Psychodynamic Psychology Exam Important Topics

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Content

Exam Important Topics

BASICS ABOUT PSYCHODYNAMIC PSYCHOLOGY

Freud invented psychoanalysis. In the 1950-60's psychoanalysis was famous. Latter it became less popular. However, there exists a body of research showing that psychoanalytic assumptions can be questioned empirically and many of them are proved through experiments. The empirical basis for psychoanalysis is less extensive than for C.B.T. Psychodynamic psychology is opened to pluralism—to dialogue with other approaches such as: cognitive science, developmental psychology, social psychology, and neuroscience.

The 4 Psychologies of Psychoanalysis and Beyond

1. Freudian approach
2. Ego psychology
3. Object relations/attachment theory
4. Self-psychology

(*each method is rooted in being applied to different patients and problems)
(the first approaches were based on clinical cases, and biased by the individual's analysts' value-ladenness & even specific cases one had)

1.**Type of patients it emerged of**: aggressive and with sexual problems. **Hypothesis:** "psypathopathology is related to failures of the child's mental apparatus to deal satisfacto- rily with the pressures inherent in a maturationally predetermined sequence of drive states, leading to fixation, and subsequent regression to these fixation points later in life when the individual is confronted with environmental adversity, intrapsychic conflicts, or a combination of both" (6).
2.**As a reaction against:** the sexual & aggressive drive theory of the Freudian approach. **Hypothesis**: the focus ought to be on the "child's adaptive capacities, and particularly the capacity of the ego to adapt to changing external and internal demands. […] Anna Freud […] developed a more comprehensive developmental theory, emphasiz- ing the notion of different *developmental lines*, which continues to be a central tenet of developmental psychopathology" (6). **Leading theories**: that of Erik Erikson's *epigenetic theory*.
3.**As a reaction against**: the "intrapsychic" focus of 1. and 2. and their inability to explain the self and interpersonal distortions found in patients with psychotic and borderline features. **Hypothesis**: the central assumption is that "a. relationships are primary to drive satisfaction, rather than secondary, as is assumed in traditional drive and ego psychology, and b. development fundamentally takes place within an interpersonal matrix, with attachment/interpersonal processes playing a key role in determining development, rather than a preprogrammed maturational process as is assumed in drive and ego psychology" (6).
4.**As a reaction against**: the theoretical abstract language of many psychoanalytic approaches. **Its aim**: replace this abstract language with one which describes the subjective self-development of patients. **Hypothesis**: "the infant needs an understanding caregiver—a need that persists throughout life in order for the individual to develop and to promote the experience of selfhood" (8).

There is no clear distinction between psychodynamic and psychoanalysis. So, in a sense, psychodynamic is the contemporary approach to psychoanalysis. The 4 orientations

above do not fully characterize psychodynamic psychology since many new approaches are formed by mixing the 4 in various ways.

Basic assumptions of Psychodynamic Psychology

to be defined	the definition given
Developmental perspective	A developmental understanding of psychopathology is central.
Unconscious motivation and intentionality	Factors outside of the individual's awareness play an important role in explaining the development and maintenance of psychopathology.
Transference	Templates of past relationships and ways of thinking influence current relationships and perceptions.
Person-oriented perspective	Focus is on understanding the whole person, including strengths and vulnerabilities.
Recognition of complexity	Emphasis is on regression and progression on interrelated developmental lines, and on the role of deferred action (events achieving new meaning based on later experiences).
Focus on the inner world and psychological causality	Focus is on how psychological factors may mediate the influence of social and biological factors.
Continuity between normal and disrupted personality development	There is no categorical distinction between normality and psychopathology: psychopathology is dimensionally distributed.

Psychodynamic treatment

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TABLE 1.3. Major Types of Psychodynamic Therapy within the Spectrum of Psychodynamic Therapies for Adults

