

# The Role of Therapist Activity in Psychodynamic Psychotherapy

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*Abstract:* The teaching of psychodynamic psychotherapy is a critical component of psychiatric residency training programs. The authors argue that encouraging our residents to become active while providing psychodynamic psychotherapy is a skill that can be taught. By helping residents to understand how to actively help patients focus on their internal world, identify and work with the defenses, and develop and maintain a treatment alliance, psychodynamic educators can enable psychiatric residents to feel far more competent when working in this paradigm. Such a stance inevitably leads to greater excitement and enjoyment for trainees, as well as better outcomes for patients.

A middle-aged man enters his therapy session with a deep sigh and palpable sense of resignation. He sits silently and looks imploringly at his therapist, who also remains silent. Finally, the patient begins to discuss his ongoing depression, seemingly intractable problems with his wife, and stress in the workplace. He asks his therapist what he can do to improve his life. Not wanting to provide advice, the therapist (who is also a PGY-3 resident) throws the question back to the patient. Throughout the session, the therapist maintains a passive stance, mirroring the slumped posture and slow, hesitant speech demonstrated by her patient. Both sink into a kind of quiet despair. Although the therapist wants to help and is well versed in the theory behind psychodynamic psychotherapy, she has not been trained to intervene actively and effectively in a manner consistent with that theory. She is not alone in not knowing what to say or do. Our students frequently feel that good psychodynamic psychotherapists say very little to patients. We, as psychodynamic educators, must do a better job of teaching residents that they can, and should, make active interventions with their patients.

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The caricature of the passive therapist who utters an occasional “ah huh” is a distorted cliché in many respects, but it remains a fairly accurate depiction of those therapists who take a “less is more” approach. In their book *Psychodynamic Psychotherapy*, Cabaniss, Cherry, Douglas, and Schwartz (2011) write, “Scores of movies, TV shows, and cartoons portray therapists as bizarrely wooden creatures with stone faces and pursed lips who say next to nothing” (p. 94). Many educators have criticized this passive approach, at times referred to as excessively “neutral.” For example, in his work *Why Psychotherapists Fail*, Chessick (1983) wrote: “efforts to achieve an unnatural ‘neutrality’ are experienced by the patient as cold rejection” (p. 19). Research suggests that therapists who are passionate about what they do, get actively involved in the process, encourage the active participation of the patient, and intervene in a focused and intentional manner achieve far better outcomes than their passive colleagues (Duncan, Miller, & Sparks, 2004; Duncan, Miller, & Wampold, 2009; Lambert & Ogels, 2004; Norcross, 2002). In their comprehensive review of more than 2,000 outcome studies conducted since 1950, Orlinsky, Grave, and Parks (1994) identified several therapist variables that have consistently been shown to have the greatest impact on treatment outcome. These include therapist credibility, skill, empathic understanding, and affirmation of the patient along with the ability to engage with the patient, to focus on the patient’s problems, and to direct the patient to their experience of affect (Norcross, 2002). However, despite these findings, many trainees are still cautioned by supervisors that, when in doubt, it is best to say nothing; some are cautioned to avoid a “pathological need to see results”; one even reports being told, “Maybe after 12 or 14 years of experience, you might have one or two helpful things to say” (personal communication to PC). This kind of comment reflects a problem, either a countertransference problem in the supervisor, or a simple lack of knowledge.

In fact, it is not only our residents who lack training regarding active techniques to engage patients in the psychotherapeutic relationship. The work of Orlinsky and Ronnstad (2005) shows us that many seasoned clinicians lack the technical skills so important in achieving good outcomes. Orlinsky and Ronnstad created a 392-item instrument, the Psychotherapists Common Core Questionnaire, and have administered it to thousands of therapists in the United State and Europe over the past 20 years. They have discovered that the majority of therapists report being highly involved in and committed to their work, value their ability to establish rapport, and use their intuitive skills. However, 76% of them reported lacking both skill and confidence in three crucial areas: (a) motivating patients to become actively involved in the process of psychotherapy; (b) knowing how and when to employ spe-

cific therapeutic interventions; and (c) understanding and tracking the therapeutic process moment to moment. We must do a better job of teaching our trainees these vitally important skills.

