*Commentary on <u>Getting into the ACT with
Psychoanalytic Therapy: The Case of Daniel</u>*

A Cognitive-Behavioral Perspective on
Robert Cohen's Case of "Daniel"

STEPHEN J.F. HOLLAND [a,b]

[a] Capital Institute for Cognitive Therapy, Washington, DC

[b] Correspondence regarding this article should be addressed to: Stephen J. F. Holland, Director, Capital Institute for Cognitive Therapy, 1729 21st Street, NW, Washington, DC 20009
Email: sholland@cognitivetherapydc.com

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ABSTRACT

Robert Cohen's case study of Daniel gives an excellent example of the potential for integrating cognitive-behavioral techniques within a psychoanalytically informed psychotherapy. Dr. Cohen introduces exercises from Acceptance and Commitment Therapy (ACT) into his work with a patient who has become stuck after a long period of good progress in therapy. The use of active techniques from ACT appears to have allowed the patient to make further progress. However, integrating a full range of interventions from first-, second-, and third-wave cognitive-behavioral treatments might have offered additional benefits to the patient as well as providing for a more complete theoretical integration between cognitive-behavioral and psychoanalytic approaches.

Key words: cognitive behavioral therapy; psychoanalysis; integration; acceptance and commitment therapy; third wave; mindfulness; emotion; case study; clinical case study.
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Robert Cohen's (2016) case study of Daniel is a beautiful example of something I personally would like to see more often: the use of cognitive-behavioral techniques by a sophisticated psychoanalytic clinician within the context and in the service of a psychoanalytically informed treatment. I will be commenting on this case from two perspectives: first as someone who practices empirically supported cognitive-behavioral treatments, meaning treatment packages that have been shown effective in clinical trials for specific disorders (Leahy, Holland, & McGinn, 2012); and second, as someone who has trained in short-term dynamic and psychoanalytic psychotherapy and has an interest in theoretical integration (Holland, 1997; Holland, 2003; Holland, 2014).

I will begin by discussing what I believe the use of techniques from Acceptance and Commitment Therapy (ACT; Hayes, 2005) added to Dr. Cohen's treatment of this patient, including the reasons for selecting ACT as the cognitive behavior therapy (CBT) model to incorporate. I will then suggest what a broader cognitive-behavioral perspective might add to

this case and might bring to the larger project of a thorough integration between cognitive-behavioral and psychoanalytic approaches.

THE VALUE-ADDED OF "ACT" TECHNIQUES

General Considerations About Psychoanalytic and CBT Practice

As Dr. Cohen outlines in his article, psychoanalytic theorists across various schools share some common assumptions: the problems our patients experience are the result of unconscious conflicts around the expression of fundamental drives or desires, these conflicts arise in the context of developmental experience, and these conflicts can be explored, understood and ultimately modified through the analysis of transference. Regardless of the relative emphasis on insight or corrective emotional experience, the assumption is that once unconscious conflicts are successfully resolved, the patient will be freed to find more adaptive ways of functioning, although it is also recognized that this process may take some time (i.e., the working-through process [Greenson, 1967; Scharff & Scharff, 2000]).

Cognitive-behavioral therapies, in contrast, teach patients techniques they can use to modify the patterns of thought, behavior and emotional coping that are presumed to cause their distress. Techniques may include some combination of cognitive restructuring, skills training, behavioral activation, exposure to anxiety evoking cues, and emotional regulation strategies, including mindfulness and acceptance. There is an emphasis on modifying current factors that maintain patients' symptoms rather than historical exploration, and it is assumed that change results from repeated practice of new, more adaptive responses.

On the surface, these two approaches can appear so different as to be almost incompatible. Psychoanalytic writers have tended to see cognitive-behavioral techniques as superficial and likely to interfere with the deep exploration presumed necessary for lasting change. Cognitive-behavioral writers tend to view psychoanalytic exploration as an unnecessary waste of time at best and counterproductive at worst, and point to extensive evidence from outcome studies that change produced in cognitive-behavioral therapy is maintained long-term without the trappings of analytic therapy.

However, for all of these differences, psychoanalytic and cognitive-behavioral approaches share at least two assumptions: 1) problematic psychological processes and structures must be activated in order to be modified, and 2) activation of these processes inevitably results in the activation of emotion. In other words, in both models effective change processes are presumed to take place in the context of emotion, and emotional experience in session is seen as an important marker of productive therapeutic work.

In psychoanalytic therapy these assumptions take the form of Freud's famous dictum (quoted by Dr. Cohen) that "no-one can be destroyed in absentia or in effigy." In other words, the reason for the emphasis on transference is that it allows emotionally alive access to the patient's interpersonal conflicts so they can be understood and modified. Much of psychoanalytic technique, from the use of unstructured sessions to defense confrontation, to working in the "here and now" of the relationship, and even regression, can be seen as an effort

to work with psychological processes when they are active and accessible for exploration and change.

