Clients' Experience of Effective Psychoanalytic-Psychodynamic Psychotherapy for Major Depression: An Empirical Phenomenological Study

Thomas Smith

Follow this and additional works at: https://dsc.duq.edu/etd

Recommended Citation
CLIENTS’ EXPERIENCE OF EFFECTIVE PSYCHOANALYTIC-
PSYCHODYNAMIC PSYCHOTHERAPY FOR MAJOR DEPRESSION:
AN EMPIRICAL PHENOMENOLOGICAL STUDY

A Dissertation
Submitted to McAnulty College and
Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By

Thomas J. Smith

May 2009
CLIENTS’ EXPERIENCE OF EFFECTIVE PSYCHOANALYTIC-
PSYCHODYNAMIC PSYCHOTHERAPY FOR MAJOR DEPRESSION:
AN EMPIRICAL PHENOMENOLOGICAL STUDY

By

Thomas J. Smith

Approved March 17, 2009

Roger Brooke, Ph.D., ABPP
Professor of Psychology
(Dissertation Director)

Constance Fischer, Ph.D., ABPP
Professor of Psychology
(Committee Member)

Jessie Goicoechea, Ph.D.
Assistant Professor of Psychology
(Committee Member)

Ralph L. Pearson, Ph.D.
Provost / Academic Vice President and Professor, The McAnulty College and Graduate School of Liberal Arts

Daniel Burston, Ph.D.
Chair, Psychology Department
Professor of Psychology
ABSTRACT

CLIENTS’ EXPERIENCE OF EFFECTIVE PSYCHOANALYTIC-PSYCHODYNAMIC PSYCHOTHERAPY FOR MAJOR DEPRESSION:
AN EMPIRICAL PHENOMENOLOGICAL STUDY

By

Thomas J. Smith

May 2009

Dissertation Supervised by Professor Roger Brooke

Although there is sufficient evidence that psychodynamic therapy for depression is effective, there is no research documenting the qualities of experience in effective psychodynamic therapy for depression. To address this lack, this study aimed to investigate clients’ experiences of both the helpful processes and the therapeutic effects of psychodynamic therapy for depression.

Letters, emails, and flyers were distributed and advertisements placed through psychological associations at the local and state level, and letters were mailed to therapists in the greater Pittsburgh metropolitan area. Solicitation procedures yielded four participants of whom three were female and one was male. Participants completed a research questionnaire, and provided written descriptions of the process and outcome of psychodynamic therapy. They expanded upon their descriptions in an individual interview.
A master psychological text that transcribed and combined each interview with each written description served as the focus of data analysis. The data was analyzed according to the empirical phenomenological method outlined by Giorgi (1975, 1985). The data analysis procedures for each text included the demarcation of meaning units, the formulation of central themes of each unit, and the integration of central themes. The results consisted of four situated structural descriptions of effective psychodynamic therapy for depression. These descriptions synthesized themes and relations among themes. A general structural description left out themes specific only to each situated description.

The study found that psychodynamic therapy helped participants to modify their involvement in a situation that was a source of suffering by teaching them to attend to their feelings differently and by facilitating their development of a complex sense of self. Regarding the effects of therapy, the therapy helped to relieve the intensity and duration of participants’ depressive episodes, to improve the quality of participants’ engagements with others and with their own projects, and to encourage participants’ resiliency and continued psychological growth after termination. Regarding the helpful facets of therapy, in addition to client discussion of important topics such as relationships and loss, and in addition to therapist interventions such as clarification and confrontation, the deeply personal therapeutic relationship and the participants’ integration of therapists’ care was central to the process of therapy. The results of the study were discussed in regard to psychodynamic theories of depression and therapy, and to research on therapy for depression.
DEDICATION

I dedicate this dissertation to my son. He may or may not be born by the time the dissertation is defended, but I am touched that he will be able to watch daddy graduate.
ACKNOWLEDGMENT

I first want to give thanks to God. I felt God’s presence throughout the entire dissertation process. Although I doubted myself at times, I still had this greater sense of purpose. I thank God for providing me with strength and for blessing me with the support of others.

I give thanks, with all my heart, to my family. My father and my mother have provided me with support in every sense of the word. From personal, to practical, to financial support, my parents enabled me to focus my efforts on the arduous process of writing a dissertation. I thank my father and my mother for their love and for their faith in me. I am also grateful to my brother and sister-in-law. Shawn, you are someone who really listened to me and my struggles and, rather than offering platitudes, you validated me and the struggle itself. My brother, we share a love of life, laughter, and music, and I am glad you have been with me in this journey. I am thankful for my grandmother. Although I may not have been confident at times, she always exuded a sense of pride in her grandson. I thank you all for your prayers.

I offer thanks to my long-time friends, Chris, Meg, Todd, Angela, Loree, and Christian. My contact with you all provided me with solace when the process was difficult and reminded me that there was more to life than my work. In this next phase of life, I look forward to our children becoming friends as well. I also want to thank new friendships that have formed along the way. Todd and Holly you expressed interest in my dissertation and concern when the process was not going well. You also celebrated
with me when I felt like I was actually making progress, and I am grateful to have you
both in my life. I thank you all for your friendships.

I express gratitude to Scott Smith for the endless inspiration he provided. Cheers!

I give thanks to Bob McInerney. He is a friend who I admire and a passionate
professor who I could only hope to emulate. I appreciate our discussions at Sharp Edge.
Slainte!

I am grateful to my research participants. You had the courage to share with me
your struggles and your growth, and I thank you.

I offer thanks to my director, Dr. Roger Brooke, for all the guidance that he
provided. I truly appreciate that he shared in my research interests and was as excited
about my research as I was. I am also grateful to my committee, Dr. Constance Fischer
and Dr. Jessie Goicoechea. I appreciate their insightful commentary and their
encouragement. I believe that my dissertation is a much better piece of work after all the
help my director and committee have provided.

I give thanks to all the faculty of the Duquesne Psychology Department from
whom I have learned over the years. You helped me to develop the ability to think
critically both in my writing and in my clinical practice.

Most of all, I thank my wife. Misty, you are my best friend, my lover, my
everything. You provided unfaltering emotional support and shared with me all the joys
and sorrows that arose throughout the process. You believed in me when I did not
believe in myself. You also provided me with the help I needed at every step along the
way. Even though you may not have understood something in the dissertation or about
the process, you tried to understand and that matters the world to me. I am indebted to
you for our long talks about and your tireless readings of the dissertation, and you know
more about phenomenology and clinical psychology than you will ever need to know. I
can honestly say that this dissertation is as much yours as mine: I could not have done
this without you. Thanks for standing by me with infinite patience. I love you.
<table>
<thead>
<tr>
<th>TABLE OF CONTENTS</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract.................................................................</td>
<td>iv</td>
</tr>
<tr>
<td>Dedication.................................................................</td>
<td>vii</td>
</tr>
<tr>
<td>Acknowledgement.................................</td>
<td>viii</td>
</tr>
<tr>
<td>1 Introduction........................................</td>
<td>1</td>
</tr>
<tr>
<td>2 Review of the Literature...............</td>
<td>4</td>
</tr>
<tr>
<td>2.1 Research Regarding the Therapy for Depression</td>
<td>4</td>
</tr>
<tr>
<td>2.1.1 Outcomes Studies......................</td>
<td>5</td>
</tr>
<tr>
<td>2.1.2 Common Factors &amp; Specific Factors Research</td>
<td>14</td>
</tr>
<tr>
<td>2.1.3 Clients’ Perceptions of Psychotherapy Studies</td>
<td>21</td>
</tr>
<tr>
<td>2.1.4 Process Studies......................</td>
<td>23</td>
</tr>
<tr>
<td>2.2 Psychodynamic Theories of Depression</td>
<td>31</td>
</tr>
<tr>
<td>2.2.1 Drive Theory...........................</td>
<td>31</td>
</tr>
<tr>
<td>2.2.2 Object Relations Theory...............</td>
<td>37</td>
</tr>
<tr>
<td>2.2.3 Libido Theory.........................</td>
<td>43</td>
</tr>
<tr>
<td>2.2.4 Ego Psychology......................</td>
<td>45</td>
</tr>
<tr>
<td>2.2.5 Self Psychology....................</td>
<td>48</td>
</tr>
<tr>
<td>2.2.6 Contemporary Theories............</td>
<td>50</td>
</tr>
<tr>
<td>2.2.7 Summary of Psychodynamic Theories of Depression</td>
<td>53</td>
</tr>
<tr>
<td>2.3 Psychodynamic Therapy for Depression</td>
<td>57</td>
</tr>
<tr>
<td>2.3.1 The Goal of Psychodynamic Therapy</td>
<td>58</td>
</tr>
<tr>
<td>2.3.2 The Outcome of Psychodynamic Therapy</td>
<td>60</td>
</tr>
</tbody>
</table>
2.3.3 The Relationship in Psychodynamic Therapy

