Chapter 34: Psychotherapy

Anthony Korner

Westmead Psychotherapy Program, Western Sydney Local Health District, and Specialty of Psychiatry, The University of Sydney, Australia.

"I can only find myself in and between me and my fellows in a human conversation"

Robert Hobson, 1985

The Psychotherapeutic Attitude

Holistic care requires doctors to attend to the psychosocial needs of patients as well as to their medical condition. Everyday human functioning involves a complex coordination of skills and social roles that carry each person's sense of identity and value. Effective clinical intervention always needs to consider the maintenance and support of the patient's dignity and self-worth. Every time a person meets with a physician there is a communicative exchange that impacts the patient's well-being and function (Korner, 2020). As medical professionals we strive to make this exchange helpful to the patient. Clinicians rely on patients' inherent resilience while attempting to effect constructive change, always fostering hope. Consideration also needs to be given to the patient's level of understanding, social resources and cultural background. Good clinical practice is underpinned by this biopsychosocial approach.

The term psychotherapy refers to treating emotional and mental disorders, problems and suffering through psychological means. It is commonly thought of as "talking treatment", although it may also encompass psychological elements other than speaking. Communication has an emotional impact that is *felt*, in addition to its factual content (Korner, 2020). A therapeutic interaction aims not only to help the patient towards improved health but also to feel better. A psychological perspective will be maintained if it is remembered that doctors are committed to the value of all human lives, understanding that every human interaction has meaning for its participants. A therapeutic attitude involves being non-judgmental, genuine, showing unconditional positive regard and maintaining a warm, empathic, patient-

centred position (Rogers, 1995). While there are many types of therapy, an emotionally connected, confiding relationship, a healing setting, a rationale for the therapeutic process, the provision of hope and some element of "ritual", requiring active participation by both patient and therapist, have been identified as factors common to successful intervention (Frank and Frank, 1993).

Psychiatric presentations form a major part of general medical practice (Davies, 2003). For many patients the only health care they will receive for their mental disorder is through a primary care practitioner. Therefore, General Practitioners (hereafter termed GPs) need to have familiarity with psychological approaches to treatment. This chapter will focus on psychotherapy as it might be employed in primary care, with an emphasis on supportive psychotherapy and options for specialist referral.

Psychological Well-Being

Medical doctors are orientated towards the identification of pathology. In contrast, patients generally seek something like "restoration of well-being". Hence it is important to have a concept of psychological well-being underpinning a recovery focus in psychological intervention. Attention is devoted to interests and relationships. The Harvard Longitudinal Study lends scientific weight to the idea that good relationships keep us happier and healthier (Vaillant, 2012). Freud[1] is said to have defined psychological health as the capacity to *love* and *work*. These days we might add *play* to love and work, recognizing the importance of recreation to maintaining a sense of satisfaction in life. We also need *rest*, often disturbed in patients with psychiatric disorders. When well, we expect adults to function in a self-organizing way. The goal of medical intervention is usually to restore this capacity, helping people to "get back on track". Medical and psychiatric interventions should provide information that allows the patient to make informed choices about their own care.

Normative Development

Humans are born into a world of continual communicative interaction and relationship. Human development is prolonged beyond any other species. Growth

[1] The statement "to love and to work" as a description of mental health is attributed to Sigmund Freud. There is a similar quote in one of his later works, "Civilisation and its Discontents": "The communal life of human beings had, therefore, a two-fold foundation: the compulsion to work, which was created by external necessity, and the power of love… ".

and learning occur, initially, in the asymmetric interaction between the immature infant and others (caregivers) with greater experience in life.

Infants are *communicants* with whom carers interact from birth (Bullowa, 1979). They have capacities for turn-taking and affective expression enabling a level of communication and relationship (Malloch and Trevarthen, 2009). Even though the infant's participation is initially instinctive, rather than reflecting conscious understanding, patterns of relating become established that involve differential processing of positive and negative affect. The infant is dependent on the carer for relief of distress which is important in providing the infant with a basic sense of security and trust.

When the infant displays positive affect, through gaze, smiles and vocalizations, he or she will typically be responded to in a more playful manner, setting up exchanges that have been described as "the proto-conversation" (Trevarthen, 2018). When the carer takes the cues of the infant and provides an attuned response, a condition is created where the infant begins experiencing life as having value, generating *"a particular kind of pleasure that neither could gain alone*" (Meares, 2016).

At around 6 or 7 months of age infants start to exhibit separation anxiety. This is thought to relate to the emerging sense of distinctness from others, particularly the primary caregiver. For the infant, this brings with it fears of abandonment. Provided the caregiver remains fairly consistent, this phase will usually be negotiated without disturbance of the developmental trajectory. Mobility and exploration increase and communication becomes more differentiated within the dyad. There is an increase in the specificity of meaning understood within the infant-carer relationship (Halliday, 1975).

With the acquisition of language in the second and third years of life, the child becomes a participant within a broader community. A secure child will go through a phase where play is sometimes carried on alone, often accompanied by chatter with the child seemingly talking to him- or her- self, while using objects (e.g. toys) to represent stories and actions, often narrating or treating the objects as if they were alive and could communicate. This kind of activity is termed symbolic play (Piaget, 2013). This form of externalized self-talk is probably a prelude to being able to think in words without the need for vocalization.

Language acquisition and the growth of other cognitive capacities means that mental life becomes structured into awareness of present, past and future, freeing the individual to think beyond the immediate present (Korner, 2020). The emergence of episodic (autobiographical) memory around the age of three also

contributes to the establishment of an inner world of associations and a sense of agency that allows for greater independence.

The child now has an inner zone of private experience, although he or she must also be continually adapting to the external world. The private domain of self emerges in the public space of relationships and physical contingencies. Personality consists of the private self, on the one hand, and public identity on the other.

