Psychodynamic Intervention in Crisis

MILTON VIEDERMAN, M.D.

This paper presents a framework for brief, intensive psychotherapeutic intervention for acute distress, manifested by feelings of depression, anxiety or anger, isolation and loneliness, that arise when crises provoke unconscious conflict. This therapy uses a technique to develop a "benevolent transference" for symptom relief and as a groundwork for gaining insight. Interventions to facilitate this process will be illustrated with case illustrations.

KEYWORDS: brief therapy; crisis; presence; therapeutic relationship; benevolent transference; suggestion; insight

INTRODUCTION

This paper will present a framework for a brief intensive psychotherapeutic intervention designed to address symptoms of distress that arise as the expression of unconscious conflict provoked by situations of crisis. This therapeutic approach has elements familiar to experienced therapists, but is specific in its conceptualization. What distinguishes this therapy from others is the induction and utilization of a special positive quality in the therapeutic relationship as a therapeutic aim and "curative factor" in its own right, beyond its role as the substrate for the trusting relationship that underlies all successful psychotherapeutic treatments. (Viederman, 2011) This involves a specific strategy and technique designed to develop a "benevolent transference" to effect change, to achieve symptom relief, and sometimes, as a precursor to meaningful insight. In this respect the relationship, considered to be a central feature of the therapy, complements understanding as a vehicle for change. A variety of interventions described to facilitate this process will be illustrated with different types of patients.

Professor Emeritus of Psychiatry, Weill Medical College of Cornell University, Supervising and Training Psychoanalyst, Columbia Psychoanalytic Center for Training and Research. ***Mailing address:*** 60 Sutton Place South, Suite 1-CN, New York, NY 10022. e-mail: mvieder@med.cornell.edu

THE NATURE OF CRISIS

This approach is designed for patients who experience the acute emergence of distress or symptoms related to unconscious conflict in the context of a changed reality experienced as disruptive or traumatic (Viederman, 1983). By distress I mean a powerful and unpleasant feeling state from which one cannot escape that may be depressive, anxious, or angry, often accompanied by a feeling of isolation and loneliness. These experiences are not always easily encapsulated in our usual DSM categories.

For the most part we live in a state of relative emotional homeostasis, in a familiar experience of ourselves and our perceptions and interactions with people in the world; this encompassed in part by the psychoanalytic concept of the representational world (Sandler. J. & Rosenblatt, 1962). Crises are sudden changes in this state that disrupt the equilibrium. These crises may be precipitated by physical illness, loss of work, conflict in love relationships and all manner of other experiences. They evoke old vulnerabilities, echoes of old conflicts unique to the individual. No one is exempt from such vulnerabilities, though they are idiosyncratic and come in infinite variety. One may view crisis as having three components; (1) a state of psychic disequilibrium as it pertains to one's perception of the world and once habitual experience of self and relationship to others; (2) a regressive wish to find safety and security in the presence of a valued, supportive person imbued with power, and (3) the need to reorganize the narrative of one's life often with modification of one's perception of past experience with important people and a changed view of the evolution of one's life. (Viederman, 1986) A therapeutic intervention in this context is designed to reestablish the previous homeostasis, though, on occasion, it may facilitate the development of more adaptive patterns under particular circumstances (Viederman, 1986). The crisis may occur in the context of an event that has important symbolic significance such as a graduation, marriage, birth of a child, or the receipt of an honorary degree. This situation invites the examination of one's life—where one has been, where one is, and where one is going.[1]

[1] Such an experience is beautifully described in Ingmar Bergman's film, *Wild Strawberries*, in which an elderly physician undergoes a dramatic personality change on the day he is to be honored by his university for his commitment to medicine. This change occurs under the catalytic influence of a new and loving experience (Viederman, 2016).

RANGE OF PATIENTS

Patients vary in their availability for emotional introspection that gives meaning to their internal world. Some patients have difficulty with mentalization (Fonagy et al., 1993). Mentalization is defined as awareness of one's own inner world of fantasies, motivations and feelings, accompanied by awareness of the existence of the "minds of others", (Fonagy et al., 1993; Fonagy & Target 1996; Fonagy et al; 2002;Target & Fonagy, 1996). Patients limited in this respect more frequently profit from an experience with a therapist who is seen predominantly as a "presence" in their lives rather then by insightful awareness of their inner conflicts although the establishment of "presence" is pertinent to all. In this paper, patient anecdotes illustrate the usefulness of the approach described. The patients described represent both psychologically minded patient's and those less gifted in the their capacity to examine the inner world.

