IMMEDIATE EFFECTS ON PATIENTS OF PSYCHOANALYTIC INTERPRETATIONS pdf

1: Yoga for breast cancer patients and survivors: a systematic review and meta-analysis

Immediate effects on patients of psychoanalytic interpretations. Garduk EL, Haggard EA. Psychoanalytic Interpretation Psychoanalytic Therapy*.*

Abstracts identified during literature search were screened by 3 authors independently. Retrieved articles were read in full by 3 authors to determine whether they met the eligibility criteria. Inclusion criteria To be eligible, studies had to meet the following conditions: Randomized controlled trials RCTs were eligible. Studies were eligible only if they were published as full paper. Studies of adult older than 18 years patients with a history of breast cancer were eligible. Studies that compared yoga with no treatment or any active treatment were eligible. Studies were excluded if yoga was not the main intervention but a part of a multimodal intervention, such as mindfulness-based stress reduction for a meta-analysis of mindfulness-based stress reduction for breast cancer patients and survivors see [19]. No restrictions were made regarding yoga tradition, length, frequency or duration of the program. If available, safety data served as secondary outcome measures. Data extraction Three reviewers independently extracted data on characteristics of the study e. Risk of bias in individual studies Risk of bias was assessed by 2 authors independently using the Cochrane risk of bias tool [18]. This tool assesses risk of bias on the following domains: Discrepancies were rechecked with a third reviewer and consensus achieved by discussion. Data analysis Studies were analyzed separately for short-term and long-term follow-ups. For the purpose of this review, short-term follow-up was defined as outcome measures taken closest to the end of the intervention and long-term follow-up as measures taken closest to 12 months after randomization [20]. Assessment of overall effect size If at least two studies were available on a specific outcome, data for this outcome was included in the meta-analysis. Overall effects were analyzed using Review Manager 5 software Version 5. A random effects model was used because it involves the assumption of statistical heterogeneity between studies [18]. SMD was calculated as the difference in means between groups divided by the pooled standard deviation. Where no standard deviations were available, they were calculated from standard errors, confidence intervals or t values [18], or attempts were made to obtain the missing data from the trial authors by email. A positive SMD was defined to indicate beneficial effects of yoga compared to the control intervention for health-related quality of life e. If necessary, scores were inverted by subtracting the mean from the maximum score of the instrument [18]. Assessment of heterogeneity Heterogeneity was explored using the I2 statistics, a measure of how much variance between studies can be attributed to differences between studies rather than chance. The Chi2 test was used to assess whether differences in results are compatible with chance alone. Moreover, subgroup analyses were conducted for current treatment status patients who were undergoing active cancer treatment; patients who had completed active treatment. If statistical heterogeneity was present in the respective meta-analysis, subgroup and sensitivity analyses were also used to explore possible reasons for heterogeneity. Risk of bias across studies Publication bias was assessed by visual analysis of funnel plots, generated using Review Manager 5 software. Funnel plots were analyzed only if at least 10 studies were included in a meta-analysis. Roughly symmetrical funnel plots were regarded to indicate low risk while asymmetrical funnel plots were regarded to indicate high risk of publication bias [22]. Three additional records were found in the International Journal of Yoga Therapy. Eighteen full-text articles were assessed for eligibility [23 - 40] and 6 were excluded. One article reported effects of yoga in patients with mixed types of cancer, not just breast cancer [37]; 1 article did not assess health-related quality of life or psychological health but natural killer cell counts [38]; 2 articles [39 , 40] reported a subgroup analysis of an already published trial [33]. Three articles reported different outcomes of 1 single trial; these articles were treated as 1 single study [34 - 36]. Hence, this was regarded as 1 included article and 2 excluded articles. Twelve RCTs, involving a total of patients, were included in the qualitative synthesis [23 - 36]. One RCT did not report any group comparisons but presented effects of the yoga intervention in a more qualitative way and therefore was not included in the meta-analysis [25]. One

RCT did not report standard deviations, standard errors, confidence intervals, or t-values [27]. Since the missing data could not be obtained from the authors of the respective study by email, this study was excluded from the meta-analysis. Finally, 10 studies were included in the meta-analysis.

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2: Psychoanalytic Theory & Approaches | APsaA

Note: Citations are based on reference standards. However, formatting rules can vary widely between applications and fields of interest or study. The specific requirements or preferences of your reviewing publisher, classroom teacher, institution or organization should be applied.

Evidence base of Psychoanalytic Psychotherapy There is a growing body of research into the effectiveness of psychoanalytic psychotherapy. Researchers have demonstrated good evidence for the positive effects of psychodynamic therapies for various psychological disorders, including depression, anxiety, post-traumatic stress disorder PTSD and eating disorders. The studies referred to here have evaluated either the general effectiveness of long- and short-term psychodynamic psychotherapy, or the impact of psychodynamic psychotherapy on specific illnesses. These studies are among an ever-increasing number being published and cited in eminent psychological, psychiatric and medical journals. Examining the effectiveness of long-term psychodynamic psychotherapy here meaning at least a year or 50 sessions in complex mental disorders, a paper from found that long-term psychodynamic psychotherapy LTPP appears to be more effective than less intensive forms of psychotherapy in treating complex mental disorders. It concluded that LTPP had a significantly higher rate of effectiveness in targeting problems and general personality functioning than shorter forms of psychotherapy. A widely cited paper from summarized the evidence for the general effectiveness of psychodynamic psychotherapy. In a paper focusing on depression, researchers produced an overview of the effectiveness of psychoanalytic and psychodynamic therapies. Research has also been conducted into the impact of psychodynamic psychotherapy in specific psychological disorders. A study investigated the effects of psychodynamic psychotherapy in panic disorder. There were 49 adults in the study, and they were all diagnosed with panic disorder. In researchers conducted a review of trials into the effect of short-term psychodynamic psychotherapy in patients with personality disorder. Research has also been done into the cost-effectiveness of psychodynamic psychotherapy, which has often been regarded as too expensive to be funded in the public sector. Consequently the extra cost incurred through using psychodynamic treatment was recouped within only six months. Long-term psychodynamic psychotherapy in complex mental disorders: Update of a meta-analysis. The British Journal of Psychiatry, 1: Effectiveness of long-term psychodynamic psychotherapy. Journal of the American Medical Association, , The efficacy of psychodynamic psychotherapy. American Psychologist 65 2: Psychoanalytic and psychodynamic therapies for depression: Advances in Psychiatric Treatment, 14, A randomized controlled clinical trial of psychoanalytic psychotherapy for panic disorder. American Journal of Psychiatry, , Short-term psychodynamic psychotherapy for personality disorder: A critical review of randomized controlled trials. Journal of Personality Disorders, 25 6: Cost-effectiveness of brief psychodynamic-interpersonal therapy in high utilizers of psychiatric services. Archives of General Psychiatry, 56,

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3: Intensive short-term dynamic psychotherapy - Wikipedia

Title / Author Type Language Date / Edition Publication; 1. Immediate effects on patients of psycho-analytic interpretations. 1.