	Psychoanalyis	Longer-term psychodynamic psychotherapy	Brief psychodynamic psychotherapy
Aims	Personality change as a result of insight into the relationship between past and present	Personality change as a result of insight into the relationship between past and present, but targeted changes are typically more limited	Changes in symptoms and adaptive capacities
Role of free association	Central feature	Important role, though more limited	Limited, emphasis on dialogue between patient and therapist
Therapist stance	Technical neutrality, evenly hovering attention	Technical neutrality less strict, more active stance	More active, supportive and often directive stance
Role of repeated working through of conflicts	Repeated focus on relationship between past and present conflicts	More limited focus on relationship between past and present conflicts	More limited, focus on conflicts in here-and-now
Role of countertransference (feelings in the therapist engendered by the patient)	Major tool to inform interventions and working through	Informs interventions and working through	Informs interventions
Major interventions	• Clarification and confrontation are used to broaden the patient's perspective • Central role of interpretation of the relationship between past and present ("there-and-then" and "here-and-now") • Limited use of supportive and directive interventions	• Clarification and confrontation are used to broaden the patient's perspective • Interpretation of relationship between "here-and-now" and "there-and-then," but also more attention to current conflicts and problems • Supportive interventions and directive interventions may be used, particularly in more supportive variants	• Clarification and confrontation are used to broaden the patient's perspective • Interpretation is limited to a specific focus in the "here-and-now" • Supportive and directive interventions are used more to help the patient adapt to current problems and circumstances and to foster change
Intrapsychic–interpersonal focus	Mainly intrapsychic focus	Intrapsychic-interpersonal focus	Intrapsychic-interpersonal focus often emphasis on the interpersonal
Frequency	3–5 times a week	1–3 times a week	1–2 times a week
Setting	Couch	Face to face	Face to face

What works in Treatment

specific set of predictions with regard to mutative factors. Research shows that relative to cognitive-behavioral therapists, for instance, psychodynamic therapists tend to place a stronger emphasis on (1) affect and emotional expression; (2) the exploration of patients' tendency to avoid topics (i.e., defenses); (3) the identification of recurring patterns in behavior, feelings, experiences, and relationships; (4) the past and its influence on the present; (5) interpersonal experiences; (6) the therapeutic relationship; and (7) the exploration of wishes, dreams, and fantasies (Blagys & Hilsenroth,

ABOUT TREATMENT METHODS

For FSD:

DIT—focused on attachment strategies and Mentalizing.

Data about treatment:

I. Sessions 1–4 (4) (forming IPAF) (epistemic trust)

II. Session 5–12 (8) (completing IPAF) (i.e. using the IPAF to look at attachment strategies) (start to see embodied self—discovering emotional-states-influence-on-the-self + non-mentalizing modes: teleological, extreme pretend, psychic equivalence; start to see self-other relations—secondary attachment strategies; affect differentiation—I am angry, ashamed, guilty; affect recognition; affect amplification)

III. Session 13–16 (4) (developing resilience after the end of treatment) [this process is done through a goodbye letter. **Content of letter**: summary of what was achieved and what was not achieved. **Its aim**: to foster mentalizing about what has/has not been gained through treatment. Also, it is a good indicator of progress level] [After the letter, the patient is taught to deal with his unresolved issues beyond the therapy setting] (*there can be regressions linked with unconscious fantasies about ending* treatment)

For BPD

TFP [Transference Focus Psychotherapy]—focused on object relations and transference during therapy.

Data about treatment: two times a week, 9-12 months. [**Supportive techniques**: reassurance, support, empathy]

Goals:

- Integration of object representations (OR)
- Improvement of affect regulation
- Increased levels of reflective functioning (mentalisation) -> increasing dialogue with MBT

Method—here and now through

- Clarification (Did you mena this, right?)
- Confrontation (a discussion in which the therapist nicely challanges the assumptions of the patient)
- Interpretation (is an insightful analysis & conclusion regarding one's paterns, state of mind etc.)
- Focusing on the activation of typical OR's in the transferance. [due to transferance, many OR's are present in the patient-therapist relationship]

Therapeutic stage as safe haven

Training and experience crucial—the therapist must not be disturbed/offended by the switching moods of B.P.D. patients.

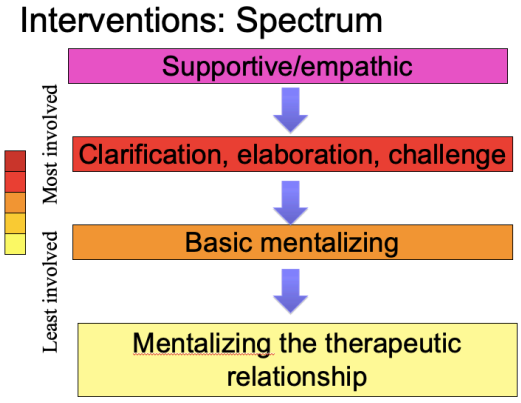
MBT

Three basic interventions

1. Stop, listen and explore [both look together[1]]
2. Stop and rewind
3. Stop and stand [more of asks patient to look]

Mentalizing the therapeutic relationship is Not as central as in T.F.P.

