Why Psychotherapy Works and Why Psychotherapy Fails

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The path toward beginning psychotherapy is strewn with obstacles. Unfair, since the reason that people seek psychotherapy is that their lives' paths have been strewn with obstacles and they need help getting around them. Why does this happen and what can be done about it? How can people find the psychotherapy help they are seeking? What makes psychotherapy work? How can psychotherapy fail? These are the questions addressed in this chapter. First let's address the most basic question: Does psychotherapy even work?

Does psychotherapy work?

The answer to this question is that the evidence is overwhelmingly a resounding "Yes." Psychotherapy works. One of the arguments made by managed mental health care is that there is no proof that psychotherapy actually works. This is often used as a justification to approve only a few sessions or deny mental health services all together. Research is showing consistently that psychotherapy works. However, even the remote possibility or uncertainly about whether it works adds to the confusion and skepticism of the general public and people actually considering psychotherapy. The general public has fears and doubts about whether psychotherapy actually works.

Psychologist researchers have conducted many studies showing the value of psychotherapy. Different types of studies draw the same conclusions. For example, two volumes of well-designed research studies, edited by psychologist Dr. John Norcross, contain reviews of studies which clearly demonstrate the therapeutic importance of transference, countertransference , resistance, and the repair of therapeutic alliances or "working relationships." (See Chapter 3) Many of the studies reviewed in these book chapters show links to specific psychotherapeutic outcomes.

Psychologist Dr. Jonathan Shedler and colleagues reviewed and analyzed hundreds of studies and demonstrated that psychodynamic psychotherapy is extremely effective. In fact, psychotherapy that included aspects of psychodynamic psychotherapy is more effective than those that do not include those aspects. (https://www.apa.org/pubs/journals/releases/amp-65-2-98.pdf and jonathanshedler.com)

Psychodynamic psychotherapy is defined as psychotherapy that includes the following features (which are discussed in Chapter 3 of this book):

1. Focus on affect and expression of emotions (instead of behavior or intellectual thoughts)
2. Exploration of attempts to avoid distressing thoughts and feelings (including defenses, resistance, the unconscious)
3. Identification of recurring themes and patterns (transference , countertransference, reenactments)
4. Discussion of experiences with developmental focus (looking at how the past has helped to form the present)
5. Focus on interpersonal relations (object relations and attachment)
6. Focus on the therapy relationship (the patient-psychotherapist relationship)
7. Exploration of fantasy life (dreams, desires, fears, daydreams) that is put into words and brought forward rather than trying to reduce its presence or learning to think about something else.

Even the popular press understands the importance of the unconscious and the role that it plays in everyday life (deBecker, 1997; Gladwell, 2005; Duhigg, 2012; Mlodinow, 2012). This is a different psychotherapy than getting advice, modifying thoughts, having steps or tasks to complete in order to make changes in behavior, or chatting, although behavior is still very important. This type of psychotherapy gets to the heart of matters that are of concern. Emotions and how they are recognized (or not) and expressed (or not) in various ways are the focus of this work. It takes a well trained and experienced psychotherapist as tour guide and a dedicated patient to do this work. But it is worth it, and the research data support this conclusion.

So yes, psychotherapy works. Psychologist researchers are conducting more and more evidence -based studies to demonstrate that psychotherapy works. Good news, because in our country there is an incredible need for it. Depression is the number one health care cost for employers, with anxiety just behind it. But direct health care costs aren't the only concern (APA, 2011). These and other behavioral health conditions also have hidden costs, decreasing productivity and increasing sick-day use, for example. Another statistic is that approximately 40 million American adults ages 18 and older, or about 18.1 percent of people in this age group in a given year, have an anxiety disorder. (NIMH)

The psychotherapist's contribution to why psychotherapy works and why psychotherapy fails.

How does one tell what should and should not be expected from a psychologist? There is some discussion in Chapter 1 of this book about whom to trust. There are some basics that are mandatory for the psychologist: being kind, responding to feedback about how the psychotherapy is working for the patient, not being chronically late to or regularly canceling client appointments, and being too aggressive or not being assertive enough in response to the patient's requests about what they need. The book How to Fail as a Therapist: 50 Ways to Damage your Patients by psychologists Drs. Schwartz and Flowers can be used as a checklist by patients well as psychotherapists. However, these sorts of errors are in cognition, problem solving, or thinking. These are, if you will, easier types of errors. The more difficult errors, just as is true with the more difficult aspects of psychotherapy, are those related to feelings and the unconscious in the psychotherapist (see Chapter 3). This is the part of psychotherapy that is the most demanding of the heart and soul of a psychotherapist. In most cases, making errors, if they are addressed and corrected, does not have to mean a failed psychotherapy. The psychologist has to be willing to recognize and self-correct and acknowledge errors to the patient, so that they can continue to work together.