In an attempt to do just this, we will outline the specific active psychodynamic interventions, technical skills, and therapeutic strategies that are associated with the best outcomes. We will discuss how residents must learn to (a) help patients develop and maintain a focus on their internal life; (b) help patients identify and turn against pathological defenses, facilitate an experience of affect, and promote the development of affect tolerance; and (c) develop and maintain a therapeutic alliance. Throughout, we will review the literature on the therapist's activity as an important but relatively neglected factor leading to change. Our goal is to stress the importance of teaching students how to become active in using their skills.

### **THERAPEUTIC STRATEGY, TECHNICAL SKILL, AND THERAPIST ACTION**

First of all, the therapist must be active in helping the patient to develop a focus in the psychotherapy. Endless, aimless free association involves extensive defensive processes and is not, in itself, associated with change. By creating and maintaining a focus, therapist and patient can begin to make changes in the recurrent patterns underlying the patient's suffering. Therapists who take charge of the timing and pacing of the session tend to achieve better outcomes than those who do not (Weinberger, 1995). Rather than allowing the patient to digress too much, the therapist must take an active stance to keep the patient on the path toward healing. Just as a clear and sustained focus has been found to have a positive relationship to outcome, the lack of therapeutic focus has been associated with high dropout rates, poor outcomes, and high rates of remission (Mohr, 2006). Students must be made aware of emerging neuroscientific ideas that support the notion that sustained focus, with intensity and repetition, is essential to creating brain change in adults (Cozolino, 2010; Doidge, 2007; Lutz et al., 2009). Indeed, "The power to direct our attention has the power to shape the brain's firing patterns, as well as the power to shape the architecture of the brain itself" (Siegel, 2010, p. 39).

As part of our active search for focus in psychotherapy, students must also learn to actively encourage patients to direct their attention to the internal problems that have prompted them to seek help. To do this, the therapist must work to block vagueness and externalization.

For example, a therapist might say, "In addition to talking about what is happening with your husband, let's pay attention to what you are feeling right now." This intervention involves both a blocking of defense (externalization) and an invitation to build an awareness of an internal world. An active and sustained focus on the inner life of the patient tends to enhance the alliance while facilitating the patient's sense of autonomy and control. Finally, an active focus on the patient's internal, emotional experience, instead of getting caught up in the story about external events, creates a new experience. Recently, I (PC) saw a young man who was struggling with mixed feelings toward women that for years had undermined all his relationships. He had seen three previous therapists, all of whom got caught up in their own curiosity about his experience as a Navy Seal, never directing sustained attention to the patient's internal world. This repeated countertransference error recapitulated the patient's experience of having been largely ignored by his parents, especially with regard to his emotional life. In contrast, focusing the work on the patient's inner experience in our sessions was both corrective and therapeutic.

Second, in addition to teaching students to be active in finding a focus for treatment, we must teach them to pay close and active attention to the patient's experience of affect. Research suggests that in order to achieve change, the therapist must help patients experience distressing emotions that they have been avoiding (Ecker, 2012; Weinberger, 1995). If students can learn to help their patients get through defensive avoidance and gain access to affective experience, they can help their patients transform maladaptive, defensive functioning into adaptive functioning (Della Selva, 1996). Patients who have experienced affect-focused therapy report increased self esteem, enhanced interpersonal functioning, and a sense of mastery and competence, in addition to a reduction or elimination of symptoms (Piliero, 2004).

To mobilize affect and emotion in psychotherapy, therapists must pay close attention to patients' nonverbal communications, especially their body movements. Because patients cannot directly report the unconscious or implicit feelings that drive their behavior, we must help students develop therapeutic skills that bring nonverbal communication into view. By watching posture, facial expression, respiratory rate, and physical activation, therapists learn to tune into the patient's unconscious, implicit system. Students should be taught that just talking about feelings will not lead to transformational change; however, active attention directed to the visceral, somatic experience of feelings that have been associated with anxiety and characteristically avoided has been shown to facilitate deep and lasting change (Abbass, Hancock, Henderson, & Kisely, 2006, Abbass, Town, & Driessen, 2012; Fosha, Sie-

gel, & Solomon, 2009; Greenberg, 2010; Malan & Della Selva, 2007; Piliero, 2004; Shedler, 2010).