2.3.4 The Therapist in Psychodynamic Therapy

2.3.5 The Technique in Psychodynamic Therapy

2.3.6 The Process of Psychodynamic Therapy

2.4 Summary

3 Method

3.1 Data Collection

3.1.1 Step One: Participant Sample & Solicitation

3.1.2 Step Two: Informed Consent & Confidentiality

3.1.3 Step Three: Research Questionnaire

3.1.4 Step Four: Written Descriptions

3.1.5 Step Five: Interviews

3.2 Data Analysis

3.2.1 Step Six: Creation of Master Psychological Text

3.2.2 Step Seven: Demarcation of Master Text into Units

3.2.3 Step Eight: Formulation of Central Themes of Units

3.2.4 Step Nine: Integration of Central Themes

3.2.5 Step Ten: Formulation of the Situated Structure

3.2.6 Step Eleven: Formulation of the General Structure

4 Results

4.1 Situated Structure #1

4.2 Situated Structure #2

4.3 Situated Structure #3
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A3.3 Research Questions</td>
<td>205</td>
</tr>
<tr>
<td>A3.4 Request for Written Description</td>
<td>206</td>
</tr>
<tr>
<td>Appendix 3: Data and Analysis Participant # 1</td>
<td>207</td>
</tr>
<tr>
<td>A3.1 Written Description</td>
<td>207</td>
</tr>
<tr>
<td>A3.2 Interview</td>
<td>212</td>
</tr>
<tr>
<td>A3.3 Master Psychological Text with Meaning Units &amp; Central Themes.....</td>
<td>225</td>
</tr>
<tr>
<td>A3.4 Integration of Central Themes</td>
<td>251</td>
</tr>
<tr>
<td>Appendix 4: Data and Analysis Participant # 2</td>
<td>255</td>
</tr>
<tr>
<td>A4.1 Written Description</td>
<td>255</td>
</tr>
<tr>
<td>A4.2 Interview</td>
<td>261</td>
</tr>
<tr>
<td>A4.3 Master Psychological Text with Meaning Units &amp; Central Themes.....</td>
<td>289</td>
</tr>
<tr>
<td>A4.4 Integration of Central Themes</td>
<td>344</td>
</tr>
<tr>
<td>Appendix 5: Data and Analysis Participant # 3</td>
<td>350</td>
</tr>
<tr>
<td>A5.1 Written Description</td>
<td>350</td>
</tr>
<tr>
<td>A5.2 Interview</td>
<td>354</td>
</tr>
<tr>
<td>A5.3 Master Psychological Text with Meaning Units &amp; Central Themes.....</td>
<td>371</td>
</tr>
<tr>
<td>A5.4 Integration of Central Themes</td>
<td>404</td>
</tr>
<tr>
<td>Appendix 6: Data and Analysis Participant # 4</td>
<td>409</td>
</tr>
<tr>
<td>A6.1 Written Description</td>
<td>409</td>
</tr>
<tr>
<td>A6.2 Interview</td>
<td>412</td>
</tr>
<tr>
<td>A6.3 Master Psychological Text with Meaning Units &amp; Central Themes.....</td>
<td>435</td>
</tr>
<tr>
<td>A6.4 Integration of Central Themes</td>
<td>477</td>
</tr>
</tbody>
</table>
Chapter 1

Introduction

Depression is one of the most prevalent mental health concerns (Lambert & Davis, 2002). In addition, the therapy of depression is the most frequently researched psychotherapy for a particular disorder (Lambert & Davis, 2002). Psychodynamic psychotherapy is a widely practiced type of psychotherapy that has a basic insight-orientation and emotion-focus. It aims at deep-seated change in addition to symptomatic improvement by addressing developmental themes, relational issues, and the significance of the unconscious. There is sufficient evidence documenting that psychodynamic therapy for depression is effective (Leichsenring & Rabung, 2008), but there is no research documenting the qualities of clients’ experience in effective psychodynamic therapy for depression. To fill this gap, my study investigated clients’ experiences of process and outcome in effective psychodynamic psychotherapy for major depression.

This research study is set apart from the current psychotherapy research milieu, firstly, in investigating a type of long-term psychotherapy of major depression that occurred in the field as opposed to a short-term therapy conducted under controlled conditions; and secondly, in examining both the process and outcome of psychotherapy instead of focusing on just one of these aspects. Lastly, this study is distinguished from other studies in that it performs a qualitative analysis of clients’ descriptions of effective psychodynamic psychotherapy rather than conducting a quantitative psychotherapy
study. In short, using an empirical phenomenological method, this study elucidated clients’ descriptions of the helpful facets and therapeutic effects of effective long-term psychodynamic therapy for depression.

The Review of the Literature follows this Introduction and surveys literature pertinent to the research topic. It addresses contemporary research concerning therapy for depression, psychodynamic theories of depression, and psychodynamic therapy for depression. The Method Chapter follows the Review of the Literature and provides a description of the empirical-phenomenological method used for the study. It highlights the steps followed, from data gathering to data analysis. The Results Chapter presents the results in the form of four situated structural descriptions of effective psychodynamic therapy for depression and one general structural description of the phenomenon. The next chapter provides an Elaboration of the General Structure with illustrations taken from participants’ descriptions. The Discussion Chapter follows the Elaboration of the General Structure and discusses results regarding the participants’ experience of being depressed, the process of psychodynamic therapy, and the outcome of psychodynamic therapy in light of the literature. It also addresses contributions of the study, limitations of the study, and offers suggestions for future research. The participants’ descriptions of effective psychodynamic therapy for depression are located in the appendices along with the solicitation and research material.

To note, the language of our culture has come to speak of depression as a noun. This manner of speaking about depression is also dominant in clinical psychology for its heuristic usefulness. Speaking about depression as a noun fits nicely within the medical model predominantly used in clinical psychology in that depression is seen as an illness.
to be treated. However, my occasional use of such languaging and speaking about
depression as a noun throughout the dissertation, especially in the Review of the
Literature, is not an endorsement of the medical model. I do not understand depression
as something one has. I understand depression as a mode of being that encompasses
one’s emotional and imaginative life, one’s body, and one’s engagements with others and
projects; therefore, depression is better spoke of as being depressed in that it is a mode of
being-in-the-world. As will be evident, the Results support such an understanding of
depression and it’s treatments.
Chapter 2

Review of the Literature

This Review of the Literature is divided into three sections, which addresses contemporary research regarding the therapy of depression, psychodynamic theories of depression, and psychodynamic therapy of depression. Section one reviews contemporary research about the therapy of depression and looks at outcome studies, common factors studies, client’s perception of therapy studies, and process studies. The relevance of these four areas of research to the development of my research method and design are discussed. Section two reviews drive theory, object relations theory, libido theory, ego psychology, and self psychology. A summary is provided at the end of the section highlighting eight key issues in the psychodynamic literature about depression, which are relevant to the discussion of the results of my study. Section three surveys the six main facets of psychodynamic therapy of depression, which also are pertinent to the discussion of my results. The particular facets addressed are the goal of therapy, the anticipated outcome of therapy, the therapeutic relationship, the therapist, the techniques used in therapy, and the process of therapy.

2.1 Research Regarding the Therapy of Depression

My study of the client’s experience of effective psychodynamic therapy for major depression is situated within a larger context of research that attempts to determine if and
how psychotherapy ‘works.’ Reviewing contemporary research regarding the therapy of depression provides a perspective from which to understand and assess my study. Four areas of research will be surveyed, concerning outcome studies, common factors studies, client’s perception of therapy studies, and process studies.