As the child grows, roles and expectations change. The infant is expected to be a recipient of care. Expectations for the assumption of responsibility and self-organization increase as the child matures. The formation of a distinct identity, the development of skills that allow for gainful employment and establishment of a peer network, become necessary for entry as an autonomous individual into the adult world. As adults we face the further challenges of establishing a home, being able to care for others and contribute to communal life. Consideration of the individual's stage of life and its attendant challenges (Erikson, 1993) is essential to appropriate psychological engagement.

Trauma and Loss

Early childhood adversity such as neglect, physical, sexual or emotional abuse, can lead to disturbance in the development of personality. Various types of insecure early attachment relationship have been shown to predict adult pathology [attachment has four main types: secure; insecure-avoidant; insecure-ambivalent; disorganised (Ainsworth et al., 2015; Bowlby, 1982; Main et al., 1985); see Chapter 13]. Individuals growing in the context of chronically inadequate, insecure or absent relationships are severely disadvantaged. Childhood loss, injury or illness may be important factors in developmental adversity. While many of these people show great resilience and make constructive adaptations to life, some will require psychotherapy, sometimes with complex needs requiring specialist services.

The extent and impact of childhood trauma, abuse, and neglect has been increasingly recognized in recent decades (Felitti et al., 2019). Recognition of the significance of trauma and loss to the individual is an important aspect of establishing a good therapeutic relationship, contributing to the process of healing. Trauma-informed care accompanied by a recovery focus has become an expectation of all mental health care (Herman, 2015).

Formulation using a Biopsychosocial Approach

Diagnosis in relation to mental disorders depends upon adequate assessment of clinical symptoms, mental state and history relating to the onset of the

condition. This provides a generic assessment, often with limited information about the individual. A more detailed history is required to individualize the assessment, considering both presenting condition and preceding developmental context. This encourages recognition of difficulties faced and adaptations made, over the lifespan.

A comprehensive approach to formulation necessarily involves biological, psychological and social dimensions (see Chapter 7). Mental disorders typically reflect a loss of capacity to coordinate responses across these domains. In a given case one or more of these areas of assessment may be more critical than another. Some points to consider in making a formulation are listed below:

- What factors account for the patient presenting *now*? Often this relates to changed circumstances, illness, relational problems, financial stresses, etc.
- Early life experience and quality of attachment relationships.
- Childhood experience including ability to relate to other children, abilities at school and other areas of competence or deficit.
- Markers of the ability to create an independent life, including occupational functioning, educational attainment and the capacity to develop and sustain intimate relationships.
- The quality of adult relationships.

Having considered these areas, many clinicians find it useful to organize factors identified into *precipitating*, *predisposing*, *protective* and *perpetuating* categories. This helps guide clinical decision-making. Formulation using a biopsychosocial model serves two primary purposes:

1. It allows sharing of the clinician's overall assessment, engaging the patient and helping them understand the rationale for treatment.
2. It informs an individualized management plan, providing interventions specific to the person and circumstances.

In the context of psychotherapeutic intervention, adequate formulation also helps the patient feel understood. People are constantly formulating actions and responses in relation to the demands of everyday life. In the psychotherapeutic context the clinician additionally seeks to incorporate developmental understanding and the role of unconscious factors in the clinical presentation. One of the goals is to help develop a shared narrative, which often has the effect of enhancing therapeutic connection.

Case illustrations are used to show the application of formulation to everyday practice:

Jenny is a 31-year-old mother of three who has had a decline in function over the last three years with frequent suicide attempts, self-harm, unstable mood, persecutory ideation and distressing internal imagery. There have been repeated admissions to hospital. This decline was associated with loss of a job at which she had performed well. She always had difficulty with the parental role, leaving these responsibilities to her husband, who was on a full-time carer's benefit since the birth of their first child. While she felt guilty about not being a better mother, she believed her husband was a good carer. Jenny reported learning difficulties in school. Her mother thought a severe febrile illness involving seizures in the first year of life had affected her. She had been told that she had been behind her siblings in pre-school development, with delayed language acquisition. She was second youngest of five. Family relationships had not been overtly traumatic although she always felt her mother was critical and had favoured her siblings. A diagnosis of Borderline Personality Disorder was made with an additional note of intellectual function in the low average range.

Jenny presents with a change in function that relates to a loss of employment (social factor), significantly affecting her sense of identity (psychological factor). There are indications that her baseline functional level had been affected by an illness characterized by seizures associated with delayed development and relative intellectual impairment (biological factor). This deficit may have been compounded by a relatively invalidating family environment (psychological factor) and difficulty establishing a sense of competence as she always felt she was deficient relative to her peers. The birth of her children was experienced as anxiety-provoking with an adaptation that involved giving up parental responsibility (avoidant adaptation) while gaining a sense of self-worth by contributing to the family through work (psychosocial adaptation).

Brief on Jenny's case comment: although a range of managements, including pharmacological and psychological intervention were provided, the key intervention, in terms of leading to sustained recovery, was a social intervention centring on supporting Jenny in a return to work.

Joe, a 35-year-old man, lives with his wife and four children. He came to hospital after the death of his cat, sobbing uncontrollably, with a wish to commit suicide. It emerged that he had also lost a friend and had suffered an assault in the preceding six months. He felt disorientated and ashamed of his behaviour. When his wife and children visited, he did not want to see them.

Joe had never been close to his parents. His father was a violent alcoholic, while his mother was passive and emotionally cold. They separated when Joe was 9 years old. Both remarried and had other children.

When he first met his wife, he was surprised at her level of interest and love. However, when they had children, she became more interested in them. The person he felt closest to was a male friend, who had died of cancer recently. Since then, he had continued to go to work, come home and talk to his cat, watch television and go to sleep. Six months ago, he was assaulted while attending to an injured man in the course of his work. He was upset by the lack of support from management.

