Journal of Psychotherapy Integration

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Psychodynamic therapy for depression has received considerable empirical support in recent years, and can presently be designated as efficacious (Leichsenring, Leweke, Klein, & Steinert, 2015). Although psychodynamic theory and therapy are widely used in clinical practice, empirically supported protocols of psychodynamic therapy are still not prevalent in everyday clinical work. Until recently, no systematic attempt has been made to integrate the central elements of different dynamic manuals with central dynamic theories and research. In this article we integrate the active ingredients of different psychodynamic therapies, combining central principles of such theories as that of Kohut with manualized treatments, such as the Supportive-Expressive Treatment, Brief Relational Therapy, Dynamic Interpersonal Therapy, and Dynamic Supportive Psychotherapy. Two evidence-supported concepts were used to integrate various active ingredients from psychodynamic treatment: Therapeutic alliance and the Core Conflictual Relational Themes (CCRT) method. Three clinical case studies demonstrate the most important active elements of this integrative psychodynamic therapy.

Keywords: psychodynamic treatment, depression, alliance, CCRT

Depressive symptoms are among the most common reasons adults have for seeking psychotherapy. A recent meta-analysis validated previous findings that psychotherapy was more effective than a wait list control group in treating depressive disorders (Barth et al., 2013). At the same time, another recent meta-analysis found that only about half the patients suffering from major depression respond effectively to psychotherapy (Cuijpers et al., 2014). Furthermore, the likelihood of relapse is relatively high (Barber, Muran, McCarthy, & Keefe, 2013; Emmelkamp, 2013). These findings suggest the need for continued efforts to improve existing treatments for depression.

It has been demonstrated empirically that short term dynamic psychotherapy is efficacious for depression (Leichsenring, Leweke,

Klein, & Steinert, 2015), but although psychodynamic theory and therapy are widely used in clinical practice, the use of empirically supported protocols of psychodynamic therapy is still not common. For short-term psychodynamic psychotherapy to become widely used, it must be integrated with up-to-date research and with broadly accepted theories commonly used in clinical practice. It has been suggested that integrating the most effective treatment principles of empirically supported psychodynamic therapy can enhance the efficacy and usability of psychodynamic therapy (Leichsenring & Schauenburg, 2014). In the present article we integrate the active ingredients of different psychodynamic therapies, combining central principles of such theories as Kohut's (1984) theory with manualized treatments, such as the Supportive-Expressive Treatment (Luborsky, 1984), Brief Relational Therapy (Safran & Muran, 2000), Dynamic Interpersonal Therapy (Lemma, Target, & Fonagy, 2010), and Dynamic Supportive Psychotherapy (Pinsker, Rosenthal, & McCullough, 1991). These ingredients are integrated in four of the modules identified by Leichsenring and Schauenburg (2014) as repeating across different effective psychodynamic treatments. We propose two ev-

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idence-based concepts for integrating the various active ingredients: Therapeutic alliance and the Core Conflictual Relational Themes (CCRT) method. We use three clinical case studies as examples of what we perceive to be the most important active elements of this integrative psychodynamic therapy.

Therapeutic alliance is commonly defined as the emotional bond established between therapist and patient, as their agreement concerning the goals of therapy (e.g., remission of symptoms, more satisfactory relationships), and as the degree of concordance regarding the tasks pertinent to accomplishing these goals (e.g., speaking about daily interactions in close interpersonal relationships; Bordin, 1979; Hatcher & Barends, 2006). There are theoretical and empirical reasons for using therapeutic alliance as a central concept in psychodynamic treatment. In some of his writings, Freud considered alliance to be necessary for treatment success. He argued that it should not be analyzed, and that the curative aspect of therapy was contingent upon it (e.g., Freud, 1912). Others regard alliance as therapeutic in its own right (Zetzel, 1966), and essential for the process of change (Safran & Muran, 2000). One of the most consistent findings in psychotherapy research is that the quality of therapeutic alliance is a predictor of outcome, so that stronger alliance is associated with better therapeutic outcomes (e.g., Horvath, Del Re, Flückiger, & Symonds, 2011). This finding is true even when accounting for the temporal relationship between alliance and symptoms in the treatment of depression (Zilcha-Mano, Dinger, McCarthy, & Barber, 2014). Training programs for therapists aimed at improving alliance resulted in stronger alliances (Crits-Christoph et al., 2006) and better treatment outcomes (Safran, Muran, & Eubanks-Carter, 2011).

The CCRT method (Book, 1998; Luborsky, 1995) has received much empirical attention and support for case formulation. The CCRT method proposes a psychodynamic understanding of psychic conflict that includes three components: a wish, a response from the other, and a response of the self. The first component is a central wish (W) that the patient has in interpersonal relationships (e.g., to be treated with respect). The second component, a response from the other (RO), includes the subjective interpretation the patient makes of the other's response to his or her wish (e.g., humiliating). The last component is the response of the self (RS), which contains emotional and behavioral parts (e.g., sadness and avoidance). The CCRT is based on the fundamental assumption of psychodynamic theory that people internalize patterns in their early relationships and repeat them during later relationships, so that the purpose of psychodynamic therapy is to widen the repertoire of perceptions and responses.

Although a variety of psychodynamic formulations have been tested empirically (i.e., Malan, 1973), choosing the CCRT as a focus has several advantages. First, there is solid research evidence of the efficacy of using CCRT, specifically for treating depression (for a review, see Leichsenring & Leibing, 2007). Second, a structured method for formulating the CCRT contributes to its practical implementation. Third, CCRT-based interpretation provides a nonaccusing understanding of the patient's dynamics, which contributes to the therapeutic alliance. Fourth, because this formulation stresses the wish or need of others, it contributes to the understanding of depression as being connected with unsatisfactory relationships, working through which is essential for psychodynamic treatment. Fifth, CCRT provides a roadmap, essential for short treatments, that delineates the target of the therapeutic process. This target is to effectively fulfil the underlying wish with satisfactory interpersonal relationships and self-understanding. Sixth, the CCRT formulation can create a connection between the different active ingredients.

