Symptom-Focused Dynamic Psychotherapy

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Early psychoanalytic perspectives were characterized by an emphasis on purported unconscious processes that contraindicated direct interventions with symptoms. However, the modern relational psychoanalytic approach offers a sophisticated base for the assimilation of action-oriented techniques. I provide a rationale for including a direct focus on symptoms in some treatments and argue that symptom intervention alone will be insufficient in many cases. My integrative model permits direct work with symptoms as well as an appreciation of their biopsychosocial etiology within a particular context. Symptom-focused dynamic psychotherapy is informed by current relational perspectives including attachment theory and self psychology. Action-oriented techniques from the cognitive–behavioral tradition may be incorporated on the basis of the patient's needs and the intervention's usability within a particular therapeutic relationship. Integrative treatment fosters the development of a consolidated and integrated self and promotes secure and balanced relationships with others.

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The question of what constitutes an appropriate goal of psychotherapeutic treatment has been debated since Freud's time. Freud (1917/1963a) emphasized making the unconscious conscious and enlarging the realm dominated by the ego while constricting that of the id. As psychoanalytic thinking evolved in ways less dominated by drive theory, some analytic authors focused on the state of the self and on object relations. For instance, Kohut (1971) emphasized the development of a cohesive self that is capable of achieving its goals and using its talents. Stolorow, Brandchaft, and Atwood (1987) have described the goal of treatment as the progressive exploration, clarification, and transformation of the patient's subjective world.

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In contrast, treatment goals discussed in cognitive–behavioral writings tend to be much less lofty, smaller in scope, and more specific. Authors in this tradition emphasize the correction of problematic behavioral excesses and deficits and cognitive distortions. For cognitive behaviorists, targeting a patient's anxiety disorder symptoms is the appropriate focus of a helpful treatment, rather than global change in the self. Amelioration or removal of a symptom is viewed as the hallmark of a successful psychotherapy.

Psychoanalytic clinicians are likely to be far more cautious in their approach to symptoms. Traditional theory has viewed symptoms as manifestations of underlying conflicts and has proposed that they will resolve only when the dynamic unconscious forces propelling them are brought to awareness in analysis or psychotherapy (e.g., Freud, 1917/1963b). Furthermore, the symptom was thought to occupy such an integral position in the psychic economy that attempting to remove a symptom prematurely was believed to result only in the substitution of another symptom. Although numerous current psychoanalytic theorists do not accept many aspects of Freudian metapsychology, few have turned their attention to specific symptomatic disorders.

RATIONALE FOR A SYMPTOM FOCUS

Readers trained in nonanalytic perspectives may find it peculiar that some clinicians might eschew directly focusing on symptoms. However, because this prohibition has been quite influential over decades, I want to articulate my view that a strong rationale exists for such direct intervention. First, some symptomatic disorders, such as anorexia nervosa and major depressive disorder, place patients in actual physical jeopardy and have relatively high mortality rates. Second, the impairment caused by some symptoms may be such that psychotherapy is not a real possibility until the symptoms abate; some symptoms are so debilitating, frightening, or preoccupying that they interfere greatly with a patient's ability to engage in psychological exploration. Finally, a patient's level of distress about a symptom might also warrant a specific-symptom focus. Patients may experience their symptoms as so ego-dystonic, anxiety provoking, or deleterious to self-esteem that their rapid amelioration is desperately sought.

The classical analytic tradition, with its emphasis on abstinence rather than gratification and renunciation of infantile wishes, may lead clinicians to adopt an unnecessarily harsh stance toward symptom relief. We may believe that nonintervention is appropriate because we think that these symptoms would diminish only over a prolonged period of time as internal conflict resolves, that people in treatment must feel worse before they can feel better,

and that in general symptomatic suffering is somehow beneficial and necessary for the therapeutic process, or at any rate, that it is unavoidable. We might also expect that symptom substitution would occur should the original symptom diminish prematurely, rendering intervention fruitless.