2.1.1 Outcome Studies

A recent review of meta-analytic outcomes declared the efficacy of therapies for depression (see Table 2.1). The review suggested that clients attending therapy exceed control clients in both no-treatment and wait-list conditions in terms of improvement (Lambert & Ogles, 2004). Reviews also point to the continued failure of research to establish a connection between a specific modality of therapy for depression and better outcomes (Beckham, 1990; Lambert & Davis, 2002). No evidence was found for the superiority of one type of therapy in four out of the seven meta-analyses in Table 2.1 (Leichsenring, 2001; Nietzel, Russell, Hemmings, & Gretter, 1987; Robinson, Berman, & Neimeyer, 1990; Steinbrueck, Maxwell, & Howard, 1983). Concerning the other three meta-analyses that found some difference in efficacy, researchers showed that cognitive therapy did moderately better than other therapies with reference to symptomatic improvement (Dobson, 1989; Gaffan, Tsaousis, & Kemp-Wheeler, 1995; Gloaguen, Cottraux, Cuchreat, & Blackburnm, 1998). However, after taking into account researcher allegiance and other statistical concerns involved in these three studies, along with results of the other four meta-analyses, the meta-analyses provided no conclusive evidence for the superiority of one modality of therapy. Even though they demonstrated that therapy worked, the meta-analyses were unable to highlight the efficacious ingredients involved in the therapy of depression.
Four out of the five meta-analytic reviews in Table 2.1 that compared different treatments of depression grouped psychodynamic psychotherapy with other therapy modalities. These “other therapies” were: interpersonal, psychodynamic, and insight-oriented therapies in Dobson (1989); interpersonal, rational-emotive, and psychodynamic/insight-oriented therapies in Gaffan et al. (1995); psychodynamic, insight-centered, supportive, and expressive therapies in Gloaguen et al. (1998); and psychodynamic, client-centered, and interpersonal therapies in Robinson et al. (1990). These groupings highlight the lack of representation of psychodynamic psychotherapy in most meta-analyses and the accompanied focus on cognitive and behavioral treatments. The Leichsenring (2001) meta-analysis directly addressed psychodynamic psychotherapy

Table 2.1: Meta-analytic Reviews of Therapies for Depression

<table>
<thead>
<tr>
<th>Authors</th>
<th>Treatment(s)</th>
<th># of Studies</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dobson (1989)</td>
<td>CBT</td>
<td>10</td>
<td>2.15</td>
</tr>
<tr>
<td>Gaffan et al. (1995)</td>
<td>CBT</td>
<td>Study 1=7</td>
<td>1.56</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Study 2=11</td>
<td>.89</td>
</tr>
<tr>
<td>Gloaguen et al. (1998)</td>
<td>CBT</td>
<td>20</td>
<td>.82</td>
</tr>
<tr>
<td>Leichsenring (2001)</td>
<td>Dynamic vs. CBT</td>
<td>6</td>
<td>.08</td>
</tr>
<tr>
<td>Nietzel et al. (1987)</td>
<td>CT, BT, CBT, other</td>
<td>28</td>
<td>.71</td>
</tr>
<tr>
<td>Quality Assurance Project (1983)</td>
<td>not listed</td>
<td>10</td>
<td>.65</td>
</tr>
<tr>
<td>Robinson et al. (1990)</td>
<td>CT, BT, CPT, gen. verbal</td>
<td>29</td>
<td>.84</td>
</tr>
<tr>
<td>Steinbrueck et al. (1983)</td>
<td>BT, CT, IPT, combo of 3, marital therapy</td>
<td>56</td>
<td>1.22</td>
</tr>
<tr>
<td>Thase et al. (1997)</td>
<td>CBT &amp; IPT</td>
<td>6</td>
<td>37% / 25% recovery-rate</td>
</tr>
</tbody>
</table>

Adapted from Lambert and Ogles, 2004, p. 142
and compared the treatment to cognitive-behavioral therapy, but even this meta-analysis focused on short-term dynamic therapy, leaving out long term psychodynamic psychotherapies of depression.

A look at the outcome measures analyzed in the meta-analyses cited in Table 2.1 will help to assess the appropriateness of outcomes research methodology for the study of psychodynamic psychotherapy. Four meta-analyses examined the Beck Depression Inventory (BDI) exclusively (Dobson, 1989; Gaffan et al., 1995; Gloaguen et al., 1998; Nietzel et al., 1987), one meta-analysis analyzed the Hamilton Rating Scale of Depression (HRSD) exclusively (Thase et al., 1997), and three meta-analyses examined multiple outcome measures including the BDI and HRSD (Leichsenring, 2001; Quality Assurance Project, 1983; Robinson et al., 1990). The BDI and the HRSD both require the endorsement of symptoms of depression: the BDI through client self-report and the HRSD by a clinical evaluator. The symptoms have already been provided for the endorser to designate and the endorser is requested to quantify the severity of the symptoms.

Solely examining the BDI and HRSD limited the results of the studies that were examined in most meta-analyses to symptoms of depression while leaving out other areas of significant change (e.g., relationships and work). Psychodynamic formulations of psychotherapy for depression do not solely focus on symptom relief. Jones, a prominent psychotherapy researcher, explained as follows: “The assessment of change in psychotherapy has focused almost exclusively on the measurement of symptomatic improvement. However, for most psychoanalytically oriented clinicians, an important goal is change of psychological structure, that is, long-term relief coupled with enduring
change in the patient’s mental functioning and personality” (2002, p. 283). Outcomes research that studies psychodynamic psychotherapy and focuses exclusively on symptomatic improvement is not congruent with psychodynamic theories and goals. Bohart, O’Hara, and Leitner (1998) proposed, “Therapies should be empirically studied in terms that are appropriate to framing assumptions of the paradigm” (1998, p. 143). In order to study psychodynamic psychotherapy on its own terms, my study did not use predefined measures of depressive symptomatology to quantify outcome.

The National Institute of Mental Health Treatment of Depression Collaborative Research Program (TDCRP) was a methodologically strict study and the largest psychotherapy study to date. A consideration of the design and findings of the paradigmatic outcome study will further situate my research study. After looking at the design in this paragraph, a series of articles on the study will be presented that regard the analysis of effectiveness and the analysis of specific aspects of the study as well as secondary analyses. This collaborative controlled clinical trial was designed to test at three different research sites the relative efficacy of two short-term therapies for depression: cognitive behavioral (CBT) (Beck, Rush, Shaw, & Emery, 1979) and interpersonal (IPT) (Klerman, Weissman, Rounsaville, & Chevron, 1984). In a report that presented the background, rationale, and plan for the TDCRP, Elkin, Parloff, Hadley and Autry (1985) thought the therapies seemed to represent two different and fundamental orientations toward psychotherapy: the behavioral and the psychodynamic. These two therapies were developed and practiced according to treatment manuals and were planned to be sixteen weeks in duration. The two therapies were compared against imipramine-hydrochloride (IMI), an antidepressant drug for which efficacy had already
been established. A pill-placebo (PLA) was introduced as a control for IMI and for the two therapies. Both IMI and PLA included a clinical management (CM) component, which can be seen as a minimally supportive therapy condition. All participants obtained a diagnosis of Major Depressive Disorder, and there were myriads of criteria for the exclusion of additional specific disorders. Participants were randomly assigned to one of four treatments. Outcome measures assessed depressive symptomatology, overall symptomatology, general functioning, and treatment specific measures.

Elkin et al. (1989) declared the general efficacy of the treatments. Clients in all treatments showed a decrease in depressive symptoms and an increase in general functioning. The findings showed few differences in efficacy between the treatments at outcome. The results also showed sparse differences in efficacy between CBT and IPT over the course of treatment and few differences in efficacy between treatments at an 18-month follow-up (Shea et al., 1992; Watkins et al., 1993). The TDCRP primary analyses, like the meta-analyses in Table 2.1, failed to shed any light on the efficacious features of therapy due to the findings of no differences in the efficacy of treatments throughout therapy, at outcome, and at follow-up.

Shea et al. (1992) reported that among clients who had recovered (39% clients in the completer sample) there were no significant differences between treatments in percentage of clients who recovered and remained well (30% in CBT & 26% in IPT), and no significant differences in rates of relapse (36% CBT & 33% IPT). The treatments ranged from 16 to 20 sessions, and Shea et al (1992) concluded that the short-term duration of these treatments is insufficient to enable most clients to achieve a complete recovery and an enduring remission (p. 786). These findings provided support for my
study on long-term, as opposed to short-term, psychodynamic psychotherapy of depression since such a focus facilitated the inclusion of clients who might achieve lasting improvement.

Outcomes measures were chosen for sensitivity to the potential effects specific to each therapy (Dysfunctional Attitude Scale for CBT & Social Adjustment Scale for IPT). The results indicated that neither CBT nor IPT produced consistent mode-specific effects at outcome or over the course of therapy (Imber et al., 1991; Watkins et al., 1993). However, certain client characteristics contributed to differential therapy outcome. With more severely depressed clients, some evidence was found for the differential efficacy and modest superiority of IPT compared with CBT and PLA-CM (Elkin et al., 1995). In addition, low social dysfunction predicted superior response to IPT whereas low cognitive dysfunction predicted superior response to CBT (Sotsky et al., 1991). After numerous primary and secondary analyses, the researchers had to take into account client factors to highlight any differential treatment outcome.

The TDCRP was a model efficacy study since the researchers designed and conducted the study as a scientifically rigorous controlled clinical trial. However, is the efficacy study the most appropriate way to study therapy? Seligman (1995) held that the efficacy study is the wrong way to assess therapy since the efficacy study leaves out essential facets of therapy as actually practiced in the field. Seligman highlighted five such facets: (a) therapy is of variable length in contrast to the fixed duration (~12 sessions) in efficacy studies; (b) therapy is self-correcting as opposed to the limited, model based techniques used in a manualized and set order manner in efficacy studies; (c) clients actively shop for and choose a therapy-therapist whereas they are randomly
(and passively) assigned treatment in efficacy studies; (d) clients typically have multiple problems as opposed to the diagnostic purity valued in efficacy studies; (e) therapy is concerned with gains in general functioning in addition to the symptom relief that is usually the sole focus of efficacy studies (pp. 965-967). The design of the efficacy study distorts the real-life conduct of therapy so much that potential results seem unlikely to contribute to any understanding of therapy outside the laboratory. Seligman turned to the effectiveness study as a method faithful to the elements of therapy as done in the field. My research is more akin to an effectiveness study. The clients who were solicited had attended psychodynamic psychotherapy in the field, and so my study was calculated to have a direct return in furthering an understanding of the client’s experience of the actual practice of the therapy for depression.