Most important, the working relationship, the "therapeutic alliance", between the psychotherapist and the patient, is the key to successful psychotherapy. This point seems obvious, but it has been called into question by managed care and insurance companies seeking

to reduce benefits and shunt patients to providers of their choice. The psychotherapist is the partner, guide, mirror, cheerleader, improved parental figure along the road of crisis resolution, anxiety reduction, self-understanding, fulfillment, and other sought-after goals. Again, this seems obvious, but some approaches to psychology, such as strict behaviorism (You have probably heard of B.F. Skinner) and some cognitive behavioral psychotherapies, minimized the importance of the relationship in the past. Psychologist Dr. John Norcross edited a 400-plus page book, Psychotherapy Relationships that Work, in which he reviewed thousands of research studies showing, for example, the importance of different aspects of the patient psychotherapist relationship. This includes how the psychologist deals with transference and counter transference, resistance, impasses (particularly difficult parts of the process) in psychotherapy, and the need for empathy on the part of the psychotherapist, to name a few. This is precisely what managed care disrupts, which has negative implications for the outcome of psychotherapy. (See chapters 3 and 10 of this book.)

Psychotherapy is hard work for the patient and often for the psychologist. Patients often present with difficult circumstances which require not only background education, skill and insight as a psychotherapist, but tolerance. Transference is very powerful and it can be an important tool, an annoying distracter, or it can completely get in the way of psychotherapy. It is the job of the psychologist to attempt to use it as a growth enhancing tool. If you will remember, from Chapter 3, transference is exactly what the word means. The feelings or behaviors from one situation or relationship are “transferred” onto another situation or relationship. This can be seen in feelings or behavior or both. It can be very powerful. Some patient stories are heartbreaking, terrifying, hard to hear, or evoke a reaction, or countertransference (see Chapter 3), in the psychotherapist. We as psychotherapists run the risk of missing important information or not hearing what the patient needs or is saying if we get too caught up in our own transferences. It is our responsibility to deal with our own feelings which occur as a normal part of working with patients. And since research conducted by Dr. Andersen and colleagues (2006, 2007) has shown that transference is real and that the unconscious is very powerful, it is also helpful to have backup and input from others doing the same work.

Negative transference from the patient, as discussed in Chapter 3, can be annoying, disruptive, infuriating, and a whole host of other feelings. Being able to hold steady as a psychotherapist, and stay with the patient (if the patient is willing to do so) to work through negative transference can be a real challenge. This means working through impasses where the psychotherapy seems to have stalled, which also is a real challenge for the patient and the psychotherapist. It all requires a leap of faith by the patient. Of the patient and the psychotherapist, the latter is really the only one who knows that there is life on the other side of the leap. Patients have not seen yet the possibilities of who they can become. For a period of time, the psychotherapist is the one who holds the key to the patients' dreams. On the other hand, glowing positive transference, when the psychotherapist is idealized and put on a pedestal, may be enjoyable and flattering, but it is unrealistic, does not contribute to the patient's growth, and can also be difficult to work through. Learning to deal with transference and other aspects of the unconscious is very important for success as a psychotherapist.

Not knowing how to help patients get past their resistances, which are often, but not always, unconscious, is also a way that the psychotherapist can contribute to the failure of psychotherapy. Resistance is not the "fault" of the patient and it is the responsibility of the psychotherapist to guide the patient through overcoming it. Our defenses, such as resistance, protect us from stress and help to keep us alive. They are unconsciously and brilliantly constructed to do so. We all have them. We all need them. It makes absolutely no sense to say that someone is "defensive." That is, until they get in the way. They may have protected us, and done a good job of it, but in time we may no longer need them. Then they can stop us from growing and reaching our fullest potential. As working resistances through is part of the core work of psychotherapy, they can get in the way of growth in the process too. It is hard work to help patients see that it is not that they are finished with psychotherapy, or that the psychotherapist is not incompetent, but that they can go further than they have ever been before or can imagine going towards achieving their life goals. They can work through what feels like being "stuck," and it is worth it to keep going. Psychologists are responsible for our own resistances so that they don't get in the way of helping the patients with theirs.

