

Chapter 2

Contemporary Psychodynamic Models

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Perhaps one of the hardest tasks facing a clinician developing an integrative practice is choosing when and how to incorporate different approaches into the work with each client. How does one develop an overarching approach to guide these choices and bring them together into an organized and complementary whole rather than a mix of a little of this and a little of that? As I noted in Chap. 1, from the beginning, most clinicians have a silent, often even unrecognized frame of reference for our professional work that reflects our personal principles and beliefs. This frame, or base, is often an important but unarticulated part of how we make clinical choices. Putting these principles into words is an important part of developing an organizing theory to guide an integrative practice.

Not surprisingly, theory that supports our personal values and beliefs tends to be the most appealing. As previously noted, these principles often influence our interventions more than we realize (e.g. see Schachter & Kächele, 2007), which is one of the reasons it is important for us to make use of every possible tool for developing self-awareness and managing inevitable prejudices and blind-spots. But it can also be extremely useful—although a bit harder—to think about and incorporate ideas that do not automatically fit into one’s professional comfort zone. For example, many of us practice the type of therapy that our own therapists practiced, that is, the kind of clinical work we have experienced as clients. We also model our work on that of supervisors and teachers with whom we feel most comfortable. Yet some of our most powerful learning experiences may come from someone who operates outside of that frame. For many clinicians, a psychodynamic approach seems to be

outside of our personal and professional belief system. Yet even for clinicians with no interest in long-term, exploratory or insight-oriented work, psychodynamic thinking can aid in the development of an integrative practice.

Psychoanalysis has long been criticized for being overly complicated, time and money-consuming, and useful only for a small number of people. The theory, or more accurately *group* of theories is complex and the language often overly complicated. Adding to the difficulty, today there are a number of different schools of psychoanalytic and psychodynamic thought with sometimes contradictory and often confusing approaches. Still, psychoanalysis today has little to do with the stereotypical image of a client lying on a couch and talking to a silent doctor four or five times a week. And psychodynamic theory has a great deal to offer to an integrative practice, even when a clinician's primary approach is not psychodynamic. Furthermore, a growing body of evidence (e.g. Leichsenring, 2005; Leichsenring & Rabung, 2008; Mishna, Van Wert, & Asakura, 2013; Roth & Fonagy, 1996; Schachter & Kächele, 2007; Shedler, 2010) points to the efficacy of psychodynamic work, on its own and in conjunction with other techniques. Because the term "psychodynamic" has different meanings for different clinicians, let us take a moment to define the term. Then we will focus on two concepts from psychodynamic thinking that can help organize an integrative practice: (1) the idea that behaviors, thoughts, symptoms and even feelings can have unconscious or unrecognized meaning and (2) the significance of the therapeutic relationship. These ideas can be useful tools for thinking about and organizing an integrative practice, even for a clinician whose primary interventions are non-psychodynamic in nature.

What Is Psychodynamic Thinking?

Psychoanalytic thinking today is a way of learning about oneself and of using that knowledge to both manage difficult feelings and experiences and enrich one's life. Numerous psychodynamic psychotherapies integrate psychoanalytic concepts, such as exploration of unrecognized reasons for overt behaviors and symptoms, with other approaches, including symptom-reduction and motivational interviewing. Like many of my analytically-oriented colleagues, I have found that psychodynamic exploration can be done very effectively in the context of less frequent sessions and with clients sitting facing their therapists rather than lying on a couch, two of the traditional techniques associated with psychoanalysis. In fact, Schachter and Kächele (2007) make a compelling argument for a revised version of psychoanalysis which integrates a wide range of contemporary techniques. The central goal of psychodynamic exploration, which runs across most psychoanalytic theories, might be said to be to bring together unintegrated aspects of the self in order to allow an individual free access to a wide variety of sometimes contradictory aspects of her internal world. Mitchell and Black (1995) tell us that psychoanalytic thought helps

clients bring together different realms of their experience, such as thoughts and feelings, past and present, words and images. Thus psychodynamic theories themselves can be said to have an integrative goal (see Holmes, 1998).

