

**Commentary on *The Case of “CG:” Balancing Supportive and Insight-Oriented  
Psychodynamic Psychotherapy with a Client Undergoing Intense Life Stress***

**Adding Supporting Evidence and Eliminating Extraneous Bio-Medical  
Constructs from the Psychodynamic Case Study**

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**ABSTRACT**

Skean’s (2005) case of “CG” is an important addition to the case study literature on brief psychodynamic psychotherapy with difficult, treatment-resistant clients. It brings to life the clinical reality of this kind of work by combining a comprehensive description of the client’s problem, family history, current life-circumstances, and the process of therapy, with a clear theoretical framework that yields specific clinical interventions and interpretations. Three areas in which this case illustrates current problems in clinical practice or case study reporting are also discussed: (1) the underutilization of available documentation from other professionals involved in the case; (2) an overemphasis on describing the psychological problems of the client rather than the morally objectionable actions of those in positions of power and authority in the culture of the client and therapist; and (3) the intrusion of incongruent medical model language and recommendations for treatment despite the adequacy and ultimate effectiveness of the psychodynamic guiding conception of the case.

*Key words:* brief dynamic psychotherapy; medical model; case study methods

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Karen Riggs Skean’s (2005) case of “CG” is a welcome addition to the systematic case-study literature on relatively brief psychodynamic psychotherapy. The client is a young adult male graduate student who is in the midst of a major academic and life crisis, and he appears at the beginning of therapy to be on the verge of a rather major personality de-compensation. Having struggled with and withdrawn from interpersonal relationships throughout his life, academics had become CG’s chief source of life satisfaction and success. However, in graduate school he has begun to fail academically, and his interpersonal relationships with members of the university community have become fraught with conflict and hostility.

Implicit in the author’s stated goal of demonstrating how one blends support-oriented and insight-oriented brief psychotherapy in working with an individual highly resistant to

psychotherapy, there are three features of this case study that strike me as particularly important: (1) It documents a case where there is not only evidence of the effective brief psychodynamic treatment of serious psychopathology, but where the therapy is provided by a psychotherapist who, though not a novice, was still early in her career development. With the benefit of supervision, she was able to identify and work through her own counter-transference reactions as she simultaneously offered an extremely curative psychotherapeutic relationship to her client. This helps to dispel the common misconception that this sort of psychodynamic work with difficult clients can only be performed by seasoned clinicians. (2) The case illustrates dramatically the manner in which current situational stressors may interact with prior personality patterns and earlier developmental difficulties to create the terrifying experience of a personality and life style beginning to disintegrate. (3) Were it not for the skillful, well-formulated, and compassionate interventions by the psychotherapist, this young man's career would have in all likelihood been effectively ended, and his sense of self so assaulted and his defenses so rigidified as to make this a crisis from which he would most probably never have recovered. In short, this case illustrates with great clarity, how in a most difficult clinical crisis, one actually does relatively brief psychodynamic psychotherapy with life-transformative results.

## CASE CONTEXT AND METHOD

The author is absolutely correct in asserting the importance of demonstrating in a systematic manner how one balances and blends support-oriented and insight-oriented approaches in brief psychotherapy. This is an approach that began being formulated independently in a number of the corners of the psychodynamic world in the 1970s (e.g., Blanck & Blanck, 1994; Malan, 1979; Horowitz, 1976; Luborsky, 1984; Malan & Osimo, 1992; Strupp & Binder, 1984), but this also coincided with a time when the publishing of case studies in the psychological and psychoanalytic literature was at low ebb (Miller, 2004). Malan is the single most important exception to this rule, but his published cases (Malan & Osimi, 1992) are difficult to obtain, particularly in the U.S. Prior to these developments, it was commonplace for more classically oriented psychoanalytic authors to write about choosing between insight and supportive approaches based upon the diagnosis, with the more severe personality disorders and psychoses generally being relegated to supportive therapy (DeWald, 1971).

## THE CLIENT

Most experienced clinicians will recognize in Skeen's clear and concise description of the client and the client's interactions with the therapist in the early sessions that he is the sort of person who tests a therapist's ability to be patient and tolerant. Doubting the value of therapy, suspicious of the therapist's intentions, and yet presenting a current life problem from which he desperately needs relief, such a client can demoralize even an experienced psychotherapist. These clients are sad and overwhelmed, and at the same time resentful, blaming of others, antagonistic to the therapist, and rejecting of offers of compassion and concern. The failure rate with such clients is disproportionately high, though since this would mostly show up as a high

drop-out rate in the early sessions of therapy, one would be hard pressed to generate accurate, interpretable, empirical outcome data on psychotherapy with this population.