This perspective of psychoanalysis was dominant in America for approximately a year span until the s. Meanwhile, in Europe, various theoretical approaches had been developed. Current Psychoanalytic Treatment Approaches Today, the ego psychology that was dominant in American psychoanalytic thought for so many years has been significantly modified and is also currently strongly influenced by the developing relational point of view. The diverse schools of therapeutic approach currently operative in America include influences from British object relationists, "modern Freudians", the theories of Klein and Bion, self-psychology, the Lacanians, and more. Truly, a kaleidoscope of approaches is now available at psychoanalytic institutions in the United States. Many psychoanalysts believe that the human experience can be best accounted for by an integration of these perspectives. Whatever theoretical perspective a psychoanalyst employs, the fundamentals of psychoanalysis are always presentâ€”an understanding of transference, an interest in the unconscious, and the centrality of the psychoanalyst-patient relationship in the healing process. Attachment Theory The term "attachment" is used to describe the affective feeling-based bond that develops between an infant and a primary caregiver. The father of attachment theory, John Bowlby, M. It is important to note that attachment is not a one-way street. As the caregiver affects the child, the child also affects the caregiver. Transference Transference is a concept that refers to our natural tendency to respond to certain situations in unique, predetermined ways--predetermined by much earlier, formative experiences usually within the context of the primary attachment relationship. Transference is what is transferred to new situations from previous situations. Freud coined the word "transference" to refer to this ubiquitous psychological phenomenon, and it remains one of the most powerful explanatory tools in psychoanalysis todayâ€”both in the clinical setting and when psychoanalysts use their theory to explain human behavior. Transference describes the tendency for a person to base some perceptions and expectations in present day relationships on his or her earlier attachments, especially to parents, siblings, and significant others. Because of transference, we do not see others entirely objectively but rather "transfer" onto them qualities of other important figures from our earlier life. Thus transference leads to distortions in interpersonal relationships, as well as nuances of intensity and fantasy. The psychoanalytic treatment setting is designed to magnify transference phenomena so that they can be examined and untangled from present day relationships. These experiences can range from a fear of abandonment to anger at not being given to fear of being smothered and feelings of One common type of transference is the idealizing transference. We have the tendency to look towards doctors, priests, rabbis, and politicians in a particular wayâ€”we elevate them but expect more of them than mere humans. Psychoanalysts have a theory to explain why we become so enraged when admired figures let us down. The concept of transference has become as ubiquitous in our culture as it is in our psyches. But this explanatory concept is constantly in use. For example, in season three of the television series Madmen, one of the female leads is romantically drawn to a significantly older man just after her father dies. She sees him as extraordinarily competent and steady. Some types of coaching and self-help techniques use transference in a manipulative way, though not necessarily negatively. Essentially, this person accepts the transference as omnipotent parent and uses this power to tell the client what to do. Often the results obtained are short lived. Resistance Along with transference, resistance is one of the two cornerstones of psychoanalysis. As uncomfortable thoughts and feelings begin to get close to the surface--that is, become conscious--a patient will automatically resist the self-exploration that would bring them fully into the open, because of the discomfort associated with these powerful emotional states that are not registered as memories, but experienced as fully contemporaryâ€”transferences. The patient is thus experiencing life at too great an intensity because he or she is burdened by transferences or painful emotions derived from another source, and must use various defenses resistances to avoid their full emotional intensity.

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These resistances can take the form of suddenly changing the topic, falling into silence, or trying to discontinue the treatment altogether. As the analysis progresses, patients may begin to feel less threatened and more capable of facing the painful things that first led them to analysis. In other words, they may begin to overcome their resistance. Psychoanalysts consider resistance to be one of their most powerful tools, as it acts like a metal detector, signaling the presence of buried material. Trauma Trauma is a severe shock to the system. Sometimes the system is psychical; the trauma is a deep emotional blow or wound which itself might be connected to a physical trauma. While many emotional wounds take a while to resolve, a psychic trauma may continue to linger. Often this lack of resolution can foster a repetition compulsion--a chronic re-visiting of the trauma through rumination or dreams, or an impulse to place oneself in other traumatic situations. Psychoanalysis can help the victim to develop emotional and behavioral strategies to deal with the trauma. Fortunately, the need for trauma survivors to have treatment is now well understood in the broader mental health community. Certain medications are helpful in the treatment of trauma, but there should always be a psychological component to the treatment, and it must be understood that treatment can be needed years after the trauma is experienced. Treatment of PTSD still contains elements that harken back to psychoanalysisâ€”trauma patients need a witness to their pain, who helps them, bit by bit, incorporate the traumatic experience with the rest of the story of their lives in some way that can make sense. Facing unbearable feelings with another human being, and supporting and employing the ego-the part of the mind responsible for decision making, understanding cause and effect, and discriminationâ€”all these techniques owe their roots to psychoanalysis.

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4: Immediate effects on patients of psychoanalytic interpretations.