We use three clinical cases to demonstrate the different modules. To protect the confidentiality of the patients, we changed their names and almost all of their background details. We also selected vignettes that do not expose them, and asked for their written and oral permission to use them.

David, a young man in his early 20s, sought therapy after a depressive episode in the wake of his failure to achieve the expected results on his SATs. He felt ashamed and hopeless. He was not satisfied with his current life, moving between jobs as a salesman, and was in a long relationship with a girlfriend whom he felt was overly dependent on him. David was a heavy smoker and used marijuana daily for relaxation. His relationship with his mother had been detached since adolescence. His relationship with

his father was disappointing and hurtful, and although David respected him, he felt that his father did not expect much of him.

Rachel, a young woman in her early 20s, came to therapy depressed and conflicted about finding an academic orientation and about leaving home. Rachel quit college because of problems she had concentrating on her studies and a feeling that she did not belong socially. She was extremely shy and found it difficult to form relationships and to feel good about herself in social situations. Rachel was the youngest child in her family. She was angry and felt hurt by her elderly parents for ignoring her needs ever since she was a child, yet she felt that she could not leave them unless she were to marry, because they needed her to take care of them.

Naomi, a 31-year-old woman, sought therapy for postnatal depression after the birth of her first child. Naomi grew up in a highly conflicted family; her parents had divorced after long years of fighting, having had little energy left for their children. She was worried about not being a good mother to her child and about driving away her husband. She also lost her job and was worried about starting a new one. When she began therapy she had a sporadic but relatively calm relationship with both her parents after years of being extremely angry with them.

Below we present four components of short-term psychodynamic therapy for depression, which integrate Kohut's theory, supportive-expressive, supportive, dynamic interpersonal, and relational elements, and rely on four central modules of the UPP-Depression protocol (Leichsenring & Schauenburg, 2014), which have been found to repeat across different effective short-term psychodynamic treatments. Two of the proposed modules (beginning and ending of therapy) are stage-specific, which invites special focus and interventions. The other two modules are not stage-specific and should be incorporated throughout the therapeutic process. The overarching concepts of therapeutic alliance and CCRT hold the four modules together.

Module 1: Beginning of Therapy

The first meeting between patient and therapist is also the first opportunity to create a positive therapeutic alliance based on a good initial bond and a general preliminary agreement about the goals of treatment. Luborsky (1976) described the initial stage of forming the alliance as dependent on the patients' belief that therapy can help solve their problems (the "goals" part of the alliance), and on the therapist providing a supportive, warm, and caring environment (the "bond" part of the alliance). There is support in the literature for the association between forming a strong alliance early in treatment and successful outcome (Horvath et al., 2011).

At the first meeting it is important to hear from patients what brings them to therapy and what they want to achieve. It is also important to hear about significant life experiences responsible for their condition and about their understanding of their difficulties. Even if an intake has already been conducted by another therapist, it is important for the patient to describe these circumstances again to the therapist, at least briefly. It is an opportunity for the therapist to show empathy with the patient's difficulties and to form a good initial alliance by finding out what the patient's goals are and what the patient thinks about how therapy works (related to the agreement components of the alliance).

At the first therapeutic meeting the therapist has ample opportunity to feel and verbalize admiration for some of the patients' efforts to struggle with their problems. For example, at David's first session the therapist said: "I understand that for a long time you have been feeling unappreciated and that nobody acknowledges your efforts. And even though you really want to give up, you keep on going to work every day." This type of complimentary remark can form the basis for an aspect of the relationship that can be highly therapeutic for the depressed patient: a "mirroring self-object" type of relationship. David may be feeling proud of his behavior, and the therapist mirrors this feeling, enhancing it (Kohut, 1971). This makes the patient feel respected and admired for various aspects of his behavior and coping, boosting his injured self-esteem (see also Module 4).

At the first therapy session it is necessary to determine the setting of the treatment: the time of the meetings, their length, and the number (or estimated number) of sessions. It is also important to specify the length of the therapy. Determining the duration of treatment was found to

significantly reduce dropout rates (Swift & Greenberg, 2012). If the therapist is aware of vacations during the period scheduled for treatment, it is important to mention them at the first meeting. These preliminary steps do not eliminate the need for working through the ruptures caused by vacations and endings, but it may make them more tolerable.

Also during the first session, the therapist explains the therapeutic process and the importance that both patient and therapist play an active role in it (Leichsenring & Schauenburg, 2014). A clear presentation of the process and of the arrangements helps patients develop an optimistic attitude and an active stance toward the forthcoming therapy.

To establish good alliance, it is crucial to deal with hopelessness and pessimism, which are part of depression. Addressing these issues can enhance motivation and enthusiasm for the treatment. It is advisable to connect lack of desire and lack of hope with the depression itself. It may be useful for the therapist to express hope and faith that the therapy can help the patient. It is recommended, if possible, to quote relevant research or the therapist's own positive experience treating similar problems. It may also be helpful to reconceptualize depressive symptoms as coping strategies, stressing that these represent the patient's efforts to help himself feel better, noting at the same time the advantages and disadvantages of each coping mechanism (Wachtel, 2011). For example, at the first sessions with David, it became clear that the intensive marijuana use helped him relax and function at work, but that it prevented him from focusing on his studies and kept him at a distance from his family.

Another strategy for coping with ambivalence is to conceptualize the patient as possessing different parts, or self states, coexisting with other parts (Wachtel, 2011). The therapist can verbalize the reasons that initially caused the patient to seek therapy. At this stage, it is important to engage the more hopeful part of the patient, while acknowledging that the other, "defensive" part is doing its best to defend the optimistic and vulnerable part by such means as cynicism, avoidance, and affective withdrawal. In this case, the defensive part can be conceived as a coping strategy, helping protect the patient's vulnerable part from being hurt again (i.e., "it is stupid of me to believe again that something can change . . ."). Among people suffering from depression, the hopeless part of the self is dominant. It is important to encourage dialogue between this part and the less dominant, hopeful part, at other stages of therapy as well.