Does training matter?

As a practicing ("licensed") psychologist, this is a question that comes up all of the time. What is the difference among all of the myriad people calling themselves psychotherapists and does it even matter? As a researcher, my first inclination is always to look at the literature. What have others written on whatever topic it is that I am trying to better understand? Did someone else already answer the question? So, I did that first.

The descriptions of the various mental health professions that I read about do not seem to me that they would be of help if I was a consumer, looking for psychotherapy for the first time, perhaps in a crisis, or at the very least under a lot of stress. The descriptions of the different professionals basically all say the same thing: They describe the training and then conclude with the type of psychotherapy that the professional is qualified to do. Are they? And by whose standards? How, as a consumer, would I ever be able to sort through all of this information? And why would anyone trust my conclusions over someone in another profession? I certainly wouldn't be able to do it. *And what makes me right?* So, now what? If I am writing a book on psychotherapy, part of my job is to answer this question: Why was training to be a psychologist to do psychotherapy the best choice for me? How can I convey that to the public?

I decided to use my own experience as a basis for discussion here. For me, as for the rest of us, this is from where my opinions originate. I try to be "objective" but I, like everyone else, make my own choices based on what I perceive to be the important facts and issues. In this case, I chose to go to graduate school in psychology because training as a psychologist, rather than as a social worker or as a nurse, seems more directly relevant to being a psychotherapist.

Getting accepted into graduate school in psychology is very competitive, and after acceptance into a graduate program, the road to completion is challenging and long. I had to take additional coursework and get an extra, not-particularly-wanted Master's degree before I got accepted. This is not totally unusual, although not everyone has to go to these lengths. The classes in psychology graduate school are small, typically eight to 10 students, and the attention received from professors is personalized and intensive. It took a long time (seven years). This is

fairly typical, in that psychologists have earned at least a doctorate (Ph.D., Ed.D., Psy.D.), which usually takes between seven and eight years. This means that psychologists earn a Master's degree and then study several years longer in graduate school to earn a doctorate degree. I was required to select a specific topic (pediatric diabetes), and design and complete a research project under the guidance and examination of a committee of four professors. This allowed me to put my broad and general psychology foundation to work, using the example of a specific problem. Then I could apply those skills to other topics about which I wanted to learn more as I developed and expanded my career. I acquired significant debt along the way, and I gave up years of youthful fun in the service of getting trained. It was a big sacrifice, and I still believe that it was worth it.

The courses offered in psychology graduate school seemed to be a better preparation for me to do psychotherapy than courses on community relations and resources, adult and child welfare, case management, casework, administration, or nursing, discharge planning, and community outreach, all of which are incredibly important. Part of the appeal for me of getting trained as a psychologist was also that psychologists are the only professionals trained and licensed to give standardized psychological evaluations which can provide details about diagnosis to help with psychotherapy (see Chapter 1). I learned a lot from doing these evaluations when I was on a Child Study Team and it still helps me to tailor psychotherapy and find the right services for my patients. (Please visit my website drpeggyrothbaum.com, under writer to see When to Refer Pediatric Patients for Neuropsychological Testing). Although some social workers now get doctorates that focus on psychotherapy rather than community relations and resources, adult and child welfare, case management, casework, or administration, earning a doctorate in psychology still seemed to me to be the most direct and thorough route to reach my goals.

By training as a psychologist, I built a thorough foundation in different aspects of development such as social, emotional, physical, intellectual and learning processes, memory, language development, behavior, and family and other relationships, health psychology, and problem solving in addition to those on mental health, psychotherapy, intellectual and

personality testing, to name a few areas of clinical work. Learning about the entire lifespan--from infant to child to adolescent to adult--was included in my training.

Building on this foundation, I expanded my training and practice to include coping with chronic illnesses, recovering from trauma and abuse, and managing learning and neuro-developmental difficulties (ADD, ADHD, various learning differences). This is in addition to my more general areas of practice such as coping with depression, anxiety, and stress. Please visit my website drpeggyrothbaum.com for more information. Having this solid foundation allows me to look at the big picture of what patients bring into my office. Specific topics were not taught separately from a foundation of general principles. For example, I don't see sensory integration, social skills, parenting, adolescence, obsessive compulsive disorder, insomnia, panic attacks and other issues as separate issues that stand alone. Rather, they are part of a whole picture of a person's life, which must be integrated to allow for greater understanding, to give a full, thorough, more complete understanding of the patient's life and to produce holistic solutions.