Shared (spoken) formulation.
"I don't know if this is right, but it seems to me that it is no wonder that you were inconsolable when your cat died, as she was the only thing that you could safely talk to. Because your dad was unsafe when you were a kid, and your mum was distant, you never felt that anyone really cared for you, and you learnt that when things go bad, like your parents separating, you just have to look after yourself. At first your wife was like a breath of fresh air, but when the children came, you seem to have lost the feeling of closeness with her. The only person that seemed to matter was your good mate, which probably made his death doubly painful. You lost him, and there was no one to talk to about your sadness. I guess you dealt with this by pulling away from everybody, spending a bit of time with your cat, and just following a routine of work and sleep. The situation got worse after you were assaulted, particularly as the lack of concern from management seems to have dovetailed with that feeling that nobody cares, which you have lived with all your life."

Brief comment on Joe's case: the shared understanding conveyed in this formulation was found helpful by the patient who engaged subsequently in psychotherapy with a positive outcome. He declined offers of alternative treatment with medication. (Case 2 from (Korner et al., 2010)).

Psychotherapy in Primary Care

Primary care is often the first point of contact for people suffering mental distress or disorder. GPs need to be able to recognize major mental disorders and prescribe appropriate treatment. However, they also need to have flexibility in responding to a range of distress and adjustment disorders for which the most appropriate form of intervention is psychological, often involving brief psychotherapeutic intervention. Judicious intervention may minimize the development of more intractable disorders. The type of intervention varies depending on the skills of the clinician. All doctors need to be able to provide adequate psychoeducation and supportive psychotherapy. Attending to the psychological well-being of patients through appropriate supportive psychotherapy is an element of all medical and psychiatric care, even when there is a focus on other interventions such as pharmacological measures or surgical procedures. Elements include active listening, adequate explanation of condition and treatment, allowing time to answer questions, considering the patient's emotional response, reaching agreement about a treatment plan and facilitating any necessary additional referrals or external support. For some patients scheduling additional sessions to allow sufficient time for talking and working through emotional problems is a necessary part of treatment.

Supportive Psychotherapy

The aim of supportive psychotherapy is to optimize the patient's psychological functioning, making use of the available psychosocial network. This involves using the therapeutic relationship to provide an emotionally safe environment for the patient where problems can be identified and worked through. The focus is primarily on the present, with a practical "here and now" orientation. As with all clinical work, an adequate assessment and formulation is required. Problems need to be prioritized and the person's social, financial and occupational resources considered. If the clinician is a GP, consideration needs to be given as to whether referral is required or whether it is possible to provide adequate support within the practice. A treatment plan should be negotiated. In many cases this will involve organizing appointments of sufficient length to allow adequate articulation and emotional processing of the problem.
Some elements of supportive psychotherapy are listed below

Create an Appropriate Framework

Primary care includes a lot of crisis support requiring flexibility on the part of the practitioner. When a psychotherapeutic intervention is required, scheduling sessions with a fixed time at regular intervals is helpful. This should be mutually

negotiated and then every effort should be made to keep to the agreed times. It should be made clear that the sessions are for talking through problems. Other interventions may also be agreed upon (see below). It needs to be made clear that the work is conducted within professional boundaries.

Active Listening

It is often difficult to express distress or disturbances of mental state clearly. The doctor needs to listen for emotional inflection and expression as well as word content. Patients experience benefit from simply being heard. The doctor needs to share what has been understood, attempting to see things from the patient's perspective and check whether there is agreement. Maintaining attention, summarising, seeking clarification and reflecting back what has been said are all elements of effective therapeutic communication.

The Therapeutic Relationship

A compassionate, trusting, responsive relationship is the basis of much healing practice.

Ventilation and Emotional Expression

If patients are in a state of emotional distress, then it is essential to allow sufficient time for expression and processing. Catharsis, the expression of strong emotion that has often been suppressed in other settings, may provide real relief for patients struggling with feelings of vulnerability or other strong emotions. Therapists need to be able to tolerate and sometimes encourage emotional expression.

Reassurance, Encouragement and Explanation

These kinds of response are characteristic of helping relationships and often contain anxiety, allowing a more rational appraisal of the situation.

Coupling and Amplification

When patients are in a fragile emotional state, it is often helpful to make simple responses, like "uh-huh" or repeating a phrase of the patient's that seems significant. This "coupling" with what the patient expresses often provides a sense of connection. Where the therapist senses something of significance for the patient, this can be amplified by showing interest in what has been said, encouraging the person to expand, often enlivening the communication (Meares, 2012).

Cognitive and Behavioural Techniques

Depending on the skills of the practitioner, these may be applied flexibly in a supportive psychotherapy. *Problem-solving* helps clarify the nature of the problem and generate alternative strategies to address it. *Re-framing* involves providing an alternative appraisal, often one with less prejudicial connotations that helps normalize a particular issue. *Mindfulness* exercises may promote greater self-awareness, helping to decrease reactivity if practised regularly. Other forms of relaxation exercise may be beneficial, increasing the person's sense of agency in being able to manage anxiety (e.g., progressive muscular relaxation; slow diaphragmatic breathing).

Lifestyle

Social and lifestyle interventions should always be considered. These may include encouraging scheduling of activities that are positive for the individual, consideration and attention to sleep hygiene, regular exercise, attention to a healthy diet and consideration of work stresses and the need for leave. For some patients, substance and alcohol abuse will need to be addressed. Cessation of smoking and modification of caffeine intake may be helpful.

Family Involvement

Many patients feel isolated and have difficulties communicating with family members, sometimes bringing problems to a professional instead. Where a matter has been kept secret, it may have had a significant impact on family relationships. Sometimes bringing something into the open with the family can be a great relief, although it is a matter of judgement that needs to be considered carefully with the patient. Family members may also be enlisted in providing practical support, helping engage the patient in a greater range of activities. Sometimes intervention in relation to a specific dysfunctional relationship may be required (e.g., referral for couples counselling).