Freedman, Hoffenberg, Vorus, & Frosch (1999) conducted one such effectiveness study using a shortened version of a Consumer Reports survey (Seligman, 1995). 99 outpatients responded to the survey during and after psychodynamic psychotherapy. The clients endorsed items pertinent to assessing effectiveness, such as specific improvement with problems that led client to therapy, client satisfaction, and global improvement. Clients checked items in regard to adaptive life gains such as relating to others, productivity at work, and enjoying life more. The study found that effectiveness significantly correlated with the client’s experience of a positive relationship with the therapist. The study also found gains in effectiveness with increase in duration (from 6 to 24 months of therapy) and in frequency (from 1 to 2 or 3 weekly sessions). Based on these findings, the researchers hypothesized that with the increased duration and/or frequency, the client had a more intensified exposure to the therapist and the positive
relationship, which in turn facilitated the internalization of the supportive and growth-enhancing qualities of the therapist.

The clients also checked any of twelve problems for which they sought psychodynamic psychotherapy such as depression, low mood, grief, general anxiety, children/familial concerns, and job problems. The researchers identified two types of depressed clients in the sample: depression with anxiety and depression with grief. The depressed-anxious group showed a positive response with specific symptom improvement when the duration and frequency of psychotherapy increased. The depressed-grief group showed a positive response with adaptive life gains when duration of psychotherapy increased. In light of these findings, my study focused on once to twice weekly psychodynamic psychotherapy of at least a year’s duration for depression to include potential gains due to frequency and duration. In addition, my research design, like that of the Freedman et al (1999) effectiveness study, is geared toward inclusion of more than just symptomatic gains.

Leichsenring and Rabung (2008) address criticisms that were raised about meta-analyses and the TDCRP. They performed the first meta-analysis on the effectiveness of long-term psychodynamic therapy and thereby compensated for the lack of representation of this long-term therapy in the field of research. Their design included the calculation of effect sizes at the end-of-therapy, and at follow-up, for overall effectiveness, target problems, general psychiatric symptoms, personality functioning, and social functioning. They therefore included many important areas of change, unlike other studies sampled by meta-analyses that solely addressed symptom relief. Leichsenring and Rabung specifically focused on the effects of psychodynamic therapy for complex mental
disorders, since, as has been noted with the TDCRP, short-term therapy has been found insufficient for complete recovery and lasting remission with this population. They examined therapy for the following disorders: personality disorders, chronic mental disorders, multiple mental disorders, and complex depressive and anxiety disorders. Leichsenring and Rabung conducted the analysis with procedural rigor and included only studies that met strict criteria regarding the type of therapy and quality of research.

Leichsenring and Rabung (2008) included twenty-three studies that met inclusion criteria. Eleven of these studies were randomized controlled clinical trials (i.e., efficacy studies) and twelve were observational studies (i.e., effectiveness studies). They included both types of studies because, as highlighted with Seligman’s (1995) commentary, there is ongoing discussion in the field concerning which type offers better evidence of effectiveness. Leichsenring and Rabung performed a comparative analysis of controlled trials. In the eight studies that provided the necessary data, comparison treatments included cognitive-behavioral therapy, cognitive-analytic therapy, dialectical-behavioral therapy, family therapy, supportive therapy, short-term psychodynamic therapy, and psychiatric treatment as usual. For all studies and for studies that focused on complex mental disorders, long-term psychodynamic therapy yielded significantly higher outcomes in overall effectiveness, target problems, and personality functioning than did the other forms of short-term therapy in the comparison group. For five studies that focused on complex depressive and anxiety disorders, psychodynamic therapy, without concomitant psychotropic medication treatment, produced significant outcomes in overall effectiveness, general psychiatric symptoms, and social functioning at the end-of-therapy. In fact, all effect sizes both at the end-of-therapy and at follow-up were large (> 0.08),
which demonstrates that outcome was impressive and stable. Leichsenring and Rabung conclude that long-term psychodynamic therapy is an effective therapy for complex mental disorders, and their meta-analysis provides sufficient evidence for the effectiveness of psychodynamic therapy for depression. However, the qualities of experience of this therapy still have not been documented. Hence, my study examined the clients’ experience of the processes that facilitated change in psychodynamic therapy for depression.

2.1.2 Common Factors and Specific Factors Research

In looking at outcome studies, the conclusion was drawn that psychotherapy for depression and, in particular, long-term psychodynamic therapy for depression, ‘works.’ The potential clinical value of outcome studies is based upon the premise that particular types of therapy are responsible for producing better outcomes; however, besides the Leichsenring and Rabung (2008) meta-analysis and a few other meta-analyses, most meta-analyses of outcome studies found no differences in outcome due exclusively to the type of therapy for depression the clients attended and so uncovered none of the efficacious features of therapy. As far back as 1990, Beckham caught sight of this kind of trend and declared that psychologists needed to develop new theories to take into account these kinds of findings (p. 210). Beckham believed that a formulation of the common factors and their effects was one such approach that made the research results intelligible and provided an understanding of the therapeutic ingredients of treatment.

Common factors are variables shared by all therapies that may be responsible for therapeutic outcome. Lambert (2003) divided the common factors into four broad areas and deduced the specific percentage of client improvement as a function of each common
factor: client factors and extratherapeutic events (40%), relationship factors (30%), expectancy and placebo effects (15%), and technique-model factors (15%). The percentages were based on extensive psychotherapy outcomes research (Lambert, Shapiro, & Bergin, 1986). Lambert used no statistical procedures to obtain the percentages and so the exactitude of the percentages may not be completely warranted (2003, p. 98). I also think the task of isolating common factors to derive a percentage is misleading because these factors are interrelated and each contributes to the others’ therapeutic effect. That notwithstanding, the common factors will be addressed to illustrate the role each plays in contributing to outcome in the therapy of depression and ultimately to show their significance for the design of my research study.

Extratherapeutic change contributes the largest percentage of client improvement in therapy (40%) according to Lambert and includes both client and environmental factors (2003). Client factors played a significant role in the TDCRP, and the only way to arrive at differential outcomes for CBT and IPT was to take into account client characteristics (Sotsky et al., 1991). Client factors also predicted change across therapies. Lower social dysfunction, lower cognitive dysfunction, and endogenous depression were significantly associated with better outcomes whereas double depression (i.e., a major depressive episode superimposed on a prior dysthymic disorder) was significantly associated with worse outcomes.

The therapeutic relationship accounts for another large percentage of client improvement in therapy (30%) according to Lambert (2003). Bachelor and Horowitz (1999) reviewed therapist characteristics that contribute to the therapeutic relationship, and they highlighted the importance of “establishing a climate of trust and safety through
responsiveness; active listening; and the communication of understanding, liking, and respect” (p. 161). In the TDCRP, a positive therapeutic relationship reported by clients early in treatment contributed significantly to the prediction of improvement (Blatt, Zuroff, Quinlan, & Pilkonis, 1996). Concerning exploratory analyses that took into account client perfectionism, the therapeutic relationship significantly predicted change at moderate levels of perfectionism whereas the relationship only marginally predicted change at low and high levels of perfectionism (pp. 168-169). This finding points to the importance of client factors and client contributions to outcome. Nonetheless, the quality of the therapeutic relationship was found to be independent of the client’s level of perfectionism, indicating therapist contributions to the relationship (p. 169).