The therapeutic stance: "not knowing"—admitting one's mistakes and emphasize that different perspectives see the world differently. [monitoring one's mistakes]



Foster mentalizing by raising awareness on: teleological mode, psychic equivalence, extreme pretend mode.

The three Intervention stages

First stage: **Supportive/Empathic**=building epistemic trust

Second stage: clarify/elaborate/challenge

- Clarify [e.g. "did I understood correctly? Did you feel abused"]
- Elaboration [e.g. invite the patient to elaborate on different personal narratives—Paul uses this a lot].
- Challenge [e.g. when we start challenging some of the understanding of the patients]

Third stage: basic Mentalizing: The above leads the patient to be able to mentalize and, thus, regain the ability to reflect on self and others. The therapist can use basic mentalizing interventions (stop and listen, stop and rewind, stop and stand). If this raises arousal to much, you revert back to clarification/supportive interventions [in MBT the focus in not so much on mentalizing the therapeutic relationship, as in TFP]

[1] The differentiation between the 1. and 3. has not been stated by the professor, thus I guessed it.

LINKING BPD SYMPTOMS WITH TFP AND MBT

The DSM Definition

The concept of B.P.D. started to narrow down to the extra-verted, accessible type of *borderline* patient. In reality, the concept of Borderline is much broader than below, and refers to a level of functioning. The criterions below are based on convention (but do a good job at highlighting the main, the more prominent features). **It is important to realize that**: *all of the features below are linked together*. A good theory is able to explain how a theory is able to cluster all these features together in one theory. **[It is important to be able (for the exam) to link together the features below and be able to describe the theoretical perspective of T.F.P. and M.B.T]**

- Frantic efforts to avoid real or imagined abandonment. [Not including suicidal or self-mutilating behavior covered in Criterion 5] [difficulty in attachment relations]
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation. [obviously, difficult in attachment leaves to this. This might switch rapidly. Happen also in normality, but in B.P.D. cases are more pronounced. This can happen also about the self.]
- Identity disturbance: markedly and persistently unstable self-image or sense of self. [The previous point leads to this.]
- Impulsivity in at least two areas that are potentially self-damaging (e.g., promiscuous sex, eating disorders, binge eating, substance abuse, reckless driving). *[Again, not including suicidal or self-mutilating behavior covered in Criterion 5]* [that "in at least two areas" is an arbitrary criterion] [the function of this impulsivity is to deal with the instability in the self and in relationships.]
- Recurrent suicidal behavior, gestures, threats, or self-mutilating behavior. [related to impulsivity]
- Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days). [splitting, switching from feeling very down to feeling very positive. Due to this, in early stages, during a crisis, it is confused with bipolar personality disorder. B.P.D. and bipolar are very distinct]
- Chronic feelings of emptiness, worthlessness [besides this faced of B.P.D. as being extravagant, extrovert, hides a deep feeling of worthlessness, can be linked to splitting]
- Inappropriate anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights). [related to impulsivity and switch between idealization and devaluation]
- Transient, stress-related paranoid ideation or severe dissociative symptoms [as a tribute to the original B.P.D. definition as a type of personality organization]

Core features of BPD:

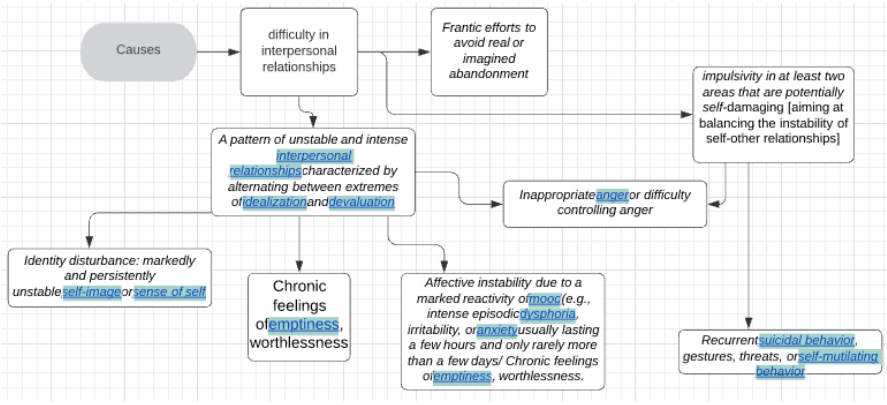
- Affective dysregulation [mood, switches between idealization and devaluation]
- Impulsivity (including self-harm, suicidality)
- Interpersonal dysfunctions
- Identity diffusion [important to not forget this, the stability of the self is attacked]
- Dissociation [absences of normal functioning, particularly in highly traumatized cases]
- Sense of inner pain ["the pain of being borderline"—it is often forgotten the deep sense of isolation of these patients.]

