

***Responses to Commentaries on Getting into the ACT with  
Psychoanalytic Therapy: The Case of "Daniel"***

**Expanding My Perspective on the Case of Daniel**

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**ABSTRACT**

I appreciate the reflections on the case of Daniel from Dr. Jill Bresler (2016) and from Dr. Stephen Holland (2016) —two experienced clinicians well versed in moving between psychodynamic and cognitive-behavioral orientations to more comprehensively meet the needs of their patients. Dr. Bresler’s response led me to think more about my development as a therapist and the process through which a psychoanalyst struggles to become more integrative. Dr. Holland’s response provided a helpful overview of additional cognitive techniques I might have used, but it also suggested that there may be limits to integrating certain aspects of different theories because of fundamental discrepancies.

*Key words:* psychoanalysis; acceptance and commitment therapy; cognitive therapy; psychotherapy integration; mindfulness; acceptance; defense (resistance) analysis; case study; clinical case study

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**JILL BRESLER’S COMMENTARY**

I am intrigued by a number of questions Dr. Bresler raises about how things might have gone differently had I from the outset been able to approach the work in a more flexible, integrative manner. In particular, she wonders whether by overvaluing the usefulness of interpretive work focused on the patient’s history, the treatment may have become too focused on an “unproductive, but comfortable” technique, slowing progress and in part accounting for the length of the work.

The evolution of how I worked with this case parallels my maturation as a clinician. I have increasingly moved away from an early idealization of interpretation as the sine qua non of therapeutic technique, but it has required some struggle. As Dr. Bresler explains, psychoanalytic clinicians, especially early in their careers, become preoccupied with whether what they are doing is truly “psychoanalytic.” When I began my training at a well-regarded psychoanalytic clinical psychology doctoral program in the late 1980s, providing insight without relying much on supportive “non-analytic” interventions was the mark of a true psychoanalytic treatment. This viewpoint, I later discovered, had a long history in psychoanalysis.

From the beginning Freud attempted to situate psychoanalysis as an original approach to treatment because it eschewed “suggestion” by the therapist and achieved its aims as much as possible by making the unconscious conscious (Collins, 1980; Levy & Inderbitzen, 2008). If psychoanalysis worked because of the personal influence of the therapist, it risked being compared to existing techniques like hypnosis that were regarded as charlatanism. In the 1950s, Eissler (1953) developed the concept of “a parameter of technique” to describe deviations from the basic model of psychoanalytic technique, which was to consist almost completely of interpretation; advice, suggestion, encouragement of any sort, while perhaps necessary in some clinical situations, was a deviation from the model technique. Eissler contended that, eventually, the reasons for such deviation needed to be understood and subject to interpretation if an analysis was to be complete.

While much had occurred in the psychoanalytic world between the Eissler’s time and my doctoral training, the belief that interpretation and insight were paramount in defining psychoanalytic treatment persisted, and perhaps was strengthened in certain “classical” psychoanalytic quarters when other approaches that acknowledged the curative contribution of other factors, such as empathy, became popular in the analytic world. Innovations that deemphasized the role of interpretation were seen as unanalytic. The focus on insight was accompanied by other technical precepts designed to reduce the analyst’s personal influence on the patient.

Of course, focusing on interpretation did not mean an exclusively cerebral form of treatment. One central goal was to interpret defenses against feelings; interpretations were to be offered in a timely manner when the patient would be receptive and able to work more intensely with the material, which meant more emotionally. Though affect was important, until recently psychoanalysis did not have an explicit model that would help clinicians understand what feelings were and how to most effectively elicit and work with them (Lane & Garfield, 2005; Lotterman, 2012).

Developing as a clinician involved unlearning an approach that disciplined me to restrict my interventions to providing understanding without allowing my own experiences to unduly influence the patient. Any departure from this path was taken to be an acting out of the countertransference: one’s personal emotional reactions had gotten the best of you and leaked into the clinical interaction, to the detriment of the patient.

Interestingly, at the time I was striving to emulate these ideals in my clinical work, they were increasingly coming under attack by clinicians, mainly located in New York, who began to call themselves relational psychoanalysts (Greenberg & Mitchell, 1983). By the time I completed my doctoral training in 1992, the questioning of the austere, interpretation-only style of psychoanalysis had spread to those who were prominent members of the psychoanalytic establishment. In the early 1990s, I attended a conference presentation by Owen Renik, the editor of *Psychoanalytic Quarterly*, which had been one of the most conservative psychoanalytic journals.. When he declared his belief that analysts inevitably enacted their own conflicts with their patients in spite of the most scrupulous efforts at self-analysis, I recall being tremendously relieved and excited at the new direction the field was taking. A freer, less austere approach to clinical interaction was in the offing (Renik, 1993).