In this chapter, and throughout this book, when we use the term “psychodynamic,” we will be referring to the idea that behaviors, symptoms, feelings and thoughts often have more than one meaning, and that some of those meanings may not be manifest, or apparent, at the present time. Exploring unrecognized or latent meanings with a client is only one possible use of this understanding. Simply recognizing the possibility that behaviors, symptoms and even feelings have more than one meaning can help a clinician think differently about what interventions make the most sense at a given time. Here is one example of how that works.

Mr. Nolan came to an outpatient clinic for help with a long-term depression that was interfering with his ability to do his work. His therapist, Ms. Bluen, soon discovered that Mr. Nolan was also an alcoholic whose wife was threatening to leave him if he did not get his drinking under control. Mr. Nolan expressed a commitment to changing his behavior and said that he had begun attending Alcoholics Anonymous already. However, he said, he did not think AA was the right program for him, since he did not feel that he needed to stop drinking altogether. Ms. Bluen, who was a psychodynamically-oriented psychotherapist who specialized in addictions and utilized an integrative approach to the work, considered several possible approaches to the problem. First, she recognized that the client might have a point. Not everyone has to give up alcohol completely in order to become sober. Second, she also knew that he might be wrong, but not yet ready to accept the reality that he did have to give up alcohol forever. And third, she thought that there were probably other reasons for resisting the program, including what she was beginning to see as his fear of feelings that might be emerging as he stops drinking and an intense hatred of feeling controlled by someone else.

Taking these possibilities into account, Ms. Bluen decided to do some educative work about the physiological and neurological impact of alcohol on the brain and the body. She explained that to interrupt what she described as a chemical chain reaction that occurred in his brain every time he drank, he needed to be abstinent for the moment. Utilizing a harm reduction approach, she told him that she thought there was a possibility that in the future the client could begin drinking again in a more manageable way. Motivational interviewing helped them focus on reasons that Mr. Nolan wanted to change his behavior—e.g. to improve his relationship with his wife and his capacity to do his job. Since research has linked addictive and impulsive behaviors with affect management difficulties (Christenson et al., 1994; McElroy et al., 1995, 1998) she also immediately began to address his difficulty tolerating feelings and introduced him to some behavioral, mindfulness and relaxation techniques for managing the unbearable emotions that triggered his drinking and others that would emerge during the process of becoming sober. She also explained that this was one of the benefits of attending AA daily. “They have lots of tools for helping you handle the impulse to drink and the feelings that will make you want to stop being sober.” Besides hoping that these tools would help Mr. Nolan

get some control over his drinking, Ms. Bluen believed that they would help him stay in therapy long enough to build the internal (ego) strengths that would ultimately make it possible for him to become a “recovering” rather than an active alcoholic.

Although it is generally accepted that insight and exploration is not the treatment of choice for overcoming addictions, especially in the early stages of the work, a psychodynamic perspective can provide a useful frame for this integrative process. For example, as Ms. Bluen worked with Mr. Nolan, she began to hear information that led her to wonder if his complaints about AA were at least partly driven by an unconscious fear that he would fail at the task of abstaining altogether. In such cases, there can be a danger that a client will drop out of therapy in order to protect his self-esteem, so that a therapist might want to address the issue directly. However, clients like Mr. Nolan may not directly present his anxiety about failing, but instead may appear defiant, resistant, and/or as though he just does not care. Based on her knowledge of this population and in response to Mr. Nolan frequently blustery behavior, Ms. Bluen decided not to make a psychodynamic “interpretation” about his fear, but instead spoke in a general and educational way about the idea that drinking often is a way of protecting a person from feelings of embarrassment and shame about not succeeding at tasks that seem ridiculously simple to accomplish. She added that unfortunately the drinking itself also often made those tasks even more difficult, but she said that in her experience people often do fail in life, and that those who stuck with AA and learned the techniques she and he were working on learned to manage those ups and downs in a healthier manner.