This is not to suggest that every patient is available for the trusting relationship described. Those with a decreased capacity for trust, and especially patients with paranoia, require a stance that is less close and intrusive. Positive transference is viewed as central to this approach but negative transference reactions that emerge should be interpreted (Norton, 1963).

BROAD GOALS DEFINING THE THERAPEUTIC APPROACH

1. The primary therapeutic goal is designed explicitly to rapidly establish a trusting relationship that resides in a benevolent transference (Viederman, 2011). The therapist evokes and gratifies the wishful unconscious fantasy of the omnipotent and omniscient ideal parent. In so doing, his presence mutes the pain, distress, and loneliness experienced by the patient in a moment of crisis. The attachment that develops in the context of the active and rapid engagement of the patient is experienced as protective and consolidates the fantasy of ongoing protection. It is likely to continue after the therapy ends in the fantasy of the ever-present protective figure, (Patient number three). The activation and maintenance of an unconscious benevolent transference is a primary goal of this therapeutic approach with the view that it has a powerful therapeutic effect.
2. The second goal as in any insight oriented psychotherapy is to facilitate insight in suitable patients by bringing unconscious conflicts to consciousness. The demonstration that current distress

evoked by conflict has its origin in vulnerabilities generated by early life experience comes as a great relief to patients.

THE CLIMATE OF THE THERAPY: THE MODUS OPERANDI

The stance being proposed is to be contrasted with the frequently caricatured rigid analytic position, defined by non-gratification, anonymity and neutrality, which is hardly rigidly applied today. This psychoanalytic stance is designed to evoke a regressive transference to be analyzed. The approach being described is the inverse. It is a friendly, collaborative, adult relationship that exploits the transference in a different way. In evoking the unconscious fantasy of finding succor in an idealized omnipotent person, the therapy may be used with less psychologically minded patients and exploits two of Bibring's (1964) five therapeutic interventions, namely those of suggestion and manipulation. This can be defined as the influence delegated to a person unconsciously perceived as a powerful figure of authority whose attitude affects the other unconsciously. The therapeutic effect of suggestion in more limited patients is of the order of a transference cure with elements of an unconscious desire to find love and to please authority (Oremland, 1972).

The therapeutic stance that defines this engagement is one of warm, responsive interest and curiosity about the patient's world and experience, and it is characterized by activity on the part of the therapist. Experience, judgment, intuition and a natural inclination in the therapist toward action are called for in this endeavor. This is not to suggest boundary violations, or simply being nice, or trying to befriend the patient. The conceptual approach is designed to construct a framework for the evolving therapy as always sensitive to the unique and individual presentation of each patient. Discrete and appropriate self-revelation by the therapist may be useful and may permit identification by the patient with the therapist, in particular situations that have posed problems for the patient. Responsiveness characterizes the interchange often in small ways. The therapist may spontaneously anticipate and supply a word that the patient is struggling to find. This is part of the rhythm and color of the developing relationship. At times a humorous quip or joining in play may be appropriate in a suitable context with the right patient. How and when to intervene, becomes the art of psychotherapy.

A caveat is in order. Psychotherapy may be seen as a mixture of science and art. The "science" relates to the theory that underlines psychodynamic psychotherapy and embraces such concepts as unconscious conflict, defense, transference, the developmental (genetic) sources of conflict. This

and and another sources of knowledge combined with the personal experience of the therapist forms an implicit and explicit base of knowledge that is expressed in an intuitive response. The art of psychotherapy lies at the interstices between the "science", the theory underlying dynamic treatment and its application to the infinite variety of human behavior.

Therapists vary in the degree to which their personalities equip them to be most effective in the utilization of this approach. Inclination toward expressiveness, comfort with self-revelation, spontaneity, and use of intuition are important ingredients. The accretion of theoretical knowledge, experience in life, comfort and confidence in the role of the psychotherapist all take time, and the novice must understand that this is a process that occurs over time. Not unimportant is the willingness to confront uncertainty and to risk error with interventions that are not meaningful to the patient. Such errors should be noted and addressed.