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Experiencing these emotions which had been previously outside of awareness seemed to be the curative factor. This cure became known as catharsis , and the experiencing of the previously forbidden or painful emotion was abreaction. Freud tried various techniques to deal with the fact that patients generally seemed resistant to experiencing painful feelings. He moved from hypnosis to free association , interpretation of resistance, and dream interpretation. Freud himself was quite open about the possibility that there were many patients for whom analysis could bring little or no relief, and he discusses the factors in his paper "Analysis Terminable and Interminable. One of the first discoveries was that the patients who appeared to benefit most from therapy were those who could rapidly engage, could describe a specific therapeutic focus, and could quickly move to experience their previously warded-off feelings. These also happened to represent those patients who were the healthiest to begin with and therefore had the least need for the therapy being offered. Clinical research revealed that these "rapid responders" were able to recover quickly with therapy because they were the least traumatised and therefore had the smallest burden of repressed emotion, and so were least resistant to experiencing the emotions related to trauma. However, these patients represented only a small minority of those arriving at psychiatric clinics; the vast majority remained unreachable with the newly developing techniques. David Malan popularized a model of resistance, known as the Triangle of Conflict, which had first been proposed by Henry Ezriel. When those emotions rise to a certain degree and threaten to break into conscious awareness, they trigger anxiety. The patient manages this anxiety by deploying defences, which lessen anxiety by pushing emotions back into the unconscious. Triangle of Persons Bowlby and attachment trauma[edit] John Bowlby , a British psychiatrist and psychoanalyst, was very interested in the impact on a child of adverse experiences in relation to its primary attachment figures usually the mother, but often the father and others in early life. He concluded, in opposition to received psychoanalytic dogma of the day, that childhood experience was far more important than unconscious fantasy. He also elucidated the nature of attachment, a system of behaviours exhibited by human and other mammalian infants which are innate and have the goal of physical proximity to the mother. Bowlby observed that the innate attachment system would be activated by loss of proximity to the mother, and that long-lasting trauma to the child could result from attachment interruption. Long term consequences included increased propensity to psychiatric disorders, poor relationship function, and decreased life satisfaction. Childhood traumatisation to the attachment bond, usually through separation from or loss of the primary mother or mother-substitute, led to adult difficulties. Since Bowlby, the effects of trauma over development have consistently been shown to have a significant detrimental impact on adult psychological functioning. As he began his video-recording work and became progressively successful against higher levels of resistance, he noted that particular themes reappeared with striking consistency in patient after patient. He also observed, from his videotaped sessions, that patients would simultaneously send off signals of their unconscious anxiety. Davanloo carefully monitored these signals of anxiety and saw that they represented the rise of complex mixed feelings with the therapist. The mix represented that part of the patient seeking relief from painful symptoms but also an active desire to avoid painful, repressed feelings. The sequence was by no means invariable, but it occurred frequently enough to allow the therapist to hypothesise its existence in a majority of cases. First, after a high rise of mixed feeling with the therapist, manifested as signals of intense anxiety tension in skeletal muscle, often manifested as wringing of the hands, accompanied with deep, sighing respirations , there would often be a breakthrough of rage, accompanied by an immediate drop in anxiety. This rage, Davanloo discovered, is intensely felt. It often has a violent impulse associated with it, sometimes even a murderous impulse. Once patients feel this rage, they are able to describe vividly detailed fantasies of what the rage would do if it were to take on a life of its

own. The rage is a product of thwarted efforts to attach from the past. Those thwarted efforts to love and be loved yield pain, in the form of what Bowlby described as protest. The pain yields a reactive rage at the loved person who thwarted attachment efforts. Complete experiencing of the rageful impulse is typically accompanied by a tremendous relief at finally getting something out which has yearned for release. However, the relief is typically short lived. Next, Davanloo almost invariably noted that patients then experience a tremendous wave of guilt about the rage. The guilt is a product of the fact that the old rageful feelings were with a person who was also loved. It is this guilt, Davanloo discovered, which is the key ingredient in symptom formation and character difficulties. Symptoms and interpersonal difficulties usually unconscious efforts to ward off intimacy and closeness are the product of guilt, which turns the rage back on the self. For instance, the rage of a two-year-old toward a mother who dies may be experienced in the present as suicidal feelings self-directed murderous rage. Beneath the guilty feelings from the past, Davanloo almost invariably noted painful feelings about thwarted efforts at emotional closeness to parents and others in childhood. Finally, at the deepest layer of feelings are the still powerful yearnings for closeness, attachment, and love. The goal of the ISTDP therapist is, as rapidly as possible, to help the patient overcome resistance, and then experience all the waves of mixed, genuine feeling, previously unconscious, triggered by the intense therapeutic process. Those feelings are traced back to their origins in the past, and then both therapist and patient come to understand how the patient came to be the "consciously confused, unconsciously driven" person in the present. Old pockets of emotion are drained, the patient has a clearer self-narrative, and self-destructive symptoms and defences are renounced. The understanding gained is not just cognitive, but goes to the fundamental, emotional core. Specific therapeutic interventions[edit] Davanloo discovered the layers of the dynamic unconscious through a process of developing specific interventions which allow the therapist to reach those layers. Those interventions are known as pressure, challenge, and head-on collision. Therapeutic encouragement and reaching through to the patient[edit] Pressure is the principal ingredient of ISTDP, and it takes many forms. Initially, pressure takes the form of encouraging the patient to describe symptoms and interpersonal difficulties as specifically as possible, so both patient and therapist get the clearest picture possible of the precise difficulties. It starts from the moment the patient walks into the room, in the form of the question, "Are there some difficulties you are experiencing which you would like us to have a look at? Again, this is exerted mainly in the form of questions, such as, "How did you feel toward your boss for humiliating you in front of your staff? We see that you got anxious and depressed, but how did you feel? Do you want us to look to your feelings? So, can we look at a specific time when you experienced anxiety? This will give us a clear picture of the problem which we can use to get to the engine. It is encouragement to renounce defences, tolerate anxiety, and walk, with the therapist, into those places which have previously been off-limits. However, as explained above, those are the patients who are healthiest to begin with. For patients with higher levels of resistance, usually the product of a more traumatised early phase of life, pressure quickly leads to the patient erecting barriers with the therapist. The combination of intentional conscious and unintentional unconscious defences is called the resistance. The therapist is constantly monitoring for both the rise in anxiety and the appearance of resistance. When resistance does make its appearance, new interventions, in addition to pressure, are called for. Pointing out and interrupting defenses in concert with the patient[edit] Challenge is a two-stage process. Patients are often quite unaware of their own defenses. Clarification takes the form of a question, meant to clarify the defense to both patient and therapist: Is a smile something you sometimes do to cover up a deeper feeling? A defense which has not been clarified is still invisible to the patient. It is also important to note that in childhood, defenses can be a useful tool in emotionally overwhelming or traumatic situations. However as we grow up, this shielding cuts us off from our full range of feelings, even when we are now emotionally able to handle the feelings. As with all powerful interventions, if it is misapplied, the consequences can be severe: This is because the patient perceives a premature challenge, applied when a defense has not been clarified, as a criticism or a personal attack. However, the proper use of challenge is as an aid or enhancement to the therapeutic alliance by removing an obstacle to the