In this way, Ms. Bluen made use of a psychodynamic frame to help her decide what aspects of Mr. Nolan’s material she should address and how she might best address it. Psychodynamic understanding also led her to the realization that Mr. Nolan was conflicted about the work, even about whether or not he wanted to become sober. Ms. Bluen was able to remind herself and also explain to Mr. Nolan that recovery from an addiction is a process, not something that happens overnight. Even when he stopped drinking, there would be work to do. “You’ll need new tools and muscles for coping with the world that you see around you without alcohol,” she told him. “It’s like working out at the gym. One workout does not give you strong muscles.” For an integrative clinician, what is perhaps most helpful about psychodynamic theory is the idea that most behaviors, thoughts, feelings, symptoms and other aspects of experience have meaning (or multiple meanings) that is not immediately obvious, and that efforts to understand some of those underlying or hidden meanings can be key to almost any kind of therapeutic work.

Acknowledging the different aspects of a client’s experience can enhance the development of trust in a clinician and at the same time diminish shame and feelings of isolation. Psychodynamic theorists have described this part of the work as providing a holding environment (Winnicott, 1965), selfobject functions (Kohut, 1977), or a “corrective selfobject experience” (Bacal & Herzog, 2003). In all of these situations, the experience of being with an attuned and actively engaged professional is in and of itself therapeutic.

Organizing Principles and Concepts

Psychodynamic thinking has undergone major changes over the years since Breuer and Freud (1957) first described the “talking cure.” Numerous schools of thought have diverged from Freud’s early conceptualization of conflict over psychosexual and aggressive impulses as the cause of psychological difficulties. Some authors have suggested that psychodynamic thinking today is by definition integrative (see Eagle, 1995; Frank, 1999; Parish & Eagle, 2003; Roth & Fonagy, 1996). Because the human psyche is tremendously complex, Pine (1990) suggests that different schools of thought help us to understand different aspects of experience, which he divides into four major categories: drives (and conflicts), ego, object and self. Today we will want to add other categories. Relational and intersubjectivity theories explore many new issues that emerge in relationships. Current research in attachment, neuroscience and affect regulation have also added to the mix.

Most psychodynamically oriented practitioners, however, would agree on certain basic tenets:

1. Provide a setting in which a client feels safe
2. Help clients recognize ways they avoid distressing emotions and learn to tolerate and become comfortable with a range of feelings
3. Be aware of the importance of relationships
4. Be aware of a client’s sense of self and sense of agency
5. Pay attention to the therapeutic relationship
6. Look for patterns of behavior and expectations that have been repeated over time
7. Think about and explore unconscious meaning

Psychodynamic psychotherapy is, of course, “talk” therapy, which means that communicating and listening effectively is an important part of the work. Interestingly, research has shown that simply putting thoughts and feelings into words to another person can be therapeutic over time (see Busch & Sandberg, 2007; Schore, 2003; Siegel, 1999) and can actually make observable changes in brain functioning (Buchheim et al., 2012). Psychodynamic clinicians focus on three central aspects of affects: (1) recognizing, (2) expressing and (3) understanding their conscious and unconscious meanings. Yet for clients who are overwhelmed by feelings or unable to manage them, opening up these emotions prior to building the skills for managing them can be more destructive than helpful. Thus psychodynamically-oriented clinicians learn to listen for resistance and defenses, and to understand these aspects of the psyche as self-protective, not as antithetical to therapeutic progression. Understanding and supporting defenses against feelings can be an important part of psychodynamic thinking, even when it looks like these protective responses are interfering with therapeutic progress. (We will return to this topic when we discuss resistance in Chap. 9).

Self, self-organization, self-representation, and self-esteem are all considered carefully by psychodynamic theorists. Psychodynamic theories are generally focused not only on the inner self, but also on interpersonal relationships. Patterns of interaction and behavior that begin in the past are often repeated in the present

and affect current behavior, as well as the ways that new interactions and experiences are understood and responded to. Most psychodynamic psychotherapists attempt to help clients identify and recognize recurring themes and patterns in their lives. There is frequently discussion of both present difficulty and past experiences and attempts to understand what themes link the two.