Broad Principles of Engagement

No rules define the specific engagement. The effort is directed toward understanding the current emotional experience of the patient and appropriately communicating such understanding to him. The aim in this approach is to rapidly enter the patient's life and world, his personal experience and to be companion to him in this experience. The therapist conveys his awareness of what is important to the patient at the present moment and in the past. Inferences are made about the patient, his concerns, and his character. These are tactfully communicated with sensitivity to the patient's capacity to integrate what is said. In so doing the therapist "recognizes" the patient and is "reciprocally" recognized by him. He becomes a "presence" in the patient's life. This type of engagement creates a bond that is a prelude for an ever intensifying attachment. It facilitates the evolution of the dialogue and the development of understanding that cements the relationship and gives it power. The dialogue between the two parties, asymmetrical though it is, has an emotional component that intensifies the process. It has the quality of a conversation that flows though it is subtly directed by the therapist who makes observations and formulates ideas about important areas to pursue. Mutative power lies in insight or meaning as the patient recognizes emotionally the truth value of what he has discovered or what has been interpreted to him. On occasion, intellectual or explanatory statements are useful in containing anxiety and guilt, particularly if imbued with the suggestive power of a benevolent authority.

Given the uniqueness of each patient, the evolution of the dialogue will

be different with each patient over the course of the treatment. (It is for this reason that manualiztion is so difficult and so limiting.) A patient's reluctance to seek treatment should be addressed early in the encounter. The therapist is not to be seen as a pathology seeker. The aim is to create an atmosphere of comfort that is to be experienced by the patient as inquiring and nonjudgmental. One might liken it metaphorically to the holding environment (Winnicott, 1965). The patient is encouraged to speak spontaneously and to express freely what comes to mind without consideration for the apparent explicit pertinence to the theme being pursued. No specific schedule for what might be accomplished in individual sessions can be defined, though a discussion of the patient's experience with the therapist after the first meeting offers a special vantage point on his or her habitual mode of relating to people and the world.

This is to be considered a brief therapy, with the patient to be seen at weekly intervals. Unlike as in the case of many brief therapies, in this approach specific recommendations for length of therapy are not defined, though often much can be accomplished in two or three sessions. On occasion it may continue as a longer psychotherapy. Given the intensity of the relationship established, there is an implicit and often explicit commitment to availability in the future. The fantasy of the ongoing relationship has a powerful influence on the patient in the sense of offering a "background of safety" (Sandler, 1960). Since the unconscious evoked transference is important, termination offers the opportunity to examine the patient's experience of attachment, dependency, separation, and loss, this muted by the therapist's availability in the future. The separation experience may be examined at the end of a single session (the third session in the case of patient number two below).

Specific Modes of Intervention

The following interventions have been found to be useful in the consultation situation and might be considered when appropriate as the dialogue with the patient continues. These are not formulae to be religiously applied but should be considered available as useful modalities to engage the patient. The interventions described below have been outlined in a previous publication pertinent to the consultation process (Viederman, 2008).

A. *Echoing or labeling the implicit affect or content of the patient's experience as it is revealed to let the patient know that he has been heard*

This is not a contrived technique but is a part of the rhythm and color of the interchange.

B. *Conveying to the patient the therapist's awareness of the nature and climate of the patient's experience as he recounts his story*
("What I hear you saying is . . . That you felt . . .) This is an important aspect of the effort designed to establish the "presence" of the therapist by sharing the patient's experience, a primary thrust of this approach.

C. *Suggesting meanings or connections of which the patient is unaware*
Particularly important is "meaning is an intervening variable" (Viederman, 2006). This concept suggests that between a stimulus and the patient's emotional response, there is a meaning that is specific to the patient. For example, an elderly woman, requiring modification of a pacemaker that had failed, was depressed and concerned about developing dementia (her neighbor had been recently hospitalized with dementia). Her concern about dementia stemmed from a period of confusion when the disturbance of cardiac rhythm had led to poor cerebral perfusion. With correction of the cardiac rhythm and a cognitive examination that revealed no impairment, she could be reassured. The depression lifted.

D. *Commenting on aspects of the patient's personality (sometimes supportive of self-esteem) and exploring the roots of character traits*
This may involve characterological inhibitions about expressing emotion, revealing needs, etc.

E. *Especially important is the use of the present to evoke associative thoughts to the past.*
The therapist first defines an important element in the patient's experience, whether it be a symptom, a character trait, or dominant concern. The patient is asked for whatever thoughts or memories this brings to mind related to his early life experience. He is told that he is not being asked for an explanation. Current experience and behavior can be understood, thereby, as a product of a dynamic past.