After working through the first ambivalence, it is time to discuss the goals of the therapy. Patient and therapist should discuss possible targets and agree on realistic ones. It is important that treatment goals include both symptom reduction and enhanced insight about relationship difficulties (Book, 1998). After formulating the focus of therapy based on the CCRT, it is helpful to incorporate the goals of the therapy into it, specifically, a more complete fulfilment of needs and interpersonal wishes (the W component of CCRT), and consequently, higher self-esteem (Book, 1998). For example, Rachel's treatment goals, which came up at the first session, were to succeed in expressing herself better in interpersonal interactions; therefore, to feel more visible and important, and less weak and emotionally unstable. These goals were close to her CCRT wish and made sense as part of the CCRT formulation, as she and her therapist came to understand them. They relate to her avoidant RS and to her resentment and anger against those she felt rejected her (RO, the subjective feeling of the other's response to her wish).

We found it helpful to end the first sessions a few minutes before the time expired, inviting the patient to reflect about the meeting, and especially inviting criticism. Similarly, it may be useful to begin the second and third sessions with the same invitation (e.g., "How did you feel upon leaving the last time?" and "What were you thinking about the meeting?"). These invitations convey a message that knowing how the patient feels about the therapy and being able to express criticism and ambivalence are important for the therapist.

Module 2: Supportive Interventions

Supportive interventions, as opposed to interpretive ones, aim directly at enhancing the therapeutic alliance and the patient's self-esteem. Supportive elements help reduce anxiety and provide a feeling of security (as opposed to interpretive techniques, which often increase anxiety). The supportive element in therapy

serves to create a sense of a secure base (Bowlby, 1988) and emotional security in therapy (Appelbaum, 2006; Silberschatz, 2012). The supportive element has two targets: provide a basis that is essential for allowing the patient to engage in further exploration and self-understanding (Wachtel, 1993), and satisfy developmental needs.

Supportive psychodynamic therapy includes important active ingredients that facilitate therapeutic change, and has been found to be efficient in itself (e.g., Appelbaum, 2006; De Jonghe et al., 2004). A recent meta-analysis found no difference in effectiveness between psychodynamic therapies with a supportive emphasis and those with expressive-interpretative emphasis (Driessen et al., 2010). It is a common finding that the supportive element in treatment is more prominent than therapists generally think, and has a strong influence on effectiveness. It was also one of the surprising findings of the large-scale Menninger research project (Wallerstein, 1989).

For patients suffering from depression, the use of supportive techniques can provide connection to what Mark, Barber, and Crits-Christoph (2003) termed "the hidden depressed self." Supportive techniques aim especially at enhancing low self-esteem, which is one of the hurtful symptoms of depression. Note that in its setting, intensive psychodynamic therapy or psychoanalysis that is not limited in time is supportive. This is partly the reason why time-limited, short-term therapy should be reinforced with supportive elements so that it provides the supportive foundation that every treatment needs. Different direct and indirect techniques can be described as supportive, as discussed below.

Adopting an Admiring, Mirroring Stance Toward the Patient

The therapist's mirroring (Kohut, 1984) can be spontaneous, a response to the patient demonstrating strengths or talents, or it can take the form of encouragement and reinforcement of desirable actions. For example, the therapist can admire Rachel for expressing herself assertively instead of reacting with her usual avoidant response. Pinsker, Rosenthal, and McCullough (1991) stressed that the admiration must be authentic and refer to topics that are admirable in the patient's opinion as well.

Creating a Relationship That Allows Idealization of the Therapist

Kohut (1984) stressed that the therapist should allow and even encourage idealization on the part of the patient, even if it feels wrong or exaggerated (e.g., the patient thinks that the therapist is the best in this field or that he was referred especially to this therapist because of an exact fit). It is a crucial need, often not met in the case of depressed people, to feel part of something (or someone) that is great and wonderful, and in this way enhance one's self-esteem.

Mentalization

This technique teaches patients to look at what happens in their lives and think about it, and to treat patiently the points of view of others, including those of their therapist, about situations and about themselves (Fonagy, Gergely, Jurist, & Target, 2002). Mentalization stresses the need to help the patient take a step back from immediate experience to be able to reflect on it (Lemma, Target, & Fonagy, 2010). It can help replace the physical symptoms of depression with mental understanding. For example, the patient can look at lack of motivation as the physical expression of helplessness. Self-criticism can also be felt as a physical attack, and reflection can moderate the attack (Lemma et al., 2010). Reflective self-observation, which is different from obsessive rumination, has been found to help alleviate depressive moods (Allen, Fonagy, & Bateman, 2008).

Counting on the Patient's Strengths

Wachtel (1993) suggested several techniques that enable working through some of the patient's concerns, and at the same time supporting and strengthening the alliance. For example, he found it important to regard problematic phenomena that the patient may be encountering as being present only at certain times. This perspective enables the therapist to examine, together with the patient, when and why a behavior is present (Wachtel, 1993). Rachel, for example, tends to describe social interactions in which she does not participate actively. On one

occasion she described a situation in which she participated, and the therapist encouraged the account and investigated what made it possible. The new awareness helped Rachel see that she possessed a wider behavioral repertoire than she had thought, which helped her stop thinking about her despair and hopelessness (I can never X). In other words, one of the therapist's goals is to identify clues regarding factors that break the pathological pattern in the patient's current behavior (Wachtel, 1993).

Working With the Inherent Tension Between Accepting the Patient and Anticipating Change

This idea is at the foundation of dialectical behavior therapy (DBT; Linehan, 1993). It is important for the therapist not to appear critical while encouraging change. The therapist can achieve this by making critical comments only when he notices a positive change (Wachtel, 1993): "This time you *did not act* in the usual destructive way of . . ." The therapist might say to Naomi: "What made you go out to dinner last Friday night, when you usually don't accept invitations?" It is preferable for the therapist to notice the new tendency without stressing the defense that has been interfering with this tendency until now. For example, the therapist can relish with Rachel her new ability to enjoy flirting responses. The therapist can suggest new options to the patient, at the same time recognizing different aspects or self states of the patient (Mark et al., 2003). Rather than saying "what you *really* want," it is preferable to say "a part of you also wants . . ."