In my own experience as well as the findings of numerous researchers (e.g. Couch, 1999; Farmer, 2009; Frank, 2005; Freedman, Hoffenberg, Vorus, & Frosch, 1999; Meissner, 2007b) any therapy relationship is important on a variety of different planes. It can, for example, provide what Kohut (1971) calls a corrective emotional experience in which old hurts are repaired and new development takes place. It can also offer clients what Winnicott (1965) calls a holding environment in which difficult or previously unarticulated material can be explored in relative safety. And it can be a setting in which interpersonal difficulties are repeated and worked through over time. By making the therapeutic relationship part of the subject of inquiry, a therapist communicates an interest in understanding feelings and thoughts as they emerge within the therapeutic space as well as outside it. In this way, a clinician provides a safe space for observing and experiencing previously unformulated, dissociated or unthought intrapsychic and interpersonal components of a client's life. I am not suggesting, however, that all of a client's dynamics must or even can be played out within a therapeutic relationship. In my experience, a good therapeutic partnership simply makes it possible for manifest and latent material to be examined, whether it emerges from within the transference or outside of it.

Transference and Countertransference

A therapist's own dynamics are also significant, for example at those times when countertransference may provide information about unconsciously received communications from a client. (However, as I will discuss further in later chapters, I do not agree with theorists who suggest that a clinician's response to a client *always* informs about unconscious or dissociated aspects of the client's experience.) Following the thinking of interpersonal theories, many contemporary practices see each therapeutic relationship as impacting clinical process (e.g. Hoffman, 1996). Mitchell (1988, 1993) suggests that each therapeutic dyad is different, thus questioning the traditional belief that a client has specific dynamics that will emerge with any therapist. From a relational perspective, both manifest and latent meaning continues to be explored through fantasies, dreams, and daydreams.

They are also found in what Sullivan (1953) has called a "detailed inquiry" into the particulars of a client's life (see Barth, 1998; Kanter, 2013). As I have already noted and will continue to discuss throughout this book, I believe that detailed inquiry into all aspects of a client's experience is key to an integrative approach. These details are like the colors and images in a painting, or the background data that gives a reader a rich sense of a character in a novel. The often unnoticed minutiae of daily life not only offer a therapist a special window into a client's reality, but

also provide a client an opportunity to put “unthought known” (Bollas, 1989) into words to another person. Numerous studies have suggested that the simple process of saying things to another person can lead to psychological change (e.g. Damasio, 1999; Rustin, 2013; Schore, 2003; Siegel, 1999). The small details, much more than the big ones, are what make each of us who we are.

Some psychodynamic theories still consider that particular material will emerge with any clinician. It has been my experience that certain themes appear consistently throughout an individual’s life, but that any relationship, whether with a therapist or another person, will also have unique characteristics related not only to the chemistry of the two individuals involved, but also to the time, place and circumstances in which that relationship unfolds.

When to Use Psychodynamic Thinking and Psychodynamic Interventions

While there are no definitive answers about who responds best to psychodynamic interventions (see Roth & Fonagy, 1996; Milrod et al., 2007; Watzke et al., 2010), it is generally agreed that in order to benefit from psychodynamic exploration a client needs to have enough psychological strength to tolerate the feelings that will emerge during the exploratory process. Some research (see Roth & Fonagy, 1996; Shedler, 2010; Wampold, 2001) indicates that psychodynamically-oriented approaches work best with clients with some self-awareness and psychological-mindedness. However, the presence or absence of these traits cannot always be determined in the beginning of therapy. For example, as I describe elsewhere (Barth, 1998), sometimes highly verbal, thoughtful and apparently insightful individuals are unable to use their apparent self-knowledge for their own psychological well-being. This is sometimes the result of alexithymia, or an inability to process certain kinds of experience with language (Krystal, 1988; McDougall, 1989); but it may also be the result of defenses, personality organization and cognitive impairment. The opposite may also be true, that is, someone who appears to have no capacity for or interest in insight may turn out to be very responsive to a therapist’s gentle exploration and offering of possible new ways of thinking about patterns that may have begun in the past and are being repeated in the present. Symptoms of depression and anxiety, inability to enjoy life, and repeating patterns of behavior that limit one’s choices have all been shown to respond to these interventions.