rise in complex feelings with the therapist. If challenge originates as a product of frustration in the therapist or as a misunderstanding of the unconscious, then stalemate is virtually assured. The majority of patients are able to experience their true mixed feelings with a combination of Pressure and properly clarified Challenge. However, a sizable minority of patients erect a massive wall of resistance with the therapist. Pointing out the reality of the defenses and encouragement to overcome them[edit] The Head-on Collision is an intervention aimed not at any single defense but rather aimed at the entire defensive structure being deployed by the patient. It is an urgent appeal to the patient to exert maximal effort to overcome the resistance, and it takes the form of a summary statement to the patient which explains the consequences of continuing to resist: You have come on your own free will, because you are experiencing a problem which causes you pain. We have set out to get to the root of your difficulties, but every time we attempt to move toward it, you put up this massive wall. The wall keeps me out, and it keeps you from knowing your own true feelings. If you keep me out, you keep me useless. Is that what you want? Because, as you see, you are certainly capable of keeping me useless to you. My first question is, why would you want me to be useless? You see, the consequences of this would be that I would be unable to help you. However, can you afford to fail? How much longer do you want to carry this burden? It is a reminder, in stark terms, that the therapeutic task is in jeopardy and may well fail. Finally, it is a reminder to the patient of the consequences of failure, as well as an implied reminder that success is also possible. A model which initially worked only with highly motivated patients able to describe a clearly problematic area can now be applied to patients whose difficulties are diffuse and whose motivation is also initially quite diffuse. The results are deep, lasting changes in areas of both symptomatic and interpersonal disturbances. It is also worth stressing that ISTDP, unlike traditional psychodynamic therapies, assiduously avoids interpretation until such time as the unconscious is open. The use of trial interpretations is explicitly avoided. The phase of interpretation only commences once it is clear to both therapist and patient that there has been a passage of previously unconscious emotion. Quite often, it is then the patient who takes the lead in interpreting: I buried the rage that day because I felt so guilty about it. He maintains a large video library of treated cases which he uses for teaching conferences. He claims efficacy with psychological symptoms, medically unexplained symptoms so-called functional or somatoform disorders , and characterological disturbances referred to as Personality Disorders in DSM. Empirical research into the efficacy of ISTDP, and other brief psychodynamic psychotherapies is active. Twenty-one of these were recently reviewed by Dr Allan Abbass and colleagues and published in Harvard Review of Psychiatry, These include 8 randomized controlled trials, 15 case series and 2 non randomized controlled trials.

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5: Concussions: How They Can Affect You Now and Later | University of Utah Health

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Psychoanalyse first started to receive serious attention under Sigmund Freud, who formulated his own theory of psychoanalysis in Vienna in the s. Freud was a neurologist trying to find an effective treatment for patients with neurotic or hysterical symptoms. He then wrote a monograph about this subject. Charcot had introduced hypnotism as an experimental research tool and developed the photographic representation of clinical symptoms. Breuer wrote that many factors that could result in such symptoms, including various types of emotional trauma, and he also credited work by others such as Pierre Janet ; while Freud contended that at the root of hysterical symptoms were repressed memories of distressing occurrences, almost always having direct or indirect sexual associations. It remained unpublished in his lifetime. This became the received historical account until challenged by several Freud scholars in the latter part of the 20th century who argued that he had imposed his preconceived notions on his patients. Freud formulated his second psychological theoryâ€" which hypothesises that the unconscious has or is a "primary process" consisting of symbolic and condensed thoughts, and a "secondary process" of logical, conscious thoughts. This theory was published in his book, The Interpretation of Dreams. This "topographic theory" is still popular in much of Europe, although it has fallen out of favour in much of North America. Freud and Jung in the center In , Freud published Three Essays on the Theory of Sexuality [27] in which he laid out his discovery of so-called psychosexual phases: His early formulation included the idea that because of societal restrictions, sexual wishes were repressed into an unconscious state, and that the energy of these unconscious wishes could be turned into anxiety or physical symptoms. Therefore, the early treatment techniques, including hypnotism and abreaction, were designed to make the unconscious conscious in order to relieve the pressure and the apparently resulting symptoms. This method would later on be left aside by Freud, giving free association a bigger role. In On Narcissism [28] Freud turned his attention to the subject of narcissism. Still using an energic system, Freud characterized the difference between energy directed at the self versus energy directed at others, called cathexis. By , in "Mourning and Melancholia", he suggested that certain depressions were caused by turning guilt-ridden anger on the self. By , Freud addressed the power of identification with the leader and with other members in groups as a motivation for behavior Group Psychology and the Analysis of the Ego. Also, it was the first appearance of his "structural theory" consisting three new concepts id, ego, and superego. Hence, Freud characterised repression as both a cause and a result of anxiety. In , in Inhibitions, Symptoms and Anxiety, Freud characterised how intrapsychic conflict among drive and superego wishes and guilt caused anxiety , and how that anxiety could lead to an inhibition of mental functions, such as intellect and speech. According to Freud, the Oedipus complex, was at the centre of neurosis, and was the foundational source of all art, myth, religion, philosophy, therapyâ€"indeed of all human culture and civilization. It was the first time that anyone in the inner circle had characterised something other than the Oedipus complex as contributing to intrapsychic development, a notion that was rejected by Freud and his followers at the time. Within a year, Sigmund Freud died. Led by Heinz Hartmann , Kris, Rappaport and Lowenstein, the group built upon understandings of the synthetic function of the ego as a mediator in psychic functioning[jargon]. Hartmann in particular distinguished between autonomous ego functions such as memory and intellect which could be secondarily affected by conflict and synthetic functions which were a result of compromise formation[jargon]. These "Ego Psychologists" of the s paved a way to focus analytic work by attending to the defenses mediated by the ego before exploring the deeper roots to the unconscious conflicts. In addition there was burgeoning interest in child psychoanalysis. Although criticized since its inception, psychoanalysis has been used as a research tool into childhood development, [39] and is still used to treat certain mental disturbances. In the first decade of the 21st century, there were approximately 35 training institutes for psychoanalysis in the United States accredited