A 65-year-old director and actor appeared for consultation with a peculiar symptom after having seen a play in which a phantom had suddenly and unexpectedly appeared in the third act. Since that time he had been dominated by an uncanny sense of an ever-present phantom. It was suggested to him that he now felt dominated by an atmosphere of imminent and unpredictable danger. When encouraged to reflect on this experience, he paused

and suddenly remembered his childhood experience of returning home from school to receive an unanticipated slap by his mother for some presumed transgression. He revealed that in the play, the phantom had been the return of the dead mother. The symptom disappeared with this understanding. He was seen for three sessions.

F. *The perspective that emerges from this exploration of the past may be utilized in an intervention, The Psychodynamic Life Narrative (Viederman, 1983).*

This is a construct presented to the patient, early in a consultation that places his current experience in the context of his early life experience and shows it to be a logical and inevitable product of that experience.

A typical narrative offered in a consultation to a 35-year-old woman with diabetes, now pregnant for the first time and obsessed by the fear of having a child with birth defects follows:

"Listen to the story you have told me. When you developed diabetes at the age of six, your mother told you that you should hide it for fear of not having boyfriends or sleepovers. Although your parents seem to have been decent people, and you have done well in life with marriage, a profession, friends, now-, in the context of this pregnancy, you are fearful that this child, whom you see is an extension of yourself, will be defective—just as you, on some level, have always felt yourself to be defective".

The patient burst into tears, composed herself, and a month later wrote a letter thanking me, indicating that her symptom had disappeared, and that our discussion had changed her life. She delivered a healthy boy.

G. *Comments about the patient's behavior with the consultant as a point of entry into the nature and quality of object relations such as to permit pursuit of these elements and examination of their roots in the past (transference).* This may involve confrontation with avoidant or aggressive behavior.

H. *Appropriate communication of the therapist's emotional reaction to the patient to pursue the quality of relationships with others (countertransference or its extension in enactment).*

I. *Finally, direct interpretation related to unconscious conflict.*

Central in this approach is the idea of confrontation. Though often defined as a hostile action, a second meaning implies an action that brings things together for comparison or to signal something for examination, something unanticipated by the patient. This may, at times, be experienced

as ego dystonic (something alien, painful or unknown to him) or simply something of which he [the patient] had been unaware. Confrontation in this respect resembles affirmation and not aggression.

THE THERAPUTIC STANCE

This approach demands activity, spontaneity, the utilization of intuition, emotional expressiveness and responsiveness, and a willingness to intervene even when uncertain. The ongoing process should be likened to an experiment with observation, hypothesis formation, tactful intervention, and the observation of the patient's response to determine the validity and usefulness of the intervention. Effective interactions have meaning to the patient. This implies recognition by the patient of the emotional significance of what has been discovered. In this regard it is to be distinguished from explanation, which is cognitive and emotionally distant. A comment on the patient's willingness to submissively accept statements that are clearly not meaningful to him offers an opportunity to examine the patient's inclination to submit to authority.[2]

Patient Illustrations

The application of these principles to a divergent group of patients will be described, each to illustrate a different aspect of the therapeutic intervention and its effect on the patient.

Patient Number 1

This patient illustrates the use of a rapidly induced benevolent transference for suggestion in a patient limited in his psychological capacity. Treatment led to the disappearance of the symptom during the first session.

The patient was a 68-year-old businessman, father to six children, committed to Orthodox Judaism. He had been referred by his neurologist, who after an extensive neurological examination revealed no organic pathology for the patient's rigidity of gait, concluded that "the sticky leg syndrome" was the manifestation of a conversion disorder. The impairment had been present for three or four weeks.[3] The patient was good-humored and hypervoluble. An atmosphere of good fellowship pervaded the encounter. Important in his life history was his father's denigration of him for mediocre school performance related to dyslexia. The patient felt his father had clearly favored his older brother.

[2] The utilization of activity and experiment is not unlike the experience of interviewing a patient in a clinical case conference where time is limited. It was in this context that many of these ideas were generated.

[3] This patient and the treatment has been described in detail [Viederman (1995)].

The family of origin had been concerned about intemperate expressions of anger when he was thwarted or when he experienced disrespect. The symptom had developed when he discovered that there was a plan to prevent him entering the synagogue by the rabbi because of a conflict related to his paranoid lawyer son-in-law. The patient's symptoms appeared when he discovered he had been prevented from entering his synagogue by a plan fomented by his "paranoid" antagonistic, lawyer son-in-law, and the rabbi leading the congregation. The patient's family acquiesced since they had been concerned that he would lose control of his anger in a confrontation and to avoid conflict had spirited him away to Florida.