In cognitive-behavioral therapy the idea that schemas must be activated to be modified is most clearly expressed in Foa's influential Emotional Processing Theory (Foa & Kozak, 1986). This theory was developed to explain the empirical finding that exposure is most effective when it evokes anxiety. Foa theorized that anxiety was the result of a "fear structure" in memory, consisting of memories of anxiety evoking cues, emotional responses, and the meanings associated with these cues and responses. The purpose of exposure is to provide new experiences that will modify the fear structure. However, if exposure does not elicit anxiety it means the fear structure has not been activated and so new information cannot be incorporated. In other words, exposure works because it offers a "corrective emotional experience." For similar reasons, cognitive therapy, following Aaron Beck's well-known model, emphasizes targeting "hot" cognitions, i.e. those thoughts that currently evoke the most emotion, as the best way to promote cognitive change (Beck, 1987).

The understanding that both approaches aim at producing change through emotionally charged experience suggests that advocates of each wrongly ignore the advantages of the other. From the CBT perspective, while Beck's original manual for Cognitive Therapy of depression (Beck, 1987) acknowledges that cognitive distortions may arise and be corrected in interactions with the therapist, CBT models have been slow to fully recognize the power and therapeutic usefulness of the therapy relationship. It is interesting to note that as CBT has matured and expanded to treat more severe and complex problems, a number of CBT models have come to place greater emphasis on the explicit use of the relationship (e.g., such models as Schema Therapy [Young, Klosko, & Weishaar, 2003], Cognitive-Behavioral Analysis System of Psychotherapy [McCullough, 2006], Dialectical Behavior Therapy [Linehan, 1993], and Functional Analytic Psychotherapy [Kohlenberg and Tsai, 1991]).

However, it could be argued that none of these models approach the depth and sophistication of a psychoanalytically informed perspective on the interplay of transference and countertransference. Similarly, some CBT models now provide specific techniques for working with memories of formative experiences (e.g., Edwards, 2007; Holmes, Arntz, & Smucker, 2007; Wild, Hackmann, & Clark, 2008), but again such techniques are not fully developed and are not present in all CBT models.[1]

Similarly, psychoanalytic clinicians ignore the potential benefits of CBT models. For purposes of this discussion, there are at least two potential weaknesses in the psychoanalytic model that cognitive-behavioral techniques may help address. First, transference is a powerful but limited tool. The most salient interpersonal interactions may or may not arise spontaneously in the relationship between a particular patient and particular therapist and even when they do may take time to unfold and may do so fitfully. CBT provides a number of alternative

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[1] Having worked in both the CBT and psychoanalytic models, my own view is that from the CBT perspective the analysis of transference and historical exploration *may* be helpful, *may or may not* be necessary, and are *unlikely to be sufficient* in any given case.

techniques to deliberately activate and modify relevant schemas. These include self-monitoring, the use of thought records in situations outside of therapy, cognitive descents (in which patients are asked explore implications of automatic thoughts to identify core beliefs), and most powerfully, planned exposures. All of these techniques can be used not only to modify patterns of thought, behavior, and emotion, but also to explore and better understand them. Thus CBT, properly applied, may supplement analytic exploration by providing a variety of more readily and reliably accessed emotional experiences related to the patient's difficulties.

A second weakness in the analytic approach is the assumption that adaptive behavior will spontaneously arise once unconscious conflicts are resolved. The problem is that in the absence of positively supportive developmental experience, patients may not have learned adaptive skills, and further, such skills may take deliberate practice and coaching to develop optimally. Here again, CBT's emphasis on skills training and homework may provide a useful adjunct to analytic treatment.

Application to the Case of Daniel

With these concepts in mind, we can now begin to consider why the introduction of ACT techniques by Dr. Cohen might have been helpful to his patient Daniel. According to Dr. Cohen, Daniel initially presented complaining of paralyzing worry, low self-esteem and lack of confidence in work and relationships. At the time Dr. Cohen introduced ACT techniques, Daniel had made considerable progress. He was experiencing success and recognition at work, he was in a relationship that was satisfying in important ways, and he had begun to make male friends.

Based on Dr. Cohen's description, we can identify several processes that were likely helpful in allowing Daniel to get as far as he did in their analytic work together. Exploration of the childhood origins of his negative sense of self and of his fears related to expression of anger, accomplishment, and emotional needs likely helped give Daniel a more realistic view of himself in relationship to others. Dr. Cohen's focus on affect and confrontation of defenses against emotional experience likely increased Daniel's comfort with negative emotion. And Dr. Cohen's more collaborative, interpersonal stance later in treatment seemed to have provided Daniel with a corrective emotional experience that allowed him to feel safe and to see that another man could understand and support his feelings and wishes. These internal shifts appear to have made it possible for Daniel to move with greater confidence in the world toward getting his needs met.