by the American Psychoanalytic Association APsaA , which is a component organization of the International Psychoanalytical Association IPA , and there are over graduated psychoanalysts practicing in the United States. The IPA accredits psychoanalytic training centers through such "component organisations" throughout the rest of the world, including countries such as Serbia, France, Germany, Austria, Italy, Switzerland, [42] and many others, as well as about six institutes directly in the United States. Theories[edit] The predominant psychoanalytic theories can be organised into several theoretical schools. Although these theoretical schools differ, most of them emphasize the influence of unconscious elements on the conscious. There has also been considerable work done on consolidating elements of conflicting theories cf. In the 21st century, psychoanalytic ideas are embedded in Western culture,[vague] especially in fields such as childcare , education , literary criticism , cultural studies , mental health , and particularly psychotherapy. Though there is a mainstream of evolved analytic ideas , there are groups who follow the precepts of one or more of the later theoreticians. Psychoanalytic ideas also play roles in some types of literary analysis such as Archetypal literary criticism. Topographic theory[edit] Topographic theory was named and first described by Sigmund Freud in The Interpretation of Dreams These systems are not anatomical structures of the brain but, rather, mental processes. Although Freud retained this theory throughout his life he largely replaced it with the Structural theory. Structural theory[edit] Structural theory divides the psyche into the id , the ego , and the super-ego. The id is present at birth as the repository of basic instincts, which Freud called "Triebe" "drives": The super-ego is held to be the part of the ego in which self-observation, self-criticism and other reflective and judgmental faculties develop. The ego and the super-ego are both partly conscious and partly unconscious. The theory was refined by Hartmann , Loewenstein, and Kris in a series of papers and books from through the late s. Leo Bellak was a later contributor. This series of constructs, paralleling some of the later developments of cognitive theory, includes the notions of autonomous ego functions: Freud noted that inhibition is one method that the mind may utilize to interfere with any of these functions in order to avoid painful emotions. Hartmann s pointed out that there may be delays or deficits in such functions. Frosch described differences in those people who demonstrated damage to their relationship to reality, but who seemed able to test it. According to ego psychology, ego strengths, later described by Otto F. Kernberg , include the capacities to control oral, sexual, and destructive impulses; to tolerate painful affects without falling apart; and to prevent the eruption into consciousness of bizarre symbolic fantasy. Synthetic functions, in contrast to autonomous functions, arise from the development of the ego and serve the purpose of managing conflict processes. Defenses are synthetic functions that protect the conscious mind from awareness of forbidden impulses and thoughts. One purpose of ego psychology has been to emphasize that some mental functions can be considered to be basic, rather than derivatives of wishes, affects, or defenses. However, autonomous ego functions can be secondarily affected because of unconscious conflict. For example, a patient may have an hysterical amnesia memory being an autonomous function because of intrapsychic conflict wishing not to remember because it is too painful. Taken together, the above theories present a group of metapsychological assumptions. Therefore, the inclusive group of the different classical theories provides a cross-sectional view of human mentation. There are six "points of view", five described by Freud and a sixth added by Hartmann. Unconscious processes can therefore be evaluated from each of these six points of view. The "points of view" are: Dynamic the theory of conflict 3. Economic the theory of energy flow 4. Genetic propositions concerning origin and development of psychological functions and 6. Adaptational psychological phenomena as it relates to the external world. Modern conflict theory addresses emotional symptoms and character traits as complex solutions to mental conflict. Moreover, healthy functioning adaptive is also determined, to a great extent, by resolutions of conflict. A major objective of modern conflict-theory psychoanalysis is to change the balance of conflict in a patient by making aspects of the less adaptive solutions also called "compromise formations" conscious so that they can be rethought, and more adaptive solutions found. How the Mind Shields Itself. Object relations theory[edit] Object relations theory attempts to explain the ups and downs of human relationships through a study of how internal representations of the self and others are organized. It is not

suggested that one should trust everyone, for example. Concepts regarding internal representations also sometimes termed, "introspects", "self and object representations", or "internalization of self and other" although often attributed to Melanie Klein , were actually first mentioned by Sigmund Freud in his early concepts of drive theory Three Essays on the Theory of Sexuality , John Frosch, Otto Kernberg , Salman Akhtar and Sheldon Bach have developed the theory of self and object constancy as it affects adult psychiatric problems such as psychosis and borderline states. Peter Blos described in a book called On Adolescence, how similar separation-individuation struggles occur during adolescence, of course with a different outcome from the first three years of life: During adolescence, Erik Erikson â€”s described the "identity crisis", that involves identity-diffusion anxiety. In order for an adult to be able to experience "Warm-ETHICS" warmth, empathy, trust, holding environment Winnicott , identity, closeness, and stability in relationships see Blackman, Defenses: How the Mind Shields Itself, , the teenager must resolve the problems with identity and redevelop self and object constancy. Self psychology[edit] Self psychology emphasizes the development of a stable and integrated sense of self through empathic contacts with other humans, primary significant others conceived of as "selfobjects". The process of treatment proceeds through "transmuting internalizations" in which the patient gradually internalizes the selfobject functions provided by the therapist. Jacques Lacan and Lacanian psychoanalysis[edit] Lacanian psychoanalysis , which integrates psychoanalysis with structural linguistics and Hegelian philosophy, is especially popular in France and parts of Latin America. Lacanian psychoanalysis is a departure from the traditional British and American psychoanalysis, which is predominantly Ego psychology. In the United Kingdom and the United States, his ideas are most widely used to analyze texts in literary theory. This is contrasted with the primacy of intrapsychic forces, as in classical psychoanalysis. Culturalist psychoanalysts Some psychoanalysts have been labeled culturalist, because of the prominence they attributed culture in the genesis of behavior. For Freud, male is subject and female is object. For Lacan , the "woman" can either accept the phallic symbolic as an object or incarnate a lack in the symbolic dimension that informs the structure of the human subject. Feminist psychoanalysis is mainly post-Freudian and post-Lacanian with theorists like Toril Moi , Joan Copjec , Juliet Mitchell , [55] Teresa Brennan [56] and Griselda Pollock , [57] following French feminist psychoanalysis, [58] the gaze and sexual difference in, of and from the feminine. Adaptive paradigm of psychoanalysis and psychotherapy[edit] Main article: Robert Langs The "adaptive paradigm of psychotherapy" develops out of the work of Robert Langs. The adaptive paradigm interprets psychic conflict primarily in terms of conscious and unconscious adaptation to reality. It was introduced by Stephen Mitchell. Fonagy and Target, in London, have propounded their view of the necessity of helping certain detached, isolated patients, develop the capacity for "mentalization" associated with thinking about relationships and themselves. Arietta Slade, Susan Coates , and Daniel Schechter in New York have additionally contributed to the application of relational psychoanalysis to treatment of the adult patient-as-parent, the clinical study of mentalization in parent-infant relationships, and the intergenerational transmission of attachment and trauma. Interpersonal-relational psychoanalysis[edit] The term interpersonal-relational psychoanalysis is often used as a professional identification. Psychoanalysts under this broader umbrella debate about what precisely are the differences between the two schools, without any current clear consensus. Intersubjective psychoanalysis[edit] The term " intersubjectivity " was introduced in psychoanalysis by George E. Atwood and Robert Stolorow The authors of the interpersonal-relational and intersubjective approaches:

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([) Immediate effects on patients of psychoanalytic interpretations,New York, International Universities Press MLA Citation Garduk, Edith www.enganchecubano.comd, Ernest A., Immediate Effects On Patients Of Psychoanalytic Interpretations.