My perspective is that distress resulting from troublesome symptoms is generally not useful, and that many times it can be harmful, promoting rigid and risk-avoidant behavior. I invite clinicians to question their own attitudes about patients' suffering. Should symptoms be alleviated if it means patients will opt for a briefer treatment or fail to explore themselves fully? Is assisting patients with symptoms a "quick fix" that we should eschew, and if so, is it because of some Nietzcheian ideal that suffering will make our patients stronger? Or, in an era in which psychiatric drugs are advertised on TV, are we reacting against the increasing conceptualization of complex human situations as remediable with a prescription for a pill or a technique rather than with self-understanding? As a culture, we tend to hold conflicting attitudes toward the relief of suffering; advertisements tout the "fast results" promised by various nostrums, but terminally ill patients are undermedicated because physicians are not taught to prioritize pain management relative to other concerns. Obviously, we do not wish to collude with some of the messages promulgated in our consumer culture that the optimal response to distress is eradication of it. Yet, it might be worthwhile to examine whether we hold views concerning the virtue of suffering that constrain our ability to consider direct techniques of symptom alleviation.

In Buddhist teachings, there is a story concerning a follower of the Buddha who expressed his dissatisfaction with his path because the Buddha had not declared his views concerning such matters as whether the world is eternal and what happens after death, and the monk determined to abandon his training unless he received answers. The Buddha responded with a tale about a man who had been wounded by a poisoned arrow. Although a surgeon was brought to treat the man, he stated that he would not permit the surgeon to remove the arrow until he knew the name of the man who wounded him, where he lived and what his occupation was, what type of bow shot the arrow, what kind of feathers were on the shaft, and so on. "All this would still not be known to the man and meanwhile he would die" (Nanamoli & Bodhi, 1995, p. 535). The Buddha emphasized the need to remove the poisoned arrow of ignorance without wasting precious time on fruitless speculation.

I consider the exploratory process of psychoanalytic psychotherapy to be powerful and transformative, and my use of this analogy here is not intended to suggest otherwise. But what about that arrow? I suggest that the most empathic and attuned therapist response to a patient in great symptomatic distress is to try to do something about the symptom as quickly as possible, even if it means that understanding is not yet perfect.

Clinicians from different perspectives tend to agree that active crisis intervention is necessary when a patient is suicidal. In such a case, it is obvious that severe consequences could ensue unless the therapist manages the situation and secures the patient's safety, making this the priority in treatment until the crisis has passed. The immediacy with which a clinician intervenes when a patient is suicidal, regardless of the clinician's views concerning underlying causality, might be appropriate in less extreme situations as well.

In contrast to the lack of emphasis on symptom amelioration in psychoanalytic works, literature from behavioral and cognitive–behavioral perspectives primarily addresses specific symptomatic disorders and often describes empirical studies measuring the efficacy of one treatment technique versus another. Treatment "manuals" now exist for a number of disorders, and cognitive–behavioral techniques predominate in the current writings on "empirically supported treatment." If addressing symptoms is often necessary, as I have posited, should patients with symptomatic problems be directed to a treatment that is exclusively cognitive–behavioral? Not necessarily; psychodynamic psychotherapy provides essential elements in a treatment that are quite different from those supplied by cognitive–behavioral therapy. The concrete, specific, problem-focused nature of the latter approach is unparalleled for effective intervention in certain situations, but such techniques are frequently insufficient for long-term changes that the patient deems important. Although persons suffering with problematic symptoms often want direct help with them, this may not be as straightforward as some cognitive–behavioral treatment manuals might suggest. I have argued for the importance of attending to symptoms, but these symptoms are part of an individual's whole self and subjective world, inseparably linked to one's defenses, interpersonal style, and other concepts stressed by psychoanalytic authors. A recent study of the efficacy of short-term action-oriented treatments by Westen, Novotny, and Thompson-Brenner (2004) found that most problems did not remit in a brief treatment, and the authors commented that symptoms are inextricably interwoven with personality characteristics and are not very malleable. Behavioral approaches often err in being mechanistic, narrow, and naive about the tenacious nature of psychopathology and patients' resistance to change. As Wachtel (1997) has stated, "Treatment that tries to remove symptoms without understanding their basis is not likely to be free of complications" (p. 22).