In spite of this progress, Daniel continued to struggle with rumination and negative thoughts about himself. He felt anxious about his acceptability in social relationships, particularly with male friends. He still showed signs of being uncomfortable identifying and expressing his feelings. And he was still experiencing ambivalence about his career and relationship and did not yet seem fully committed to either. A cognitive-behavioral perspective would suggest that more active, structured techniques might be helpful to address what had not been fully dealt within the analytic work thus far.

Why Choose ACT From Among the CBT Possibilities

It's worth pausing for a moment to consider Dr. Cohen's choice of ACT from all of the CBT models currently available. ACT has been identified by its founder, Stephen Hayes (Hayes,

2004), as a "third-wave" cognitive-behavioral therapy (the first wave being the original behavioral treatments based on conditioning principles, and the second wave being the cognitive revolution of theorist-practitioners like Beck (1987), Ellis (2001) and Michenbaum (1985). Third-wave therapies are characterized by a return to behavioral meta-theory, a corresponding de-emphasis of cognitive techniques and the incorporation of Buddhist concepts of mindfulness and acceptance. There is also a greater emphasis on the role of emotion and the negative consequences of emotional avoidance. While there is no uniformly agreed upon list of third-wave treatments, other forms of CBT generally considered to be part of the third wave include Dialectical Behavior Therapy (DBT, Linehan, 1993), Mindfulness Based Cognitive Therapy Segal, Williams, & Teasdale, 2012), Integrative Behavioral Couples Therapy (Christensen & Jacobson, 1998), the Unified Protocol (Barlow, et al., 2010), and Functional Analytic Psychotherapy (Kohlenberg & Tsai, 1991).

It is not surprising that third wave models in general, and ACT in particular, have piqued the interest of psychoanalytic clinicians such as Dr. Cohen. I have argued elsewhere (Holland, 1997; Holland, 2003; Holland 2011) that the lack of a model of defense is one of the great weaknesses of traditional cognitive-behavioral theory. With its emphasis on experiential avoidance as a central factor in human suffering and on the importance of acceptance of negative emotion, ACT is one of the CBT models that begins to address concepts similar to psychoanalytic concepts of defense. In addition, ACT's rejection of the kind of rational disputation used in cognitive therapy parallels similar objections to this strategy by analytic theorists like Wachtel (1997).

And so, in ACT Dr. Cohen finds a CBT model that allows him to use the kind of active, skills-based interventions that are typical of CBT while staying true to psychoanalytic principles and his goals for Daniel. Specifically, he wants Daniel to be better able to tolerate and express his emotions, to ruminate less, to be less troubled by negative beliefs about himself, and to take further actions to pursue goals such as satisfying employment and close relationships.

Daniel's Two Primary Fears Regarding Emotions

Daniel expresses two primary fears about experiencing his emotions: 1) that he will become overwhelmed by his feelings, and 2) that others will be able to perceive his emotions (the "tell") and will reject him. In order to help Daniel be better able to tolerate his feelings and challenge his belief that he will be overwhelmed by them, Dr. Cohen has Daniel practice various ACT exercises in which he deliberately evokes negative thoughts and feelings and allows them to stay in consciousness without trying to change them.

To target Daniel's rumination and negative beliefs, including his belief that he will be overwhelmed by his emotions, Dr. Cohen uses the ACT concept of "defusion" (Hayes, 2005). In ACT, patients are taught to de-fuse from their thoughts—that is, rather than regarding their thoughts as a representation of reality that they must do something about or as negative experiences that they have to change, patients are encouraged to distance themselves from their thoughts and to see them as mental phenomenon that can simply be allowed to come and go. In ACT, defusion is practiced through specific exercises, including mindfulness (Hayes, 2005).

As Dr. Cohen notes, Daniel often resisted doing the ACT exercises, forgetting his book, not practicing between sessions, and so forth. Dr. Cohen interprets this as reflecting Daniel's ambivalence about making progress on his goals because of his historical fear of evoking his father's envy and rage. While there may be some truth in this, from the perspective of a cognitive-behavioral practitioner, resistance and avoidance are typical when patients begin exposure work. We are, after all, asking them to deliberately engage with the things that make them most anxious. Dr. Cohen attempts to offer some interpretations of Daniel's resistance (for example, suggesting that Daniel might be afraid of being close to Dr. Cohen), but these do not seem to lead to any productive associations or emotion, at least in the sessions that Dr. Cohen describes in detail. Dr. Cohen also deals with Daniel's resistance to doing the ACT work in ways that are common in cognitive-behavioral therapy. Specifically, Dr. Cohen has Daniel practice in the session exercises that he does not complete as homework; Dr. Cohen models the exercises for Daniel; and Dr. Cohen helps Daniel identify reasons to engage in behaviors and/or situations that are uncomfortable by drawing on ACT work in values clarification and making a commitment to working to achieve those values.