Students should be made aware of the vast literature showing the many advantages of focusing on affect and emotion in psychotherapy. For example, a focus on the feelings, emotions, and sensations triggered by talking about conflictual situations is most likely to lead to exploration of the unconscious underpinnings of the patient's problems (Bridges, 2006; Greenberg, 2010). Mobilization of affect in psychotherapy may also bring traumatic memories to the fore (Ecker et al., 2012). Furthermore, mobilization of affect creates a kind of new experience that is important in change, particularly the kind of experience that facilitates profound moments of meeting (Stern, 2004). Finally, mobilization of affect in the psychotherapeutic relationship helps patients build tolerance for this experience. Research suggests that helping patients physically experience their feelings at the edge of tolerance, so that previously overwhelming emotions can be regulated and integrated, is essential to promoting health (Ogden, Pain, Minton, & Fisher, 2005; Schore, 2009). When a therapist confronts a patient with his or her defenses, challenging the patient to face what he or she has been avoiding, the patient will inevitably experience anxiety. If the therapist backs off, anxiety will be reduced and likely be too low to create the necessary conditions for healing to take place. If anxiety is too high, and the patient cannot think straight, no therapeutic work can be achieved. Stimulating a moderate level of anxiety will increase the likelihood of therapeutic change (Caryer & Greenberg, 2010; Cozolino, 2010; Schnarch, 2011).

Finally, the therapist must be active in building and maintaining a therapeutic alliance. A solid therapeutic alliance is the very bedrock of psychotherapy (Martin, Garske, & Davis, 2000). Horvath, Del Re, Flückiger, and Symonds (2011) conducted a meta-analysis of the research involving the relationship between alliance and outcome for more than 14,000 cases of individual psychotherapy, demonstrating that the alliance made a robust contribution to treatment outcomes. In providing treatment guidelines, the authors emphasize a few critical contributions to the therapeutic alliance, including the commitment of the therapist to the "business of therapy," with an emphasis on therapy as a collaborative enterprise. While many equate the therapeutic alliance with the emotional bond between patient and therapist, it is vastly more complex. A solid alliance is based on agreement between patient and therapist on the nature of the problems to be addressed, the goals of treatment, and the therapeutic tasks (Bordin, 1979). Therapists must be good at building alliances understood in this manner.

Skill is important. A study by Piliero (2004), based on patients' experiences in two emotionally focused types of dynamic psychother-

apy, indicated that therapist level, skill, and competence, rather than warmth and sympathy, were most highly related to patient satisfaction and positive outcome. Being able to trust the therapist and view him or her as a resource appears to be much more important than simply liking the therapist. Thus, the therapist must actively demonstrate skill right from the start of therapy. Rather than allowing a patient to ramble on in a tangential fashion, for example, the therapist should encourage the patient to be specific and to focus on the task at hand. This activity will help move the treatment in a positive direction. Especially with patients who are resistant and/or have chronic and complex disorders, active therapeutic interventions are required to facilitate the development of an alliance (Simeon-Onken, Blaine, & Boren, 1997).

In fact, much evidence suggests that both patient satisfaction and outcome are related to specific active interventions provided by the therapist. Bachelor (2011) found that patients place great emphasis on helpfulness, joint participation in the work of therapy, and signs of a negative therapeutic relationship. These results imply that an engaged therapist, who reviews the problems to be addressed and participates actively in the change process, is viewed by patients as most helpful. Owen and Hilsenroth (2011) demonstrated that patient-rated alliance in the psychodynamic treatment of 68 outpatients was significantly related to improvement on a measure of broad functioning. Specific psychodynamic techniques, including linking current feelings or perceptions to those from the past, focusing on repetitive relational patterns over time, and identifying recurrent patterns in the patient's actions, feelings, and experiences, were all found to enhance alliance in ways that improved outcome (Owen & Hilsenroth, 2011). In another study by this same team (Owen, Hilsenroth, & Rodolfa, 2012), alliance measures from both cognitive-behavioral and psychodynamic treatments were obtained and compared, leading the authors to conclude that the specific and active psychodynamic techniques utilized in both groups were associated with postsession change. In contrast to patients who experienced the active intervention of their therapists, patients who rated their therapist as being relatively inactive reported fewer positive post-session outcomes. The effects of such active interventions appear both to last and to increase over time, even after therapy has ended (Abbass et al., 2012; Shedler, 2010; Svartberg, Stiles, & Seltzer, 2004).