I experienced the difference between having a Master's degree and a doctorate when I was in school. In graduate school, I decided that I wanted to do research as well as psychotherapy when I graduated, so I needed to get some additional training. While I was earning my Ph.D. in psychology, I earned a Masters (Ed.M) in Educational Statistics and Measurement. It required 30 hours of additional coursework. I would have loved to continue on to earn the doctorate, but financial and time constraints would not allow it. I knew many of the students who were continuing on and one fall semester, as I was taking one of my last classes, many of them were in the same class. But they were also taking courses working toward the doctorate at the same time. I remember that about half way through the semester, they were already so far ahead of me. They had learned things that I had not learned, and in fact still haven't learned, and they understood the coursework in much more depth. It was obvious to me, at that early date, that there was a significant difference between my Ed.M. and their Ed.M. plus Ed.D. I fell behind quickly. It still makes me somewhat sad that I do not have all of the skills that I need for my research projects.

Another way that I learned firsthand about the ways in which the differences in training matter was actually through my experience as a psychologist. I decided that I wanted to focus on development throughout the lifespan, not psychopathology or mental illness. So, I earned a doctorate in developmental psychology, as opposed to clinical psychology, and thus had to do extra coursework to get licensed as a psychologist. I like the perspective that I chose and I like looking at issues that the patients bring into psychotherapy as part of development: They are normal given the circumstances of the patient's life and can be "caught up" and healed. This has positioned me well to work with various types of trauma, patients with learning disabilities, neurological impairments, and chronic illnesses. I love this kind of work.

However, as a result of my training, there are also gaps in my knowledge which limit the way I practice and what I feel competent doing. I have no experience working on an inpatient psychiatric unit. I have no training in substance abuse. I have very little training in adult assessment and adult psychological evaluation (although, as I mentioned earlier, I was on a Child Study Team for a year and a half). I have not worked with patients who have made suicide attempts in the past. I recognize these limitations and do not work with patients in my practice with these issues. I have other strengths and recognize what I cannot do. I suppose that if I went back to graduate school or took more courses at a training institute that might help. But I am happy this way. Further, I am fortunate to have a supervisor (see below) who has expertise in those areas that I do not, and can provide guidance when necessary. In addition to all of the unconscious material that the patient and psychologist bring into psychotherapy, there is the intellectual competence that is required by the psychologist. Having expertise and recognizing when one does not have it is crucial.

Earning a doctorate is a good start, but continuing education does not end. After the two year required supervised hours after a doctorate, I continue to this day with weekly (paid) supervision by senior psychologists and take continuing education courses. My first supervisor--who taught me a lot of what I know and still use as a psychologist today--and I worked together for 10 years. She was the best imaginable fit for a fledgling psychologist. I then worked with three others before finding the best fit with a senior psychologist for my current professional level, and we have been working together for 13 years. I cannot image doing psychotherapy

without individual supervision, as well as the two or three peer groups with other psychologists that I attend monthly.

I believe that I made the right choice in terms of being the most effective psychotherapist possible. Training matters. Type, length, breadth, and content of training matter.

For more information on what psychologists do, how we are trained, and on psychotherapy, visit:

http://www.apa.org/helpcenter/about-psychologists.aspx
http://www.apa.org/helpcenter/therapy.aspx
http://www.apa.org/helpcenter/talk.aspx
http://www.apa.org/helpcenter/psychotherapy-works.aspx
http://www.apa.org/education/grad/faqs.aspx

The patient's contribution to why psychotherapy works and why psychotherapy fails.

The failure of psychotherapy can be caused by the psychologist, the patient, or a combination of the two. First, it can fail if the patient is so overcome with fears that he or she cannot bear the thought of calling a psychologist to get started in psychotherapy. I often have new patients tell me that they got my name from their doctor a year or so ago. It is really hard to take that first step and make a call and then to make an appointment. People often feel that there is something wrong with them, they cannot be helped, or that they will end up in a hospital. These and other fears are quite common, although each person feels alone in having them. In my experience, the vast majority of the time, things are not as bad as you think they are.

Let's say you choose insight-oriented psychotherapy (See Chapter 3). How can this fail and how can it succeed?