Blagys and Hilsenroth (2000) conducted a review of psychodynamic and cognitive–behavioral treatments in order to understand the techniques and processes that distinguished between the two approaches; they identified seven elements of consistent difference. Compared with cognitive–behavioral clinicians, dynamic therapists tended to focus more on access to

and expression of emotion, to emphasize the identification of patterns in patients' behavior and internal states, to focus on the past as an important determinant of present experiences, and to stress investigation of blocks and resistances to patient engagement in treatment. Dynamic therapists also placed more emphasis on patients' interpersonal experiences, with particular focus on the therapeutic relationship, and explored dreams, wishes, and fantasies to a greater degree. I suggest that it is possible to do all of these things *and* attend to particular symptoms as well in an *assimilative* integration (e.g., Messer & Warren, 1995); that is, a psychodynamic focus is maintained while additional techniques are assimilated into the basic model. Mitchell and Black (1995) stated that the psychoanalytic attitude is characterized by respect for "the complexity of the mind, the importance of unconscious mental processes, and the value of a sustained inquiry into subjective experience" (p. 206). No aspect of this stance is incompatible with some direct attention to symptoms.

In my view, analytic and cognitive–behavioral perspectives, in isolation, can be misattuned to patients' real needs. However, an integrative approach enables the clinician to attend to specific problems in an effective manner while at the same time appreciating the intricacies of the entire self-system in which they are embedded. The incorporation of symptom-focused techniques into a relational psychotherapy fosters an inclusive approach in which neither present difficulties nor past etiological influences are neglected, and the focus can oscillate between concrete specific issues and more global themes. Atwood and Stolorow (1984) described psychoanalytic treatment as a method by which a patient acquires reflective knowledge of unconscious organizing and structuring activity. The use of active techniques may in fact facilitate this process by assisting patients to focus on their internal states and interpersonal interactions.

Moreover, if we return to our earlier discussion of respective goals of treatment in the two perspectives, we might consider that perhaps accomplishing some measure of what each perspective views as a worthy goal of treatment has potential to facilitate goals valued by the other. For example, a patient who makes some discernable progress in overcoming compulsive behavior may then be less defensive about his conduct and more able to reflect on himself, and his increased insight permits further problem solving from an enlarged perspective. It is possible to shift back and forth, often rather rapidly, between a symptom focus and analysis of other material in which each discussion can further the other. A perspective that begins on the "outside," that is, with cognitive and behavioral aspects of symptoms, can interpenetrate with work that commences on the "inside," with analysis of self–object needs, defenses, and so forth.

THE RELATIONAL CONTEXT

In an extremely influential work, Mitchell (1988) described Freudian drive theory as outdated, stating, "We have been living in an essentially post-Freudian era" (p. 2). Mitchell noted that for the first half-century of psychoanalytic thought, the guiding vision of treatment was one of the exploration and eventual renunciation of infantile instinctual drives, but that a revolution has occurred over the past several decades. In 1983, Greenberg and Mitchell coined the term *relational model* to characterize a perspective that focuses on relations with others rather than drives. The shift to a relational model has invigorated psychoanalytic thinking. It also enables a type of integration with other theoretical frameworks that was not possible with drive theory's view of the individual as a relatively closed system and its focus on invariant stages and the primacy of fantasy. The nature of relationally oriented mental processes, their genesis, and their potential transformation in treatment may be illuminated in diverse ways, including, I believe, by some nonpsychoanalytic methods that attend to symptoms.

Mitchell (2000) commented that a distinctive feature of postclassical analytic literature is its tone of emancipation and liberation. Whereas classical writings have tended to emphasize restraint, recent authors have focused on the beneficial impact of more expressive phenomena such as self-disclosure and the deep affective engagement between analyst and patient. These shifts have been occurring among self psychologists, object relations theorists, interpersonalists, and others, and this increased emphasis on the legitimacy of noninterpretive interventions provides support for the inclusion of a variety of responses in the clinical situation. Current trends in psychoanalytic theory are more focused on the validity of patient needs and clinicians' responses to those needs. For example, Bacal (1985) suggested that the concept of *optimal responsiveness* might better describe a growth-enhancing interpersonal milieu than Kohut's (1971) *optimal frustration*. The context of contemporary psychoanalytic writing supports a much broader range of interactive possibilities than was the case when drive theory was the dominant paradigm. Since the mid-20th century, developments such as Winnicott's (1960/1965) recommendation that the analyst provide the patient with a "holding environment" and Kohut's (e.g., 1968) proposal of a noninterpretive approach for some patients have become widely accepted and have paved the way for a current focus in the literature on the clinician as a real person whose actions and inactions all have an impact on the patient. In such a "two-person" model of interaction, much more consideration is given to actions of the clinician that could potentially be helpful, including spontaneity, authenticity, and the offer of

a new relational experience. Frank (1999) has suggested that interaction, intersubjectivity, and mutuality characterize the two-person model.