Giving Advice

The supportive mode makes it possible for the therapist to advise the patient while meeting basic requirements (Pinsker et al., 1991). The first requirement is to make sure that the purpose of the advice is to promote the therapy (and therefore, it is used only in specific cases). The second requirement is to make it clear that the advice is based on the therapist's expertise and not on his or her authority. Finally, the rationale for the advice must not be stated as an imperative (in the case of Rachel, e.g., "you should go to work") but rather as an explanation ("most people who stop working don't feel bet-

ter; not working protects you from certain stressors in the short term, but usually harms self-esteem.") If the CCRT is already formulated, it can be helpful to note where the advice "meets" the CCRT. For some patients this may be a compulsory repetition of a problematic relationship pattern (e.g., being controlled or dependent), but for others it can be a corrective experience (e.g., feeling cared for and close to someone).

Module 3: Expressive and Interpretive Interventions

Interpretive techniques having to do with unconscious processes are considered to be the heart of psychodynamic therapy. In many ways, interpretation of transference (the influences of personality styles that are rooted in developmental history on a novel relational experience with the therapist; DeFife, Hilsenroth, & Kuutmann, 2014) is unique to psychodynamic therapy, and research has found it to be useful (for a review, see Høglend et al., 2011). The module includes two parts: (a) understanding and working through the interpersonal difficulties of the patient *outside* the therapy room, and (b) working through the *therapeutic relationship* and strengthening the therapeutic alliance at points of rupture. In the end, both parts are assumed to affect the alliance, one as the main goal, the other as a by-product, as we demonstrate below.

Part 1: Focusing on the Patient's Main Difficulty Outside the Therapy Room

When conducting short-term psychodynamic treatment, it is important to focus on a specific interpersonal issue that is dominant in the patient's life (Lemma et al., 2010; Malan, 1973; Mann, 1973). In their recent integration of common elements as the basis of randomized control trials focusing on psychodynamic treatment of depression, the authors of the UPP protocol (Leichsenring & Schauenburg, 2014) recommended formulating the central psychodynamic issue through CCRT, so that it is evidence-supported and specifically tailored to treating depression. For example, working on the responses of the self has been found to be related to positive therapy outcomes (Luborsky & Crits-Christoph, 1998). Formulating the understanding of the patient's dynamics and working

through its three parts can form the basis for the interpretive part of the therapy.

As mentioned in the introduction, the CCRT formulation consists of pointing out the basic interpersonal wish (W) of the patient that is not being fulfilled, the typical subjective way in which the patient perceives the other's response to his or her wish (RO), and the way in which the patient usually responds to the other's response (RS). Working through on the unfulfilled wish toward others (W) can include, first of all, helping the patient become aware of the wish while accepting having unsatisfied interpersonal needs. This aim is accomplished by normalizing the need or wish and by showing empathy toward it. If the wish or need is felt as legitimate, there is a better chance for the patient to communicate it more adaptively to others and, therefore, to receive more meaningful responses. The wish can appear in a way that should not become the target of therapy (e.g., aggressive or revengeful interpersonal wishes). These types of wishes are called regressive, in contrast to progressive ones (Book, 1998). Part of the process in these cases is to find the progressive wish beneath the regressive one.

Working through the perception of the RO usually means enhancing the understanding of the patient that he or she is perceiving others' responses *subjectively*. Mentalization can help the patient become more understanding of others' responses (understanding their state of mind, needs, etc.; Fonagy et al., 2002). The RO can manifest in two ways (Book, 1998): the first one is similar to distortion transference (e.g., regarding other people as trying to humiliate the patient, although they are merely trying to get close); the second is similar to repetition compulsion, where the RO reflects the real response of the other (e.g., regarding other people as trying to humiliate the patient while they actually act in a humiliating way). In the process of therapeutic change, the patient needs to understand what in his or her behavior evokes such a response.

There are two components to working through the typical ways in which the patient responds to others (RS): emotional and behavioral. The objective of the therapist is to point out these typical responses, and to enable the patient to attend to them empathically through mentalization. After some of these typical inflexible defensive behaviors and symptoms

have been somewhat altered, there is usually a better chance of attending to the patient's needs. In the following examples the CCRT is used in a session as a way of understanding a situation described by the patient, occurring *outside* the therapy room.

Rachel began the session by describing how her first day of the semester went. She attended two classes, the first of which had a male teacher. She sat in the front, and noticed that the other students seemed older. She felt the teacher was talking to her, and she felt great throughout the entire lecture. She thought about how interesting the subject was, and she was happy that she chose this course. The other class had a female teacher. Everybody was young. The teacher asked them to introduce themselves, and when it was her turn to speak, Rachel felt that the teacher did not like her. The teacher had a frozen expression on her face. Rachel felt that she would like to take a different course. At the end of the day she told herself that the teacher acted in a cold manner toward everyone, and tried not to let this fact ruin her day. She knew how such things affected her.

Therapist:	"You have a natural need to feel special, visible, not part of the crowd (W). When you feel that you are swallowed up in the shuffle (RO), it makes you want to avoid the situation (behavioral RS); it drags you down (emotional RS)."
Rachel nods in agreement:	"At the bar (where she works) there are many waitresses, but I am the only female bar attendant. They are all men, older than me. Now they want to add another female attendant, and that makes me angry even though I tell myself girls should help each other."
Therapist:	"You feel you have a special place there."
Rachel	nods.

Therapist: "Something about men noticing you, the barmen, the male teacher, it feels good . . ."

Rachel agrees (this is entirely new—until now Rachel has always been shy about men). She starts speaking openly and fluently (this is also highly unusual) about her conflicting need to be admired by men, which can make her both obsessive and extremely embarrassed. In this case, the therapist's intervention was quite amorphous and not specific to the situation. The advantage of amorphous intervention is that it occasionally opens up new associations, as was the case here. Book's (1998) advice is to make specific interventions, as demonstrated in the next example.