The following interchange occurred during the first session. As the patients spoke of the incident in which he had been prevented from entering the synagogue, he said with great anger. "They cannot stop me from walking into the synagogue. When I was a child, my parents, in complaining of my obstinacy, said I could walk through a wall if I wanted to." At this point I stopped him and stated affirmatively. "Did you hear what you just said?" I repeated, "They can not stop me from walking into the synagogue." I continued with insistence, "You've been unable to walk because you are afraid to walk into the synagogue. You're afraid of the anger you feel. Your confidence has been undermined. You have been warned by your family that you would do harm if you confronted the Rabbi. Now that you know what this symptom is about, you will be able to get up, and walk normally. The patient arose and walked about the office without difficulty and without his cane.

When the patient arrived for the second session, his head was sagging. I interpreted this as a reflection of the shame he had experienced in being excluded from the synagogue and he straightened his head. The symptom disappeared. He then revealed that he was the proud skipper of a sailing vessel in New York harbor and that even after the leg symptom developed he had been able to walk normally when on the deck of his boat. I pointed out that this was a situation where he was master. When he invited me to join him for a cruise, I tactfully refused. His disappointment was apparent, and he expressed the thought that I was not confident enough in him as a skipper to accompany him. "This is certainly not true! I have absolute confidence in you as a skipper", I replied. He expressed his gratitude for my confidence in him, a confidence that he had never experienced with his father. The patient was seen for six sessions at weekly intervals with no further symptoms.

This patient, limited in his self-examining capacity, relinquished his

conversion symptoms in the context of a therapeutic relationship in which I became a transference object, an idealized figure akin to a rabbi or teacher, a good father—people highly valued in his world. As such he was affected by my strongly affirmative statements that had the power of suggestion (Bibring, 1964). My responses were authentic, and I believe that my understanding had validity as the source of his symptoms, though they were explanatory and not transforming insights for the patient.

Patient Number 2

This patient illustrates the power of the establishment of presence in the first session with relief of distressing symptoms and the separate impact of interpretation and insight as it develops in the second and third sessions in a patient gifted with capacity for self reflection.

The second patient was a 54-year-old married woman, the mother of two children, now confronted with the imminent death of her husband after eight years of treatment for leukemia. She was extremely anxious and upset and had an adjustment disorder with anxiety. The treatment consisted of three weekly sessions with and eight-month follow up after the husband's death.[4]

She was an intelligent, articulate woman, highly expressive, whose affect shifted from tears of frustration and sadness to laughter. She was not significantly depressed but was extremely distressed about her experience with a dying husband.

In the first session she revealed her distress at the uncertainty of the situation and the difficulty in dealing with a husband who was denying his imminent death. It was apparent that she found herself in a situation she had never before experienced and felt that she no longer had control over her life. In this session I consistently echoed my understanding of the various aspects of her experience and the uncertainty she confronted on a daily basis.

She arrived for the second session enthusiastically stating that she felt so much better after our previous meeting "For the first time I have some one to talk to. I have been speaking to friends but it has not helped. Now I can cry and even go to pieces. There is someone here for me". She responded affirmatively to my comment that she seemed to be a woman who had always been in control of her life, a control that had now escaped her and caused great distress She laughingly affirmed this characterization of herself. When asked what thoughts and memories of her past came to

[4] It can be viewed on an edited DVD (Viederman, 2010).

mind as she considered this need to control her world, she reflected on and spoke of her mother who had been passive, dependent, a woman who "seemed unable to balance her checkbook". When I wondered whether it was important for her to be different from her mother, she responded affirmatively. "Because she was that way I wanted to be different" As we pursued this theme, it became apparent that her concern about control crystallized around the feeling that she could not control health. "Had there had been illnesses in the family?" I asked. Gradually, what emerged was the patient's experience with a mother who had a long history of medical problems—tuberculosis before the patient was born, repeated bouts of pneumonia, a hysterectomy during the patient's adolescence, and later, shock treatment for depression. I responded with a smile and a simple "hmm," and she laughed, recognizing how upset she had been by her mother's illnesses, frailty, and vulnerability. Gradually it began to dawn on her, with increasing emotional intensity, that because her mother was fragile, it had been important for her to be different from the mother. Her current situation, with her husband as a primary focus of attention, so much resembled her mother's situation, and this disturbed her. "Thank you so much. I never would have thought of that!"