Case Example

A 48-year-old man, Bob, presents to his GP with what he describes as "extreme stress". His workload has been increased in the context of other staff being laid off. He has noticed increased irritability and is concerned that this is affecting his work and family. He has been getting home late, not seeing his children regularly, and sleeping poorly. This has worsened over two weeks, since the changes at work. He is an ambitious and somewhat driven man. He doesn't have low mood but is anxious and shaky at assessment. He describes feeling "at the end of his tether", although this refers to his emotional state rather than to suicidal ideation. He is otherwise in good health.

The doctor agrees with the patient's characterisation of severe stress, pointing out he has also become extremely anxious. After assessing his physical state and reassuring Bob that there doesn't seem to be any physical problem, the doctor suggests taking a day or two off work, scheduling a further appointment to address the anxiety symptoms he is getting. With initial reluctance Bob agrees to take a day off and come back the following day. When reviewed Bob expresses a degree of relief and was pleased to have seen his children that morning. The doctor guides Bob in a progressive muscular relaxation exercise. After this Bob becomes quite emotional, saying he'd never realized how tense he was until he'd experienced this relaxed state. He talked at some length about the sense of being burdened by multiple responsibilities and gave further background to his symptoms. Bob felt further relief from this expression of emotion, feeling he was well enough to go back to work the next day. The doctor was somewhat concerned he may be pushing himself too soon but provided a work certificate for one day, making a further appointment for the following week. There was a discussion of work-life balance and the need to schedule positive activities with the family. The following week Bob reported improved function at work, feeling that having been able to open up about his problems had made a big difference.

Liaison With Other Services

Involving other specialized services may be necessary (e.g., Psychologist, Anxiety Disorder Program, Community Mental Health Team, Drug & Alcohol services; Social Welfare Services). For many patients the GP will be the main case manager for coordination of services. It has become standard practice for GPs to develop Mental Health Care Plans in conjunction with psychologists and other Mental Health Practitioners, enabling access to psychotherapeutic interventions for patients who may otherwise be unable to afford them.

Psychoeducation

Mental disorders and disturbances in emotional or mental state are all embodied processes. As such it is relevant to educate patients regarding underlying physiological processes, using simple language supplemented by supportive written material where possible (there are many Mental Health-related websites with readily accessible information – for example Beyond Blue; Black Dog Institute; Project Air, etc).

It is helpful for patients to recognize that symptoms aren't simply imaginary but have a basis in bodily processes. While it is beyond the scope of this section to address psychoeducation in relation to specific mental disorders, the body's response to stress and some of the physiology underpinning anxiety and emotion are briefly described, as well as some physiological processes that support mental well-being.

Stress Response (see Chapter 18: Anxiety Disorders)

In humans, it is the perception of threat that elicits the stress response, sometimes referred to as the "fear cascade". *Threat* includes perceived danger to personal integrity, self, or relationships. The source of threat may not always be obvious even to the person experiencing it. Emotional responses often bypass conscious cortical processing systems, involving rapid non-conscious pathways in central parts of the brain (e.g., amygdala). Other parts of the nervous and endocrine systems (involving production of stress hormones, cortisol and adrenaline) get activated with recruitment of the *fight-flight* response, or the more drastic *freeze* responses, perhaps better termed *tonic immobility* and *collapsed immobility* (Kozlowska et al., 2015).

Normal functioning, supporting social engagement and higher neural functioning, is regulated by the *parasympathetic* part of the autonomic nervous system, operating outside conscious control. In response to threat, the system mobilizes and orients to appraise the threat. If the threat continues, a full *flight-fight* response will ensue. This involves considerable physiological arousal sometimes associated with bodily symptoms of panic. If the level of threat is perceived as life-threatening, a different physiological response may be elicited involving a relative shut-down of many bodily systems. In other species this is associated with a "death-feigning" response, protective in some circumstances. In humans *collapsed immobility* may be associated with numbing and marked reduction in cognitive and motor function or even loss of consciousness. Emotional accompaniments can include a sense of helplessness or emotional distress (Kozlowska et al., 2015; Porges, 2011).

Models of Mental Life and the Brain-Mind System

Mental life and personal experience are supported by a complex coordination of interacting neural networks that give rise to consciousness and the sense of personal existence. Some areas seem particularly important in supporting the experience of emotion, relational interaction, and sense of self. Three areas of the brain are emerging as important in this regard (Knox, 2010): a) the *mirror neurone system*, closely related to the cortical motor system, is activated while observing movement in others and seems to be important in the sense of relationship, participation and connection with others; b) the *Central Midline Structures* (CMS), including the limbic system, a relatively ancient part of the central nervous system in evolutionary terms, are critical to the experience of emotion, understood as a whole person response to environmental interaction; and, c) the *default network*, a widely distributed network in the brain, characteristically active when the person is **not** involved in particular tasks (i.e. states of relative rest; internal focus). Indications are that this area is important in the experience of thoughts, feelings, processing of memory and other forms of "self-related processing".

Bodily Bases of Well-Being

Adequate rest, recreation, sleep and nutrition are all important to mental well-being. In humans, as social beings, the capacity to express ourselves and share with others, coordinating ourselves in social and work networks is supported by the parasympathetic nervous system (through the vagal nerve), helping maintain the body in a relaxed, socially engaged mode (Porges, 2011). Social connection and relationships with others are important to mental balance throughout life. Processes such as meditation and relaxation techniques support well-being by slowing breathing, leading to stronger vagal regulation of the heart and cardiovascular system, supporting higher mental functioning. Creative expression may be an important aspect of well-being for many, giving representation to the complexity of human lives.

Appropriate Referral

GPs are involved in referral to acute psychiatric services in relation to presentations such as psychosis, the suicidal patient, severe mood disturbances and specific conditions covered elsewhere. Doctors generally need to familiarize themselves with available specialist services. The focus here is on referral for psychotherapy.