Ackerman and Hilsenroth (2003) provided a review of what they termed therapist attributes and techniques that positively influence the therapeutic alliance. In terms of personal attributes, therapists were warm, respectful, interested, open, flexible, and confident (p. 28). With regard to techniques, therapists were attentive, supportive, and understanding, and they facilitated exploration, reflection, and depth (p. 28). In the TDCRP, the therapeutic alliance, as assessed by clinical raters, had a significant effect on outcome in all treatments with no significant difference between treatments (Krupnick et al., 1996, p. 536). In fact, more variance in clinical outcome was attributable to therapeutic alliance than to the treatment method (p. 536). Ratings of patient contribution to the alliance were significantly related to outcome while therapist contribution was not (p. 537). This finding again highlights the importance of client factors and contributions, and is consistent with research demonstrating the impact on outcome of the client’s perception of the relationship (Bachelor & Horvath, 1999, p. 161).
Expectancy and placebo effects account for a significant percentage of client gains in therapy (15%) according to Lambert (2003), and involve the client’s knowledge of participating in a supposedly credible treatment and his or her corresponding expectation of getting better. The Robinson et al. (1990) meta-analysis of therapies for depression revealed no significant differences in effect size obtained for therapy versus (attention or pill) placebo (ES=.28) (p.34). The results of the TDCRP also indicated a lack of general and significant differences between the therapies and PLA-CM (a supportive professional contact with pill placebo) (Elkin et al., 1989, p. 977). Analyses of the TDCRP data further showed that high patient expectation was significantly associated with greater likelihood of complete response and lower depression severity at termination (Sotsky et al., 1991, p. 1002). In addition to expectancy and placebo effects, the process of therapy fosters hope; Synder, Michael, and Cheavens (1999) thought that clients become hopeful in therapy by finding a new goal, a new pathway to a goal, or a new sense of agency about reaching a goal.

While looking at the common factors research, the importance of client factors for therapeutic outcome came to the fore. This should come as no surprise because clients are the ones who bring their environment and personal characteristics with them into the consulting room, clients are the ones contributing to the therapeutic relationship, and clients are the ones expecting to improve. In light of important contributions clients make to the process of therapy and their own outcome, my research study centered on clients. My research study analyzed clients’ experiences and feelings regarding the helpful facets and effects of psychodynamic psychotherapy with clients who found
treatment effective. In this way, my research unpacked the fit between these particular clients and psychodynamic therapy-therapist.

Technique factors comprise variables unique to specific therapeutic models and they contribute to 15% of client improvement according to Lambert (2003). Nevertheless, a move toward technique-based training has occurred across the field of psychotherapy with an increased enthusiasm for attempts at research to substantiate such a shift (Ogles, Anderson, & Lunnen, 1999, p. 39). This trend is seen in the efforts of a Task Force appointed by Division 12 (Clinical Psychology) of the American Psychological Association (APA). With psychotropics increasingly seen as the sole treatment of choice for depression and other psychological disorders, Division 12 sought to have clinical psychology prove its efficacy in a way that would be convincing to the field of psychiatry and medicine (Brooke, 2006). With this aim, they set forth research criteria for empirical validation, such as the use of randomized controlled clinical trial comparisons, that came to reflect the research designs valued in medicine and psychiatry. The Task Force established a list of empirically validated treatments based on studies that met the research criteria (1995). For treatments of depression, cognitive behavior therapy (Beck et al., 1979) was listed as a well-established treatment with reference to the Dobson (1989) meta-analysis; interpersonal therapy (Klerman et al., 1984) was likewise deemed well established with reference to the TDCRP (Elkin et al., 1989) and to another study (DiMascio et al., 1979). Brief dynamic therapies were considered only probably efficacious treatments due to studies not meeting the research criteria. However, The Task Force realized the preposterousness of this notion of granting validation of a
treatment and revised its premises to recognize that research can only really result in empirical support of a treatment (Chambless et al., 1996).

My study challenges the dominance of the empirically supported treatments (EST) model. At an empirical level, the EST movement ignores the important research findings of the general efficacy and equivalence of most therapies and the significance of common factors by focusing on research findings that only support particular types of therapy (Elliot, 1998, p. 143). In addition, the EST research criteria emphasized the necessity of meticulous diagnosis of a client’s disorder using a nosological system with additional strict exclusion criteria if the client meets the criteria for an additional disorder. However, the assumption of diagnostic specificity is weak at best (Elliot, 1998, p. 121). Comorbidity is a common occurrence, and research has continually shown that clients diagnosed with the same disorder (e.g., depression) do not respond the same way to treatment in light of numerous other client factors (Elliot, 1998; Sotsky et al., 1991). The EST research criteria also emphasized the need for the studied therapy to be manualized and for the therapist to follow the manual when conducting therapy. However, adhering to a treatment manual can make therapy less effective by limiting therapist flexibility (Elliot, 1998, p. 121).

At an epistemological level, the EST movement forfeits a psychological approach for a medical model (Bohart, O’Hara, & Leitner, 1998; Henry, 1998). Within this model, the psychotherapist diagnoses the client’s psychological disorder and uses the appropriate psychological treatment. The researcher demonstrates that the treatment cures the disorder by conducting a randomized clinical trial comparison with a placebo or another treatment and requires treatment manualization and diagnostic specificity to tightly define
these variables. The medical model and EST research criteria placed great emphasis on
the psychological disorder and accompanied symptoms and not on the individual and his
or her unique and holistic being (Elliot, 1998, p.121). But psychodynamic and other
psychotherapies do not focus exclusively on symptom removal (Todd & Bohart, 1999, p.
461). The medical model and EST research criteria also placed emphasis on the
treatment as the cure and not on the therapist or the therapeutic relationship’s healing
potential (Bohart et al., 1998, p. 144). However, the relationship and the therapist are
said to be of the utmost importance in psychodynamic and other psychotherapies. In
order to study psychodynamic psychotherapy on its own terms, my research addressed
the client’s perception of change with reference to more than just his or her disorder and
analyzed the client’s view of the impact of the therapy, therapist, and therapeutic
relationship.

At a political level, the EST movement is discriminatory (Elliot, 1998, p. 119).
Firstly, the EST list of well-established treatments included almost exclusively cognitive
and behavioral oriented treatments with only a few studies establishing brief
psychodynamic therapies as probably efficacious. The EST list appears to reflect the
schism between academic clinical research (predominantly cognitive and behavioral) and
130). The EST criteria showed a bias toward therapies developed according to the
medical model which offer particular treatments for particular disorders and marginalized
psychodynamic and other psychotherapies that developed in the field and have a more
open-ended approach (Todd & Bohart, 1999). Secondly, the EST criteria systematically
suppressed other kinds of research that would shed light on effective psychotherapy
(Bohart et al., 1998). Henry (1998) reported, “The scientific paradigm that accompanies the EVT movement is unlikely to lead to any new knowledge about the mechanisms of therapy because it is not discovery oriented” (p. 121). In contrast, my research addressed a type of treatment for depression—psychodynamic—that is widely practiced in the field yet threatened by the EST movement to be disenfranchised for not conforming to the medical model of treatment. My research used a qualitative method that is discovery-oriented and appropriate for the elucidation of the workings of psychodynamic therapy but that has also been marginalized by the EST criteria. This qualitative research method honors the depth and subtlety of human experience addressed in psychodynamic treatment.

2.1.3 Clients’ Perceptions of Psychotherapy Studies

The findings of research consistently support the significant impact of client factors on the therapeutic relationship and therapeutic improvement (Asay & Lambert, 1999; Sotsky et al., 1991; Tallman & Bohart, 1999). My study did not attempt to isolate and quantify client characteristics such as ‘expectation for help.’ Rather, my study solicited those clients who found treatment effective, and focused retrospectively on their experiences of effective process and outcome in psychodynamic psychotherapy for depression.

A study by Gershewski, Arnkoff, Glass, and Elkin (1996) addressed client experience of therapy for depression. To ascertain clients’ perceptions of helpful aspects of treatment, they used data from the TDCRP with the primary measures taken from an Evaluation of Therapy form completed by the 154 subjects who finished the study. The questionnaire included the following open-ended question: “Were there any aspects of
your treatment that were particularly helpful to you? If so, please describe these.” (p. 237). Gershefski et al. developed a coding system to categorize clients’ answers addressing different potential helpful aspects of treatment: specific categories (cognitive, interpersonal, cognitive-interpersonal, biological); common categories (learned something new, therapist helped, symptoms improved); research categories (personnel helped, project helped), and nothing helped (p. 237). They found that common factors categories were most frequently coded and that there were no group differences (p. 238). In regard to specific factors, the results showed that the cognitive category was more frequently coded for CBT clients when compared to the other treatments (p. 240).

Rennie (1996) provided an astute commentary of the Gershefski et al. (1996) study concerning clients’ perceptions of treatment for depression. First, Rennie assessed the adequacy of the data. He thought that the mode of inquiry (written responses to simple questions on a questionnaire administered with other questionnaires) limited the depth of the clients’ responses and elicitation of their experiences (p. 263). Second, Rennie evaluated the method of categorizing the data. He considered the approach as primarily motivated by theory since the researchers derived categories of responses from the literature prior to analyzing the data and thereby transformed the clients’ experience of treatment (p. 265). Rennie concluded, “These are not studies about the participants’ perceptions of treatment. Instead, they are primarily studies of the extent to which the perceptions as represented were in keeping with what was expected by the researchers” (p. 653). At their foundation, these studies are not discovery-oriented and they cannot elucidate ambiguities concerning the therapeutic process. Rennie (1996) anticipated that a qualitative research approach would be able to come to terms with these issues. My
study used a qualitative approach, empirical phenomenological, in order to appropriately study clients’ perceptions of effective psychotherapy.