Even with the introduction of ACT techniques, progress for Daniel is slow, as he struggles to consistently use the techniques. However, over time it is apparent that he does employ both ACT concepts and ACT exercises, and in particular he reports regular practice of mindfulness meditation. Eventually Daniel moves beyond the impasse that prompted Dr. Cohen to introduce ACT. He commits to marry his girlfriend, he takes risks to reveal himself more in his relationship to a male friend, and eventually he reports less distress and begins to taper the frequency of sessions and to discuss termination.

What Specifically Did ACT Add?

So how do we understand what ACT added to this treatment? From a cognitive-behavioral perspective, Daniel is afraid to experience his emotions and so practices avoidance in a variety of forms. The CBT treatment of choice for anxiety and avoidance is planned exposure to anxiety-provoking cues. We know from experimental studies that exposure is most effective when it is repeated and is even more effective when the repetitions are massed, that is, spaced closely together in time (Wolitzky-Taylor, Horowiz, Powers, & Telch, 2008). As noted above, Dr. Cohen's encouragement of emotional exploration and confrontation of defenses against emotion in the analytic phase of their work likely did help improve Daniel's affect tolerance, and could be understood as forms of exposure. However, it is likely that the frequency of such experiences, limited as they were to during sessions and when the occasion arose, were not sufficient for maximum effectiveness.

One reason Daniel may have been able to make further progress with the introduction of ACT is that regular practice of ACT exercises increased the frequency of Daniel's exposure to feared emotional cues. In addition, Dr. Cohen reports that mindfulness was the ACT technique Daniel practiced most consistently toward the end of treatment. There is a large and growing body of evidence that mindfulness practice by itself is an effective treatment for anxiety and depression (Khoury, et al., 2013). It also seems that the ACT model may have provided Daniel with an explicit conceptual rationale for tolerating his emotion that resonated with him and helped motivate him to do the exercises. As Daniel began to be better able to tolerate

uncomfortable feelings and thoughts, he was likely more willing and able to pursue valued goals rather than being deterred by potential discomfort.

There was also important cognitive work that took place using ACT. Daniel's tendency to ruminate was likely helped by the practice of defusion techniques as well his mindfulness practice. I think it is also likely that by suggesting that Daniel was "fused" with thoughts such as the idea that he would not be able to tolerate his feelings or that his feelings would be unacceptable to others, Dr. Cohen communicated that he (Dr. Cohen) did not believe such thoughts were true. And as Dr. Cohen encouraged Daniel to pursue goals, like a close friendship with his male friend. Dr. Cohen communicated that he believed these desires were legitimate and not likely to lead to the negative consequences Daniel feared. Thus Dr. Cohen's use of ACT defusion techniques, in addition to providing practice in not getting caught up in rumination, may have helped change some of Daniel's beliefs.

Finally, Dr. Cohen suggests, and I concur, that, while we do not have any direct evidence of this, it is reasonable to consider that there might have been an important relational message in his use of ACT with Daniel. By recommending they try a different approach, Dr. Cohen demonstrated his interest in and willingness to be flexible in helping Daniel. The care and humility in such a choice would be in direct contrast to Daniel's father, whose narcissistic vulnerability would not allow him to recognize and meet his son's needs. In this Dr. Cohen also made clear that it was his wish that Daniel be able to move to complete mature independence rather than staying stunted in his growth in order not to be threatening to Dr. Cohen. Had Dr. Cohen either continued to hammer away in a psychoanalytic form of treatment that was no longer feeling productive, or worse still, concluded and in some way communicated that Daniel was not capable of making more progress, he might well have unconsciously participated in a re-enactment of aspects of Daniel's experience with his father. Thus, we might consider the introduction of CBT techniques in the form of ACT as a profoundly relationally attuned choice.

In summary, I would suggest that Dr. Cohen's work with Daniel is in the best tradition of Wachtel's (1977) pioneering integrative model of cyclical psychodynamics: Active behavioral techniques (in this case from ACT) are used to help modify current behaviors that maintain maladaptive relational patterns that are understood to have formed in earlier developmental experience.

AN ARGUMENT FOR INCLUDING ALL THREE
WAVES OF CBT IN DANIEL'S THERAPY

We could stop the discussion here. However, I would like to make to make a broader theoretical point. While third-wave models, including ACT, with their emphasis on emotion and experiential avoidance, have opened up new avenues for integration between CBT and psychoanalytic approaches, for a thorough integration I believe we need to include all three waves of CBT.