Needless to say, the counter-transference reactions reported by the author are nearly universal among psychotherapists working with such clients. What is far from universal, and in fact relatively rare in my experience, is the understanding and implementation of a therapeutic framework that permits the therapist to understand her negative counter-transference feelings towards a client like CG as an indication of the amount of rejection and humiliation in his own developmental history. This leads her to openly accept his mistrust of her and his difficulty using therapy for positive benefit, at which point he relaxes some, and does begin to form a therapeutic alliance.

Here Skean comments that she finds it hard to imagine another therapeutic orientation that would have permitted her to weather the negative transference without withdrawing or retaliating against his “resistance.” While I do think this is true for most problem-solving oriented theories of psychotherapy, and particularly true for manualized approaches, I would think that many of the more existential/experiential therapies might have provided a framework of acceptance and support that might have helped the therapist contain her sense of rejection and failure with CG.

There is an element of Skean’s approach that I do think is unique to the guiding psychodynamic conception employed in this case, and that is the use of well-planned and well-timed interpretations linking the client’s difficulty using therapy with the disappointments in his current and past interpersonal relationships. These, as well as the direct suggestion that some clients seem to benefit more from therapy when they talk in detail about their family history, were clearly interventions made from a psychodynamic perspective. Even when such therapeutic interventions are made by therapists using other theories, the approach always owes its use to the psychodynamic tradition, whether this debt is acknowledged or not. So I believe it is fair to say that this case is a building block in the establishment of a “case law tradition” (Miller, 2004) that demonstrates what may be the unique ability of relatively brief psychodynamic psychotherapy to promote dramatic life improvements in very difficult cases of this kind.

These life improvements are clearly linked in this case to the client taking the risk, for the first time in his life, of relating to another human being the dynamics of his family of origin and the experiences of his childhood, which were periodically horrific. He begins to understand the defenses that he created to survive in his family, and how these defenses are now contributing to the interpersonal conflicts of his present situation. In other words, he begins to develop insight, and it seems clear that the therapist’s guiding conception is providing a framework for him to organize his experience in a meaningful and constructive way. As he does this, he also begins to take new interpersonal risks and to plan for a means of surviving failure in his doctoral program. Again, I would agree that it is hard to imagine an approach being successful with such a difficult clinical problem that (1) did not include taking a detailed developmental/family history; (2) did

not identify and interpret defenses from childhood; and (3) did not relate the past defenses and conflicts to the present situational crisis.

## **CONFIDENTIALITY**

Skean is to be commended for the careful steps taken to alter the factual aspects of the case in such a way as to protect the identity of the client without substantially altering the significant psychological features and meaning of the case. This is critical in a case such as this where the client has finally taken the risk of trusting another human being to be truly helpful, honest, and non-exploitive. The client's real and substantial improvement from a position of great vulnerability to adaptive strength and resiliency offers a critical lesson in psychotherapeutic process and hope to the discipline, practitioners, clients, and students alike. Such lessons can only be widely learned when cases are published, but this must never be done in a manner that is likely to expose the client to the disclosure of their confidential information. The author's careful attention to this issue during the editorial review process, and assurances that the client's identity has been carefully protected, suggest her continuing respect and concern for her client. Standards 4.04(b) and 4.07 of the APA Code of Ethics (APA, 2002) specifically address the need to balance protection of a client's privacy with the public good of knowledge development, training, and educating in the profession. (See Miller, 2004 for a more in-depth discussion of the issues of confidentiality in published case studies.)

## **AREAS OF CONCERN**

I have three areas of concern about the case study under examination. One is methodological, namely the sources of data used in the write-up. The second has to do with the weight given to the reality of current circumstances in the case formulation, and the third concerns the intrusion of the medical model into the guiding conception of the case (brief psychodynamic psychotherapy). I wish to be clear from the outset that the author's treatment of each of these issues is consistent with either accepted methods of doing case studies or accepted methods of clinical practice, and so my critique is really aimed at these accepted assumptions rather than at the author's conduct of the case-study, per se.