An active therapeutic stance at the beginning of treatment has been shown to be particularly critical in promoting therapeutic alliance in brief psychodynamic psychotherapy. Marcolino and Iacoponi (2003) studied the impact of the therapeutic alliance on outcome in brief psychodynamic psychotherapy, demonstrating that higher ratings of the alliance measured at the third session were correlated with greater

symptom change. Therapists with greater alliance ratings were more actively engaged in the treatment process. Their patients experienced being well understood by their therapists and viewed their therapists as highly involved in the issues discussed in treatment (Marcolino & Iacononi, 2003). Heinonen, Lindfors, Laaksonen, and Knekt (2012) conducted a study of 326 outpatients receiving short-term and long-term psychotherapies and concluded that active, engaging, and extroverted therapists produced faster symptom reduction in short-term therapy than their less engaged colleagues. Therapist confidence in and enjoyment of their work also predicted better results (Heinonen et al., 2012). Once again, we see the interaction of therapist variables, alliance, and, above all, activity at work in the outcome of psychotherapy.

Hilsenroth and Cromer (2007) underscored the contribution of the alliance even during the assessment phase of treatment. The most critical aspect of fostering the alliance during the assessment was the depth of psychological assessment and therapist involvement. Therapists who outlined cyclical relational themes and provided patients with a new understanding of themselves during the assessment phase fostered a greater therapeutic alliance than those who were less involved. Patients reported more positive responses to the assessment process when therapists worked toward developing empathic connections, interacted collaboratively with them to develop individual goals, and reviewed assessment results openly and freely. Patients also valued an extended assessment and did not feel as though it “dragged on.” Deeper therapeutic alliances were fostered when a therapist facilitated patient affect, clarified precipitants and sources of distress, explored in-session process, facilitated the experience of affect between therapist and patient, and communicated to the patient a willingness to explore uncomfortable themes (Hilsenroth & Cromer, 2007). Hilsenroth and Cromer’s results indicate that our students should be actively curious and collaborative during the assessment, rather than more passive, with the “wait and see” approach typical of many psychodynamic therapists. In our own experiences with extended assessments, patients almost universally report being relieved to have achieved some depth of understanding and to have experienced the active ingredients of therapy on this first visit.

Another crucial aspect of developing a strong treatment alliance involves active attention to negative transference feelings. When a patient feels misunderstood or even mistreated in some manner, the capacity of the therapist to adjust and understand the perspective of the patient seems to have a direct correlation with the strength of the therapeutic bond. Gottman’s (2002) research suggests that this ability to make and accept repair is one of the most important factors in creating healthy

and resilient relationships. Muran, Safran, and Eubanks-Carter (2010) also emphasize the importance of negotiating therapeutic disruptions for strengthening the therapeutic alliance. Because ruptures in the alliance are common events, occurring in as many as 50% of sessions and often responsible for premature termination and negative outcome, it is important that we help our students to become adept at handling these bumps in the road. When a rupture or even a misalliance is actively addressed and resolved, a positive outcome is more likely. In order to deal with disruptions in the therapeutic alliance with aplomb, three specific skills seem particularly important: self-awareness, affect regulation, and interpersonal sensitivity. The successful therapist is taught to focus actively on the patient's experience, on his or her own experience, and on the interpersonal field, making use of a variety of active teaching methodologies (Muran et al., 2010). Students should be made aware of the vast literature advocating an emphasis on the experience and expression of the patient's mixed feelings toward the therapist (Abbass et al., 2012; Della Selva, 1996; Davanloo, 1990.) It may be that such a focus is particularly effective in activating unconscious, implicit emotional memories that are largely responsible for our patient's reactivity and suffering. By facilitating the experience in the here and now of previously avoided feelings and then coupling this experience with a disconfirming response, therapists may be able to reconsolidate these traumatic memories such that they no longer get activated (Ecker et al., 2012). Indeed, research may provide evidence to support the notion of the "corrective emotional experience" outlined by Alexander and French (1946) decades ago.