In the third session she enthusiastically commented on how profoundly she had been affected by the emotional recognition of her fear of being like the mother and the need to be different. A few days before, while waiting impatiently for a repairman, the patient had a sudden insight that she described enthusiastically. Her impatience was related to her mother's expectation that she (the patient) had a wonderful home and that she should stay at home. This idea was so contrary to her sense of self. She continued with enthusiasm "I have been able to figure this all out all by myself. This is great! So thank you". Her expression of gratitude reflected the sense of autonomy and control, and the fact that I had given her the tools to do this by herself, so important for a woman who needed control. The patient when on to discuss the tension she had felt before a dinner she planned with her younger daughter the week before she requested our consultation. The daughter had been bothered by the patient's expression of distress and vulnerability. "She needed me to be strong—I had the feeling that I couldn't fall apart. Who was there for me?" These were the precise words she had used in the second session as she discussed the relief she had felt after our first meeting. Her relationship with her mother had deteriorated, and when she realized that this would not be true with her daughter, she felt liberated. They had a wonderful time.

Given the patient's improvement and her obvious resilience and coping

ability, I suggested that we might terminate. She thought it reasonable and reassured herself that she could call me. She became tearful as she wondered how people could "handle such situations alone". I reminded her that she had expressed her concern about being alone during our first meeting and suggested that my presence had muted her anxiety. She reflected on this and realized that since we had been meeting, she hadn't even thought of being alone. "That's pretty good", she said, shaking her head up and down with a smile.

One month later the patient wrote, stating that things were going well. "As well as could be expected". She was reassured that I was "only a phone call away". The letter ended with the salutation "fondly".

A follow-up eight months later, after her husband's death, revealed that she was experiencing a normal grief response. Of particular interest was an event that had occurred during the memorial for her husband when her older daughter, with whom she had had a conflictual relationship, had spoken of the devoted care that the patient had bestowed on her husband. Everyone had commented on how wonderful the eulogy had been, yet the patient was disturbed and puzzled to find herself angry. "My daughter had stolen the show". When encouraged to reflect on this experience, the patient remembered that she had been an only child "the apple of my parents' eye". When this daughter was born, she became the center of everyone's attention. The patient was surprised to realize that displacement by this daughter had been the source of ongoing conflict with her. "It's not so good to be in competition with your own daughter."

This patient illustrates two separate therapeutic effects. Her description of relief after she left our first meeting ("Now I have someone to talk to") related to my "presence", the development of a benevolent transference. It was only as the second session continued that she recognized the power of her mother's constraining expectations and her fear of identifying with this mother. Her reaction to termination permitted an interpretation of the dependent transference that had developed in this brief therapy. She acknowledged that she "had not given a thought to the fear of being alone since she had been seeing me. That's pretty good isn't it" she said with a laugh.

Patient Number 3

This patient illustrates the evocation of a benevolent transference in a patient who had sought such a figure since childhood and how the development of this transference undid long-standing traumatic symptoms.

The patient was a 65-year-old married father of one, a writer, referred

because of a long history of distressing symptoms. He would awaken with extreme anxiety and would clench his arms across his breast, as if to protect himself. He would be flooded periodically with painful traumatic memories of his father's beatings, and those memories would dominate him for hours. He had an anxiety disorder with elements of posttraumatic stress.

This man was intelligent, articulate, and spontaneous. He told his story coherently, as if pressured to spell it out. The dominant theme had to do with physical and psychological abuse by a violent father and a mother who constantly denigrated him. His story was one of a relentlessly unhappy childhood. "Important" was a theme that developed early in the consultation. A psychologist friend had asked him whether there had ever been an important adult in his childhood to whom he could turn for comfort and reassurance. The patient had always been painfully aware of the absence of such a person in his life. His world had been dominated by hostile insensitivity to his needs. A prototypic experience characterizing his deprivation was his attachment as a three-year-old to a complicated set of blocks with which he played that afforded him a sense of his own intelligence and mastery. His father had taken them away and given them to a cousin, totally indifferent to the painful loss experienced by his child. The patient's early adult life had been dominated by an angry sense that people to whom he turned betrayed him. A psychologist at college had been indifferent to him. Teachers, doctors, all had let him down. Yet his adult life had evolved in a different way. The patient married late to a very beautiful woman, now an active professional who was caring and loving and whom he loves profoundly. A son, with whom he has an excellent relationship, was now a student at an Ivy League college and doing extremely well. His writing career has been successful but had not been a source of great pride. He now described his enthusiasm about the process of finishing a play about his own life.