A crucial factor is that the doctor recognizes professional limitations. Highly complex presentations require a psychiatric review, often involving multidisciplinary work. Specific services will be indicated for particular counselling

needs: drug and alcohol services, bereavement counsellors, sexual assault services, structured psychotherapeutic services or combined psychotherapeutic, psychiatric and behavioural approaches (e.g., Dialectical Behaviour Therapy, Anxiety Disorder clinics, youth-oriented services, such as *Headspace*). With milder presentations the GP may be optimally placed to provide advice and support.

Attempts to treat complex patients alone may lead GPs to become overinvolved which may result in boundary violations such as developing inappropriate relationships. However, the GP often continues to have an important role in the provision of community care with challenging patients, in conjunction with other mental health services.

Some patients present with lifelong difficulties, often falling into diagnostic categories of treatment resistant depression, personality disorder, addictive disorder, post-traumatic disorder, somatisation disorder, dissociative disorder or others. Where trauma is shown to have been significant in development, the terms "complex post-traumatic stress disorder" or "developmental trauma disorder" have been used. (Herman, 2015; Van der Kolk, 2014).

For those who are dysfunctional but motivated to seek intensive help, more specialized intervention can be sought. There is a confusing array of available psychotherapies. For simplicity these are considered under the categories of, 1) Psychodynamic therapies; 2) Cognitive-Behavioural Therapy (see Chapter 33); and 3) Structured Therapies. For purposes of referral, the doctor should understand that psychodynamic therapies are in the psychoanalytic tradition, acknowledging that unconscious factors influence well-being. They rely upon sustained engagement in a therapeutic relationship oriented to empathic understanding of the patient's inner world, emotional life and patterns of coping. Aims include working through trauma and the development of greater autonomy and flexibility. These approaches require extensive training and supervision. The most intensive therapies (i.e., psychoanalysis four or five times a week) are emotionally challenging and require a reasonably high level of function and motivation on the part of the patient, with a capacity for reflective and symbolic thought. Many psychodynamic practitioners work in frameworks of once or twice a week, face-to-face sessions with most patients. This is a more realistic and affordable option for many patients.

Additionally, doctors can augment the supportive care they provide through online resources and involvement with self-help groups. Even when patients are referred on, the GP maintains a supportive role when episodes of care with other services and therapists have been completed.

Psychodynamic Therapies

Psychodynamic therapies are oriented to helping people make sense of experience. This includes exploring unconscious and traumatic influences, and considering experience within the therapeutic relationship. People with long-established emotional difficulties, recurrent self-defeating patterns of behaviour and complex experiences of trauma and loss may benefit. Psychodynamic therapies typically involve a sustained engagement over at least 12 months. A sense of demoralization or lack of fulfilment may be common factors for patients seeking therapy, transcending diagnostic categories (Frank and Frank, 1993).

All people experience life through the lens of past experience, albeit usually without realizing how past experience is shaping present interaction. Individual modes of coping are developed in early life through experiences with caregivers and significant others. These adaptations are established while the infant is in a pre-verbal state. Such habitual patterns are not accessible to conscious awareness but rather happen automatically (unconsciously), being manifest in behaviour, particularly in relational life. The emerging experience of self is affected by relational interactions. Not only is there "no such thing as an infant" (Winnicott, 1986) but there is no sense of meaning for an individual in isolation from his or her environment.

Psychodynamic therapies all employ the technique of *free association* which encourages patients to express whatever is felt, following the drift of internal images. This is a key to understanding patterns of interest and growth, traumatic disruptions and avoidances, inhibitions and self-protective measures that have become established. While there are many competing theories, there has been a trend towards recognizing the centrality of relationship-seeking in development, with increasing emphasis on applying understanding from normal developmental interactions to the situation of therapy. Another change of emphasis has been from "neurosis", where individual anxiety was often seen as having an irrational basis in infantile relationships, to the increasing recognition of trauma, often in the form of an early relational environment involving abuse, neglect, or mismatches between infant and carer that have contributed to failures in development (Meares, 2004).

Growth requires an empathic and responsive relationship that recognizes the patient's distinct individuality and value while maintaining clear boundaries. Apart from basic needs for safety and security we also need new experience in order to develop (Korner, 2020). In a successful therapy there will be a broadening of adaptive capacities and improved tolerance of affect with a greater sense of the person being able to take responsibility for his or her life. Some brief orienting comments are made below regarding three central aspects of psychodynamic

therapies: framework and boundaries; transference and countertransference; defence and adaptation.

Freud is credited with developing the technique of free association, although as Jones points out: "There can be no exact date for the discovery of the 'free association' method… it evolved very gradually between 1892 and 1895, becoming steadily refined and purified from the adjuvants - hypnosis, suggestion, pressing, and questioning - that accompanied it at its inception" (Jones, 2019).

Therapeutic Framework and Boundaries

The intention of the psychodynamic therapist is to provide an emotionally safe space, a "secure base" from which the patient may be able to safely explore his or her experience. The regularity of meetings in the same place at specific times is an important part of establishing a sense of reliability. Patients also need to be clear that information they disclose will be held confidentially. Consistency of sessions in time, place and person, a confiding relationship and understanding of the limits of contact and alternative options (e.g., for crisis care) constitute the therapeutic framework, often referred to as "the frame".

Ethically, breaches of confidentiality should only relate to questions of safety of the patient or others (e.g., when patient is suicidal; when patient is making credible threats against others; when information is disclosed that reveals a child is at risk). The frame also needs to include some explanation of therapeutic process, involving encouragement of the patient to speak openly about his or her inner life and experience, with a view to improving self-awareness, understanding and facilitating the realization of personal goals.

Patients will sometimes behave in ways that put pressure on the therapist to deviate from the framework (e.g., seeking for a session to be extended or seeking an alternate time). While the therapist needs to have some flexibility, major changes to the framework should be kept to a minimum. The task is to understand, with the patient, the nature of any deviation to the frame, and to bring the patient back to the normal routine of sessions.