The death of a loved one Witnessing an act of violence Trauma is often but not always associated with being present at the site of a trauma-inducing event. It is also possible to sustain trauma after witnessing something from a distance. Young children are especially vulnerable to trauma and should be psychologically examined after a traumatic event has occurred to ensure their emotional well-being. While the causes and symptoms of trauma are various, there are some basic signs of trauma that you can look out for. People who have endured traumatic events will often appear shaken and disoriented. They may not respond to conversation as they normally would and will often appear withdrawn or not present even when speaking. Another telltale sign of a trauma victim is anxiety. Anxiety due to trauma can manifest in problems such as night terrors, edginess, irritability, poor concentration and mood swings. While these symptoms of trauma are common, they are not exhaustive. Individuals respond to trauma in different ways. These cases illustrate the importance of talking to someone after a traumatic event has occurred, even if they show no initial signs of disturbance. Trauma can manifest days, months or even years after the actual event. Emotional Symptoms of Trauma Emotion is one of the most common ways in which trauma manifests. Some common emotional symptoms of trauma include denial, anger , sadness and emotional outbursts. Victim of trauma may redirect the overwhelming emotions they experience toward other sources, such as friends or family members. This is one of the reasons why trauma is difficult for loved ones as well. It is hard to help someone who pushes you away, but understanding the emotional symptoms that come after a traumatic event can help ease the process. Physical Symptoms of Trauma Trauma often manifests physically as well as emotionally. Some common physical signs of trauma include paleness, lethargy, fatigue, poor concentration and a racing heartbeat. The victim may have anxiety or panic attacks and be unable to cope in certain circumstances. The physical symptoms of trauma can be as real and alarming as those of physical injury or illness, and care should be taken to manage stress levels after a traumatic event. Short-Term and Long-Term Effects of Trauma All effects of trauma can take place either over a short period of time or over the course of weeks or even years. Any effects of trauma should be addressed immediately to prevent permanence. The sooner the trauma is addressed, the better chance a victim has of recovering successfully and fully. Short-term and long-term effects of trauma can be similar, but long-term effects are generally more severe. Short-term mood changes are fairly normal after trauma, but if the shifts in mood last for longer than a few weeks, a long-term effect can occur. While there are online assessments available for trauma, professional assessment is recommended over self-assessment. The victim or loved one will be biased and predisposed to see certain things, while a professional is objective and trained to compensate for bias. If you would like more information on getting a professional assessment for yourself or a loved one who has experienced trauma, call our hotline at. Drug Options While trauma, unlike some other mental disorders , is induced by an event or experience, it can be treated through the use of certain medications. Not all trauma requires medication, but it can be a useful tool in treating the symptoms of trauma, such as anxiety and depression. It is important to work with a healthcare professional to determine whether medication is necessary. If depression is severe and felt over an extended period of time, it may be treated with common antidepressant drugs. Clinical depression is defined as any depressive episode lasting longer than three months. Many trauma victims fall under the category of anxiety sufferers who are eligible for anti-anxiety medication. Medication Side Effects One of the considerations in whether or not to medicate for the symptoms of trauma is the presence of medication side effects. All medications have side effects, and the severity varies widely depending on drug class and individual body chemistry. Some side effects are more manageable than others, and potential negative side effects should always be compared to the potential benefit

to the patient. Drug Addiction, Dependence and Withdrawal Unfortunately, it is not uncommon for victims of trauma to turn to drugs as a means of self-medicating and coping with the effects of trauma. Government studies estimate that 25 percent of people experience trauma before the age of 16, and those individuals are much more likely to become addicted to drugs or alcohol. Medication Overdose Medication overdose occurs when someone ingests a significant enough amount of medication to cause physical harm. Overdose often occurs in conjunction with substance abuse, but it may be accidental and occur under regular circumstances. Any instance of overdose should be taken seriously, and professional help should be sought to ensure that an overdose does not reoccur and to determine if the cause is substance abuse. Depression and Trauma Depression and trauma have high comorbidity rates, and feelings of despair, malaise and sadness can last longer than a few days or even weeks. When a trauma occurs, post-traumatic stress disorder often occurs. The Department of Veteran Affairs estimates that depression is between three to five times more likely to occur in trauma victims who develop PTSD than in the general population. Addiction and Trauma When the symptoms of PTSD , depression and anxiety become too much to cope with through normal means, many victims of trauma turn to substance abuse. As mentioned, victims are much more likely to develop addictions than other members of the general population. It is essential for the loved ones of a trauma victim to look out for the symptoms of addiction after trauma, even if the addiction is the only outward sign of PTSD. Getting Help for Trauma-Related Issues If you or a loved one is suffering from trauma, there is help available. With a variety of Trauma treatment options and caring professionals willing to help, the outlook for recovery is good. Often, people just need a little help with taking the first step. Call our hotline at to start the journey toward recovery today. Mental trauma involves painful feelings and frightening thoughts invoked by witnessing or experiencing a traumatic event. While most people process and deal with these feelings after a short time, some people are unable to do so. Understanding Trauma The belief is that greater harm is done when a person is more directly exposed to traumatic experiences. Learn more about what this means here. Our helpline is offered at no cost to you and with no obligation to enter into treatment.

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Page | 1 Foreword This document is a literature review of research into the effectiveness of psychoanalysis and psychoanalytic psychotherapy, intended as a resource for counsellors and psychotherapists.

