Facilitating the Process of Working Through in Psychotherapy

Facilitating the Process of Working Through in Psychotherapy provides a detailed understanding and de-mystification of the concept of “working through” in dynamic psychotherapy, the most vital but neglected aspect of the therapeutic process.

Just as there are multiple factors responsible for the creation and perpetuation of symptoms and suffering, multiple interventions are frequently required to work through and resolve them. This volume spans topics such as multiple causation, repetition compulsion, and the polarities of experience, while emphasizing the importance of providing a corrective emotional experience, recognizing and repairing ruptures to the alliance and facilitating a positive ending to treatment. Verbatim transcripts of the author’s therapy sessions illustrate the factors responsible for working toward enduring change, and readers are taken through theory, research, and practice.

This book is essential reading for all psychotherapists who are committed to increasing therapeutic effectiveness while enhancing their own personal and professional development.

Patricia Coughlin is a Clinical Psychologist with over 40 years of experience as a therapist and teacher. She is the author of Maximising Therapeutic Effectiveness in Dynamic Psychotherapy (Routledge, 2016), Lives Transformed (Routledge, 2007), and Intensive Short Term Dynamic Psychotherapy (Routledge, 2004). She lectures, teaches, and trains psychotherapists internationally.
To the memory of Dr David Malan – the original “iron fist in the velvet glove” – a true English gentleman who was passionate about doing work of depth and significance in the briefest amount of time.

He was convinced that dynamic psychotherapy can be “not merely effective, but uniquely effective”, and dedicated his life to the study of psychotherapy in order to prove it. That he and his amazing wife, Jennie, became dear friends has been a true blessing in my life.
## Contents

_Acknowledgments_  
ix

1 Working Through: From Insight to Sustained Change  
2 Working Through from the Start: The Central Importance of the Initial Encounter  
3 Complexity and Multiple Causation  
4 The Repetition Compulsion  
5 The Corrective Emotional Experience  
6 Rupture and Repair  
7 Autonomy and Attachment  
8 A Good Goodbye

_Bibliography_  
157

_Index_  
167
This book is the culmination of over 40 years of study and practice in the art and science of dynamic psychotherapy. It couldn’t have come to fruition without the help and assistance of many. Jonathan Entis provided the motivation to do the book and encouraged me every step of the way. For reading the manuscript with great care, and providing valuable feedback, I am in debt to Drs Tor Wennerberg, Ron Albucher, Brandon Yarns, and Erin Hall.

I’ve had extraordinary teachers and supervisors throughout my training and career, most notably Dr David Malan and Dr Habib Davanloo. My colleagues – most of whom have also become dear friends – have been a constant source of support and inspiration and are almost too numerous to mention. Bjorn Elwin, Agneta Bongers, Peter Lillingren, Angela Cooper, Allan Abbass, Allen Kalpin, Jeffrey Magnavita, Jon Frederickson, Diana Fosha, Leigh Mc Cullough, Kristin Osborn, Steven Shapiro, Bruce Ecker, Jonathan Shedler, Susan Fisher, Andrew Ursino, Janet Jaffee, John Rathauzer, Robert Neborsky, Josette ten-have de Labije, Jim Schubmehl (my first ISTDP supervisor), David Wolff, Diane Byster, Jody Whitehouse, Martha Stark, and Jennie Malan.

My students and patients teach me something new and valuable every day. Growing with you, and through all of our struggles, has enriched my life without measure.

Finally, my warmest appreciation to Zoe Meyer and Jana Craddock, my editors at Taylor & Francis.

My deepest gratitude to Angel Cardon, who edited and formatted the book in preparation for publication. Her attention to detail and heartfelt commitment to the project were a source of inspiration and support that proved invaluable.

None of this would be possible without my family and friends, who are the very breath to my life. I devote this volume to my three darling grandsons: James, Michael, and Benjamin.
Chapter 1

Working Through
From Insight to Sustained Change

Introduction

In therapy, as in life, it is follow-through that makes all the difference between success and failure; between those who live full and successful lives and those who are a mere flash in the pan. While we all seem to long for the sudden insight that irrevocably alters everything, rendering change effortless, the fact is most enduring change involves focus, determination, and persistence. It also involves the courage to take risks and tolerate anxiety for growth. Such a process is not for the fainthearted. This is as true for the therapist as it is for the patient.