Transference and Countertransference

All people develop expectations based on past experience. This is a normative process with predictive value that begins from birth. The earliest patterns of expectation emerge in relation to significant others (carers, siblings) during a period where memory is recorded in procedural and perceptual systems outside conscious awareness. This is to say that interactional patterns employed in

communication and social behaviour are influenced by early experience in a relatively automatic way. In clinical situations the patient unconsciously displaces behavioural patterns and emotional reactions from past relationships onto the therapist, the phenomenon of ***transference*** (Freud, 1997). While unconscious displacement of past experience occurs, it is also important to recognise that the patient's experience is of feelings in the present, relating to the immediate interaction. Transference involves the feeling experienced in the therapeutic relationship by the patient towards the therapist. Working with transference implies not only understanding the patient's condition but also reflecting upon experience in the therapeutic relationship.

Clinical circumstances where patients present with hostility, gift-giving, seductive behaviour, intense demands, or incoherence may all reflect transference influences. See the box below for an illustration of this kind of presentation.

A young man presents to his psychiatrist with unbridled hostility, verbal abuse, and threats. This follows a previous encounter where he had disclosed an extensive history of abuse from a sadistic and controlling father. The psychiatrist sensed that this was a man for whom any expression of vulnerability had met with violent responses during his development. When a link was made, recognizing his courage in talking about past abuse, the man calmed considerably.

Later experience modifies perceptions and expectations and is more accessible to consciousness. In therapy patterns of behaviour and interactional response become evident in the therapeutic conversation (see the box below for an example).

Establishing an emotionally responsive therapeutic relationship creates a situation where the thoughts and feelings being experienced in the therapeutic relationship can be reflected upon, often with recognition that there are parallels with other, earlier relationships. Understanding transference has potential to put into words matters that had been relatively unconscious to the individual. The young woman mentioned above eventually discovered that the therapist wasn't going to react with hostility and became more able to share her inner experience.

A young woman with an eating disorder finds it difficult to speak in therapy. It emerges that whenever she made attempts to pursue her interests her father would react harshly, brooking no opposition. Her mother was employed as the father's agent in vetoing the daughter's initiatives. Silence at home often reflected anger on the part of her father. The therapist is aware that prolonged silence would be experienced as hostile by this patient. Accordingly, there is an effort to provide a responsive, turn-taking environment, different from the atmosphere of her home environment.

In her original environment, this patient could not establish a sense of agency. It was expected this would take time to emerge in therapy because of her anxiety that whatever she puts forward would be squashed by the "other".

This isn't always a straightforward process. Often transference experiences are associated with strong emotion, reflecting earlier traumatic experience. When therapy continues over relatively long periods, an increased intensity of emotionally-charged interactions may develop with some patients. However, if safety in the therapeutic relationship has been established, there will be gradual integration of these powerful affects.

Just as the patient has responses with a background in early experience, so do therapists. At times therapists will also struggle with powerful emotional responses. Some of these will be directly related to the patient's behaviour. However, there is often a component that relates to the therapist's past. These responses, occurring within the therapist, are broadly referred to as the ***countertransference***. While distortions related to the therapist's background may sometimes interfere with therapy, countertransference can also be a source of new information. An evoked response in the therapist, quite outside the range of his own previous experience, influences the therapeutic interaction in the example provided in the box below.

A young woman, in therapy for some months, sits in stony-eyed silence, refusing to respond to the therapist's comments. The therapist is uncomfortable, feeling a cold sense of threat in the relationship. Giving voice to this discomfort, by saying that "something doesn't feel quite right", leads to the patient disclosing a detailed story involving an imagined killing and suicide. The sense of lethality in the silence informed the therapist's response.

The full range of emotions may be evoked in patient and / or therapist, at times with significant intensity. This may encompass hostility, anger, love, hatred, envy, sexual feelings, etc. The therapist needs to contain strong evoked emotion and help the patient to contain anxiety and distress, so that it becomes possible to reflect on interactions. The therapist strives to keep emotional arousal within tolerable limits, sometimes referred to as working within the "window of tolerance". The therapeutic relationship is also an emotional journey where the sense of connection is often rewarding for both patient and therapist. A positive sense of connection is probably necessary to the integration of trauma.

Supervision enables the therapeutic interaction to be seen with greater clarity. Learning about one's own responses is also facilitated by having a personal therapy. This has been a traditional part of psychodynamic training. A modern understanding of transference and countertransference is that *both* patient and therapist contribute to this dimension of the therapeutic relationship.

Defence and Adaptation

Given that humans always live in communities and cultures, learning to find one's way as a social participant in life is a complex task. The sense of self is dependent upon feeling on the one hand and language, relationship and culture on the other. Strong feelings can be difficult to contain. Traumatic experiences, like an assault or an unexpected shock, disrupt our sense of self and actually narrow our consciousness. This kind of experience involves *dissociation*, impairing the capacity to function in a socially responsive way, often associated with a sense of fragmentation, hypervigilance, numbing or depersonalisation.

In everyday life there are many things that we would prefer "not to know about". Uncomfortable feelings are avoided. We change our mindset to think about less unpleasant things or alternatively we might become argumentative, criticizing whatever may have caused offense. Given the opportunity for reflection, people may come to see that they are behaving "defensively" and that this affects social interaction. One person may react to conflict by withdrawing and ruminating on feelings of guilt about an interaction, an *internalizing* strategy. Another person may respond angrily and blame others for his discomfort, an *externalizing* (or *projective*) strategy. Sometimes the experience of reality may be so distressing as to provoke reactions involving *disavowal* or *denial*.