While the consensus developed that it was no longer tenable to aim for such an impossible objectivity, such ideas do not simply disappear, especially when they derive in part from the complexities and discomfort of the therapeutic situation. It is tempting to take on an air of objective authority as a therapist, especially as a beginning therapist, when one doesn't understand much but wants to be seen not only as competent but authoritative. Believing that something as rarefied as interpretation is the key to therapeutic progress—as opposed to what might seem to be more ordinary aspects of human interaction that characterize supportive interventions—also appeals to therapists who wish to feel they have some special expertise besides creating a good relationship with the patient.

Wachtel (2008) has called the maintenance of outmoded clinical precepts based on classical technique “the default position.” Gray (1996) has termed a similar resistance to practicing in ways consistent with current developments in theory the “developmental lag” in technique. What this suggests is that changes in clinical practice occur slowly, often only through great struggle. Only gradually could I accept that Daniel was not the ideal analytic patient who responds to accurate interpretation and sustains gains through insight alone (I've never seen one). As much as Daniel needed to give up habitually comfortable modes of handling affects, I too needed to relinquish habitual clinical attitudes, which involved mourning the loss of the sense of certainty such beliefs provided.

I also find Dr. Bresler's focus on the idea of mentalizing as an essential aspect of treatment to be useful, but I have struggled to understand what in fact promotes mentalization in higher functioning patients. Much of the literature describing mentalization focuses on patients with borderline disorders or extremely traumatic histories (Allen, Fonagy, & Bateman, 2008). In those cases, interpretations that attempt to acquaint the patient with unconscious mental content can be extremely threatening and work against the patient's capacity for self-observation.

Describing the need for the therapist to cultivate an attitude of curiosity rather than certainty, Allen (2013) states: “In this mentalizing process, I am not making expert declarations about the patient's mind—much less the patient's unconscious, but rather offering my thinking and feelings for our mutual consideration (p. 195).” Is such a stance necessary in higher functioning patients or can more typical interpretations be effective? I suspect that better functioning patients who can hear interpretations that point to unconscious mental contents achieve greater mentalization not only by becoming familiar with their underlying fears and wishes but also by identifying with the way the analyst observes their minds.

As the emphasis in contemporary analysis has shifted from the central goal of discovering unconscious content to developing a process for ongoing self-observation and the ability to tolerate and reflect upon affects and impulses, psychoanalytic work has become easier to integrate with mindfulness. The advantage of adding techniques like ACT and mindfulness meditation to psychodynamic treatment, as Dr. Bresler notes, is that patients practice these skills on their own, which not only leads to skill development, but promotes more independent functioning. This was especially helpful for Daniel, who relied a great deal on what happened in sessions to deal with his distress and had more difficulty managing troubling experiences on his own. While meditation does not necessarily promote the same sort of mentalization that occurs in therapy, I was struck when I first began learning about mindfulness by how familiar the goals

seemed to be to successful dynamic therapy.<sup>1</sup> For instance, consider this passage from Williams Teasdale, Segal, and Kabat-Zinn's (2007) self-help book on *Mindfulness Based Cognitive Therapy for Depression*:

If we actually *practice* bringing awareness to the chain of reactions to particular moments and circumstances, we have an excellent opportunity, each time we do so, to break the strong link between these basic “gut feelings” and the totally automatic and also largely unconscious reactions that follow so rapidly on their heels...Bringing them into awareness weakens their influence on our mind and enables us to respond to them in ways that do not evoke or perpetuate aversion (pp. 120-121).

This statement elegantly captures the work psychodynamic therapists do in helping patients expand their emotional awareness; it's hard to imagine a better modern day translation of the Freud's famous axiom, “Where id was, ego shall be” (Freud, 1923/1961). Descriptions like this in the mindfulness literature showed me that the language of mindfulness could capture in jargon-free language the work I was already doing.

A danger of the insight-oriented approach, as Dr. Bresler suggests, is that the work becomes more focused on the content of the insights obtained (observations about neglected aspects of the patient's personal history) than the process of observation per se. An over-reliance on insight often leads to an over-emphasis on discovered facts about the patient and moves the treatment away from the process of curiosity and self-reflectiveness as goals in themselves. One function of the introduction of ACT was to tilt the balance of Daniel's treatment towards promoting his ability to self-observe in the face of uncomfortable emotion instead of attempting to discover additional cognitive explanations for his troubling behaviors. The process of discovering personal, historical explanations for mental phenomena is considered a core aspect of the psychoanalytic approach; but as Dr. Bresler notes, it also threatens at times to promote, in certain patients, a reliance on affect-avoiding rumination.