As soon as she sat down, Naomi started pouring out stories of how annoyed she has been with everyone in the past week: her mother invited her to a picnic in a place that was extremely uncomfortable for her to get to with the baby. She became so angry that after the picnic she felt she could not go to a meeting with her friends, although she had anticipated that meeting eagerly. Her parents-in-law were critical and nasty when they visited, and her husband was annoying as usual, in his clumsy and slow way. Naomi seemed miserable and started putting herself down for being so aggressive with her husband and taking it all out on him.

Therapist: "You were deeply hurt about your mother not finding a picnic place that suits you (emotional RS). You feel you really need your mother to think of you and take your needs in consideration (W). Your parents were busy with their needs while you were growing up (RO), and you are still sensitive about it, as you are when your husband or parents-in-law act in a way that doesn't seem to fit your needs (RO). They all make you furious (RS)."

Naomi was moved to tears. The conversation continued about how deeply sensitive she was to her mother not seeing her needs, and about her forgetting the other efforts that her mother

made so that the picnic would be a pleasant one. All this while Naomi's baby was crawling around the room. While the baby was playing, the therapist took the clock off the low table so that she could not reach it. Just before the meeting ended the therapist put the clock back, and the baby went for it happily.

Therapist: (taking the clock again, talking to the baby): "I'm sorry, sweetie, did you think I put the clock back for you? I was thinking about myself needing to know what time it is, and not about you . . ." Naomi smiled.

In this example, the interpretation was specific to the situation ("you were deeply hurt about your mother not finding a picnic place . . ."), as opposed to the more global interpretation in the former example ("you have a natural need to feel special . . ."). The therapist is also modeling how it is possible to have someone's (the baby's) needs and desires in mind, even if they cannot be fulfilled at the moment.

The two clinical examples demonstrate how conceptualization of the everyday situations that the patient talks about in the course of therapy helps the patient widen her understanding and awareness of her dynamics and behavior, and strengthens the therapeutic alliance based on the patient's feeling of being understood.

Part 2: Working on Empathic Failures or Ruptures in the Therapeutic Alliance

Working on the transference is considered to be the most crucial, meaningful part of psychodynamic therapy. This has been the position since psychoanalysis first made its appearance, and it is the opinion espoused by the present study. The transference work could take place while working on the CCRT, as it is enacted in the therapeutic relationship. This type of work provides an experience-laden, emotional learning rather than one that is more cognitive (Book, 1998).

A key challenge in psychodynamic therapies is to maintain a strong alliance even when facing difficulties in the therapeutic relationship, and leveraging these difficulties to deepen the alliance and the patient's understanding of her

conflicts. Kohut (1984) termed the instances when the patient feels that the therapist is not empathic as "empathic failures," and stressed the importance of the therapist understanding the failure, taking responsibility for it, and adopting again an empathic stance. Safran and Muran (2000) proposed a relational therapeutic outlook that focuses attention on fluctuations and difficulties in the alliance, seeking to work out the ruptures and repair them (Safran & Muran, 2000). It may be helpful to regard ruptures in CCRT terms, containing the wish (W) that the patient holds with regard to the therapist, the patient's subjective experience of how the therapist reacted (RO), and the response of the patient (RS).

Silberschatz (2012) understood and empirically examined ruptures as tests that patients administer to their therapists. The tests are intended to determine whether the therapist would traumatize the patient and can cope with traumas similar to those that the patient has experienced. Silberschatz (2012) argued that when therapists "pass the tests," the patients' symptoms improve, and when they do not pass them, there is no improvement and there can even be deterioration. Gumz, Geyer, and Brähler (2014) found that episodes of high instability occurring in psychodynamic therapy were accompanied by discontinuous change. In one of their examples of a depressed patient, it was clear that these types of episodes can be characterized as ruptures in the therapeutic relationship.

Because talking about ruptures can appear to the patient as an accusation, Safran and Muran (2000) spelled out several important steps to be taken in addressing ruptures. They stressed the importance of talking from the personal experience of the therapist about the "here and now," the concrete, rather than the general tendencies of the patient. They advised talking in a tentative way, inviting a dialog, and using such words as "I noticed that we behave as if we were playing ping-pong, passing the ball across the table . . .", "Does this sound familiar?", "Does this make any sense to you?" It is especially important for the therapist to assume responsibility of his or her part in the rupture. The objective is to expand awareness of the interpersonal phenomenon. Therefore, it is not recommended to connect it with other instances in the patient's life, unless the therapist feels that it is safe and not accusing. The two following vignettes demonstrate working through ruptures.

Rachel becomes quiet. This is not unusual, and the therapist finds herself having done most of the talking for the last few minutes.

Therapist:	What's happening? You disappeared . . . Where are you?
Rachel:	Nothing comes to mind. There's nothing else for me to say about this topic.
Therapist:	Does this have to do with the way we spoke about it before?
Rachel:	I do not know . . .
Therapist:	Maybe something in the way I was relating to it . . .
Rachel:	I do not know . . . It seems that you always know so much about things (RO). I just feel I do not have anything to say (RS) . . .
Therapist:	Even when the topic is you . . .
Rachel:	Yes.
Therapist:	When I think of our conversation in the last few minutes, I notice that you were talking very little and I was talking a lot. I think I wanted to fill the space, to fill our conversation and make it more fluent.

Rachel sits quietly.

Therapist:	Maybe it happens with other people as well. You want to join in, to feel appreciated (W), but you feel that the other people are so smart (RO), while you feel empty (emotional RS) and are shutting down (behavioral RS).

Rachel agrees. She starts talking fluently about how she can spend hours with people without opening her mouth. She describes a social event at which she participated a few days before, where she was invited by her sister

to meet some of her sister's friends. She says that she kept quiet the entire evening, feeling weird and stupid. Rachel speaks rapidly for a few minutes and comments about it, mentioning her unusual fluency with a little smile.