### **INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY (ISTDP)**

A specific model of brief psychodynamic psychotherapy, Intensive Short-Term Dynamic Psychotherapy (ISTDP), has developed an evidence base for the treatment of a wide range of psychiatric disorders while providing a system of active techniques for the therapist similar to those described here (Abbass et al., 2006; Abbass et al., 2012). It is a particularly intriguing system to consider as a component of education for trainees because it provides specific tools for assessment and intervention based on psychodynamic principles. In our experience, both seasoned therapists and trainees who are newly embracing psychodynamic ideas become quite excited when exposed to this model, because it provides a guide for active yet empathic interventions. Train-



ees are delighted to discover a model of specific interventions based on dynamic concepts with such a growing evidence base. This model provides specific technical skills that are often lacking in the training of psychotherapists. Whereas much teaching in psychodynamic psychotherapy is centered around historical and emerging paradigms of psychopathology or general descriptions of the therapeutic relationships, it is less frequent to find a model outlining a specific process for interventions based on dynamic ideas. In our experience, trainees describe feeling more competent themselves and armed with a road map when exposed to this model, which facilitates an active and engaged stance with their patients. This model is based on psychoanalytic theory, but it employs specific and active techniques. In some sense, each therapy session is an experiment. The patient's response to our interventions is the central assessment tool and guide to intervention. Rather than relying on theorizing, trainees can learn to listen and watch the patient's response for the information they need to guide the process.

The model of ISTDP outlines the critical importance of identifying and strengthening both the conscious and the unconscious therapeutic alliance. The ISTDP therapist is not passive but takes an active stand for the patient, his or her health, growth, and development. The therapist immediately enlists the patient in a shared effort to establish treatment goals, to become emotionally engaged in the process, and to identify and abandon self-destructive psychological defenses. In agreement with Frieda Fromm-Reichmann's (1960) declaration that the patient is in need of an experience, not an explanation, the ISTDP therapist attempts to facilitate the direct experience of complex, anxiety-provoking feelings within the treatment session. Rather than exploring general themes, the therapist focuses the patient on particular feelings toward specific people in the patient's life. The active identification of defenses against the experience of affect is a central feature of this model. By connecting these defenses with the patient's presenting complaints and encouraging the direct experience of the patient's deepest feelings, lasting change can often be produced in weeks or months (Abbass et al., 2006; Abbass et al., 2012; Davanloo, 1990). In addition to an active approach to resistance, the ISTDP therapist is especially alert to conflicts emerging within the transference, addressing these conflicts directly and immediately, as they emerge. Inevitably, complex transference feelings are linked with similar feelings toward important figures in the patient's past and current life. Rather than interpreting these connections between past and present, therapist allows the patient to reveal these links, on the heels of his or her own experience of feelings toward the therapist.

By creating and maintaining a tight intrapsychic focus, blocking defenses, and encouraging the direct experience of previously avoided emotions, ISTDP has been shown to be an effective technique for activating the innate desire of the patient to be an authentic self, to connect intimately with others, and to heal. We have all seen patients who seem to have a very positive conscious alliance, but whose unconscious remains in lock-down, resulting in a lack of depth and complexity to their communications. In contrast, even patients who consciously resist can demonstrate a strong unconscious alliance. ISTDP provides for us a way of understanding nonverbal communication and directs students to the critical importance of signals and cues from the patient's body. For example, when a patient makes eye contact, sits forward, and rolls up his or her sleeves, even if the patient is saying, "I don't know about this therapy, Doc," he or she is unconsciously signaling a readiness to engage. Being able to assess the level and pathway of anxiety is a particular strength of this model. When anxiety is being channeled into the voluntary, striated muscle, with tension, hand clenching, and sighing respiration, it is a sign of readiness to address the feelings underneath the anxiety. In contrast, an individual who is physically limp and passive, presenting with somatic complaints of gastrointestinal symptoms or headaches, rather than the observable presentation of anxiety, will require interventions aimed at increasing the capacity to tolerate feelings and anxiety without resorting to the defenses of passivity and somatization. Being able to observe, understand, and assess the physical, nonverbal, communication of our patients greatly enhances our ability to intervene in specific and targeted ways in alignment with their current needs and capacities.

A review of the literature related to ISTDP underscores the vital contribution of an actively involved therapist to the development of the therapeutic alliance (and, ultimately, to the outcome of treatment), in both traditional dynamic psychotherapy and in other settings, including the emergency room (ER) (Abbass, Campbell, Magee, & Tarzwell, 2009; Abbass et al., 2006; Abbass, Kisely, & Kroenke, 2009; Abbass et al., 2012). A study examining the effectiveness of this emotionally focused method of intervention in an ER with patients who were experiencing unexplained medical symptoms demonstrated both clinical utility and significant cost savings to the health care system (Abbass, Campbell, et al., 2009). In that study, therapists began working with patients on the emotional issues precipitating the physical symptoms that brought them into the ER from the first moments of the interview. The therapist helped the patient to identify the trigger event, as well as the people involved. The therapist then inquired, as per the theoretical underpin-