Why write (or read) a book on the process of working through? While the working through phase of therapy is considered the most important in determining the outcome, it is also the most neglected in our field (Aron, 1991; Giovachini, 1975; Wachtel, 2011). In fact, there has not been a single published text devoted to this crucial process. The present volume is an attempt to fill in the gap in order to elucidate and expand upon the various therapeutic processes required to translate emotional insight into enduring change.

Research and clinical experience suggest that neither intellectual insight nor emotional catharsis alone is sufficient to promote deep and lasting change in symptoms and character disturbances. Change is a process, not a singular event. The work is multifaceted and requires us to help patients experience the feelings, wishes, and fantasies they have avoided; face painful and difficult truths; consolidate insights into a solid and coherent sense of self; examine distorted and pathological beliefs; and clearly understand the ways in which their internal conflicts have been played out in relationship to others. The process through which defenses break down, anxiety-provoking feelings are faced and experienced, and insight is consolidated in such a way that enduring change is achieved has been termed “working through.”

Working through and resolving the patient’s core conflicts, such that he is free from suffering and able to create a meaningful and fulfilling life, is an ambitious goal and not one shared by all therapists. Some are content to reduce or eliminate symptoms or simply produce behavioral change.
If that is the case, this book is probably not for you. However, if you strive to become an expert in your field, achieving better and more consistent results than average, a willingness to push yourself and your patients to achieve ambitious goals seems to be required (Wampold et al., 2017). Embracing such goals is no guarantee of always achieving them, but putting all you’ve got into the effort, and bolstering that effort with ongoing skill development and knowledge acquisition, is necessary to enhance therapeutic effectiveness. To this end, we will examine the history and evolution of the concept of working through and explore its component parts: the notion of multiple causation, the repetition compulsion, understanding complexity and tolerating uncertainty, balancing the polarities of attachment and autonomy, facilitating a corrective emotional experience, creating and maintaining a strong conscious and unconscious alliance (including dealing with ruptures), attending to meaning and coherence, revising and consolidating an integrated sense of self, and dealing with spiritual matters and concerns as they emerge. Case examples will be used liberally throughout the text in order to illustrate and expand upon the points being made.


In the early days of psychoanalysis, Freud was interested in helping patients face and experience primitive and threatening id impulses; the repression of which he considered the root cause of their symptoms and suffering. Consequently, his initial work involved trying to find ways to bypass resistance in an effort to unearth repressed emotions and the memories with which they were associated. Over time he discovered that such cathartic work was often followed by the “return of the repressed,” prompting him to shift his focus from uncovering id impulses to strengthening the ego. In this way, previously unconscious feelings and memories could be tolerated, mastered, and integrated into an ongoing sense of self.

Additionally, Freud noticed that patients were repeating, rather than remembering, their anxiety-provoking and guilt-laden emotional conflicts, both in their current life and in the transference. Breuer found this transfer of unresolved conflicts from the past into the present with the therapist personally distressing and considered it an obstacle to the therapeutic process. In contrast, Freud found that the transference of unresolved conflicts onto the person of the therapist proved the most powerful therapeutic tool in our arsenal, if managed properly. “Only when the resistance is at its height can the analyst, working in common with the patient, discover the repressed instinctual impulses which are feeding the resistance” (Freud, 1914, p. 155). It is just such an experience, in the here and now with the therapist, through which the patient discovers the power of his own unconscious. Through the vehicle of the transference, the forgotten past becomes present with the
therapist, where it can be faced, understood, and integrated into a solid sense of self. Playing out these anxiety-provoking impulses and fantasies in one’s imagination creates a kind of liminal space between repression and acting out, both of which are destructive. By creating such a healing and therapeutic space, we create a kind of “playground in which it is allowed to expand in almost complete freedom” (Freud, 1914, p. 154). Often, this experience with the therapist, with links to past genetic figures, leads to insight into the original source of his disturbance. Being encouraged to experience and express previously forbidden impulses and fantasies directly toward the therapist, with no untoward consequences, is often profoundly corrective and healing. In this way, the past is resolved in the present.