Identification is a more complex form of adaptation in which a person emulates the characteristics of another as a whole, including behaviour, style and demeanour. It may be conscious or unconscious. When it occurs early in life it is invariably unconscious. Some people may perceive complex states as emanating

from an external source (*projection*) and, simultaneously and unconsciously, *identify* these complex personal characteristics, felt to be intolerable or alien to self, in a particular other person. This complex phenomenon is referred to as *projective identification* (Klein, 1946).

When this occurs in therapy there is likely to be a sense of intensity, perhaps a sense for the therapist that the patient is "getting under my skin", which can be confusing and disturbing. The patient is likely to attempt to control or coerce the other (therapist) in the case of *projective identification* because there is, at some level, awareness that the other represents an aspect of self that should be under control. Sometimes defensively projected feelings may be induced in the therapist. For example, the psychotherapist begins to feel the sadness or rage that the patient denies or from which they have dissociated. If understood, this then provides a way of it being communicated and returned to the patient. This would be a case of the therapist processing an experience that had arisen in the countertransference.

Similar unconscious processes may be at play when a patient acts impulsively or dangerously instead of talking about problems, the process of *acting out*, which may sometimes be induced in psychotherapy. For instance, a patient who feels abandoned during a break in therapy may self-harm. The therapist tries to maintain a reflective position, understanding the meaning of the behaviour. In order to manage these difficult situations, the therapist needs to find a reflective space in supervision or peer review. This assists in processing and containment, fostering development of the therapeutic response.

Many patients, notably those in the group of Cluster B (extroverted) Personality Disorders (such as Borderline Personality Disorder) have established an organization of experience into "me" and "not-me", or "good" and "bad" from an early, pre-verbal age. This leads to a failure to see the world and the people in it as whole entities with good and bad qualities. This is a form of dissociation known as *splitting* and is typically an adaptation to disorganized attachment. A common manifestation of this division into "good" and "bad" in clinical practice is that, where there is a team of people involved in the care of such a patient, there will be a polarization of attitudes, sometimes leading to conflict over the treatment approach.

Patterns of response develop as part of an individual's repertoire in relational interaction in the same kind of way as has been described for transference. Some kinds of adaptation to the environment are operative from the earliest phases of life (e.g. dissociation). Others depend upon later development and verbal capacity (e.g. intellectualization). The reflective space created in therapy may allow the person to "see" the ways in which they interact and identify what is helpful, or self-defeating. Often the best way of coping early in life may no longer be helpful as the

person matures. However, it should be remembered that we all need to cope in some way and that all defences serve a protective function in some circumstances.

Psychodynamic Therapy: Summary

The agent of change in psychotherapy is generally considered to be an empathic therapeutic relationship. This involves the therapist's capacity to imagine the other's point of view, sense their strengths, engage with shared understanding and engender new possibilities.

Some psychodynamic approaches have been developed for working with patients once considered "unanalyzable", such as those with Borderline Personality Disorder. One such form of therapy is the Conversational Model (Hobson, 1985; Meares, 2005), for which there is a manual (Meares, 2012). Transference-Focused Psychotherapy (Clarkin et al., 2007) is another evidence-based psychodynamic approach for borderline personality disorder.

The processes of psychodynamic therapy include exploring emotions, examining avoidances, identifying recurring patterns, discussing past experience, focusing on relationships, examining the patient-therapist relationship and valuing fantasy life (Shedler, 2010). With respect to the valuing of 'fantasy' life, engaging the person's imagination and dreams provides great potential for assisting the person to understand his or her needs and desires, facilitating a more generative life that fits with the individual as opposed to simply meeting external expectations. For people willing to commit to a process of collaborative self-examination, psychodynamic therapy can be a life-changing experience.

Group Therapies and 12-Step Programs/Structured Therapies

Doctors need to familiarize themselves with available resources. A detailed account of the vast array of psychotherapeutic modalities is beyond the scope of this chapter. However, available resources typically include a range of counselling and self-help services (e.g. drug and alcohol groups, day programs for mental health, sexual assault services, eating disorder programs). Availability is variable across public and private health services in Australia. So-called "12 step" programs such as Alcoholics Anonymous, Narcotics Anonymous, Gamblers Anonymous and GROW (for people with mental disorders) are widely available. Mindfulness training has grown in popularity (e.g. Mindfulness Based Stress Reduction). Some practices, such as meditation or yoga may provide psychological benefit without being explicitly "psychotherapeutic".

A brief description is given of two structured, manualized therapies which have been supported as evidence-based treatments for people with personality disorder. The best known of these is *Dialectical Behaviour Therapy* (DBT), developed over the last few decades as a treatment for borderline personality disorder, particularly for those with affect instability who also self-harm (Linehan, 2014). This has a structured approach with individual therapy and skills-based group therapy, as well as provision of out of hours support for patients. When first introduced it was described as a variant of cognitive behaviour therapy (Linehan et al., 1994). It is based on skills that centre on emotion regulation, differentiating "rational mind" from "emotion mind". The underpinning philosophy has its roots in Buddhist teaching, emphasizing mindfulness: becoming aware of mental and emotional life while striving to minimize reactivity. The program is one year and involves contracts around attendance and committing to cessation of self-harm. DBT has demonstrated benefit in patients with borderline personality disorder and is widely, though not uniformly, available in both private and public sectors in Australia.

Mentalization-Based Therapy (MBT) was developed in the United Kingdom and has stronger links to psychodynamic therapy (Bateman and Fonagy, 2016). It also involves a combined group and individual approach. There is a focus on staying in empathic relation to the patient while working on promotion of "mentalizing" (reflective thought). Three types of mental state that often interfere with mentalizing are identified: 1) "psychic equivalence" where the patient has certainty of the truth of their own position and an incapacity to tolerate other perspectives; 2) "pretend mode", referring to states where people are operating on the basis of fulfilling other's expectations without a sense of genuineness; and 3) "teleological mode" which is action driven, with the person focused on results ('action not words'). MBT cautions that hyperactivation of the attachment system is a real danger in therapy and can sometimes create problems that prove difficult to resolve. In part for this reason, MBT cautions against prolonged therapies, arguing that 12 – 18 months would usually be an appropriate episode of care. MBT has limited availability in Australia although is likely to become more widely practised.