nings of ISTDP, about the experience of feelings toward the person involved. In most cases, patients are initially unaware of their emotions, only their symptoms. So, for example, instead of connecting with anger toward her son who was dealing drugs out of her home, a patient who had come into the ER complaining of chest pain started to feel a tightening of her chest and difficulty breathing when questioned about her feelings toward him. The therapist was then able to show the patient (rather than tell her) that she seems to get anxious, with chest constriction and trouble breathing, when talking about her son. Furthermore, instead of facing her feelings toward him, she was keeping them inside, which created her symptoms. This method of tracking whether feelings are accessible, or are being diverted into defenses or anxiety, allows therapists to show patients the connection between defenses against feelings and presenting problems, and has proven very effective (Abbass et al., 2012).

In another study, Abbass and his colleagues (2008) randomly assigned 30 patients to this kind of active "trial therapy," in contrast to a more conventional psychiatric intake. Patients were also evaluated using the Brief Symptom Inventory and Inventory of Interpersonal Problems before the initial session and again 6 weeks later, after a waiting period when no treatment was provided. At 6-week follow-up, the data indicated that one third of the patients who had received the active intervention were no longer symptomatic and required no further treatment. Seven of the 30 patients discontinued all medication after this initial session, and two of the patients, who had been on disability, returned to work. These data suggest that when we actively engage patients psychodynamically from the inception of treatment, exploring the factors responsible for their current pain and distress, the alliance is strengthened and therapeutic effects can be achieved very rapidly. A yet unpublished study (Abbass, personal communication) went further, studying the effectiveness of 12 psychiatric residents in their initial assessments of 300 patients. The therapeutic effects demonstrated in the pilot study were replicated. This is especially noteworthy because the results were obtained by residents after only a year of training in ISTDP.

## CONCLUSION

Learning principles of psychodynamic psychotherapy has been a bedrock of the educational process for psychiatric residents. However, this education is complex, and in truth it takes years to become truly

wise and a master at most anything. This reality, however, should not serve as a justification to withhold teaching active techniques in psychotherapy. Residents must be taught how to actively focus their patients' attention on the internal world, how to identify and work with defensive processes, and how to facilitate the treatment alliance. Many students go to medical school because they want to do something active aimed at the reduction of suffering. They enjoy being active and are generally excited to learn how much they can actually do to help patients dynamically. On the other hand, being active may not come naturally to many students. Indeed, some may gravitate to psychiatry and to psychotherapy in particular with the fantasy that they can be relatively inactive. In addition, being active in the way we describe requires some work that is very hard for many, especially many beginners. For example, while active techniques designed to enhance an affect focus can be outlined and taught, only those therapists who have increased their own capacity to tolerate intense mixed feelings without resorting to undo anxiety or defensive processes will be able to learn these techniques. We are asking residents to be fearless about bringing affect to the fore, against the patient's effort to avoid affect, all in the context of a situation in which residents have no experience that this will be helpful. Learning this is hard! Above all, we should be attuned to how difficult it is for our students to learn active techniques in psychotherapy, and how tempting it might be for some of them to resort to "getting by" by imitating a passive stereotype. Learning to be active involves a willingness to make mistakes. Few mistakes can be made by a learner who sits quietly, listening, perhaps at least feeling that he or she is bearing witness and in some sense "being there" for a patient. Finally, people often enter psychiatry because they see themselves as healers; as part of their self-concept, they need to see themselves as "nice and kind." Actively challenging defenses and working to facilitate affect can often fly smack in the face of this preferred view of the therapist/self.

Let us return to the scenario of the PGY-3 psychiatry resident, struggling to make a connection with her desperate patient. We must teach this resident to become actively curious. Rather than passively turning questions back on her patient, this resident has numerous avenues to explore. For example, she might begin by actively eliciting examples—examples of the problems with people at work, examples of problems in the marriage, and a discussion of the feeling of depression. With these examples in hand, the resident can then work with her patient about his own feelings toward people in the workplace and toward his spouse, and the patient and therapist can explore how these feelings are experienced. Defenses against feelings can be identified, and encouragement toward the experience of true feelings can be encouraged. In this kind

of more active conversation, both the patient and the resident/therapist will abandon their passive postures and sit up in their seats.

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