2.1.4 Process Studies

Outcome studies do not shed light on process variables. First, outcome studies simply demonstrate that client participation in a certain therapy is followed by client gains (Beckham, 1990, p. 219). The potential for researchers to draw conclusions from outcome studies is based upon a simple logic: if clients attend therapy X and achieve gains Y, then gains Y are due to therapy X. However, outcomes studies do not directly explicate the therapeutic process. Second, most outcome studies have not in fact elucidated ambiguities about therapeutic process with continued findings of the general and nondifferential efficacy of therapies for depression. Beckham as far back as 1990 called for a cessation of brand name comparisons of therapy and proposed that process research was needed to delineate the curative factors in the therapy of depression (Beckham, 1990, p. 207).

Ablon and Jones (1999; 2002) analyzed process in the TDCRP. A look at the findings of their studies will provide further invalidation of the utility of outcome studies for analyzing effective therapeutic process. Ablon and Jones’ work centered on the Psychotherapy Process Q Set (PQS) developed by Jones. They explained, “The PQS is a 100-item instrument that furnishes a language and rating procedure for the comprehensive description, in clinically relevant terms, of the therapist-patient interaction in a form suitable for quantitative comparison and analysis” (1999, pp. 66-67). The PQS was developed pantheoretically to include descriptors valued across different therapeutic models. Here are some examples of PQS process items: “therapist adopts a
supportive stance,” “patient has difficulty beginning the hour,” and “self-image is a focus of discussion” (Ablon & Jones, 1999, p. 67-68). Clinical judges read transcripts from CBT and IPT sessions in these particular studies, and assessed each session by rating the 100 process items, from least to most characteristic.

Ablon and Jones (1999) arrived at characteristic items that typify CBT and IPT process in the TDCRP, and found five out of ten of the most characteristic items were the same. In both CBT and IPT, the therapist was supportive and asked for more information, and the discussions centered on the client’s current life situation, interpersonal relationships, and self-image. Ablon and Jones further identified process items that predicted positive outcome in CBT and IPT with the BDI and HRSD used to measure outcome. Twenty-two of the twenty-three items that predicted outcome referred to client characteristics, experiences, or qualities contributing to the process; these results point to the importance of client factors for successful therapeutic outcome. In IPT, the process correlates of positive outcome were along the following lines. The client displayed excitement and hope about therapy. He or she comprehended the nature of therapy and was able to comment on the progress of therapy. The client was introspective and self-expressive, and attempted to become closer with the therapist. The client felt helped, and was able to develop insight and to express feelings. Although this description centered on IPT, eighteen of the twenty-three client-referenced process items that predicted successful outcome were the same for both therapies, which again points to the similarity between the process of CBT and that of IPT.

Additional similarities were found in another study between the process of CBT and IPT (Ablon & Jones, 2002). Ablon and Jones developed ideal prototypes of courses
of CBT and IPT. They asked expert academics and clinicians from both orientations to respond to a questionnaire form of the PQS, rating the degree to which each item was characteristic of their formulation of an ideal regimen of therapy according to their respective model (p. 777). Ablon and Jones correlated the ideal prototypes with the actual process of therapy sessions in the TDCRP, which were assessed by clinical judges who rated transcripts using the PQS. The process in both CBT and IPT sessions adhered strongly to the ideal prototype of a regimen of CBT, and adherence to CBT prototype correlated with positive outcomes for both CBT and IPT (p. 779-780). In a related study (Ablon & Jones 1998), the CBT prototype positively correlated with both CBT and psychodynamic therapy sessions; however, in this study the psychodynamic prototype positively correlated with successful outcome in both therapies in this study. Taking into consideration these findings, the logic of outcome studies that enables inferences about process does not hold. Without the accompanied process research, researchers should not hastily attribute client improvement to the ingredients considered curative in a certain type of therapy simply because clients improve following the completion of that therapy. Outcomes research needs process research to ground findings. Ablon and Jones (2002) proposed a shift to the study of process as it occurs naturalistically. In light of these considerations, my study addressed both process and outcome in effective psychodynamic treatment of depression. I solicited participants who sought a therapist in the field where the process of psychotherapy unfolded without the constraints of controlled experimental conditions.

Gibbons et al. (2002) provided a descriptive evaluation of therapist interventions in the process of CBT and IPT sessions in the TDCRP. Clinical coders read transcripts of
sessions and categorized therapist statements into various therapist response mode
categories such as learning statements, clarifications, restatements, questions,
information/directional statements, self-disclosures, and role-play interventions. Coders
also took into account the time frame and person referenced in the statements. Gibbons
et al. found that therapists in both CBT and IPT were rather active, employing
clarifications to expound upon the therapeutic material, questions aimed at information
gathering, and statements that directed the client or provided the client with information
about therapy (p. 20). The therapist’s statements usually referenced the present or an
unspecified time frame and were directed toward the client and, to a lesser extent, toward
significant others, the therapist, or unspecified people.

In a related study, Connolly, Crits-Christoph, Shappell, Barber, and Luborsky
(1998) provided a descriptive evaluation of therapists’ statements from the process of
supportive-expressive (SE) dynamic psychotherapy sessions with depressed clients.
They found that therapists used mostly clarifications and questions during sessions (p.
295). Therapists’ statements concerned significant others, the client, and his or her
parents, and most often referred to the present time frame. Connolly et al. (1998) and
Gibbons et al. (2002) found an affinity between the process of SE dynamic therapy and
that of IPT. Both sets of therapists primarily used questions and clarifications concerning
the present time frame, but SE therapists were less active and used more clarifications
(Gibbons, pp. 22). However, the significance of the results of these studies is limited
because the studies focused on therapist statements without examining the contributions
of client statements. In addition, therapist response mode categories were derived prior
to the analysis of therapist statements, and so the results reflected researchers’ prior
formulations about therapy more than they concerned actual therapist statements. The surface level descriptions (e.g., therapists used mostly clarifications) tell little about the significance of interventions for the client and for therapy. My own research directly questioned clients to elicit descriptions of effective process in psychodynamic psychotherapy and grounded all interpretations of the data in their descriptions, which enabled study of the depth and healing potential of the therapeutic process.

Jones, Ghannam, Nigg, and Dyer (1993) studied a single case of twice-weekly, two-and-a-half-year psychodynamic psychotherapy of a female with major depression. A look at the study will highlight the potential and limitations of using a quantitative method for process research. Jones et al. applied the PQS to videotaped sessions to provide a sketch of process items that best characterized the psychotherapy; the most characteristic process descriptors are as follows (p. 385). The client initiated discussions of important material, and interpersonal relationships were a major theme. Against a backdrop of therapist support, the therapist comported herself in a didactic fashion and was confident in her interventions. The therapist made interpretations related to actual people in the client’s life and put forth her understanding of the meaning of these peoples’ behavior. The therapist connected client’s feelings with past situations and pointed out recurrent themes in the client’s life, focusing significantly on cognitive themes.

Jones et al. (1993) in the same study subjected the item ratings of psychotherapy process to a factor analysis and yielded four process factors: therapist acceptance/neutrality, psychodynamic technique, therapist interactive, and patient dysphoric affect (p. 386). The therapist acceptance/neutrality factor was characterized, of
course, by the therapist’s nonjudgmental acceptance and neutral stance. In addition, the therapist provided empathy and accurately perceived the therapeutic relationship. The therapist spoke in a clear and organized fashion, and asked for elaboration while making other statements intended to facilitate the client’s speech. On the other hand, psychodynamic technique was typified by the therapist’s delineation of the client’s fantasies. The therapist highlighted client’s use of defenses and attempted to strengthen them. The therapist pointed out feelings unacceptable to the client, focusing particularly on guilt, and interpreted the warded-off feelings. In order to strengthen the therapeutic relationship, the therapist was also accommodating to the client when their interaction was troublesome. Jones et al. performed a time series statistical analysis to take into account the effect of previous therapy process factors on subsequent outcome throughout psychotherapy. They found that lower symptom scores, assessed from the Global Severity Index (GSI) on the Symptom Checklist 90-R (SCL-90-R) were predictable from lower Therapist Acceptance/Neutrality (Factor 1). To the researchers’ surprise, when the process was characterized by less therapist acceptance and neutrality, the client’s symptoms decreased.