Clients who cannot tolerate their feelings, who are in crisis or highly symptomatic, who cannot pay attention to their own thoughts and actions or do not have what is called an observing ego, and who cannot tolerate a developing relationship with a therapist are often not good candidates for psychodynamic exploration, but they often respond to a combination of supportive work and approaches that help them manage these feelings. Some clinicians fear that trying to understand latent or hidden meanings and historical reasons for problematic patterns of behavior will interfere with taking active steps to change behavior. However, understanding meanings can

sometimes enhance interventions focused on behavior (see for example Connors, 2006; Frank, 1999; Wachtel, 1997). Kohut (1984) goes so far as to suggest that the simple act of a clinician trying to understand what a client is experiencing is probably more important than an interpretation of unconscious meaning. A number of authors (e.g. Connors, 2006; Frank, 1999; Stern, 1997; Wachtel, 1997) suggest that some active, symptom-focused interventions can be viewed as early stages of psychodynamic work. They may make it possible for a client to begin to feel both hope and trust that therapy and this particular therapist can make a difference in his life.

The following chart can help a clinician decide when to work within the frame of psychodynamic thinking, and when a more active intervention is necessary (Table 2.1).

There are many times when psychodynamic interventions are not indicated, yet psychodynamic thinking can help a clinician make decisions about what is going on and what might be an effective approach. Here is another example of how this can work.

Anna Louise had been hospitalized for a severe depression. She had been stabilized with a combination of medication, individual, group and family therapy. She was highly motivated to return home to her husband and two young children, and did well on a series of progressively longer home visits. However, one day shortly before her discharge Anna Louise began complaining that she was feeling depressed and suicidal again. Her treatment team began to consider the possibility that she needed a higher dose of medication, but her therapist suggested that she was struggling with tremendous ambivalence about going home. “She is afraid,” the therapist said. “Here at the hospital she’s gotten support and nurturing. When she gets home, she will have

Table 2.1 Psychodynamic interventions

Psychodynamic interventions can be useful when	Psychodynamic interventions are often not helpful when
A client is interested in understanding something about the reasons for their behavior, thoughts, feelings and symptoms	A client’s symptoms need immediate intervention
A client can tolerate feelings and thoughts that emerge as the understanding work is going on	A client has little or no access to feelings and/or thoughts
A client who has been participating in a program, doing therapeutic assignments, or otherwise engaged in therapeutic activities begins to resist, withdraw from or otherwise stop engaging in the work	A client is not able to think abstractly (this can sometimes be a temporary condition due to symptoms, and should be revisited periodically in the course of a therapy)
A client has feelings about a therapist that appear to be related to previous relationships, repeat old relational patterns, or seem to reflect a part of the client’s self	A client is not interested in understanding or exploring possible meanings of her behaviors, symptoms, thoughts and feelings
	A client is psychotic, confused or suffering from alexithymia (the inability to use language to process feelings)

high expectations for herself, and she will assume that everyone else will have equally high expectations. She will be facing the demands of two small children, a household that needs to be run, a family pet, and her extended family.” The team agreed that Anna Louise was not consciously acting depressed and suicidal, but that these feelings had emerged unconsciously as a way of keeping her in a safe and secure environment. With this conceptualization of her dynamics, the clinical team began to work with her and her family to set up a nurturing support system, including having her go into weekly psychotherapy and attend an ongoing parenting support group for young mothers that would help her feel more secure without being infantilized. Anna Louise was able to leave the hospital as planned and moved forward in her life with the support of her family, friends, therapist and support group.

