. You might try looking at the questions again after you read each chapter and use them as a study guide.

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