Late in his life, Freud (1937) came to appreciate the role of the superego’s resistance to recovery and healing. He discovered that patients suffered, not only by defending against anxiety-provoking and painful feelings, but also due to an unconscious sense of guilt about these forbidden feelings and wishes, which demands punishment. Furthermore, he discovered that some patients experienced a great deal of secondary gain from their symptoms and were loath to give them up. Both factors must be addressed for lasting change to take place.

Here we begin to understand the notion that multiple factors are often responsible for the creation and maintenance of the patients’ disturbance. These include anxiety and resistance to facing one’s own primitive impulses, repeating instead of remembering, the unconscious need to suffer, and the secondary gain of illness in alleviating the patient from taking responsibility for his life. The complex and difficult nature of uncovering and removing all factors responsible for the patient’s pathology was considered the most arduous, time consuming, and frustrating part of the work. That said, working through, from feeling to de-repression, to insight and change, has been deemed the most important factor in achieving lasting change (Freud, 1914). No wonder many in the field agree that working through is the most difficult and time consuming of our therapeutic tasks. Giovachini (1975) wrote, “the two most enigmatic words in psychoanalysis are ‘working through.’”

**How Is Working Through Accomplished?**

Although much has been written about the opening phase of treatment, as well as the termination phase, there are very few guidelines for maintaining focus, deepening the process, and consolidating change in the mid-phase of treatment. As a result, therapeutic effectiveness often suffers. Like the middle game in chess, there is no play book to guide us. To master the game, you must understand the underlying principles involved so that you can respond both strategically and spontaneously to what arises in the here and now, while keeping your eye on the goal. Just as no two games of chess are ever
exactly alike, no two therapies will follow the same trajectory. The successful clinician has a method he is passionate about and skilled in implementing in a structured but flexible manner, taking many factors into account in order to maximize effectiveness (Coughlin, 2017).

Just how is this process of working through accomplished? In “Remembering, Repeating and Working through,” Freud (1914) suggested that therapy required a necessary division of labor. The therapist’s job involved identifying and clarifying the resistances to remembering and experiencing anxiety-provoking emotions. It was then up to the patient to overcome these resistances. In his early work, Freud applied a pressure technique and was quite direct in encouraging patients to take an active role in overcoming their resistances to the therapeutic process. Over time, he became increasingly passive and pessimistic about this process, suggesting that we “bow to the superiority of the superego’s resistance.” Davanloo (1990) considered this a wrong turn and returned to Freud’s early and more active stance in confronting resistance as soon as it appeared.

Therapy is not something that is done to the patient but can only be successful if the patient actively collaborates with the therapist in achieving therapeutic goals. The therapist can guide and encourage the patient in these efforts, but the work of translating these insights into action must be squarely placed in the patient’s lap. The patient must, first and foremost, change his conscious attitude toward his illness. “He has usually been content with lamenting it, despising it as nonsensical and under-estimating its importance…” (Freud, 1914, p. 152). Then, he must find the courage to face “an enemy worthy of his mettle, a piece of his personality, which has solid ground for its existence, and out of which things of value for his future life have to be derived” (Freud, 1914, p. 152).

Again, Freud was referring to multiple factors, including the patient’s will and courage to do the work required; the need to understand both the benefit, purpose and cost of symptoms; and, finally, to integrate seemingly disparate and even detestable parts of the self, in order to become whole and live a life of meaning and purpose. This is a multifaceted process involving many steps, which often need to be repeated in order to ensure lasting change. Ultimately, “working through” names a battle to be fought and a labor to be done which the neurosis has, for so long, only served to postpone. This is the struggle within oneself; “it is the labor of transformation that makes possible the rejection of the neurotic encumbrance and its symptomatic trappings in favor of a novel and presumably healthier mode of life” (Sedler, 1983, p. 75).