The Limitations of ACT Vis a Vis the Psychoanalytic Model

First, consider ACT's advantages and limitations as an integrative model. ACT's emphasis on the central role of experiential avoidance is, in fact, more consistent with psychoanalytic concepts of defense than is Beck's cognitive therapy. However, other aspects of ACT are less compatible. Fundamental to ACT is the assumption that all attempts to feel better or change negative thought patterns are likely to be counterproductive and potentially dangerous. (It should be noted that in this respect, ACT is the most radical of the third wave models). In other words, in ACT patients are helped to see that their efforts to control their thoughts and emotions are part of the problem and encouraged instead to accept their feelings as they are and commit to behaviors based on their values (Hayes, et al., 2012). Of course, when we as therapists are working psychoanalytically we want our patients to feel better and be more realistic in their view of themselves and relationships, even if feeling better sometimes involves acceptance of the tragic and ironic (Messer & Winokur, 1980). We assume that such internal changes will bring about lasting improvements in our patients' functioning, and we are suspicious of behavioral change in the absence of internal change.

In addition, ACT is not particularly interested in how people represent themselves and others in their own minds, something central to psychoanalytic ways of working. And while ACT teaches tolerance of negative emotion, it does not particularly focus on emotion as a source of information about people's internal states, wishes, and needs (other third wave models such as DBT are more compatible in this way). In emphasizing values as the key source of motivation, ACT de-emphasizes the importance of primitive and biologically fundamental needs and wishes and of the conflicts people experience around them and, therefore, risks being too moralistic. In addition, there is little in ACT that parallels the psychoanalytic focus on transference and countertransference enactments. As the name implies, ACT can be seen in many ways as boiling down to this: Accept discomfort, and Commit to ACT according to your values. From a psychoanalytic perspective this is useful but profoundly incomplete advice.

I think it is also important to note the limits of empirical support for ACT and other third wave models. There is a growing body of clinical trial evidence that supports the effectiveness of third wave treatments. However, in spite of claims on theoretical grounds that ACT should lead to better outcome, including on criteria other than symptom reduction such as life satisfaction, recent meta-analyses conclude that there is at this point no evidence that ACT is more effective than what have now been termed "traditional" CBT treatments (first and second wave models) (Bluett, et al., 2014, A-Tjak, e al., 2015). In addition, two recent clinical trials comparing ACT to "traditional" CBT (t-CBT) found that t-CBT led to better long-term outcome on depression and quality-of-life measures. ACT achieved better initial outcome among treatment completers for anxiety in one study, but this difference was no longer present at follow-up (Arch et al., 2012, Forman et al., 2012).

The Psychoanalytic Approach as an Information-Processing Model

It is important to note that while concepts of unconscious conflict and defense are central to psychoanalytic thinking, psychoanalytic theory is not solely a defense model. It is also an information processing model (among other things). Think of Malan's (1995) Two Triangles, a

heuristic for guiding interpretation in short-term dynamic therapy. The three points of the "Triangle of Conflict" are Feeling/Impulse, Anxiety, and Defense. Thus therapists are encouraged to make interpretations that link patients' maladaptive defenses to their anxieties about feelings and impulses. The three points of the "Triangle of Person" are Parent, Other, and Therapist. This guides therapists to make interpretations linking patients' perceptions of people in their current life, including the therapist, to experiences with figures in their childhood. While the Triangle of Conflict is obviously about defense, the Triangle of Person is about information processing: we perceive the present through the lens of the past. When we as therapists suggest that a patient perceives people in their current life in a certain way because of experiences with people in their past, we are, among other things, making a cognitive intervention. We are seeking to change some aspect of the patient's belief. Psychoanalytic theory generally assumes that for that cognitive change to be profound and long lasting it will have to be reinforced by having a different experience with the therapist or others in the patient's life. In a similar way, central to behavioral and cognitive models is the assumption that cognitive change is facilitated by experience that disconfirms dysfunctional beliefs.

I believe that Wachtel (1997) mistakenly dismisses the potential of active cognitive interventions to facilitate the psychoanalytic goals of modifying patients' beliefs about themselves and others. To be sure, one must explore patients' experience thoroughly before seeking to change it and part of that cognitive work will likely involve helping patients accept and embrace aspects of themselves that are "primitive" and "irrational." However, by the end of a successful analytic treatment, we expect our patients to not only feel and act differently, but to think differently, and here I believe cognitive techniques associated with first and second wave CBT can be helpful.

Application to the Case of Daniel

To illustrate, I'd like to describe how I might formulate the case of Daniel and some of the techniques I might use if I were going to treat him using the full spectrum of CBT models at my disposal.   It is not my intention to claim that my formulation would be the correct way to treat Daniel from a CBT perspective. Another CBT therapist might formulate and treat Daniel somewhat differently, just as two psychoanalytic therapists might use somewhat different analytic approaches. Nor am I suggesting that my CBT formation is better than or would lead to better outcome than Dr. Cohen's treatment of this case.   But I hope the exercise will suggest various alternative that are possible.