Data sources in the case-study. One of the stated goals of the PCSP journal is to develop a model of systematic and rigorous case studies to answer the typical criticisms leveled at case studies by research methodologists. One of the most salient of these criticisms is that the case study is contaminated with observer bias, since the observer is also usually the therapist, and the therapist is invested in portraying the client or the therapist in ways that are either self-serving or theory-serving. My experience of clinical reality is that while psychotherapists may be vulnerable to these biases, there are in many clinical situations safeguards and checks against these sorts of bias, namely other clinicians and supervisors who have seen the client or followed the treatment process. In settings where this multiplicity of views of the client is matched by an atmosphere of free and open clinical dialogue (rather than the enforcement of clinical orthodoxy

that is associated with some training paradigms or settings), an opportunity exists to create the type of democratic knowledge community associated with the epistemology of Richard Rorty (1979). While not satisfying every dyed-in-the-wool positivist, such checks on the reliability, validity, authenticity, and honesty of the clinical report do go quite a distance in correcting an obvious shortcoming of many case studies.

In the Case of CG, Skean had a marvelous opportunity to bolster the degree of trust that others would put in her claims because there were two clinical supervisors involved in the case, as well as a consulting psychiatrist, and a general physician treating an unrelated medical problem (but who made the initial referral, and obviously had a degree of psychological sophistication). While Skean notes in section 1.B that “both of these supervisors later read the case transcript and found it consistent with what had been done,” how much stronger the support would be for that claim had the supervisors contributed comments on the case for publication (perhaps as second and third authors). By the same token, the psychiatrist’s and physician’s perceptions of the client at different points in the process would have provided further consensual validation for the case report (and perhaps fourth and fifth authors for the publication). We are used to thinking of case-studies as single-author enterprises when in reality often they really aren’t, and the methodology would be greatly improved by capturing this consensual validation in the actual reports in a more systematic and complete manner. The opportunity here to have four potentially unique and independent assessments of the process and outcome of the treatment was seemingly within the author’s grasp, and it was allowed to slip away.

Case formulation. My second reservation is in the area of case formulation. This case illustrates beautifully a common feature of clinical reality which Freud originally referred to as the “repetition compulsion,” William James (1896/1966) called a “self-fulfilling expectation,” and Wachtel (1997) more recently has dubbed “cyclical psychodynamics.” All of these phrases refer to the human tendency to recreate in our actual current lives the traumatic circumstances of our childhood. Somehow (the exact mechanism varies with each theory) the residual emotional and cognitive effects of these early experiences leave us open to inviting people in our current environment to treat us in ways that leave us feeling exactly as we did in childhood -- afraid, humiliated, angry and resentful. Because the focus of clinical work is often the individual and not the system, it is easy in a case like that of CG to emphasize how his distrust and paranoia created the experience of feeling abused by his department chairperson, rather than to comment on how modern day corporations, including institutions of higher education, often reward and promote into positions of power individuals who are power-oriented and rather exploitative of other human beings. It is the experience of many a graduate student, including the present author, that graduate students are often at the mercy of the personality quirks of their research supervisors, and often feel abused and powerless in the process. At places in the CG case study, Skean seems to imply that CG’s experience of graduate school as a reenactment of his relationship with an abusive father was due mostly to his own projections and paranoia, while at other times she seems to imply that the real dynamics of his department were probably quite accurately being perceived by “CG.”

I believe it is quite typical of our field to wish to appease those in authority, particularly if they are paying for our services, and in control of our clinical services. We tend to equivocate in identifying the real forces in our culture that drive people “mad,” and in this way we are not serving the real interests of our clients or the public who have an interest in these problems being truly prevented in the future. Granted, without CG’s developmental history, he would not have been as vulnerable to personality disintegration under the tremendous stress of his graduate department, but that does not mean that the stress induced on graduate students by the actions of the department chair are any less destructive or morally reprehensible. As I have written elsewhere (Miller, 2004), I believe therapists have a moral responsibility to their clients to acknowledge the client’s perceptions of having been morally injured by the actions of parents, teachers, and other caretakers who did not live up to their responsibilities. This strengthens the therapeutic alliance, and it is not an unnecessary intrusion of the therapist’s values into the case. Case studies are an excellent vehicle for raising these moral issues in clinical treatment, and I think this too was a missed opportunity, though given the strength of the therapeutic alliance reported I wonder if perhaps the author’s written presentation of the case isn’t more morally neutral than were her actual clinical responses.