To achieve such ambitious therapeutic goals, “It is evident that greater, not less, knowledge of the manifold intricacies of human behavior is necessary before one can acquire the skill in finding for each individual, the most suitable and economical form of treatment” (Alexander & French, 1946). In the end, they found, “Re-experiencing the old, unsettled conflict, but with
a new ending, was the secret of every penetrating therapeutic result.” Furthermore, “Only the actual experience of a new solution, in the transference or the everyday life of the patient, gives the patient the conviction that a new solution is possible, and induces him to give up the old neurotic pattern.” In this sense, then, the patient must *live through*, and not simply *work through*, the old conflict to a new and more satisfying end. And we, as therapists, must come adept at facilitating just this kind of experience.

**Altered Sense of Self**

While Freud (1914) emphasized the importance of overcoming resistance, including resolving the transference, in order to uncover and resolve conflicts regarding traumatic memories, subsequent ego psychologists emphasized the need to integrate the previously forgotten memories and repressed feelings into the patient’s ongoing sense of self. Along these lines, Wolstein (1982) suggested that it is not enough to work through or overcome the past but to “work toward” a new and expansive future. In the process of renouncing defense and resistance, in order to face and experience conflicted feelings regarding the past, stalled development resumes (Kohut, 1984). Since internal working models of self and others are developed very early in life and often operate out of sight, as a guiding fiction, they must be updated and expanded as new information is assimilated and experience is deepened and expanded.

For example, some who have lost weight and maintained the loss for decades continue to see themselves as “fat,” just as those who have been sober for decades may still consider themselves an “addict.”

How do behavioral changes result in an alteration in identity and sense of self? To process change on that level, we must revise and reorganize our story or narrative. Whether we are a victim or a hero in that narrative has a huge impact on health, well-being, and overall functioning. It’s not just about what one does or doesn’t do, but how we see and define ourselves that matters most. This often requires bringing the past into present consciousness and re-evaluating situations and beliefs based on current reality, as opposed to memories from the past. This must also include the employment of current tools and knowledge, rather than outmoded and unexamined beliefs and capacities. It has been said that neurotics are stuck in existential time, with the sense that they are, always have been, and always will be, damaged in some way. As conflicts and problems are addressed and resolved, the meanings associated with them must be reevaluated and revised, along with one’s sense of self.

Insight and emotional freedom are not always enough to ensure lasting change. These factors must be integrated into a stable, ongoing sense of self for change to endure. Narratives must be revised, and identities alerted, in order to accommodate a new and expansive sense of self.
Human beings are storytellers and seek to create meaning in their lives. A reflective construction of a new personal meaning is often required to consolidate deep and lasting change. This reflective processing and “symbolization of a client’s emotional experience, in the context of salient and personal stories, is viewed as a key intervention strategy that enables clients to meaningfully integrate their narrative and emotional lives ...” (Angus et al., 2012, p. 55).

**Therapist Factor**

The therapist’s role in promoting this kind of therapeutic encounter is key. To help patients in this manner, the therapist must be comfortable with the patient’s intense and often disturbing feelings and wishes, as well as his own. The therapist with “his technical skill and the transference events are indispensable factors in the overall process” (Loewald, 1960). Research has confirmed the central importance of therapist variables to the outcome. His skill and tenacity, superior meta-cognitive skills, deep domain-specific knowledge, and emotional intelligence exert a far greater impact on the therapeutic outcome than either patient variables or the treatment model employed (Duncan et al., 2009; Kaplowitz, Safran & Muran, 2011).

This speaks to our own development as therapists, including the ability to identify multiple causes of our patient’s misery, while tolerating both complexity and uncertainty along the path to resolution. The best therapists have a theory and method they are enthusiastic about and adept at implementing across a wide spectrum of patients. The theory and technique used to guide the work of the author are that of Intensive Short-Term Dynamic Psychotherapy (ISTDP), a multifaceted model of treatment that is garnering increasing empirical evidence as both clinically and cost-effective with a wide variety of patients (Abbass, 2003, 2015; Shedler, 2010). ISTDP has proven effective in treating anxiety, panic disorder, depression (including treatment-resistant depression), personality disorders, and conversion, as well as somatic disorders and unidentified medical symptoms.