An anecdotal description can not convey the subtle nuances of the relationship that evolved during our contact. He was a likable man and it was easy to respond to him. I echoed the descriptions of his experiences, acknowledged the extreme pain that he suffered. I commented on his play as an attempt to develop a coherent narrative of his life. At the end of this first session he asked if it was OK to show me a photo of himself and his wife when they were young. I commented on the beauty of his wife and the fact that they were a handsome couple.

When the patient returned the following week he attributed the diminished anxiety and the absence of traumatic memories on awakening

that morning to the fact that he was coming to see me. He had finished his play. He was aware of his hopelessness and self-loathing, especially for not having confronted his parents when he remembered and re-experienced events from his traumatic past. I suggested we examine the context in which the traumatic memories reemerge. Recently, the patient recalled he had seen a film in which a boy had been rescued from a painful past by an older person. He was jealous and resented the fact that he had not had this experience. Yet, he described a wonderful married life. His only regret was that he had burdened his wife with his traumatic past. I reminded him that he had told me of happy moments as well and how he experienced relief when he spoke to his wife of these traumatic episodes. In response to his concern that he had wasted much in his life, I commented on Freud's adage of love and work [Freud, 1930]. Certainly he had experienced love, and even satisfaction with work.

The patient returned a week later to say that his anxiety was almost absent in the morning and that he had had no painful evocations of traumatic memories. It had been enormously helpful to be able to talk so openly to an "older, compassionate person" who had listened to his story. He said he had this strange feeling that I was a friend. I reminded him that he had spoken when we met of the absence of an older person in his childhood who was responsive to him. He repeated his sense of me as a compassionate, interested person who liked him and gave him the feeling of well-being and reassurance. Very important was the sense that I respected him. Before he came for consultation he had thought that he would have to go over all the painful details of his life to have a witness to his experience. He now found that it was not necessary. He could go on by himself but was reassured that he could call me at any time. One month later I received the following letter from the patient.

> *Dear Dr. Viederman,*
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> *I want you to know how grateful I am for the time I spent talking to you. You are a kind and compassionate man, a man of great knowledge and wisdom, and I was lucky to have been referred to you. Though we spent only three sessions together, I benefited from them a great deal more than I can say and I take comfort in knowing you're there, if I need to speak to you again.*
>
> *My deep gratitude.*
>
> *Sincerely,*

One year later I receiver a New Years card from him again expressing his gratitude to which I responded in a note by commenting on the fact that our relationship continues even though we do not see one another.

The experience with this patient illustrates how the establishment of a benevolent transference may be useful in situations of chronic difficulty, when the therapeutic relationship fulfills a very special, long-standing need. The therapeutic experience with this patient led to a "corrective emotional experience" although not in the sense of a contrived transference stance by the analyst (Alexander, 1960). At the age of 65 the patient had found a long-wished-for benevolent and loving parental figure that he craved. Thereby a precise and specific need was fulfilled. Symptom relief followed. This experience coincides with, but goes beyond, what Orenstein and Orenstein (1977) called the "curative fantasy". They suggest that a patient in crisis approaches a physician with the unconscious wish to find an omniscient and omnipotent person to protect them him/her from danger. One may also view this change from the point of view of a transference cure (Oremland 1972), in which the patient relinquishes symptoms in order to be loved by the therapist. More pertinent in this situation was the experience of love rather than a plea for love. I speculate that the writing and the completion of his play was a symbolic event, akin to crisis that pushed the patient to seek consultation and offered the potential for a transformative experience.

Patient Number 4

This patient illustrates a situation in which a person, unable to engage in a meaningful therapy over many years, suddenly became available psychologically in the context of a changed reality that activated early vulnerability and fantasy wishes.

The patient, a 59-year-old woman had been referred 15 years earlier for treatment of anxiety generated by the discovery and treatment of a lymphoma, now successfully cured. She was an unhappy woman in an unfulfilling relationship with her religious Jewish husband, and she had two adopted children. The son was extremely aggressive and difficult to control and the daughter had difficulty at school. Unlike the situation with her son, the daughter's attentiveness and dependence were sustaining and gave the patient her only relief. Her work as a part-time teacher in a Hebrew school was unfulfilling. Our contact had been infrequent and was often by telephone since she lived in a distant suburb.