Video Game Depression Symptoms, Causes and Effects Depression is likely to strike many people to some degree in their lifetime. According to the Centers for Disease Control and Prevention, 9. If you or someone you know is depressed, it can cause a marked drop in interest in pursuing life to the fullest, and can, unfortunately, drive a person to attempt suicide if left untreated. Help is available; call our hotline at to learn how to break the cycle of depression. What Are the Types of Depressive Disorders? However, common factors exist among all types. Major Depressive Disorder Major depressive disorder occurs when the person has feelings of sadness, hopelessness, or anger that persist over a period of weeks and interfere with daily life. It can lead to suicide in severe cases. The symptoms last longer than with major depression, but they are not as severe. Atypical Depression Atypical depression can be hard to diagnose and it often lasts for years. Some of the common symptoms of depression, such as decreased appetite, are reversed; the person may have cravings for chocolates or sweets. Bipolar or Manic Depression Bipolar disorder is characterized by cycling between depressive periods and manic periods in which the person engages in a lot of activity and feels extremely empowered and positive. The time between phases varies from person to person. A lack of sunlight, exercise, and fresh air causes irritability and lethargy in people who suffer SAD. Postpartum Depression Postpartum depression occurs often with women who have recently given birth. The time of onset varies; it can occur as early as three months or as late as a year after delivery. It is moderate to severe. Psychotic Depression Patients who suffer psychotic depression exhibit psychotic symptoms along with the depression, such as delusions or hallucinations. The hallucinations can affect any or all of the senses. Usually, the delusions involve feelings of unwarranted guilt or inadequacy. Many potential causes for depression exist. It can be genetic, meaning the patient has a family history of depression. Personal trauma and sources of stress, such as a failed relationship or a lost job, can also cause depression. Social isolation as the result of conflict with family and friends can be a contributory factor, and certain medications, such as high blood pressure medication, have depression listed as a possible side effect. What Are the Signs of Depression? If you notice that you or someone you know seems to be lethargic, socially withdrawn, or has declining physical health, depression may be present. There are several physical and emotional symptoms to look for when determining whether a person has clinical depression, but you should always seek an official diagnosis before making a decision. Emotional Symptoms of Depression The emotional symptoms of depression potentially include the following: Some of the physical effects include erratic sleep habits, loss of appetite or increased appetite with atypical depression , constant fatigue, muscle aches, headaches, and back pain. Short-Term and Long-Term Effects of Depression In the short-term, depression is likely to cause loss of appetite, weight loss, and other physical symptoms. If you develop insomnia or hypersomnia sleeping too much , you will be fatigued and lethargic. In the long term, you can experience malnutrition from not eating enough or become obese from eating too much. You can also experience a drop in short-term memory, finding it easier to forget things. Long-term depression can also lead to suicide; EverydayHealth states that over 66 percent of suicides have depression as a factor. A myriad of tests exists online to determine whether you may be depressed. Many of them ask the same questions: Psychological self-diagnosis is a risky venture at best, but with official evaluation, you can get proper treatment and medication. Antidepressant Drug Options You have a variety of choices for antidepressants. Some of the most common are SSRIs, or selective serotonin reuptake inhibitors. These help the brain to regulate the release of serotonin and dopamine; these are brain chemicals thought to be responsible for creating feelings of happiness and satisfaction. Common brand names are Paxil, Prozac, and Zoloft. Some older types that are still used are MAOIs monoamine oxidase inhibitors , tetracyclics, and tricyclics. These drugs can have harmful side effects. Medication Side Effects The side effects of antidepressants might cover a

wide range of symptoms, some of which include:

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For example, both Garduk and Haggard () and Luborsky, Bachrach, Graff, Pulver, and Christoph () have examined the immediate impact of interpretations on patients' levels of resistance, insight, and other variables.

Advanced Search This article reviews the role of psychological factors in the development of persistent pain and disability, with a focus on how basic psychological processes have been incorporated into theoretical models that have implications for physical therapy. To this end, the key psychological factors associated with the experience of pain are summarized, and an overview of how they have been integrated into the major models of pain and disability in the scientific literature is presented. Pain has clear emotional and behavioral consequences that influence the development of persistent problems and the outcome of treatment. Yet, these psychological factors are not routinely assessed in physical therapy clinics, nor are they sufficiently utilized to enhance treatment. Based on a review of the scientific evidence, a set of 10 principles that have likely implications for clinical practice is offered. Because psychological processes have an influence on both the experience of pain and the treatment outcome, the integration of psychological principles into physical therapy treatment would seem to have potential to enhance outcomes. The experience of pain is shaped by a host of psychological factors. Choosing to attend to a noxious stimulus and interpreting it as painful are examples of 2 factors involving normal psychological processes. To be sure, pain is a subjective experience, and although it is certainly related to physiological processes, how individuals react to a new episode of pain is shaped and influenced by previous experience. Indeed, without learning from experience, it would be difficult to cope with pain and maintain good health. Thus, these psychological processes have tremendous value for survival. Therefore, in this article, we focus on the most important psychological factors that have been incorporated into theoretical models of pain that may explain pain perception and treatment benefits. In our view, awareness of these factors is crucial for understanding patients in pain and is a prerequisite for integrating them into clinical practice. Applying psychological knowledge in the clinical practice of physical therapy, however, has been quite a challenge. A majority of physical therapists are aware of the importance of psychological factors and attempt to utilize this awareness in their practice. However, there is an apparent lack of knowledge and tools to adequately apply this knowledge. We acknowledge that there is currently a lack of clear information as to how psychological factors should be utilized by physical therapists and other clinicians. One area that is particularly relevant is how early physical therapy treatments might prevent the development of chronic musculoskeletal pain. As a review of psychological interventions designed to prevent chronicity has shown positive effects when the psychological techniques are appropriately administered, 6 competent application appears to be vital. In our view, an understanding of the basic psychological processes is, therefore, an essential base for competent application of psychological principles in the clinic. To date, there has been broad recognition of the importance of a biopsychosocial view of pain, but a lack of clarity in how the psychological factors actually fit in, not least in clinical situations. How might psychology be utilized to improve care? To this end, we will focus on the central psychological factors and highlight the psychological processes that affect the pain experience over time. Indeed, we emphasize how psychological factors may contribute not only to the experience of acute pain but also to the development of chronic pain and disability over time. What might be quite a normal and appropriate response in the acute phase paradoxically may be a poor method of coping with persistent pain. Accordingly, we will highlight how psychological factors affect the development of persistent disability and illustrate the processes by describing pertinent theoretical models. Psychological Processes In this section, we provide an overview of fundamental psychological processes that are involved in most types of pain problems and highlight how these processes may contribute to the development of a persistent pain problem. A basic theme is that the psychological processes are highly intertwined and function together as a system. We consider them individually as a means of presentation. Note that these processes also form the basis of the models presented in the next section. There are different ways in

which we might group psychological factors. In our presentation, we attempt to portray the influence of psychological factors, as illustrated in Figure 1 , as a sequence of processes, starting with initial awareness of the noxious stimulus, then cognitive processing, appraisal, and interpretation that leads people to act on their pain ie, their pain behavior. Although we present this as a sequence for understanding, we are aware that this is a model, and much more work is needed to fully describe these processes. In addition to the model, Table 1 provides an overview of the main factors and their possible consequences for the experience of pain. Figure 1 A modern view of pain perception from a psychological view according to Linton.

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However, they insists that interpretations often are a great help to patients psycho-dynamic theory influenced by Freud, therapy deriving from the psychoanalytic tradition that views individuals as responding to unconscious forces and childhood experiences, and that seeks in enhance self-insight.