To address the surprising finding, Pole and Jones (1998) continued the research and focused on two process factors: therapist acceptance/neutrality and psychodynamic technique. Pole and Jones (1998) also wanted to highlight the role of free association and discussion of key topics in the process and outcome of the psychotherapy with one female client. Free association was gauged by measuring the Co-Occurrence Rate of specific word pairs in the client’s speech with an increase in the rate indicating a shift from “external, reality-constrained discourse” to “internal, freely associated discourse”
Key topics were calculated through Topic Focus Ratios that indexed the proportion of client or therapist speech allocated to four topics: mother, father, brother, and guilt (p. 178). The results of analyses showed that the client’s free associations increased with treatment length, were influenced by therapist’s use of psychodynamic techniques (Factor 2), and predicted symptom change (decrease in GSI on the SCL-90-R). The researchers also found after analyses that the client became more aware of guilt over time, that her increased ability to free associate predicated her expression of guilt, and that the therapist’s use of psychodynamic techniques (Factor 2) influenced the client’s awareness of guilt. Further analyses shed light on the surprising finding in the Jones et al. (1993) study that decrease in therapist acceptance and neutrality (Factor 1) led to symptomatic improvement for the client. Pole and Jones (1998) found that the therapist exhibited a non-neutral stance while speaking about the client’s mother, father, and guilt, thereby encouraging the client to talk more about these topics, but assumed a more neutral stance during other topics. In turn, the client’s discussion of her mother and father was associated with a decrease in symptoms.

The process studies demonstrated the advantages of directly examining process in psychodynamic psychotherapy and connecting it with outcome, rather than only addressing therapeutic outcome as in the case of most outcome studies. However, the process studies still used quantitative measures to assess process and outcome. For instance, the PQS is an instrument that allowed for the rating and quantification of the therapy process, potentially resulting in the finding that the therapeutic process was most characterized by the “therapist asking for more information and elaboration” (Ablon & Jones, 1999). Such a description does not capture the depth and metaphorical nature of
psychological life and therapeutic change. A therapist asks for more information and a client may see this as an indication that the therapist knows what he or she is doing, is interested in the client, and essentially cares about the client. These multiple meanings are not evident in the process descriptor item provided in the PQS. The client may also note that the therapist’s offering a cup of tea gives him or her the same impression as the therapist’s questioning, but of course, ‘offers a cup of tea’ is not included on the PQS. These multiple meanings are further inaccessible because process measures like the PQS utilized clinical raters and did not inquire into clients’ feelings and perceptions. This procedure flies in the face of the majority of research that continually showed the significance of client contributions to therapeutic process and outcome (Asay & Lambert, 1999; Sotsky et al., 1991; Tallman & Bohart, 1999). In my research, by gathering clients’ descriptions via written descriptions and interviews, and by analyzing them qualitatively, the study made accessible the depth and metaphorical nature of change.

In summary, outcome studies have offered a limited analysis of the process and outcome of therapy. Studies that were sampled by most meta-analyses focused solely on symptom relief and on the type of therapy as the cure, but with findings of no differential efficacy, they of course were unable to highlight the efficacious ingredients in the process of therapy. As for psychodynamic therapy in particular, although this therapy is widely practiced, and both the benefits of long-term therapy and limitations of short-term have been documented, Leichsenring and Rabung (2008) performed the first and only meta-analysis on long-term psychodynamic therapy and found that this therapy for depression was effective for the treatment of depression. That notwithstanding, no research has documented the clients’ experience with regard to effective psychodynamic therapy, even
though common-factors research has shown that client factors contribute significantly to the process and outcome of therapy. Process studies were better at examining the process of psychodynamic therapy, yet these studies too provided limited analyses by typically using quantitative measures and having researchers, not clients, rate the process.

Therefore, my study consisted of a qualitative analysis of the process and outcome of long-term psychodynamic therapy for depression, focusing on rich client descriptions of processes that facilitated change and of outcomes in many areas of their lives. Whereas the above research was used to inform the development of my research method and design, the next two sections regarding psychodynamic theory and psychodynamic therapy will be used for the later discussion of the results.

2.2 Psychodynamic Theories of Depression

2.2.1 Drive Theory

Psychodynamic formulations of depression reflect the general development of the psychodynamic perspective. The foundation of a psychodynamic understanding of depression is classical Freudian drive theory. Freud and other drive theorists as well as object relations theorists wrote about what was then called “melancholia,” which is characterized by the severity of depression. Freud’s thoughts on depression were set forth in his essay “Mourning and Melancholia” (1917/1957), in which he compared depression with mourning and concluded that depression has three preconditions: loss of the object, regression of libido into the ego, and ambivalence (p. 258).

First, Freud (1917/1957) held that depression results from the unconscious loss of a loved object (p. 243). In mourning, too, there occurs a loss of another who was loved, and in that case, the mourner is aware of the loss of a real object in his or her world and
feels the emptiness in his or her world (p. 247). On the other hand, in depression, the loss occurs in the ego and the person feels that he or she is impoverished (p. 246). This loss may be due to death yet can also be a loss through neglect or even disappointment (p. 251). Freud highlighted the significance, for depression, of the internal, emotional response to any type of loss.

The second precondition of depression for Freud was regression of libido into the ego (1917/1957, p. 258). When an obstacle to a relationship occurs (e.g., death, neglect, disappointment) the libido, once displaced onto the loved object, is withdrawn into the ego and the person loses interest in the world (p. 249). This regression is in the service of forming a narcissistic identification with the lost object wherein the individual identifies with the other and with the functions the other can serve in the individual’s psychological life (p. 251). Identification harkens back to the oral stage of libidinal development wherein the ego incorporates and devours the loved object (i.e., mother) in order to metaphorically take in the adored other in fantasy (p. 250). In depression, after the dissolution of a complicated relationship, the individual also attempts to keep the relationship with the beloved alive in his or her thoughts, memories, and fantasies. The process occurs as if he or she is wailing: *although the relationship with my beloved was severed, I can hold and adore him or her within myself.*

The movement of regression is not simply a movement of love but also a movement of hate. With the loved object identified and substituted within the ego, the ego sets itself against itself and takes itself as its object (Freud, 1917/1957, p. 247). A “critical agency” is instituted, an agency known as the “conscience” (p. 247). Freud later called this critical agency the superego (Freud, 1923/1961) and implicated its
development with the completion of the Oedipus complex during the phallic stage of
development. The critical agency judges the ego as if it were the lost loved object, and
the ego’s hate and sadism toward the lost object operate fully on the substitute object
within the ego (p. 251). In other words, the person’s anger is turned inward toward him
or herself and away from the real person for whom the aggression is intended (Karasu,
1990, p. 10). This process can be inferred in the self-reproaches of the depressed person.
Freud held that “with insignificant modifications [the self-reproaches] do fit someone
else, someone whom the patient loves or has loved or should love” (1917/1957, p. 248).
The reproaches were originally meant for the beloved, but the individual instead
reproaches him or herself. The person says ‘I am worthless’ instead of saying ‘my
beloved is worthless’ because he or she feels partly to blame for the loss and wants the
beloved back. Self-reproaches can be seen as a defense that hides an accusation against
the other and as an instance of “the return of the repressed” in which the manifest
symptom (self-reproaches) is an expression of a hidden feeling (anger) (Malan, 1979, p.
129).

Ambivalence is the third precondition of depression according to Freud
(1917/1957, p. 258). The person first identifies with and takes in the other who was lost
in order to hold him or her in a loving embrace, only then to outlet aggression. Yet this
process serves to protect the lost loved object by venting the hostility on a substitute
object, i.e., the ego. The unconscious conflict between love and anger are evident in
these two processes and in the guilt so pervasive in depression. The person guards
against the conflicting feelings by repressing the anger and embracing the love.
However, the repressed anger returns to haunt the individual in pangs of guilt. Freud
highlighted the culmination of the conflict: “It is possible for the process in the [unconscious] to come to an end, either after the fury has spent itself or after the object has been abandoned as valueless” (p. 257). The process of depression is finished after running its course.

Abraham contributed his own seminal essay on depression (1924/1953) based on traditional psychodynamic theory. Whereas Freud elucidated the processes of melancholia in adulthood, Abraham delineated the developmental seeds of the processes and their fruition in adult disappointments. As such, he proposed five etiological factors in depression: (a) “a constitutional factor....over-accentuation of oral erotism” (p. 456); (b) “a special fixation of the libido on the oral level” (p. 457); (c) “a severe injury to infantile narcissism brought about by successive disappointments in love” (p. 458); (d) “the occurrence of the first important disappointment in love before the Oedipus-wishes have been overcome…with a permanent association…established between his Oedipus complex and the cannibalistic stage of his libido” (p. 459); (e) “the repetition of the primary disappointment in later life.—This is the exciting cause of the onset of a melancholic depression” (p. 459).

The developmental seeds of depression are sown in the oral stage of development as seen in the place that oral-constitution and oral-fixation hold in Abraham’s formulation as well as in the particular importance the stage holds in psychodynamic theory. Malan’s analytic observations lend credence to this formulation, and he noted that themes of feeding as well as concern with the mouth, teeth, and mother’s breast occur with regularity in therapy with depressive clients (1979, p. 150). Abraham proposed that the depressed individual had a particular temperament characterized by orality along with an
unresolved conflict at the oral stage. The constitution and fixation result in an intense desire for oral gratification along with a corresponding wish to destroy the desired object, originally the mother’s breast, which is both the first object of desire and the object of frustration (Karasu, 1990, p. 10). This individual has significant relational needs coupled with anger when such needs are not met.