The Old definition of BPD as a level of personality functioning

Adolph Stern coined the term, in 1938, *borderline* to refer to a group of patients between psychotic (hallucinations, delusions etc.) and neurotic (just all kinds of emotional and mental conflicts in life) symptoms. For Stern these patients were hard to treat due to their in-between status. 1955, these types of patients are described in more detail. ("on the borderline"). This personality functioning was characterized by sever disturbances in self-identity. The use of primitive defense mechanism distorts reality and especially interpersonal relationships, as conceptualized in T.F.P.

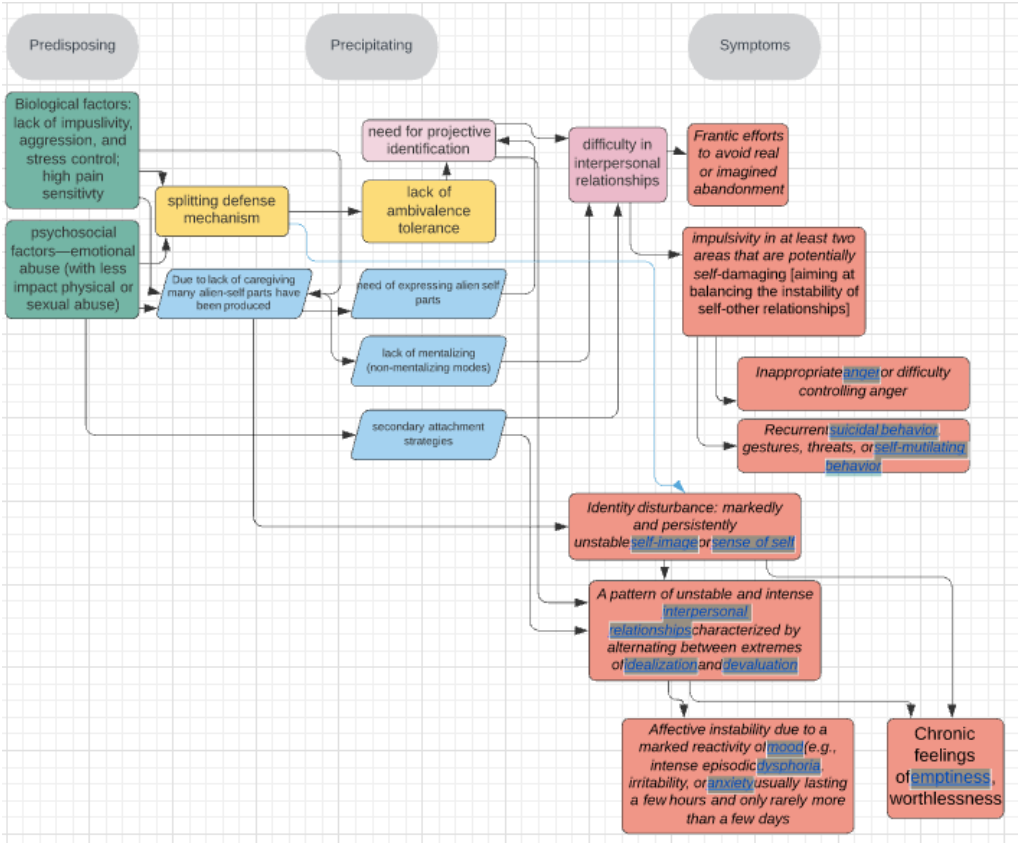
Linking these definitions with TFP and MBT

*I think that between "difficulty in interpersonal relationships" and "a pattern of unstable […]| is situated the factor of splitting. This chart aims as less as possible to provide a personal interpretation. It does not differentiate between predisposing precipitating, and perpetuating factors. The chart is based on the suggestions mentioned by the professor in "The DSM definition"



TFP and MBT model (predisposing, precipitating, and symptoms)

With green predisposing factors. With yellow precipitating factors in TFP. With blue precipitating factors in MBT. With pink precipitating factors common to both TFP and MBT. With red are the symptoms. (*I am not fully sure this chart is correct, think over it yourself) *the meaning of this colors does not apply in the "Psychodynamic Psychology Notes 2020" text.