Freud believed that people could be cured by making conscious their unconscious thoughts and motivations, thus gaining insight. The aim of psychoanalysis therapy is to release repressed emotions and experiences, i. It is only having a cathartic i. Manifest symptoms are caused by latent hidden disturbances. Typical causes include unresolved issues during development or repressed trauma. Treatment focuses on bringing the repressed conflict to consciousness, where the client can deal with it. How can we understand the unconscious mind? Remember, psychoanalysis is a therapy as well as a theory. Psychoanalysis is commonly used to treat depression and anxiety disorders. In psychoanalysis therapy Freud would have a patient lie on a couch to relax, and he would sit behind them taking notes while they told him about their dreams and childhood memories. Psychoanalysis would be a lengthy process, involving many sessions with the psychoanalyst. Due to the nature of defense mechanisms and the inaccessibility of the deterministic forces operating in the unconscious, psychoanalysis in its classic form is a lengthy process often involving 2 to 5 sessions per week for several years. This approach assumes that the reduction of symptoms alone is relatively inconsequential as if the underlying conflict is not resolved, more neurotic symptoms will simply be substituted. The psychoanalyst uses various techniques as encouragement for the client to develop insights into their behavior and the meanings of symptoms, including ink blots, parapraxes, free association, interpretation including dream analysis , resistance analysis and transference analysis. It is what you read into it that is important. Different people will see different things depending on what unconscious connections they make. However, behavioral psychologists such as B. Skinner have criticized this method as being subjective and unscientific. Click here to analyze your unconscious mind using ink blots. For example, a nutritionist giving a lecture intended to say we should always demand the best in bread, but instead said bed. Freud believed that slips of the tongue provided an insight into the unconscious mind and that there were no accidents, every behavior including slips of the tongue was significant i. This technique involves a therapist reading a list of words e. It is hoped that fragments of repressed memories will emerge in the course of free association. Free association may not prove useful if the client shows resistance, and is reluctant to say what he or she is thinking. On the other hand, the presence of resistance e. Freud reported that his free associating patients occasionally experienced such an emotionally intense and vivid memory that they almost relived the experience. This is like a "flashback" from a war or a rape experience. Such a stressful memory, so real it feels like it is happening again, is called an abreaction. If such a disturbing memory occurred in therapy or with a supportive friend and one felt better--relieved or cleansed--later, it would be called a catharsis. Dream Analysis According to Freud the analysis of dreams is "the royal road to the unconscious. As a result, repressed ideas come to the surface - though what we remember may well have been altered during the dream process. As a result, we need to distinguish between the manifest content and the latent content of a dream. The former is what we actually remember. The latter is what it really means. Freud believed that very often the real meaning of a dream had a sexual significance and in his theory of sexual symbolism he speculates on the underlying meaning of common dream themes. Clinical Applications Psychoanalysis along with Rogerian humanistic counseling is an example of a global therapy Comer, , p. This rests on the assumption that the current maladaptive perspective is tied to deep-seated personality factors. Global therapies stand in contrast to approaches which focus mainly on a reduction of symptoms, such as cognitive and behavioral approaches, so-called problem-based therapies. Anxiety disorders such as phobias, panic attacks, obsessive-compulsive disorders and post-traumatic stress disorder are obvious areas where psychoanalysis might be assumed to work. The aim is to assist the client in coming to terms with their own id impulses or to recognize the origin of their current

anxiety in childhood relationships that are being relived in adulthood. Svartberg and Stiles and Prochaska and DiClemente point out that the evidence for its effectiveness is equivocal. Salzman suggests that psychodynamic therapies generally are of little help to clients with specific anxiety disorders such as phobias or OCDs but may be of more help with general anxiety disorders. Salzman in fact expresses concerns that psychoanalysis may increase the symptoms of OCDs because of the tendency of such clients to be overly concerned with their actions and to ruminate on their plight Noonan, Depression may be treated with a psychoanalytic approach to some extent. Psychoanalysts relate depression back to the loss every child experiences when realizing our separateness from our parents early in childhood. An inability to come to terms with this may leave the person prone to depression or depressive episodes in later life. Treatment then involves encouraging the client to recall that early experience and to untangle the fixations that have built up around it. Particular care is taken with transference when working with depressed clients due to their overwhelming need to be dependent on others. Shapiro and Emde report that psychodynamic therapies have been successful only occasionally. One reason might be that depressed people may be too inactive or unmotivated to participate in the session. In such cases a more directive, challenging approach might be beneficial. Another reason might be that depressives may expect a quick cure and as psychoanalysis does not offer this, the client may leave or become overly involved in devising strategies to maintain a dependent transference relationship with the analyst. Critical Evaluation - Therapy is very time-consuming and is unlikely to provide answers quickly. The case study method is criticized as it is doubtful that generalizations can be valid since the method is open to many kinds of bias e. However, psychoanalysis is concerned with offering interpretations to the current client, rather than devising abstract dehumanized principles. Abnormal psychology 2nd ed. Several entries in the area of psycho-analysis and clinical psychology. Introductory lectures on psychoanalysis. The Ego and the mechanisms of defense. Hogarth Press and Institute of Psycho-Analysis. An obsessive-compulsive reaction treated by induced anxiety. American Journal of Psychotherapy, 25 2 , Crossing traditional boundaries of therapy. Treatment of the obsessive personality. Some Empirical Approaches To Psychoanalysis. Journal of the American Psychoanalytic Association, 39, Why psychoanalysis is not a science. Comparative effects of short-term psychodynamic psychotherapy: Journal of consulting and clinical psychology, 59 5 , You are the Therapist Read through the notes below. Identify the methods the therapist is using. A young man, 18 years old, is referred to a psychoanalyst by his family doctor. It seems that, for the past year, the young man Albert has been experiencing a variety of symptoms such as headaches, dizziness, palpitations, sleep disturbances - all associated with extreme anxiety. The symptoms are accompanied by a constant, but periodically overwhelming fear of death. He believes that he has a brain tumor and is, therefore, going to die. However, in spite of exhaustive medical tests, no physical basis for the symptoms can be identified. During one session, in which Albert is encouraged to free associate, he demonstrated a degree of resistance in the following example: My father came home early, and instead of my mother taking me out, the two of them went out together leaving me with a neighbor. Occasionally, Albert is late for his appointments with the therapist, and less often he misses an appointment, claiming to have forgotten. He feels both happy and guilty at the same time. Sometime later, after the therapy sessions have been going on for several months, the analyst takes a two weeks holiday. During a session soon afterward Albert speaks angrily to the therapist.

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