Stepped Care

It is difficult to provide adequate resources to cater for everyone that might benefit from psychodynamic and structured therapies. Despite this there is evidence that such interventions can be cost-effective (Hall et al., 1999). State projects such as SPECTRUM in Victoria, and Project Air in NSW aim to provide improved access to therapy for those relying on public mental health services. Consumer groups as well as health professionals have been involved in designing these programs which have an online component as well as an on the ground presence. They are organized through a stepped process where initial access to services is facilitated. Patients are

able to access brief psychological intervention quickly. If required, further intervention is organized (medium-term psychotherapy or group therapy). Longer interventions, such as DBT, MBT or longer psychodynamic therapies are reserved for those who have continuing difficulties in recovery. While coordination of such services remains aspirational in many areas, the GP who has good awareness of available resources may have an important role in coordinating such a stepped care approach, selecting from resources available in public and private sectors.

Further Reading

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*(4), 245-258.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist*, *65*(2), 98.

Cite as:

Korner, A. (2024). Psychotherapy. In Boyce, P., Harris, A., and Malhi, G.S. (Eds.), *The Sydney textbook of psychiatry* (pp. 508–530). The University of Sydney.

References

Ainsworth MDS, Blehar MC, Waters E, et al. (2015) *Patterns of attachment: A psychological study of the strange situation.* Psychology Press.

Bateman A and Fonagy P (2016) *Mentalization based treatment for personality disorders: A practical guide.* Oxford University Press.

Bowlby J (1982) Attachment and loss: retrospect and prospect. *American journal of Orthopsychiatry* 52(4): 664.

Bullowa M (1979) *Before speech: The beginning of interpersonal communication.* Cambridge University Press.

Clarkin JF, Levy KN, Lenzenweger MF, et al. (2007) Evaluating three treatments for borderline personality disorder: A multiwave study. *American Journal of Psychiatry* 164(6): 922-928.

Davies J (2003) *A manual of mental health care in general practice.* Commonwealth Department of Health and Ageing, Mental Health and Suicide, Commonwealth of Australia.

Erikson EH (1993) *Childhood and society.* WW Norton & Company.

Felitti VJ, Anda RF, Nordenberg D, et al. (2019) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American journal of preventive medicine*.

Frank JD and Frank JB (1993) *Persuasion and healing: A comparative study of psychotherapy.* JHU Press.

Freud S (1997) *Dora: An analysis of a case of hysteria.* Simon and Schuster.

Hall J, Caleo S, Stevenson J, et al. (1999) *Economic analysis of psychotherapy for borderline personality disorder patients.* Citeseer.

Halliday MAK (1975) Learning how to mean. *Foundations of Language Development*. Elsevier, pp.239-265.

Herman JL (2015) *Trauma and recovery: The aftermath of violence--from domestic abuse to political terror.* Hachette uK.

Hobson R (1985) Forms of Feeling., London. Tavistock Publications.

Jones E (2019) *The life and work of Sigmund Freud.* Plunkett Lake Press.

Klein M (1946) Notes on some schizoid mechanisms. *The International journal of psycho-analysis* 27: 99.

Knox J (2010) *Self-Agency in Psychotherapy: Attachment, Autonomy, and Intimacy (Norton Series on Interpersonal Neurobiology).* WW Norton & Company.

Korner A (2020) *Communicative exchange, psychotherapy and the resonant self: Roads to realization.* Routledge.

Korner A, Bendit N, Ptok U, et al. (2010) Formulation, conversation and therapeutic engagement. *Australasian Psychiatry* 18(3): 214-220.

Kozlowska K, Walker P, McLean L, et al. (2015) Fear and the defense cascade: clinical implications and management. *Harvard review of psychiatry*.

Linehan M (2014) *DBT? Skills training manual.* Guilford Publications.
Linehan MM, Tutek DA, Heard HL, et al. (1994) Interpersonal outcome of cognitive behavioral treatment for chronically suicidal borderline patients. *American Journal of Psychiatry* 151(12): 1771-1775.
Main M, Kaplan N and Cassidy J (1985) Security in infancy, childhood, and adulthood: A move to the level of representation. *Monographs of the society for research in child development*. 66-104.
Malloch S and Trevarthen C (2009) Musicality: Communicating the vitality and interests of life. *Communicative musicality: Exploring the basis of human companionship* 1: 1-10.
Meares R (2004) From Neurosis to Trauma. *Meanjin* 63(4): 16-25.
Meares R (2005) *The metaphor of play: Origin and breakdown of personal being.* Routledge.
Meares R (2012) *Borderline Personality Disorder and the Conversational Model: A Clinician's Manual (Norton Series on Interpersonal Neurobiology).* WW Norton & Company.
Meares R (2016) *The poet's voice in the making of mind.* Routledge.
Piaget J (2013) *Play, dreams and imitation in childhood.* Routledge.
Porges SW (2011) *The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation (Norton series on interpersonal neurobiology).* WW Norton & Company.
Rogers CR (1995) *On becoming a person: A therapist's view of psychotherapy*. Houghton Mifflin Harcourt.
Shedler J (2010) The efficacy of psychodynamic psychotherapy. *American psychologist* 65(2): 98.
Trevarthen C (2018) Conversations with a two-month-old 1. *Parent-infant Psychodynamics*. Routledge, pp.25-34.
Vaillant GE (2012) *Triumphs of experience.* Harvard University Press.
Van der Kolk B (2014) The body keeps the score: Brain, mind, and body in the healing of trauma. *New York*.
Winnicott DW (1986) The theory of the parent-infant relationship. *Essential papers on object relations*. 233-253.