She called one day in extreme distress. Although her son had continued to be aggressive, he was now in Israel and seemed to be doing slightly better. What distressed her was a changed relationship with her daughter. The patient had been extremely pained a year-and-a-half earlier when the

daughter left to enroll in a religious school in Israel. Here she had fallen under the influence of a young teacher who encouraged her to marry early. Arrangements were made for her to marry one of the many children of a rabbi in her community. The mother was very unhappy with the marriage, which had occurred a few weeks before she called. Worse was the change in the relationship with the daughter, whose daily telephone calls had almost ceased. Furthermore, the daughter's insistence that she live her own life with less intrusion by the mother was experienced by the patient as a painful loss. During an argument with her daughter she discovered that her children spoke about how invasive she had been in their lives. The patient was enraged, despaired, and felt terribly alone. I encouraged her to pursue thoughts about a similar experience in her past; she spoke of her father's death when she was 13. Her father had been very aggressive, and her mother very unhappy. I commented on the similarity to her own experience with her husband. After the father's death, the patient developed an extremely close loving and attentive relationship with her mother. The patient called her every day, just as her daughter had previously called her.

The patient reported she felt considerably better the following week. She had been struck by my comment about her experience of loss, and she remembered when she had been in chemotherapy so many years before, she had experienced much happiness in having a daughter and desperately wished she would live to see her daughter married. It was ironic that marriage had resulted in the loss of this daughter who had been central in her life. Their relationship had echoed her experience with her own mother.

When the patient called one month later for a brief telephone follow-up visit, she revealed she felt immensely better and that for the first time in her life realized how much her early life experience had affected her. She had spoken to her son of her terrible sadness during the Jewish holiday, Succoth, and revealed her distress related to her inability to conceive a child. He responded by revealing his pain at being an adopted child and not the natural son of his father, thereby being unable to carry on the Cohen tradition, a position of special respect in the synagogue. A similar revelation to her daughter about her early experience touched the daughter, who then affectionately opened her house to the patient on the Friday night Shabbat. The patient had never before revealed anything about her private world to her children. She ended the conversation by thanking me for "caring".

DISCUSSION

The approach elaborated above is to be contrasted with the multiple brief, psychodynamic psychotherapies that have been described by Mann (1982), Davanloo (1980, 2005), Malin (1973), Malin & Sifneos (1972). One might view these therapies as variations of an active more traditional analytically oriented psychotherapy. Of the more recent brief therapies, Interpersonal Psychotherapy (Weissman et al., 2007) is the one that in some ways approximates my approach but in most respects is different. It addresses four external life events; bereavement, role disputes, role transitions and interpersonal deficits but is thereby more limited in addressing only a few of the infinity of events that may provoke a crisis. Interpersonal Psychotherapy is well structured with defined phases and goals over the course of the treatment and lasts from 12 to 16 weeks with beginning, middle and end phases. It does not define the therapeutic relationship as a central part of the therapeutic experience as does the approach described above.

In elaborating this view of the use of "benevolent transference" for change, I realize that I am treating only one aspect of human behavior and experience. I am dealing only with what Schafer (1970) calls the comic view of reality, thereby ignoring the romantic, ironic, and particularly, the tragic view of human experience that encompasses pain, disillusionment, and the eventuality of death. "The comic vision seeks evidence to support unqualified hopefulness regarding man's situation the world. . . . It sees conflict as being centered in situations and being eliminated by effective manipulative action" (Schafer, p. 281). It is essentially the view of life that suggests the fairytale inevitable happy ending. Certainly life is more complicated than this and other patients require other psychotherapeutic endeavors. Yet in pursuing the course that I took in the situations I describe, I evoke the hopeful, wishful and positive inclinations that are part of the human experience and utilize these possibilities in the service of relieving distress.

SUMMARY AND CONCLUSIONS

A therapeutic approach designed to evoke and crystallize an unconscious benevolent transference that provides a "background of safety" (Sandler, 1960) is elaborated. This is especially useful for patients in acute crisis generated by reality events that disturb psychic equilibrium and evoke early painful vulnerabilities. What distinguishes this approach from others is the primacy placed on the therapeutic relationship as a therapeu-

tic aim and as a "curative factor" in its own right and not simply as a substrate for the trusting relationship necessary for all analytic therapies. Methods designed to achieve this goal are presented. The therapist's aim is to establish himself as a presence in the patient's world by actively communicating his/her understanding of the patient's current experience throughout the encounter. In this respect the therapist is reciprocally recognized and enters the patient's world. This does not obviate the use of an interpretive stance when useful in appropriate patients.

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