My new patient, Mary, has had many previous psychotherapists. She was severely traumatized as a child, and she says that one of her previous psychotherapists was nice, but didn't know what to do to help her. Another one was "freaked out" by what was done to her.

This reaction, countertransference, (see Chapter 3) and can happen and can be a problem if psychotherapists either do not have adequate training or do not have sufficient backup, such as “supervision” with a peer group or a paid experienced senior psychologist. In time, this patient told me something that was, quite frankly, disgusting. I told her, “You didn’t do it,” but I was bothered by what she said and talked to my supervisor. My supervisor helped me to gain a fuller perspective and to help Mary, but it could have so easily gone a in a different unhelpful direction.

Many patients, particularly traumatized patients, often have multiple failed psychotherapies. This may have happened to you. If this happens, it is harder for both the patient and the next psychologist to be successful. This can create further emotions of anger, despair, and disappointment in patients, particularly trauma survivors. Survivors can feel like their worst fears are being realized and they really are “a hopeless case.” Repeated failures also can lead some psychotherapists to decide that trauma survivors and people with BPD are untreatable. Sometimes this is because they have behaviors that interfere with treatment (see Chapter 6), such as making too many demands, being rude to the staff, or refusing to follow recommendations. Thus, the responsibility for successful psychotherapy lies with both the patient and the psychologist.

In addition to aspects of the psychotherapist's training and competence level, each patient makes a contribution to the success or failure of her own psychotherapy. See Chapter 6 for a discussion of behaviors that interfere with treatment. Basics such as showing up for appointments, minimizing self-destructive behavior, not making demands on the that are outside of the boundaries of what is being offered (phone calls, repeated requests for duplicate bills, calling the psychotherapist at home, to name a few), paying on time, and not being verbally abusive to the therapist are a few examples. Patient contributions to the failure of psychotherapy are often hard for policy makers, employers, and the public to understand. Why would someone apparently sabotage their own treatment, especially if they are claiming to want and need help? Transference, resistance, and other unconscious concepts are challenging to the uninitiated and do not necessarily make sense. Managed care companies, not understanding and not caring as they wish to save money, often become punitive, looking for excuses to cut benefits. It is a

delicate and difficult balance for patients between personal responsibility and the unconscious that they cannot or do not wish to recognize or legitimize.

Psychotherapy can fail if the patient's resistance is so strong that the patient is committed to repeating or reenacting the same scenario over and over again. For example, repeatedly cheating on lovers or being overly critical about small quirks will probably result in the relationship ending. This can then be perceived as proof that nothing will work out and that the patient will be left alone. If the psychotherapist is able to help the patient see the pattern and take responsibility for it, psychotherapy has a better chance of succeeding. But even with a competent psychotherapist, the patient may prefer to continue the pattern, believing that they are right. As my mentor says, "Just because it is a perfect transference doesn't mean that you can do anything about it." The patient has to help.

Psychotherapy can also fail if you, the patient, are looking for a quick, easy, cheap fix. Just as it took time for you to accrue your traumas, painful memories, worries, difficult experiences, losses, dashed hopes, dilemmas and questions about life, mistakes, and other experiences, it will take time to solve them, work them through, and come out on the other side. Our society wants a quick, easy, cheap fixes for everything. We want it NOW. We don’t want to have to put in the time or the money. One of the fears about psychotherapy that looks at the past is that it will be endless (see Chapter 2). We all certainly know those stories. But my motivation to work with you towards your “graduation” from psychotherapy begins as soon as you walk in the door of my office. My goal is to do your psychotherapy with you and get you out so that you can go on with your life. You can always come back, and I will be flattered if you choose to work with me again in the future. I realize that it is might take longer than you want it to take. But if you stick with it, past all of the bumps, resistances, and impasses, you will be rewarded with a richer and more peaceful inner life and the ability to better meet your goals. It’s likely that before we met, you would have tried several short-term quick fixes and found that they did not work. If you think about all of the other tasks in your life, when you did them thoroughly and did them well, that produced a better outcome. You may have had to try more than once. This is also true of psychotherapy. On the other hand, keep in mind that sometimes psychotherapy is short,

and that this may not necessarily be the same as a quick fix. That might be all that is necessary for you to feel that you have reached your goals.

Below are some examples of difficulties that can happen in psychotherapy and how they can be worked through by the patient and the psychotherapist together.