Questions to Ask from a Psychodynamic Perspective

Exploring feelings, the therapeutic relationship and a client’s past can stir up many issues for a client and for a clinician, which is one reason that it is so important for every therapist to spend some time in personal therapy. It is also a reason that psychoanalytic training is so rigorous. The work of self-knowledge is an ongoing process, however, which means that every client and every clinician is involved in learning more about themselves in the course of their lives. Interestingly, as McWilliams (2004) has explained, clients also need to learn about the psychodynamic process. Assuming that a clinician has been and is currently working on understanding personal dynamics and feelings that emerge in the work, here are some questions that can bring psychodynamic thinking into almost any clinical contact.

1. Focus on affect and expression of emotion: How are you feeling right now? How are you feeling talking about this topic?
2. Exploration of attempts to avoid distressing thoughts and feelings: How do you usually tend to deal with these feelings? What ways of managing these thoughts and feelings work best for you? What have you tried that doesn’t work?
3. Identification of recurring themes and patterns: When have you felt this way in the past? What have you usually done in this kind of situation?
4. Discussion of past experience (developmental focus): What are the similarities between this situation and similar times you’ve experienced these feelings and thoughts? What makes you think this situation is the same as that one? Are there some of the differences?
5. Focus on interpersonal relations: what is happening in this interaction, with this person, and what does it mean to you? What do you think it means to them? What makes you think this?
6. Focus on the therapy relationship: Am I understanding what you’re trying to say correctly? Does this feel helpful? Can you tell me if some of these feelings and thoughts that we’re talking about with other people are also occurring in therapy?

Some clients are not able to accept or make use of exploration of their internal conflict and/or confusion. In these instances, even when they are in supportive, cognitive-behavioral, structural or medication therapies, they may enact some aspect of their difficulties and/or behavioral patterns, drawing a therapist into a living experience of their emotional world. As we will see in other chapters, sometimes thinking about possible meanings of the dynamics in which a clinician has become involved can be helpful without necessarily exploring them with the client. In order to do this, discussion with a supervisor or one's own therapist can help untangle a clinician's dynamics from those of a client.

Traditional psychoanalytic theory, often called "one-person" theory because it focuses on the intrapsychic or internal world of a client as the source of all enactments, encourages therapists to push a client to look at these feelings and behaviors as reflective of something about her own history and personal conflicts. The concept of therapist as participant observer (Sullivan, 1953) who unconsciously and frequently unknowingly influences the situation or person she is observing paved the way for contemporary recognition of a clinician's role in the development of any transference dynamic. Our personalities, individual dynamics and history color how we listen to and participate in a client's transference enactments. Mitchell (1993) likens this way of looking at transference and countertransference as going to a party and accepting an invitation to dance. At some point it is a therapist's job to ask, "Why are we dancing this particular step? Why did we choose this music?" Contemporary psychodynamic theories offer a wide continuum of approaches to a clinician's exploration of her role, ranging from a clinician's silent observation of her own thoughts and feelings, to requests that a client articulate what he understands about his therapist's feelings and thoughts, to a clinician's revelations to a client of aspects of her internal world.

A Word About Training

There is a reason that psychoanalytic training takes a long time. Clinicians are asked to understand their own psychodynamic thoroughly, to be able to use themselves easily in the therapeutic process, and to be able to think about and recognize psychodynamics from a variety of theoretical and clinical perspectives. Many analysts and analytically-oriented psychotherapists today consider that a therapist's reactions to a client contain useful information about the internal world and relational patterns of both client and clinician (see, for example, Davies, 2006). Because a clinician's psychodynamics also inevitably impact the therapeutic work, it is crucial to understand one's own dynamics in order to keep them from interfering with the exploration of a client's dynamics—especially in those inevitable moments when a client's struggles, personality or dynamics trigger something in a clinician. Even therapists not interested in doing long-term, psychodynamically oriented psychotherapy can benefit from being in that kind of therapy for a period of time. Given the research showing the importance of the therapeutic relationship to the success of

any therapeutic endeavor, it would seem that a therapist's commitment to self-understanding would enhance any kind of therapeutic approach and perhaps should be a requirement in all psychotherapeutic training. That said, however, even the most experienced psychoanalyst continues to evolve and to understand things differently over time. Similarly, psychodynamic theories are continuing to develop as new research and different issues emerge in the culture. They are not finished products that are ready to be applied "out of the package" to each clinical situation. Instead, each moment in clinical practice is an opportunity to explore and learn something new.