**ISTDP: A Multi-modal Treatment Model**

Subsequent to his work with Lindemann on the front lines, with patients who were in a crisis due to external circumstances, Davanloo (1978, 1980) set out to develop a therapeutic technique designed to precipitate an intrapsychic crisis in patients with chronic difficulties. By pressuring the patient to experience feelings he had long been avoiding, and challenging him to abandon defenses rigidly held, he was able to create an intrapsychic crisis that reliably triggered an opening into the unconscious and sped the process of change. Armed with a deep understanding of psychoanalytic theory and a keen intuitive understanding of the unconscious, Davanloo began to experiment with more active and specific techniques. In addition, he videotaped all his sessions in order to track effectiveness. He eventually developed the central dynamic sequence, a structured but flexible method for reliably obtaining ambitious therapeutic goals with a wide range of patients, in a relatively brief period of time (Davanloo, 1978, 1980, 1990, 2000).

When Malan (Davanloo, 1978, 1980) first observed this work on videotape, he was able to see the ways in which Davanloo was using the two triangles to navigate the therapeutic process (Figure 1.1). All of the specific interventions he had developed were integrated into a process of dynamic assessment (which he referred to as a “trial therapy”) that was designed to gather specific information about the difficulties to be addressed. These data were then used to formulate, and test out, a hypothesis about the nature of the conflicts responsible for these difficulties. Ultimately, the patient’s response to intervention was employed as the primary diagnostic tool and guide to further intervention. This method of assessment was also designed to assess the patient’s current capacity to engage in this intensive form of treatment.

**Figure 1.1** The Two Triangles.

![Diagram of the Two Triangles](image-url)
Phase I: Inquiry

Davanloo (1978, 1980, 1990) advocated a phenomenological approach to inquiry, in which a specific and detailed examination of the patient’s presenting problems is the initial focus. Understanding the nature, history, and severity of the problems to be addressed is step one in the process. This includes an examination of the situations and triggers in which symptoms and presenting problems arise, with a particular emphasis on the precipitating incident motivating the patient to seek treatment.

Right from the start, we must be attentive to the creation of a therapeutic alliance. At this phase of the work, we attempt to achieve agreement about the problems and goals for therapy. Agreement on the therapeutic task, another essential element in the creation of a conscious therapeutic alliance, often takes place later in the process, once defenses have been relinquished. It should be noted that, during the opening phase of inquiry, only defenses that interfere with the process of obtaining this vital information are addressed. When defenses, such as vagueness, externalization, or defiance, prevent the phase of inquiry from taking place in any meaningful way, the process must move to phase II, defense work.

Phase II: Defense Work

Davanloo (1990) developed operational definitions of many dynamic concepts and processes, including that of defense work. This process involves (1) the identification and (2) clarification of defenses, as well as (3) an examination of costs and benefits of the defenses in question. It is essential that the patient is helped to see that his symptoms and presenting problems are created and/or exacerbated by the habitual use of defenses. Once he sees clearly that his defensive avoidance of his true feelings is the engine perpetuating his difficulties, and is able to enumerate the negative consequences of such avoidance, he is put at choice – to continue to suffer or face his true feelings in order to heal and obtain his freedom from suffering.

Defense work often evokes strong feelings in the patient, either grief over the cost of his defenses or anger toward the therapist for pointing them out. Again, the patient is put at choice – to face or avoid the feelings coming up in the here and now.

Assessment and Regulation of Anxiety

One of the most common mistakes therapists make is keeping anxiety too low for change to take place. As soon as the patient becomes uncomfortable, they pull back. In contrast, Davanloo (personal communication, 1988–1991) encouraged us to move in and focus on the conflicts and feelings triggering anxiety. His method has been based on Freud’s second theory of anxiety,