What do I consider as perpetuating factors:

Secondary attachment strategies
Avoidance of negative-self part (due to splitting—idealization and devaluation)
Projective identification (leads to vicious cycles of perpetrator and victim)
Deactivation of mentalizing modes

MBT Model's given in the texts

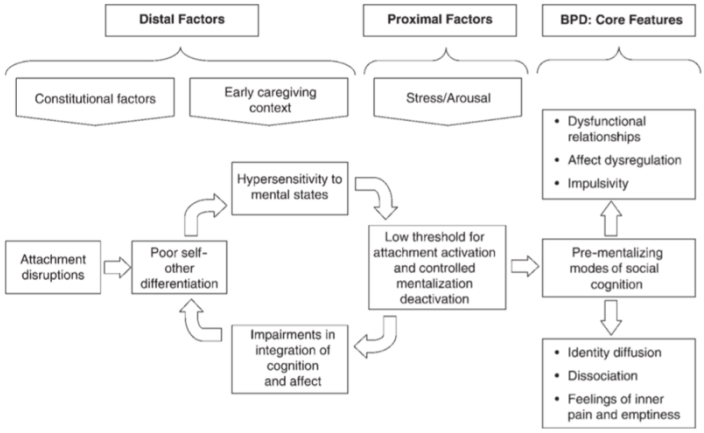


Figure 2. A mentalization-based model of BPD.

Table 1
Four Dimensions of Mentalizing: Distinguishing Features and Hypothesized Underlying Neural Circuits

Polarity	Features	Neural circuits
Automatic	Unconscious, parallel, fast processing of social information that is reflexive and requires little effort, focused attention, or intention; therefore prone to bias and distortions, particularly in complex interpersonal interactions (i.e. when arousal is high)	Amygdala Basal ganglia Ventromedial prefrontal cortex (VMPFC) Lateral temporal cortex (LTC) Dorsal anterior cingulate cortex (dACC)
Controlled	Conscious, verbal, and reflective processing of social information that requires the capacity to reflect consciously and deliberately on and make accurate attributions about the emotions, thoughts, and intentions of self and others. Relies heavily on effortful control and language	Lateral prefrontal cortex (LPFC) Medial prefrontal cortex (MPFC) Lateral parietal cortex (LPAC) Medial parietal cortex (MPAC) Medial temporal lobe (MTL) Rostral anterior cingulate cortex (rACC)
Internal	Understanding one's own mind and that of others through a direct focus on the mental interiors of both the self and others	Medial frontoparietal network (more controlled)
External	Understanding one's own mind and that of others based on external features (such as facial expressions, posture, and prosody)	Lateral frontotemporoparietal network (more automatic)
Self–Other	Shared networks underpin the capacity to mentalize about the self and others	Shared representation system (more automatic) versus mental state attribution system (more controlled)
Cognitive–Affective	Mentalizing may focus on more cognitive features (more controlled), such as belief-desire reasoning and perspective-taking, versus more affective features (more automatic), including affective empathy and mentalized affectivity (the feeling and thinking-about-the-feeling)	Cognitive mentalizing involves several areas in prefrontal cortex; affectively oriented mentalizing seems particularly related to the VMPFC

<u>SUBTLE DIFFERENCES BETWEEN FSD AND BPD treatment and BETWEEN TFP AND MBT</u>

*in TFP it is spoken about 'perpetuator and victim cycles' and the explanation for this is the lack of **ambivalence tolerance** which makes the patient project on the other.
*in MBT it is spoken about 'expressing one's alien's self-parts' by **projecting** them on another. You have problems with "being ugly" you project it on another "Look at how ugly you are".
<u>Thus, projective identification is both in TFP and MBT, but the explanation behind it is a bit different for each</u>.