Daniel's Diagnosis of Depression and Anxiety

Cognitive behavioral treatment traditionally starts with diagnosis, in order to identify specific DSM (American Psychiatric Association, 2013) disorders that are relevant to the client

and CBT treatments that have been shown to be effective for those disorders.[2]

I concur with Dr. Cohen that Daniel suffers from depression. Similarly, I agree that while he does not seem to meet criteria for a DSM diagnosis of narcissistic personality disorder, narcissistic issues, meaning questions of self-worth, play an important role in Daniel's struggles (though I do not see the primitive defenses of idealization and devaluation that I typically associate with narcissism).

I am curious that Dr. Cohen does not include anxiety in his diagnosis of Daniel. I may not be sufficiently familiar with psychoanalytic diagnostic systems. However, from a DSM and CBT perspective, anxiety is a prominent part of Daniel's clinical presentation. Daniel fears being judged negatively by others and sometimes avoids actions or situations as a result (see examples below). Thus, he meets criteria for social anxiety disorder. I believe this has important implications for Daniel's treatment. He may also meet criteria for generalized anxiety disorder (GAD). At the least I would want to target his cognitive style of obsession and rumination and his avoidance of negative emotion, which are typical of GAD.

Empirically Supported CBT Interventions for Depression and Social Anxiety

And so if I were working with Daniel, I would start with the empirically supported CBT interventions for depression and social anxiety. Using Beck's (1987) cognitive therapy for depression, I would target Daniel's negative beliefs about himself, the world (including other people), and the future. I would also use behavioral activation to increase activities likely to lead to experiences of pleasure and accomplishment. For social anxiety, I would use cognitive techniques to target Daniel's negative beliefs about himself and his fears that others will judge him and reject him. I would also make extensive use of exposure both in session and between sessions. These exposures could include role plays, deliberately engaging in typically avoided social situations between sessions, and practice in evoking the very social judgment that he fears (Leahy, Holland, & McGinn, 2012).

Much of the work involved in the protocols for depression and social anxiety overlap, and so I would expect targeting symptoms of either would likely help both. Eventually I would want to move from challenging conscious automatic thoughts that arise in specific situations; to

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[2] As a side note, there has recently been a movement in the CBT world to question the use of DSM diagnoses, for many of the same reasons psychoanalytic therapists object to DSM. Some newer CBT treatments, such as ACT (Hayes, et al., 2012) and the Unified Protocol (Barlow, et al., 2010), are designed to be transdiagnostic rather than disorder-specific (though as Craske[2012] has pointed out, the hope that transdiagnostic approaches will be more effective in treating comorbidity than disorder specific treatments has yet to be empirically demonstrated). My own view on this is that one does not need to be dualistic in how one thinks about diagnosis: we can simultaneously acknowledge that the DSM has serious limitations and hardly captures all that might be usefully understood about any individual while also recognizing that people do present with identifiable symptom clusters and that specific CBT protocols can be helpful in formulating and treating those symptoms.

identifying and modifying underlying assumptions, which may or may not be fully conscious; to finally targeting core beliefs Daniel has about himself in relation to others. I would assume that working on both Daniel's depression and his social anxiety would ultimately lead us to attempt to modify his core sense of himself as inadequate and unacceptable.

In a case as complex as Daniel's, I would likely also draw on a number of other CBT models. Young's Schema Therapy (Young et al., 2003) is a second wave (i.e., cognitive) model that was developed to treat personality disorders. It emphasizes identification of core maladaptive schemas early in the therapy process and consistent work throughout demonstrating how these schemas influence the ways patients react to current situations. In addition to standard cognitive-behavioral interventions, Schema Therapy makes deliberate use of the therapy relationship to provide corrective emotional experiences. It also employs techniques such as two-chair exercises and imagery restructuring to target the meanings associated with developmental experiences that contributed to the creation of core schemas.[3]

Given that rumination is a central feature of Daniel's struggles, I would likely draw on Well's (2009) Metacognitive Therapy (MBT). MCT also derives from the cognitive therapy tradition, but it parallels third-wave models in some important ways. The central idea of MCT is that people have beliefs (meta-cognitions) about worry and rumination: i.e., that worry and rumination cannot be controlled and that they are useful. We see this in Daniel's fear that if he stops worrying he will act on his feelings in ways that will lead others to reject him. Treatment aims to modify such metacognitive beliefs rather than targeting the thoughts per se that occur during rumination. In fact, similar to ACT, patients are discouraged from engaging and challenging ruminative thoughts.