## STEPHEN HOLLAND'S COMMENTARY

Dr. Holland's comments helpfully outline the additional interventions a cognitive therapist familiar with both Second and Third Wave cognitive therapies would use to approach Daniel's difficulties, and he specifically identifies particular dysfunctional thoughts and beliefs evident in the case material that he would seek to modify. In doing so, Dr. Holland rejects

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<sup>1</sup> Allen (2013) was impressed by the overlap between *mindfulness*, which has roots in Buddhism, and *mentalization*, which was derived from developmental psychology and psychoanalysis. But he noted five important differences: (1) a person can be mindful of non-mental states but mentalization always refers to attending to products of the mind; (2) unlike mindfulness, mentalization has a social context, since an individual can mentalize his own and others minds and the process is believed to develop in a social matrix as part of the attachment process; (3) the understanding of mentalization originated in developmental research, while mindfulness is a centuries old technique for contemplation; (4) mentalization consists of both reflection and the narrative “elaboration and interpretation of mental states,” while mindfulness is restricted to a form of attention or concentration (p. 33); and (5) mindfulness, based on its roots in religion, entails an ethical perspective.

Wachtel's (2011) contention that traditional, Second Wave CBT techniques are less compatible with psychoanalytic goals than acceptance-based, Third Wave approaches. Dr. Holland's argument rests on his assertion that psychoanalytic practitioners, like cognitive therapists, aim to change their patients' beliefs, and thus should find cognitive techniques that modify thoughts compatible with their goals. He writes: "[B]y the end of a successful analytic treatment, we expect our patients to not only feel and act differently, but to think differently..." (2016, p. 47).

Like Wachtel (2011), I find traditional cognitive techniques that seek to "restructure," "modify" or "replace" dysfunctional thoughts hard to square with psychoanalysis. This is especially the case with contemporary approaches that reject the authoritative stance taken in the past by analysts who presented themselves as judges of whether aspects of the patient's experience reflected healthy reality testing or were significantly distorted by unconscious influences. Wachtel's (1977) original integration of psychoanalysis and behavior therapy was based on his observations of behavior therapists working in the pre-cognitive era, before Beck and Ellis emphasized the role of dysfunctional beliefs in psychopathology. Wachtel (2011) was impressed by those therapists because their work demonstrated a sensitive and effective focus on helping patients experience strong affects in contrast to some analytic practitioners whose work he felt had become "overly verbal and insufficiently experiential (p. 25)." As some of the same behavior therapists who had impressed Wachtel with their sensitivity to emotion moved in a more cognitive direction, he saw them talking their patients out of their feelings to "overemphasize cognition at the expense of the rest of psychological life" (p. 27). Wachtel writes:

The "cognitive" era in CBT was in large measure an era of over concern with *persuading* people that their thoughts were irrational; *disputation*, much more than immersion in or validation of the patient's experience, was the central thrust of this stage in the evolution of cognitive therapy (2011, pp. 27-28).

I think Dr. Holland and I may differ as to whether traditional cognitive therapists and psychoanalysts share a similar goal of changing their patients' cognitions. A key focus of contemporary psychoanalytic therapy is helping patients understand the determinants of their distressing thoughts and feelings and to realize that these are only one of a number of ways they may think about their experiences, a goal that jibes well with Third Wave approaches. Rather than categorize some thoughts as irrational or inappropriate in an effort to suppress them, patients are guided to empathically recognize such thoughts as ways they came to see the world in the context of their unique personal histories.

Examining thoughts to assess their accuracy seems fundamentally in conflict with helping patients non-judgmentally attend to them. This incompatibility reflects, I think, the distinct way cognitive therapy and psychoanalysis understand problematic thinking. Second wave cognitive therapy sees such thoughts as deriving from underlying schemata that are purported to develop in childhood following rather straightforward social learning approaches (Beck et al., 1979). By contrast, psychoanalytic theories suggest that problematic assumptions are learned through a complex process of internalization in which the developing child identifies with parents and other significant attachment figures. Identification is not a simple form of imitation or modeling, but follows from the child's love for the parent and wish to memorialize a

nurturing image of him or her. So even aspects of the parent that might be hostile, critical or demeaning are not easily discarded, since they are recalled in the context of an attachment relationship which is necessary for the child's survival. From this perspective, showing that beliefs based on such identifications are irrational or undesirable means asking the patient to question and try to eliminate a part of the self that at one point was highly valued, even essential. Psychoanalytic theory would suggest such beliefs would not succumb easily to rational disputation.

Recent research (Cristea et al., 2015; Kazdin, 2007; Longmore, & Worrell, 2007) has called into question whether the cognitive restructuring elements are essential in cognitive therapy; such findings have provided a rationale for developing acceptance based therapies, though as Dr. Holland notes, research does not unequivocally show that ACT is more effective than traditional cognitive therapy. What this suggests is that while cognitive therapists may believe their successes follow from helping patients think more rationally, other therapeutic processes may be at work.