Sylvia was physically abused as a child. Her father hit her and her siblings, sometimes with his hands, sometimes with a belt. She was a single parent for several years, with two daughters and one son. It has been important to her not to be abusive to them in any way. She is currently in a second marriage, having left the first husband who was irresponsible financially. The second husband is basically a good man, but he was raised by a cold, distant mother and an often-absent father. No surprise, he has some temper issues. A couples psychologist, in response to my patient's statement during a session that her husband was verbally abusive to her, said, "Abuse is a form of caring." Can you imagine? I opened my door to see my patient sitting in my waiting room shaking, waiting for me to reassure her that this statement was wrong. I was furious! I implored both of them to let me try one more time to find them a psychotherapist who could help them. I apologized for the inept referrals that I had made. I talked about how important they were to me. It went much better. They did well. My patient and I spent a fair amount of time in our sessions talking about forgiveness. What does it mean to forgive and give another chance? No one in her family had ever apologized for anything and they had certainly done things that were not easy to forgive, if at all. My patient was able to see that this was a possibility that she had never considered before.

Much earlier in my working relationship with my patient, I had been talking with her about respecting my office policies and my work boundaries (see Chapters 5, 6). She paid me late and cancelled frequently. First I dealt with it on a surface, cognitive, behavioral level. This was what I could offer. I am running a business. I am only one person. But I also wondered with her if there were any situations where her own boundaries had been violated and if there had been attempts in her life by other people to try to pressure her into doing things that she could not do and that she had already said that she couldn't do. After working on these issues for several weeks, during which the behaviors continued, she finally started to cry. She said that she

had no idea what I was talking about, but that she respected and trusted me enough to assume that I was trying to tell her something important. She wanted me to explain it again.

A leap of faith.

She understood and changed her behavior. Then the "real" work began. She began to think about and describe what it had felt like growing up with a father who did not respect her boundaries. He did not respect her physical boundaries in that he hit her. It didn't matter that it hurt or that it was wrong, he did what he wanted to do. As we worked together, we explored the possibility that she had married two abusive men--although they did not hurt her physically--as an unconscious reenactment of her childhood experience with her father. It was such an impressive accomplishment that she was not abusive with her own children. However, as reenactments often go, to try to be different she was sometimes too lenient with her children, especially her son, just as her father had been with her brothers. She also observed that sometimes she was too harsh and critical with her daughters, replicating part of her childhood experience.

We began to pay attention to her feelings when dealing with her own children. Under what circumstances was she too lenient or too harsh? What happened? Then what happened? How did she feel at the time and then afterwards? When was she able to perceive her impulses and catch herself from acting on them? What did her children say and feel? What could she do differently? How did she then feel? How did that affect her relationships with her children?

We also turned our attention to how these scenarios played out at work. Who tried to push her to do things beyond her assigned responsibilities? How did that happen? Who was discourteous to whom at her job? How could she set limits and boundaries while still fulfilling her responsibilities at her job?

As we worked, my patient gained more and more insight into her feelings and how they affected her behavior. Her feelings changed and she was calmer and more self-assured. She didn't feel like a victim or like her life was out of control. Her self esteem improved. Her

relationships improved. She was more successful at her job. By connecting the past with the present, we changed the future. By directly addressing her feelings, she was able to recognize her impulses and change her behavior.

In another example, Joanna had multiple surgeries as a child due to a serious car accident. She was in the hospital for days or sometimes weeks at a time. Her parents felt helpless during these hospitalizations, and reduced their own stresses by buying Joanna lots of gifts and treats. They also had to take a lot of time off work without pay. They never really managed their money well, and by the time that Joanna was a teenager, they were deep in debt. They declared bankruptcy, but continued to accrue debt. Joanna expected to emerge from college with significant debt herself. She also found herself doing a lot of behaviors common to trauma survivors: spending too much money, having unprotected sex, connecting with boyfriends who drove fast cars, smoking, eating, and drinking too much, and other self destructive behaviors. Life had always been beyond her control, so what was the harm in doing these things? She ate to comfort herself, a habit that had been established when she was in the hospital. This in turn made her feel worse about herself, as she continued to gain weight. She felt hopeless and out of control.

Finally, as a young adult, she found herself having panic attacks and feeling depressed and decided to enter psychotherapy out of desperation. Nothing felt connected to anything until I began to wonder with her if she saw any patterns.