Mindfulness Based Cognitive Therapy (MBCT; Segal, 2012) offers a similar perspective on worry and rumination as something that our minds are prone to engage in but that can be counterproductive. MBCT uses various forms of mindfulness meditation to help counteract the tendency to ruminate. In addition, I would have in mind Borkovec's (Borkovec, Alcaine, & Behar, 2004) model of GAD, which suggests that worry and rumination suppress emotional experience and uses active techniques to have patients practice experiencing and tolerating emotion.

Given Daniel's fears about his emotions I would want to draw on some CBT models of emotion. Leahy's (2015) Emotional Schema Therapy is similar in some ways to Metacognitive Therapy in that it comes out of the cognitive therapy tradition and focuses on patients' metacognitions, in this case metacognitions about their emotions. Leahy's research finds that depression and anxiety are associated with negative beliefs about emotional experience such as, "My emotions are overwhelming. My emotions make no sense. Other people cannot understand

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[3] Interestingly, Young's concepts of schema avoidance (i.e., people avoid experiences that might activate negative schemas) and schema compensation (i.e., people act in ways that attempt to compensate for negative schemas) provide a cognitive model that can map in some ways onto psychoanalytic ideas of defense.

my emotions. Expressing emotions will only make me feel worse." Similarly, the emotional regulation skills module of DBT (Linehan, 1993) educates patients about the adaptive functions of emotion, including communication and providing information about their internal state.

Putting It All together in Working with Daniel

       What might all of this look like in working with Daniel? Dr. Cohen gives us detailed descriptions of five sessions. During these sessions Daniel expresses a number of beliefs that could be grouped into three broad interrelated categories listed below. In some instances Daniel states these fears directly, at other times they are strongly implied in things he says:

Social anxiety fears of being inadequate and rejected

- Daniel cannot measure up to the former employee who is big, outgoing and social.

- Matt (one of Daniel's male friends) was bored when conversation switched to Daniel.

- If Daniel plays a game with people who are supervisees, the interaction will inappropriately cross boundaries.

- The former employee who was friendly to Daniel might just be that way with everyone.

- If Daniel calls Matt back, Matt will think he's pursuing him in a sexual way.

- It's not OK for Daniel to tell Matt that Daniel doesn't like the book. If Daniel does, it will hurt Matt's feelings.

- The words Daniel writes in the cover letter are not appropriate.

Fears about the consequences of feeling emotions

- "It's too painful to feel this stuff."

- If Daniel has these feelings, there might be a "tell" (an inadvertent, unwanted revealing of his feelings) and people will know what he feels and that will be embarrassing.

- Daniel might reveal unsavory parts of himself and push others away.

- If Daniel allows himself to feel his feelings in private (e.g., in meditation), they will be more likely to be apparent to others.

- If Daniel doesn't pay attention to his critical worried feelings, he might do things or say things he'll regret.

Fear about his motives

- Maybe Daniel doesn't really want to be with people.

- Daniel is not sure he really wants to help people as a goal.

- Since Daniel's scared about a new job, maybe he just wants to escape and play games.

- If Daniel helps women, it's just because he wants to sleep with them and they will figure that out.

It's striking how many of these thoughts are common for people suffering from social anxiety. While Dr. Cohen does attempt some informal challenges to these thoughts in addition to his use of ACT techniques, a number of other possible interventions come to mind.

First, I would want to encourage Daniel to practice stepping back and question some of the thoughts he has in specific situations, such as when he thinks Matt is bored or the former employee is just being nice. I would point out Daniel's tendency to discount positive evidence, such as the fact that Matt came to his house. I would also talk about the fact that when situations are ambiguous (we don't actually know what Matt or the former employee feels), it is common to interpret them as consistent with our pre-existing schemas—in this case, Daniel's core sense of himself as inadequate and uninteresting. I would also want to challenge Daniel's assumption, so common in social anxiety, that in order to be acceptable one must be an ideal social object, i.e., big and gregarious and socially accomplished.

Regarding Daniel's fear that his feelings are unacceptable, I would first want to explore which feelings he means and what makes them unacceptable. (I assume Dr. Cohen has a good idea of this from his work with Daniel). I would then want to use cognitive techniques to challenge these thoughts: Does he see other people express such feelings? What does he think about them when they do? What happens to them socially when they express these feelings?

 I would suggest that Daniel start with the assumption that perhaps his feelings actually make sense and encourage him to explore and understand what information they may be giving him about his needs and desires. Of course I would have in mind and want him to think about the ways that his family life influenced these beliefs: both the experience of his father being out of control of his emotions and the ways that his parents were unable to recognize and respond supportively to Daniel's feelings.