In another episode, toward the end of the session, Naomi began talking about an interaction that deeply moved her. A woman sat down next to her on a bench in the mall, and started talking very intimately with her. She felt the woman really understood her. The woman had some deep insights about Naomi's child and husband. Naomi told her therapist the things the woman had told her, and said that she had spoken about it with her sister and a friend. As Naomi was talking, the therapist felt uneasy, feeling resentment toward what she felt was "witchcraft." The therapist felt that her resentment had to do with Naomi's unspoken criticism.

Therapist: Your story makes me think of our therapy. Maybe this is your way of telling me how you feel here.

Naomi: Yes . . . maybe . . . I was thinking what it would be like to be in therapy with her. I thought that for many of the sessions here I just ventilate, unloading my frustration, and usually I cannot even remember what you told me.

Therapist: I think you have a point. It's not easy for me to hear this, but actually I'm happy you're bringing it up. Why do you think this happens?

Naomi: I think I really need to ventilate. I wait all week for that. With her I was not preparing to ventilate. She took me by surprise.

Therapist: You have a great need for recognition from me for all your trouble and frustration with your family members . . . (W)

Naomi: Yes . . . I need so much . . . I get dissatisfied here too.

Therapist: Just like with your family, you remain frustrated here because you're not getting what you need (RS).

Naomi: I need so much . . .

Module 4: Termination and Prevention of Relapse

Starting with the first session, when the termination point is determined, and throughout therapy, attention must be paid to the limited time available, to the upcoming termination of treatment, and to progress in achieving the stated goals. In the last few sessions, the therapist should pay special attention to summing up what has been accomplished in the therapy in two main areas: (a) widening the perceptions of others and expanding the repertoire of reactions of the self (RO and RS), and (b) moving toward better fulfillment of the underlying wish (W). The therapist should connect these domains with the patient's depressive symptoms (Book, 1998).

A return of symptoms is expected at termination, which in CCRT terms usually means going back to the original, often pathological RS. The W is less likely to be fulfilled at termination because of the anticipation that the therapist is about to leave the patient. Instead of a corrective emotional experience, the patient's original experience of the other letting her down or deserting her (RO) is reenacted (Luborsky, 1995; Book, 1998). Therefore, when ruptures inherent in treatment occur in the therapy room, it is extremely important to resolve them, acknowledging the disappointment, taking the opportunity to examine the CCRT, and checking whether and how it has been changing. The therapist can acknowledge the patient's feeling that termination may be premature, and share the patient's feeling of sadness about it.

Although during termination the patient may experience the therapist as disappointing, usually the patient can also remember the therapist as having been helpful. Mentalization of the integration of the different aspects of the therapist can be important. It is useful also to reassure the patient that she internalized the therapy and can continue doing part of the work by herself, as shown in the following example. As the end of the therapy was approaching, Rachel

talked about how she had recommended to her sister and to a good friend to start therapy, and that both would start soon. She sat quietly for a minute.

Therapist: You feel therapy has been helpful to you and can be helpful to those closest to you too.

Rachel: Yes, but . . . I'm afraid that they will have therapy and my therapy is ending . . . I'm afraid that I will feel alone and that all the things we talked about here will disappear . . .

Therapist: You are afraid to feel alone and not be visible again (RO). Once I'm not there anymore for you . . .

Rachel: Yes. I cannot be sure that things have really changed for me . . . I feel jealous of them that they will have a therapist . . .

Therapist: You cannot be sure . . . Do you feel that things can go back to how they were? To you being so shy and avoidant (RS)?

Rachel: Actually, not really . . . I know that people at [the new workplace] see me differently now. I hope I do not go back to being so quiet that nobody notices me (behavioral RS).

Lemma, Target, and Fonagy (2010) suggested giving the patient a "goodbye letter" that contains the central understandings of the therapy, a description of the process, and thoughts about the work that can be done in the future. This letter should be handed to the patient three sessions before the end of the therapy and used as a kind of transitional object that stays with the patient after therapy ends. A pilot study showed that patients accepted such a letter positively (Gelman, McKay, & Marks, 2010).

Discussion and Conclusions

This article has presented clinical material from three psychodynamic cases, as illustrations of an integrative view of the central active ingredients of short-term psychodynamic therapy. The model is based on Leichsenring and Schauenburg's (2014) proposal for the integration of repeated effective elements of psychodynamic therapies for depression, and on the most prominent manualized forms of short-term psychodynamic therapies: Supportive-Expressive (Book, 1998), Brief Relational Therapy (Safran & Muran, 2000), Dynamic Interpersonal Therapy (Lemma et al., 2010), Supportive psychotherapy (Pinsker et al., 1991) and psychodynamic theory (especially Kohut, 1984). We elaborated on the concepts of CCRT and therapeutic alliance, and focused on these terms as threads connecting the four modules. Table 1 summarizes briefly the four modules and their techniques.

The importance of the CCRT conceptualization has been stressed across the modules. Specifically, the concept of CCRT was crucial in the first module in formulating an understanding of the patient's key difficulty underlying the symptoms of depression. It was also used in the second, supportive module to help understand the meaning of various supportive acts of the therapist, such as providing advice. The CCRT formed the basis for interpretive interventions in the third module, where interpersonal conflicts in the patient's life and in the therapeutic relationship (transference) were understood and interpreted within the theoretical framework of CCRT. Finally, the CCRT was essential in understanding regressive symptoms during the process of separation, in the last module.

The concept of therapeutic alliance was the other thread tying the modules together. The objective of forming and strengthening the therapeutic alliance was formulated as a key target underlying the modules. The first module is aimed at forming a strong alliance. The second, supportive module can be viewed as the "alliance module," aimed directly at forming a secure base, and as an opportunity to develop a healthier relationship. The third, interpretive module makes the patient aware of problems in relationships outside and inside the therapy room, deepening collaboration and working directly on ruptures in the alliance. The last mod-

Table 1
Summary of Modules and Their Techniques

Module	Techniques

Module 1: Beginning of therapy	1. Create a good initial alliance:
	  a. Find out what the patient's goals are and what the patient thinks about how therapy works.
	  b. Verbalize admiration for the patients' efforts and struggles.
	2. Determine the setting of the treatment and explain the therapeutic process.
	3. Address hopelessness and enhance motivation:
	  a. Reconceptualize depressive symptoms as coping strategies.
	  b. Conceptualize the patient as possessing different parts or self states.
	4. Discuss the goals of treatment.
	5. Invite criticism.