*IPAFS in DIT have in common with OR's in TFP the three components: *object-representation*, *self-representation*, and *affect linking the two*. However, IPAFS have also a defense function (i.e. an unconscious reason for using that defense mechanism) (e.g. avoidance of own aggression). OR's do not necessarily have a defense function. OR's represent simply the manner through which we form representations [in our development].

Overview Entire Course

a. FSD (Functional Somatic Disorders) and its causes
b. DIT (Dynamic Interpersonal Therapy) for FSD
c. BPD in general
d. TFP (Transference focus Psychotherapy) for BPD
e. MBT (Mentalize Based Treatment) for BPD — Part I and Part II

a. FSD=a spectrum of disorders in which in which psychic distress is equivalised with physical pain/illnesses. **Causes**: biological (genetic polymorphism) + environmental (trauma)→allostatic load reached (stress)→non-mentalizing mode + secondary attachment strategies (hyper-attachment/hypo-attachment)→perpetuating the cycle of stress→FSD

Proximity seeking=to escape pain one seeks the proximity of a desired person. However, in the case of FSD patients being in contact does not alleviate the pain thus they are automatically use secondary attachment strategies.

Non-mentalizing modes:
Teleological—all needs a concrete cause, a bodily cause, an external proof
Extreme pretend—hyper mentalization, being out of touch with reality, aberration.
Psychic equivalence mode—believing 'I feel terrible' means 'the world is terrible' (conceiving all that you belief as if not a belief, but a fact) (intolerance of alternative perspectives)

Mentalizing and FSD. Distress in stress regulation or secondary attachment→disruption in mentalizing (including embodiment). (unable to link their emotions with their states in the body)

b. Therapies for FSD: DIT (Dynamic Interpersonal Therapy)=focused on secondary attachment strategies + embodied mentalizing + epistemic trust. 1.Therapist and patient formulate an IPAF (Interpersonal Affective Focus—an unconscious pattern of relation to oneself and others) (First phase: validate the patient) (Second phase: working through the IPAF and consolidating progress) (Third Phase: teach the patient to do it on its own)

c. **BPD in general**. BPD=a chronic disorder involving self-destructive behaviour/thoughts, intense interpersonal conflict, incoherent representation of self and others. (between neurosis and psychosis, have mild psychotic symptoms during treatment). **Causes**: biological factors (a biological endophenotype characterised by impulse aggression and emotion dysregulation) + early aversions (bad childhood) **Dynamic**: due to the fear that all could turn bad one adopts splitting→lack of ambivalence tolerance→B.P.D.

d. TFP=focused on **object relations:** self rep←emotion→other). Presence/absence of another→emotion/diff image of self.

In normal cases—**ambivalence tolerance**=accept the bad side of stuff. However, this is impossible in BPD due to bad primary defence mechanisms (splitting/project identification). (**splitting**: either good/either all bad) (in order to defend from bad x, you split all into good-bad, without in-between) (**project identification**—pretend that the bad x in you is not in you, but in the other)

This therapy focused on integration through clarification/confrontation/interpretation of the inter-relation patterns of patients (idealising or denigrating self/others) + looking at transference.

(9-12 months treatment—2 times a week)
Therapeutic setting as "safe haven".
Developmental therapy=takes into consideration the effects of childhood.

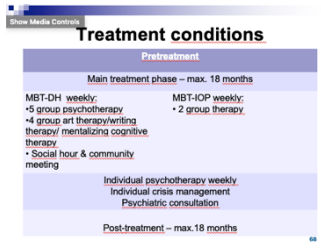
e. MBP=focused on mentalizing. Mentalizing=the imaginative ability to interpret human behaviour in terms of internal mental states (needs, desires, feelings, beliefs, goals).

A secure attachment plays a vital role in forming the ability to mentalize=marked mirroring gaining an image of self/unmarked mirroring leading to the sensation of alien self—introducing structures with different agency then oneself→splitting + primary mentalizing (teleological mode; extreme pretend; psychological equivalence)

Also such a patient equates external states as part of oneself (in a paper)

The therapy:

1—regaining their epistemic trust,
2.basic interventions: stop, listen and explore; stop and rewind; stop and stand (clarification, elaboration, challenge)
3.basic mentalizing→mentalizing the therapeutic relation.