Perhaps most importantly, I would want to do exposure. This would involve having Daniel deliberately allow himself to stay in contact with his feelings using techniques similar to the ACT work Dr. Cohen does with him. Given the social nature of these fears, I would also suggest that Daniel practice communicating his feelings to others, starting with relatively small and low risk actions, such as telling a co-worker he is a little anxious about an upcoming meeting, or letting Matt know he's looking forward to getting together with "the women," or telling his girlfriend that he's not sure whether he wants a new job.

I would understand Daniel's struggle over what to do about the fact that he does not like the book Matt gave him as an example of these fears. Anxiety about disagreeing with others is common in social anxiety. As noted above, Dr. Cohen makes a couple of attempts to interpret this conflict as related to Daniel's fear of closeness, but Daniel keeps rejecting those interpretations and returning to his fear of telling Matt what he thinks. I would take Daniel at his word at the moment (not that fear of closeness is not also likely present). I would want Daniel to see this as a specific case of a more general fear about expressing his feelings.

I'd likely use cognitive challenges to help Daniel see that it could be okay to disagree, and that if Matt reacts badly that's about Matt. I would probably suggest role-playing the conversation with Matt, both as an exposure exercise and to make sure that Daniel had the

necessary social skill to disagree respectfully. (While my guess is that Daniel does have adequate social skills, given the poor modeling around emotional expression Daniel received in his family it is possible that he does not. And if not, I might then employ with Daniel some interpersonal effectiveness skills from DBT). Again, I would suggest repeated practice expressing contrary opinions with others as exposure to these fears.

There is wonderfully rich material in Daniel's image of himself as a pimply awkward adolescent and his memory of feeling uncomfortable presenting himself in drama class. I would consider these important expressions of his core sense of self and would want to work with them. Just as an example: I might encourage Daniel to engage in a type of roleplay using a two-chair conversation (Greenberg, 2002) between his adult self and that pimply adolescent. I might also have Daniel identify the beliefs he took away from his experience of the drama class and help him to see how, while the beliefs may or may not have been accurate and helpful at the time, they likely do not apply to his life now. Done right, these kinds of exercises could lead to some deeply emotional work.

Daniel's anxieties about his motives seem to arise when he finds himself experiencing some feeling—fear of playing a game with his co-workers, hesitation to supervise younger employees, and, we might speculate, some degree of sexual attraction to the woman he helps. Rather than simply noting these experiences as one aspect of his emotional life, he begins to obsess about their possible meaning. I would want to point out to Daniel the ways he attempts to use thought in the form of worry and rumination to try to resolve unpleasant or ambivalent feelings. I would suggest he practice in the session identifying the original emotions, allowing himself to stay with the feelings, trying to explore their meaning, and ultimately placing them in the context of the range of emotional experiences he has over time.

It would be interesting to take a cognitive-behavioral perspective on Dr. Cohen's interpretation of one of Daniel's core conflicts, his fear of accomplishing things in his life lest he wound his father and elicit his anger and rejection. Inherent in all such conflicts are beliefs which may be more or less conscious (i.e., that others will respond as his father did) and conditioned emotional responses which may be functionally separate from the belief (i.e., an automatic fear response to any impulse to brag or assert oneself) (Holland, 1997). A common assumption in psychoanalytic work is that once a conflict is made conscious, the patient will be freed to resolve it. A cognitive-behavioral perspective would suggest that active cognitive and exposure exercises could help that process. In addition to the standard cognitive and exposure exercises, I would consider image restructuring exercises such as having Daniel imagine asserting himself as an adult with images of his father as he experienced him as a child or imagining a caring relative intervening with the father. (For an example of this, see Leahy, Holland, & McGinn .[2012, Chapter 6, pp. 243-256]).

CONCLUSION

What I have outlined above would, of course, take much more time than the five sessions Dr. Cohen describes in detail in his paper, and none of this is intended to discount the effective work Dr. Cohen did using ACT in these sessions. Rather it is to suggest what a broader CBT perspective might add. While I am suggesting a number of additional conceptualizations and

techniques, I hope that it is apparent that all of these are compatible with Dr. Cohen's formulation of Daniel's difficulties and his goals for him.

At the end of his case study of Daniel, Dr. Cohen asks an important question: would his work with Daniel have proceeded more rapidly had he introduced active techniques earlier in treatment? My answer would be a resounding maybe. It is important to be properly humble about these things. While I do a lot of short-term and medium-term therapy, I, too, have some patients I have seen for many years. Nonetheless, the point of integration is to try to find ways of working with patients that will be more effective and efficient. I think it is reasonable to hope that introducing active CBT techniques into a psychoanalytically oriented treatment might help speed the therapy process while supporting the ultimate goal of deep change in sense of self in relation to the world that I understand to be at the core of the psychoanalytic enterprise. I believe that Dr. Cohen's case study of Daniel is an important piece of evidence of what might be possible in such an integration.

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