Regarding Daniel, I suspect providing evidence against his beliefs would have had a limited effect; often, we were both able to recognize that some of his worries were not supported by the current facts, yet they still troubled him. To give up such ideas, no matter how irrational from a contemporary point of view, might feel to Daniel at some level as though he is being asked to sever a connection to a part of himself that derives from his early relationship with his parents. (Recall how difficult it was for Daniel to be consistently critical or angry with either parent.) ACT-consistent processes such as defusion and mindful observation allowed Daniel to be less negatively affected by such thoughts without feeling the need to disparage or eliminate them.

Cognitive structuring techniques may not fit well within a psychoanalytic framework because the two approaches stem from fundamentally incompatible world views. The notion that reason will prevail in the face of a patients' wildly idiosyncratic, long-held beliefs is consistent with the notion that CBT can achieve rather remarkable success through short-term treatment undertaken by a therapist who is able to effect his cure by easily establishing a collaborative, non-conflictual relationship. It is also compatible with the CBT view that those seeking help suffer mainly from symptoms that can be focally treated rather than deeper experiences of demoralization that reflect larger concerns about how to live a meaningful life or, whether in the face of widespread human suffering, such a life is even possible.

Messer and Winokur (1980), borrowing a framework used by scholars to describe literary genres<sup>2</sup>, argue that behavior therapy reflects a "comic" vision of reality; this does not mean it was humorous, but that its premises are similar to characteristics of dramatic comedy. The comic vision, according to Messer and Winokur,

emphasizes the familiar, controllable, and predictable aspects of situations and people. Conflict is viewed as centered in situations, and it can be eliminated by

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<sup>2</sup> Messer and Winokur took these literary analogies from a paper by Schafer (1970).

effective manipulative action or via the power of positive thinking. Endings are happy ones free from guilt and anxiety (p. 823).

Psychoanalysis, by contrast, is more consistent with what Messer and Winokur described as the romantic, tragic, and ironic visions; these visions emphasize an approach to life that sees the human journey as lonely and perilous, where conflict and paradox are inevitable, suffering and loss are ubiquitous, and outcomes are uncertain and often ambiguous. Messer and Winokur described these differences between psychoanalysis and behavior therapy at a time when the cognitive approach was in its infancy, yet traditional cognitive therapy retained many of the “comic” aspects of its behavioral predecessor. Those characteristics have led some to see cognitive therapy and its popularity as reflecting a cultural tendency to focus on naively simplistic solutions to problems and to avoid recognition of significant social and political difficulties (House & Loewenthal, 2008). Third Wave approaches such as ACT are appealing in that they take a rigorous empirical stance toward treatment outcomes, but the resulting interventions, though based on behavioral theory, seem compatible with approaches that emphasize the ubiquity of human suffering and the quest for meaning (Elkins, 2012; Hayes, 2012; Yovel & Bigman, 2012).

I would not wish my description of this incompatibility to suggest I am dismissive of Second Wave cognitive approaches. Many psychoanalysts view CBT as the simple-minded villain who cruelly displaced psychodynamic approaches from their leading role in the psychotherapy world. Too often such ill-informed critiques fail to take into account the ways that analytic treatments that do not include active techniques are often not as helpful as patients desire. Dr. Holland’s perspective reveals his admirable desire to make use of a variety of such techniques to help patients with what most troubles them. Yet I believe that in spite of Dr. Holland’s attempt to bridge these two approaches, more work needs to be done to discover if aspects of these therapies that seem so at odds with each other can be effectively harmonized.

Finally, I wanted to note that Daniel successfully terminated treatment. At the time I completed his initial case study (Cohen, 2016), Daniel was meeting with me once every three weeks. Things continued to go well in spite of several challenges: his wife slipped and fell, causing a bad break to her leg; shortly afterwards the wife’s sister ended her marriage and came to live with the couple for a month. Though this was stressful for Daniel, bringing up angry and resentful feelings, he was able to take good care of his wife—who was housebound for several weeks—and express his discomfort to her about the sister-in-law being there for so long. At several points, he wondered if we should meet more frequently, but except for one extra visit, he continued to come every three weeks. He said he felt comfortable and effective at work and was still keeping up relationships with male friends. He no longer reported feeling depressed or highly anxious and was pleased he handled the recent challenges with less stress than he would have in the past.

A few weeks after his sister-in-law moved out, Daniel decided to end treatment. Daniel reported that he still struggled with difficult feelings and self-critical thoughts, but he knew how to remain in contact with them without spiraling into depression or anxiety. Daniel was able to movingly look back on our work with gratitude. In the last session we enjoyed together our sense that our relationship had been important for both of us.

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