Module 2: Supportive interventions	1. Adopt an admiring, mirroring stance toward the patient. 2. Create a relationship that allows idealization of the therapist. 3. Use mentalization and reflective self-observation. 4. Help the patient count on his strengths. 5. Work with the inherent tension between accepting the patient and anticipating change. 6. Give reasoned advice.

Module 3: Expressive and interpretive interventions	Use CCRT conceptualization to:
	  1. Focus on the patient's main difficulty outside the therapy room.
	  2. Work on ruptures in the therapeutic alliance.

Module 4: Termination and prevention of relapse	1. Sum up what has been accomplished in CCRT terms. 2. Explain the return of symptoms in CCRT terms. 3. Use mentalization to integrate different aspects of the therapist. 4. Give a "goodbye letter."

Note. CCRT = Core Conflictual Relational Themes.

ule works through separation, building on the alliance and on understandings achieved in the area of interpersonal difficulties that contribute to ruptures in the alliance at termination.

A limitation of the present project is that it provided only brief descriptions of each technique, as opposed to books that have been written to demonstrate separately each of the techniques mentioned in this article (e.g., Safran & Muran, 2000; Wachtel, 1993). This limitation makes it more difficult for therapists who are not acquainted with the theory and practice on which the article is based, to apply the modules without some background. Therefore, the present article should be used in combination with previous work, not as a substitute for it. Further research is needed to customize the modules to different populations.

Integrating active elements from psychodynamic research with clinical perspectives is crit-ical for bridging the two languages. Such integration is especially important today because empirically supported psychodynamic treatments are still not commonly used in clinical practice. As clinicians and researchers, we hope that the present project represents a step forward in this direction.

References

Allen, J., Fonagy, P., & Bateman, A. (2008). *Mentalization in clinical practice*. Washington, DC: American Psychiatric Press.

Appelbaum, A. H. (2006). Supportive psychoanalytic psychotherapy for borderline patients: An empirical approach. *The American Journal of Psychoanalysis, 66,* 317–332. http://dx.doi.org/10.1007/s11231-006-9026-2

Barber, J. P., Muran, J. C., McCarthy, K. S., & Keefe, R. J. (2013). Research on psychodynamic thera-

pies. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 443–494). New York, NY: Wiley.

Barth, J., Munder, T., Gerger, H., Nüesch, E., Trelle, S., Znoj, H., . . . Cuijpers, P. (2013). Comparative efficacy of seven psychotherapeutic interventions for patients with depression: A network meta-analysis. http://dx.doi.org/10.1371/journal.pmed.1001454

Book, H. E. (1998). *How to practice brief psychodynamic therapy: The core conflictual relationship theme method*. Washington, DC: American Psychological Association Press. http://dx.doi.org/10.1037/10251-000

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, & Practice, 16,* 252–260. http://dx.doi.org/10.1037/h0085885

Bowlby, J. (1988). *Attachment, communication, and the therapeutic process. A secure base: Parent-child attachment and healthy human development*. New York, NY: Basic Books.

Crits-Christoph, P., Gibbons, M. B. C., Crits-Christoph, K., Narducci, J., Schamberger, M., & Gallop, R. (2006). Can therapists be trained to improve their alliances? A preliminary study of alliance-fostering psychotherapy. *Psychotherapy Research, 16,* 268–281. http://dx.doi.org/10.1080/10503300500268557

Cuijpers, P., Karyotaki, E., Weitz, E., Andersson, G., Hollon, S. D., & van Straten, A. (2014). The effects of psychotherapies for major depression in adults on remission, recovery and improvement: A meta-analysis. *Journal of Affective Disorders, 159,* 118–126. http://dx.doi.org/10.1016/j.jad.2014.02.026

DeFife, J., Hilsenroth, M., & Kuutmann, K. (2014). Beyond transference: Fostering growth through therapeutic immediacy. In P. Luyten, L. C. Mayes, P. Fonagy, M. Target, & S. J. Blatt (Eds.), *Handbook of contemporary psychodynamic approaches to psychopathology*. New York, NY: Guilford Press.

de Jonghe, F., Hendricksen, M., van Aalst, G., Kool, S., Peen, V., Van, R., . . . Dekker, J. (2004). Psychotherapy alone and combined with pharmacotherapy in the treatment of depression. *The British Journal of Psychiatry, 185,* 37–45. http://dx.doi.org/10.1192/bjp.185.1.37

Driessen, E., Cuijpers, P., de Maat, S. C., Abbass, A. A., de Jonghe, F., & Dekker, J. J. (2010). The efficacy of short-term psychodynamic psychotherapy for depression: A meta-analysis. *Clinical Psychology Review, 30,* 25–36. http://dx.doi.org/10.1016/j.cpr.2009.08.010

Emmelkamp, P. M. (2013). Behavior therapy in adults. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 495–538). Hoboken, NJ: Wiley.

Fonagy, P., Gergely, G., Jurist, E. J., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York, NY: Other Press.

Freud, S. (1912). *The standard edition of the complete psychological works of Sigmund Freud: Volume 12. The dynamics of transference* (J. Strachey, Ed.). London, United Kingdom: Hogarth Press.