The medical model and psychotropic medication. Finally I want to comment on the intrusion of the medical model into this case despite its not being the primary guiding conception given for the case. This too seems to be a familiar theme on today’s clinical landscape. Here is a case where the contemporary psychodynamic case formulation, diagnosis, and treatment plan are well and broadly conceived, and ultimately produce a remarkable outcome.

The use of “DSM-IV” terminology (APA, 1994) that conveys a very different conception of the meaning of depression and paranoia grounded in an underlying medical model of disease symptoms, presumably of organic origin, requiring psychotropic medication, sends a confusing message. Is the author simply acknowledging how others representing the dominant ideology or discourse would describe the case, or does she mean to suggest that this language adds to her own understanding of the case? Some might view this as an innocuous acknowledgement of the current political realities within the mental health establishment.

On the other hand, my own view is that I don’t see where the *DSM-IV* categories add anything to our understanding of the case except to describe it in terms foreign to the guiding conception in what seems an effort to appease the dominant “gods” and keep them from becoming angry. The translation of the clinical specifics of the Skean case into the supposedly universal language of *DSM-IV* reinforces the belief that it warrants being the universal language, when in fact it is a very stilted, dehumanized, and less useful language than the language already used by the author to write up the case. (As one illustration of the problematic nature of the *DSM-IV* categories, in my recent book [2004, pp. 49-54] I analyze two sample cases from the *DSM-IV* “Casebook” (Spitzer, Gibbon, Skodol, Williams, & First, 1994), showing how *DSM-IV*-based conclusions distort each of these cases and provide a misleading cover for moral judgments under the guise of a scientifically descriptive tool.)

Were this merely a semantic issue, it would seem petty to make such a point of it. But of course it is not, as can be seen by the critical point in the therapy of this very client. Facing almost certain dismissal from his abusive department, he spirals downward further into depression. The psychodynamic literature related to the guiding conception of this case is replete with discussions of moderate to severe depression, and moderate to severe depression treated successfully on an outpatient basis with supportive-expressive psychotherapy (e.g., Blanck & Blanck, 1994; Malan, 1995). Yet we psychotherapists have been just as intimidated by the pharmaceutical industry's research/propaganda machine as we have been by the American Psychiatric Association's promotion of the *DSM-IV*. We are drawn into diluting not only our conceptual frameworks but our carefully developed therapeutic models and clinical strategies.

Of course, at the time this case study was being conducted there was almost universal confidence in the research showing the empirical superiority of SSRI-based medications (such as Prozac) in the treatment of moderate to severe depression. Not to refer for a psychiatric evaluation was considered by some in the research community tantamount to unethical practice. Now with recent revelations about the pharmaceutical industries widespread unethical research practices with psychotropic medications (Whitaker, 2002; Healey, 2004; Valenstein, 2000) and new meta-analyses of existing data (Kirsch, Moore, Scoboria, & Nicholls, 2002), it turns out that those making the charges of unethical behavior were in some ways themselves guilty of the very same charge they leveled at others -- the unethical treatment of clients. Had the author in this case trusted her own guiding conception more, indeed if psychology as a profession had trusted more of its own indigenous guiding conceptions (whether cognitive-behavioral, humanistic, systems theory, or psychodynamic) in both the areas of assessment and treatment, CG and hundreds of thousands of clients like him might have been spared the often confusing experience of having one's trusted therapist urging a referral for a psychiatric evaluation just as the work is getting close to one's deepest emotions and feelings. For example, why refer for medication that will blunt affect when affect suppression is a big part of the difficulty in effectively using therapy in the first place. In any event, because the psychiatrist decided that CG's eye condition was a contraindication for medication, the interpretation of impact of brief supportive/expressive psychodynamic psychotherapy is not confused by the introduction of medication into the case history.

None of these criticisms are meant to detract from Skean's conclusion that the careful balancing of supportive and insight-oriented, psychodynamic therapy in a case-specific manner can be a very helpful modality for dealing with a very difficult client. However, these criticisms do point the way to how the case might have been even more convincing and clinically instructive.

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