A SYMPTOM-FOCUSED DYNAMIC PSYCHOTHERAPY

My model of symptom-focused dynamic psychotherapy uses a relational approach that is particularly informed by self psychology and attachment theory. I sometimes assimilate techniques from cognitive and behavioral traditions into this work on the basis of my assessment of the need for and usability of such methods. The need for an active approach relates to issues of life impairment and patient distress resulting from symptoms mentioned earlier. Usability includes issues such as the state of the treatment relationship and a patient's readiness for change (Prochaska, DiClemente, & Norcross, 1992). For instance, a patient who is angry at the therapist and is not convinced that his addiction is a problem may have some needs for symptom management, but it will not be usable until certain conditions shift. The clinician's countertransference experience must be considered as well. If the therapist is having an inadequately understood experience of a wish to rescue or feeling of coercion or frustration, active techniques should not be offered until further reflection can be done. If both need and usability are present, and my experience is one of a calm sense that my patient could benefit by an additional element in treatment, I will offer the possibility of using active techniques and proceed—or not—on the basis of the patient's reactions. Because these techniques can be so beneficial, my preference is to err in the direction of offering them, and allow the patient to consent or not. Discussion of symptom-focused techniques should be conducted in a spirit of collaboration, tentativeness, and openness to the patient's communications. If the patient accedes, as is very often the case, I will begin implementing the technique in an exploratory fashion and processing the experience.

Proffering such strategies may or may not constitute the optimal therapeutic intervention in a given situation. An important contemporary development in psychoanalytic thinking is an emphasis on the *specificity* of the therapeutic dyad and a move away from a "one size fits all" approach proposed by Bacal (1998). He has emphasized the fact that each analytic couple is a complex and unique relational system, and that what is optimal for a particular patient in terms of the clinician's responsiveness will not necessarily be ideal for another. Specificity theory postulates that there cannot be a single correct intervention for a patient that would be applicable by all clinicians. The therapeutic interaction will be unique to the particular dyad, and the potential for therapeutic action is related to the

specific characteristics of each partner in the dyad. Specificity theory suggests careful attention to the unique properties of each therapeutic dyad to ascertain the range of activities that might be helpful. At times, I believe that the proffer of active techniques may be seen as an appropriate response to the clinician's experience of the needs of a particular patient.

Although use of more active techniques may cause dynamically trained clinicians to worry that they are failing to uphold some higher standard of analytic purity, I argue that use of these measures, in fact, facilitates a dynamic psychotherapy by strengthening the treatment relationship as well as by assisting the patient in beneficial ways. Important self–object needs that may have been long suppressed can reemerge in treatment and be well responded to by assistance with symptom management. Moreover, use of such techniques may foster engagement with insecurely attached patients by engendering greater trust and comfort in avoidant patients and by helping more preoccupied or disorganized patients with affect regulation difficulties that otherwise might derail the treatment. An optimally responsive treatment process that facilitates self-cohesion and attachment security enables greater exploration of difficult material and self-reflective capacity.

Wachtel (1994) has noted that although this is an era in which psychotherapy integration is proceeding rapidly, the existence of "separate and bifurcated cultures" persists for psychoanalysis and behavior therapy. As Stolorow and Atwood (1979) pointed out, subjective preferences play a large role in one's adherence to any personality theory. Moreover, such allegiances are often suffused with passion and a sense of identification that goes well beyond a reasoned and informed understanding of one's choices. Postmodern thought suggests that our notions of inner/outer, self/other, interpretation/new relational experience, and action/insight as rigidly demarcated dualities do not accurately represent the infinitely more complex reality of intricate interrelationships. I hope that as our understanding of these false dichotomies grows, it becomes more possible to practice in a way that integrates the insights drawn from long-term immersion in patients' subjective worlds with those emerging from research studies into a seamless whole.

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