DIT—focused on attachment relations and mentalizing
—sessions 1-4 (Building epistemic trust through empathizing and forming an IPAF)
—sessions 5-13 (working through the IPAF) *
—sessions 13-16 (goodbye letter and consolidating the analytic function.
Four components of IPAF
a. Self-representation. [**biological predisposing of F.S.D.:** polymorphism with H.P.A axis; also, **biological preceptory**: chronic infections, whiplash] [**e.p.m.**: no bridge between ideas and reality—stop and rewind] [**equivalence**: ignore + show alternatives; **teleological**: validation→switch focus to feeling and relate them to interpersonal relationships]
b. Other representation.
c. Affect.
d. Defense mechanism function.

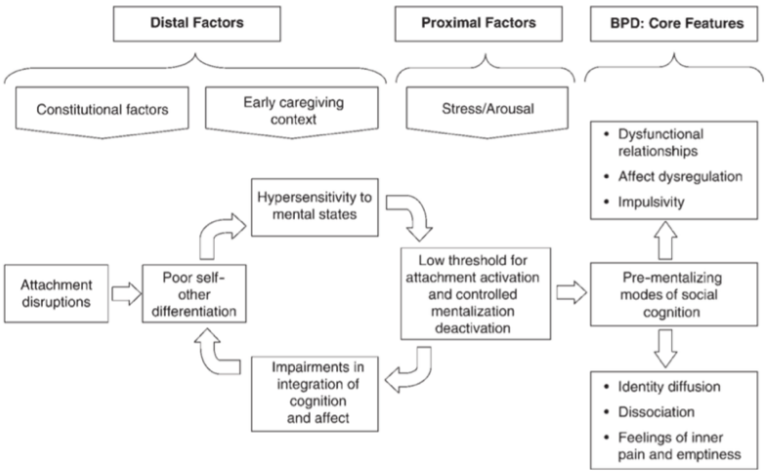
There is a causal chain between this IPAF and the somatic symptoms
*Seeing the body as the embodies sit of emotions (recognize 'somatic' markers, and recognize markers of emotions). Differentiating emotions from actions and physical sensations: making the patient look at the correlation between emotions, interpersonal relations, and bodily reactions. Looking at interpersonal relations (secondary attachment strategies) [advising patient to find new ways of relating]. Encouraging affect recognition, affect differentiation, affect amplification.

—disclosure of patient's through for 'normalizing' experience.
*epistemic trust is the highway to learning, it represents a new *How* for learning. The therapist needs to speak in a marked way, to validate the patient, for the patient to recognize the therapist as a trusted source.
Three basic interventions: confrontation: suggest another point of view (not knowing stance important); clarification; interpretation
Empathic interventions: reassurance, support, adequate empathy
Types of epistemic trust: epistemic trust, epistemic distrust (reactivate); hypervigilance/over trust (learn)
Two stances: Not-knowing stance and inquisitive stance.

TFP— (9-12 months/two times a week)
Three basic interventions: confrontation, clarification, interpretation
Looking at how the **object relation diet** is transferred in the therapeutic relation.
Projective identification creates a vicious cycle. **From identity diffusion to identity integration**. The **therapist needs to contain negative emotions—safe haven**. **Aims**: Improving affect, improving OR integration, improving reflection (mentalizing)

MBT—(max 18th months max + post-treatment 18th months max)
—MBT-IOP—2 group therapy + individual session weekly + psychiatric consultation + individual crisis management.
—MBT-DH—weekly: 5 group psychotherapy + 4 group art therapy/writing + social hour and community meeting.
Types of epistemic trust: epistemic trust, epistemic distrust (reactivate); hypervigilance/over trust (learn)
Two stances: Not-knowing stance and inquisitive stance.
The spectrum of interventions: supportive/empathic→clarification, elaboration (diving deeper into a topic, exploring the emotions, thoughts, events etc.), challenge→basic mentalizing (here we use the **three basic principles**: stop and listen [more collaborative]; stop and rewind; stop and stand [more put the patient to look)→mentalizing the therapeutic relationship

B.P.D. have problem with internal mental states self & other mentalizing. B.P.D. have problem with abstract mentalizing and thus they cannot inhibit the tendency of the bodily mentalizing to imitate others. (4 mentalizing systems: external/internal; cognitive/affective/; automatic/controlled; bodily/abstract). Self & other mentalizing are linked… this explains the identity diffusion of B.P.D.



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