Evidence

Until recently, psychodynamic or "insight-oriented" psychotherapy and psychoanalysis were perhaps the least studied forms of psychotherapy, with much of the evidence of their impact coming from anecdotal descriptions and case studies. In a critical evaluation of psychodynamic theories, Eagle (1989) writes that one issue relevant to evidence-based research is that, "psychoanalytic writers attempt to employ clinical data for just about every purpose but the one for which they are most appropriate—an evaluation and understanding of therapeutic change." Recently, this has begun to change. For example, Wallerstein's (2000) study provides fascinating, in-depth data about the experiences of a group of men and women in long-term psychoanalysis, including how successful the treatment was and what the analysts themselves believed to have been the change factors.

It has not just been a lack of research in the field that has led many clinicians and clients to reject a psychoanalytic approach. Shedler (2010) notes that potential clients are often put off by historical images of arrogant and authoritarian psychoanalysts. Others are disturbed by the idea of an analyst sitting in silent judgment as they pour out their inner turmoil. The commitment of both time and money to long-term therapy has also been a problem for many clients and clinicians. Yet despite these negative characterizations of psychoanalysis (and by extension, talk therapy), there is growing evidence that psychodynamic psychotherapy helps many people get better. Some studies have shown that while a number of short term, "evidence-based" techniques have greater immediate impact on clients. Changes that occur in long term therapy (which is usually talk therapy) have a more permanent effect on the individual. For example, Leichsenring (2005), Leichsenring and Rabung (2008), Roth and Fonagy (1996), and Shedler (2010) have reviewed and evaluated research on a wide range of psychotherapies, including a number of both cognitive behavioral and psychodynamically-oriented psychotherapies. Their findings have been consistent: that longer term therapy appears to have longer-lasting results, especially with individuals with personality disorders, and that a variety of therapeutic interventions are effective with different symptoms and difficulties. Further, individuals undergoing long-term psychodynamic psychotherapy showed changes in brain functioning that did not show up in control participants. These changes were accompanied by changes that indicated a lifting of their depression.

According to Roth and Fonagy (1996) the belief that specific clients and symptoms respond better to specific therapeutic interventions is not based on hard evidence as is sometimes believed. They write that the evidence about what therapies work for what disorders and groups of clients provides very little consistent guidance for clinicians to go by. Many of the studies have been, they suggest, too small to provide statistically useful results, but even large scale trials (e.g. Crits-Christoph, 1996) have not always been definitive (see also Seligman, 1995). However, like Wampold (2007) and numerous other researchers, they have found that a client's sense of a therapist's knowledge and experience, and interest in what a client is actually experiencing, can play a more important role than the specific therapeutic approach.

Conclusion

Putting thoughts into words out loud, to another person, can sometimes give us a chance to think about our own ideas differently, and leading to growing self-awareness and concomitant psychological change. A psychodynamic approach does not always involve what has traditionally been seen as interpretation or insight. Instead, as numerous contemporary psychoanalysts have suggested (see for just some examples, Bromberg, 2001; Fonagy, Gyorgy, Jurist, & Target, 2003; Frank, 2004; Hoffman, 1996; Holmes, 1996; Mitchell, 1993; Wallerstein, 2000) psychoanalysts today recognize that thoughts, feelings, behaviors and symptoms often have meaning that is not immediately clear either to a person experiencing them or to an observer. Such unspoken, unarticulated or unconscious meaning can play a role in ordinary daily behavior as well as in dreams and impulsive and unexplained actions. They can also impact how a client responds to therapy and therefore how a client uses any interventions, including those that are not psychoanalytically-based. Striving to understand these unspoken and unrecognized aspects of a client's everyday life, as well as those manifested in psychopathology, can be an important clinical intervention itself. This information can also help a clinician decide what other intervention(s) might be most useful for a client at a given time in their lives and in the therapeutic process.

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