Gelman, T., McKay, A., & Marks, L. (2010). Dynamic interpersonal therapy (DIT): Providing a focus for time-limited psychodynamic work in the National Health Service. *Psychoanalytic Psychotherapy, 24,* 347–361. http://dx.doi.org/10.1080/02668734.2010.513556

Gumz, A., Geyer, M., & Brähler, E. (2014). Psychodynamic therapy from the perspective of self-organization. a concept of change and a methodological approach for empirical examination. *Clinical Psychology & Psychotherapy, 21,* 299–310. http://dx.doi.org/10.1002/cpp.1840

Hatcher, R. L., & Barends, A. W. (2006). How a return to theory could help alliance research. *Psychotherapy: Theory, Research, & Practice, 43,* 292–299. http://dx.doi.org/10.1037/0033-3204.43.3.292

Høglend, P., Hersoug, A. G., Bøgwald, K. P., Amlo, S., Marble, A., Sørbye, Ø., . . . Crits-Christoph, P. (2011). Effects of transference work in the context of therapeutic alliance and quality of object relations. *Journal of Consulting and Clinical Psychology, 79,* 697–706. http://dx.doi.org/10.1037/a0024863

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy: Theory, Research, & Practice, 48,* 9–16. http://dx.doi.org/10.1037/a0022186

Kohut, H. (1971). *The analysis of the self*. New York, NY: International Universities Press.

Kohut, H. (1984). *How does analysis cure?* Chicago, IL: University of Chicago Press. http://dx.doi.org/10.7208/chicago/9780226006147.001.0001

Leichsenring, F., & Leibing, E. (2007). Supportive-expressive (SE) psychotherapy: An update. *Current Psychiatry Reviews, 3,* 57–64. http://dx.doi.org/10.2174/157340007779815655

Leichsenring, F., Leweke, F., Klein, S., & Steinert, C. (2015). The empirical status of psychodynamic psychotherapy–an update: Bambi's alive and kicking. *Psychotherapy and Psychosomatics, 84,* 129–148. http://dx.doi.org/10.1159/000376584

Leichsenring, F., & Schauenburg, H. (2014). Empirically supported methods of short-term psychodynamic therapy in depression–towards an evidence-based unified protocol. *Journal of Affective*

Disorders, 169, 128–143. http://dx.doi.org/10
.1016/j.jad.2014.08.007

Lemma, A., Target, M., & Fonagy, P. (2010). The
development of a brief psychodynamic protocol
for depression: Dynamic interpersonal therapy
(DIT). *Psychoanalytic Psychotherapy, 24,* 329–
346. http://dx.doi.org/10.1080/02668734.2010
.513547

Linehan, M. (1993). *Cognitive behavioral treatment
of borderline personality disorder.* New York,
NY: Guilford Press.

Luborsky, L. (1976). Helping alliances in psycho-
therapy: The groundwork for a study of their rela-
tionship to its outcome. In J. L. Claghorn (Ed.),
Successful psychotherapy (pp. 92–116). New
York, NY: Brunner/Mazel.

Luborsky, L. (1984). *The principles of psychoana-
lytic psychotherapy.* New York, NY: Basic Books.

Luborsky, L. (1995). Are common factors across
different psychotherapies the main explanation for
the dodo bird verdict that "Everyone has won so all
shall have prizes"? *Clinical Psychology: Science
and Practice, 2,* 106–109. http://dx.doi.org/10
.1111/j.1468-2850.1995.tb00033.x

Luborsky, L., & Crits-Christoph, P. (1998). *Under-
standing transference: The Core Conflictual Rela-
tionship Theme method.* Washington, DC: Ameri-
can Psychological Association.

Malan, D. H. (1973). *Individual psychotherapy and
the science of psychodynamics.* London, United
Kingdom: Butterworth.

Mann, J. (1973). *Time-limited psychotherapy.* Cam-
bridge, MA: Harvard University Press.

Mark, D. G., Barber, J. P., & Crits-Christoph, P.
(2003). Supportive-expressive therapy for chronic
depression. *Journal of Clinical Psychology, 59,*
859–872. http://dx.doi.org/10.1002/jclp.10178

Pinsker, H., Rosenthal, R., & McCullough, L. (1991).
Dynamic supportive psychotherapy. In P. Crits-
Christoph & J. Barber (Eds.), *Handbook of short-
term dynamic psychotherapy* (pp. 220–247). New
York, NY: Basic Books.

Safran, J. D., & Muran, J. C. (2000). *Negotiating the
therapeutic alliance: A relational treatment guide.*
New York, NY: Guilford Press.

Safran, J. D., Muran, J. C., & Eubanks-Carter, C.
(2011). Repairing alliance ruptures. *Psychother-
apy: Theory, Research, & Practice, 48,* 80–87.
http://dx.doi.org/10.1037/a0022140

Silberschatz, G. (2012). Transformative processes in
psychotherapy: How patients work in therapy to
overcome their problems. *Psychotherapy in Aus-
tralia, 18,* 30–35.

Swift, J. K., & Greenberg, R. P. (2012). Premature
discontinuation in adult psychotherapy: A meta-
analysis. *Journal of Consulting and Clinical Psy-
chology, 80,* 547–559. http://dx.doi.org/10.1037/
a0028226

Wachtel, P. L. (1993). *Therapeutic communication:
Principles and effective practice.* New York, NY:
Guilford Press.

Wachtel, P. L. (2011). *Therapeutic communication:
Knowing what to say when* (2nd ed.). New York,
NY: Guilford Press.

Wallerstein, R. S. (1989). The psychotherapy re-
search project of the Menninger Foundation: An
overview. *Journal of Consulting and Clinical Psy-
chology, 57,* 195–205. http://dx.doi.org/10.1037/
0022-006X.57.2.195

Zetzel, E. R. (1966). The analytic situation. In R.
Litman (Ed.), *Psychoanalysis in the Americas:
Original contributions from the first Pan-Ameri-
can Congress for Psychoanalysis* (pp. 86–106).
New York, NY: International Universities Press.

Zilcha-Mano, S., Dinger, U., McCarthy, K. S., &
Barber, J. P. (2014). Does alliance predict symp-
toms throughout treatment, or is it the other way
around? *Journal of Consulting and Clinical Psy-
chology, 82,* 931–935. http://dx.doi.org/10.1037/
a0035141