First, we spent time talking about Joanna's memories of being in the hospital. She had many painful procedures, over which she had no control. They saved her life, but it felt like she was being tortured. In some ways, when she felt out of control with her drinking and smoking, at least it was familiar. When she felt sick or scared by some of the risks that she was taking, that also felt oddly familiar. At least she wasn't alone with it, because sometimes she was with her boyfriend and she knew that he loved her. Joanna missed a lot of her childhood because it was interrupted by pain and medical procedures. She had trouble making friends. It always seemed that when she returned to school after an absence due to hospitalization that everyone already had friend groups established and a few of her friends had moved. She didn't know how to go

about getting herself included. She was lonely. So she accepted anyone who was available or approached her as a friend because it was better than being alone and she liked being liked. As we explored her choices, it occurred to her that making bad choices in friends and boyfriends actually placed her in a situation where she was out of control because of her own choices. The same thing was true with drinking, smoking, having unprotected sex, and other risky behaviors. It felt like she was in control and making her own choices, but in reality she was replicating the trauma of her childhood. As we examined her choice and her emotions over time, she was able to stop doing the at-risk behaviors, save money and spend her money wisely, and find a lovely non-abusive husband who completely accepted her past without judging her.

Another example is Sam. Sam is a young man whose mother died when he was five. He barely remembers her, but feels that she was very wonderful and loved him very much. She was ill with cancer before she died a slow death. His father became very depressed after his wife died. Sam was mostly raised by his maternal grandmother. He remembers always feeling emptiness inside and being lonely. After working with Sam for awhile I began to suspect that he had undiagnosed ADHD. School had been difficult for him, although he seemed bright. He had trouble keeping a job and often moved on for seemingly minor reasons. He was in and out of relationships with women. He had a sense that his constant seeking comfort and the “perfect” woman was somehow related to the early loss of his mother. He was ready to make those connections. It was hard for him to trust and believe that people would always be there for him and meet his needs. He often got angry when he felt that he was going to be abandoned or that his needs weren’t going to be met. This played out in his difficulty learning to trust me, making demands for extra time outside of the sessions that I could not meet, and learning that I did not mean to hurt him when I inquired about possible connections between his past and present or could not meet one of his requests. Sometimes we reached impasses where he felt that I wasn’t hearing him and I felt that I was out of ways to help him see that I wasn’t doing what he thought that I was doing. A couple of times it seemed like we were really stuck and wouldn’t be able to move forward. We both just kept at it until we were able to connect better and he reached a new understanding. He had a particularly tough time when I went away for vacations. He finally understood that I needed a rest just like everyone else. It had nothing to do with him or not wanting to work with him. We also came to understand how his undiagnosed ADHD affects so

much of his life. He did not want to take medication, choosing instead to learn to slow down, relax his mind, and think through all decisions carefully.

After learning to trust me through the ups and downs of our working relationship, Sam was able to transfer that experience and seek out and maintain a relationship with a nice young woman. He was able to better recognize and talk through his fears about being abandoned and alone. They still nag at him from time to time, especially when he is feeling vulnerable, but he accepts them as part of his life and deals with them as if they were a weak ankle. *Go carefully and rest from time to time.* Seek support and comfort when needed.

The courage and persistence of my patients allowed them to stay engaged in psychotherapy all the way through to the end. My training as a psychotherapist, particularly as a psychologist and particularly as psychologist who does psychoanalytic psychotherapy allowed me to do my part in these success stories.

In summary, psychotherapy can help improve coping with both feelings and behavior. This conclusion is supported by evidence that comes from working with patients and from research. Patients can learn to improve coping, including having better relationships, where there is respect, cooperation and mutual needs are met. This improved coping will likely transfer to other relationships and situations as well. Navigating through the labyrinth of available mental health professionals can feel like an overwhelming task, especially for someone already not feeling as energetic as usual. No matter what you do, select a psychologist who is known professionally to at least one person you trust. Asking a pediatrician or family physician is often a good place to start. Neighbors or friends who have been in psychotherapy can often also recommend a psychologist. And be sure to select a psychologist who has a specialty that matches your specific needs. The person suggesting the psychologist will often know about this, and it can be verified with a call or consultation appointment with the psychologist. Remember, as in any other relationship, “chemistry” or the “match” makes a big difference as to how comfortable you can reasonably feel. The work can be hard, but it helps to start on comfortable ground.

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