Abraham further believed that the individual’s fixation and corresponding adult depression derived from a severe narcissistic injury occurring through disappointments during the pre-Oedipal stages. An “infantile prototype of melancholic depression” is reactivated when an adult suffers subsequent disappointments (p. 464). Feelings stirred up when an adult suffers such a disappointment in a relationship resonate with feelings he or she experienced as a young child who was shaken to the core by severe and continual disappointments.

Abraham expounded upon the relationship between early childhood experiences and depression, and he first implicated the anal stage in the development of depression (1924/1953). Abraham separated the anal stage into an earlier and later stage, and connected inherent sadistic impulses with these stages. During early childhood, the later anal stage deals with retaining (feces) and discharging aggression via controlling (objects), whereas the earlier stage concerns expelling (feces) and destroying (objects). In adulthood, a person stuck at the later stage tends to contain anger and instead to exert control over his or her thoughts, fantasies, relationships, and environment. On the contrary, a person stuck at the earlier stage tends to express anger and to fantasize about damaging his or her relationships and environment, or to actually damage relationships and/or environment. Abraham connected the characteristics of early anal stage with the
loss of the loved object in depression. While Freud (1917/1957) caught sight of, “a relationship between object-loss and tendencies, based on the earlier stage of the anal-sadistic stage to lose and destroy things” (p. 435), Abraham went further to definitively implicate the anal stage in the formation of depression. If the earlier anal-sadistic impulses are stronger, then after a disappointment, an adult will regress to the early stage, expelling and destroying the loved object, and depression will ensue. Abraham was pointing to the individual’s tendency to let go of the beloved due to anger at rejection and to get him or her out of sight and mind, much as a child for the first time reluctantly yet forcefully lets go of feces.

For Abraham, the regressive slide does not stop at the earlier anal stage but proceeds back to the oral stage (1924/1953), and he in turn delineated two stages of the oral-cannibalistic stage. During infancy, the earlier oral stage concerns sucking, yet in this autoerotic stage, the ego is without an object and pre-ambivalent (p. 496). When suckling at the breast or bottle, the infant exists as part of its environment without differentiating people or important parts of people in that environment, and so the infant has no opposing feelings toward these. The later oral stage, a stage where ambivalence comes to the fore, deals with biting and has a connection with the mechanism of introjection. The infant has a more differentiated sense of self and others including a sense of his or her aggression toward and desire for the breast or bottle as seen respectively in the tendency to bite or devour either. Abraham connected the ego introjection of the lost loved object in depression with the characteristics of the later oral stage. He wrote, “The introjection of the love-object is an incorporation of it, in keeping with the regression of the libido to the cannibalistic level” (p. 420). Introjection is a more
primitive mechanism than the ego identification of which Freud spoke. Abraham caught sight of the individual’s inclination to take in and keep the beloved in the center of his or her thoughts and fantasies after the disruption of the relationship, much as the child takes in the liquid nourishment provided at the breast or bottle.

Abraham highlighted the connection between depression and the anal-sadistic, oral-cannibalistic stages: “The course run by melancholia [has] two phases—the loss and the re-incorporation of the love-object” (p. 447). Abraham agreed with Freud that the introjected object assumes the role of the individual’s conscience, that self-criticisms originate from the conscience, and that self-reproaches are actually a criticism of the other person (p. 461). The person thereby escapes the conflict of ambivalent feelings by turning aggression against him or herself instead of toward the other person (p. 438). This period of self-torment ends through the appeasement of sadistic desires, and afterward, the beloved is safe from being destroyed. The individual reinstates the object in the world through another act of expulsion (p. 464). This time it is an act of liberation since the person is letting go of the other person and of the anger he or she felt toward that person. Abraham concluded, “During an attack of melancholia the love-object goes through a process of psychological metabolism within the patient” (p. 464).

2.2.2 Object Relations Theory

Other psychodynamic theories that followed classical drive theory focused on the significance of object relations (Karasu, 1990, p. 10). These theorists examined the importance of an individual’s ‘good’ and ‘bad’ representations of others, and in particular highlighted the person’s feelings of aggression toward ‘bad’ representations and attempts at reparation with ‘good’ representations. To begin with, Rado (1928) highlighted, in a
manner similar to that of Abraham, the significance of early childhood and of contemporary narcissistic injuries in the formation of melancholia; he then added to such a formulation by underlining the importance of self-esteem. He believed the most outstanding characteristic of depression to be the collapse in self-esteem (p. 421). To better understand this fall in self-esteem, Rado (1928) analyzed the contribution of the ego’s dependence on narcissistic love objects (p. 422). A person who experiences depression usually depends solely on others for the maintenance of his or her self-esteem.

According to Rado (1928), after the loss of another on whom he or she depended, the individual first experiences angry rebellion (p. 423). But the person soon realizes that rebellion against the loss is ineffective and so adjusts the method by passing into a state of depression. The person confesses feelings of guilt and feelings that he or she is to blame for the loss (p. 429). The individual slips into a state of “remorseful contrition” and does penance (p. 429), all of this in an effort to beg for pardon and to thereby regain the beloved in fantasy if not in actuality. Rado concluded that, “Melancholia [is] a great despairing cry for love” (p. 423). Rather than engaging in a futile reaction of anger toward the beloved, the person abuses him or herself to win back the other’s love.

Like Freud, Rado (1928) assumed that passing into a state of depression occurs by a regressive movement; the ego no longer attempts to win forgiveness from the loved object in the world, but rather withdraws and tries to win the pardon of the superego (p. 424). This process harkens back to childhood around the time of superego formation when a child of narcissistic leanings completely depends on his or her parents for self-esteem. This child starts to replicate intrapsychically the reprimands of the parents with hopes of securing their love on an unconscious level (p. 424). Rado considered a
childhood “narcissistic injury” the most likely primary cause for reparation, an injury replicated with future disappointments (p. 424). The child who totally depends on primary caregivers for self-esteem is easily disappointed, becomes depressed, and goes through an internal process of making amends with them, and this pattern is relived with subsequent adult disappointments.

In explicating the process of reparation with contemporary losses, Rado (1928) proposed two facets of introjection, thereby adding to Freud’s original formulation. Rado connected these two facets with the child’s development of object relations. Throughout development, the child has to contend with his or her representations of the “‘good’ (pleasure-conferring) and the ‘bad’ (frustration-inflicting) objects” (p. 432). ‘Good’ and the ‘bad’ are originally isolated representations, but the child eventually consciously learns to relate to a unified representation while the ‘good’ and ‘bad’ representations are relegated to the unconscious. Rado consequently formulated two processes of introjection in depression: “The ‘good object,’ whose love the ego desires, is introjected and incorporated in the super-ego…. [the ‘bad object’] is incorporated in the ego and becomes the victim of the sadistic tendency now emanating from the superego” (p. 434-435). The individual abuses him or herself and welcomes such abuse in the service of penance. Rado was pointing to the conflict in depression between love and hate and between abuser and abused, a struggle that cannot be taken up in relation to the beloved and so is taken in. The person is living a drama between good and bad where he or she is both actors.

Rado (1928) not only referenced the point of superego formation but saw the “hunger-situation of the infant” as the “deepest fixation point” for depression (p. 427).
Rado explained, “We [can] trace the chain of ideas [in melancholia], guilt—atonement—forgiveness, back to the sequence of experience of early infancy: rage, hunger, drinking at the mother’s breast” (p. 427). The infant feels rage in the absence of the mother’s breast, subsequent hunger without the object of nourishment, and finally, satiation while drinking at the mother’s breast. For Rado, this natural sequence of experience becomes unconsciously associated with and formative of the process of depression: guilt (that rage killed the lost loved object); atonement (with the punitive quality of hunger) as an act of reparation; forgiveness from the lost loved object (like bliss at mother’s breast). In this vein, the painful affects a person experiences during depression are actually part of the process of repairing a relationship. The individual feels guilty, and atones through self-punishment as a way of securing a belief that he or she is worthy of forgiveness by another who was loved and lost. In short, for Rado, the process of depression is nothing other than an attempt at reparation: an unconscious attempt to reinstate a lost love relationship (initially through dual introjections) by eventually doing away with ambivalence (through atonement), thereby restoring self-esteem (p. 435).

Klien (1935/1975, 1940/1975) further delineated the importance of object relations in the formation of depression. To begin with, she succinctly highlighted the manner of developing external and internal object relations in childhood:

Along with the child’s relation, first to his mother and soon to his father and other people, go those processes of internalization…The baby, having incorporated his parents, feels them to be live people inside his body in the concrete way in which deep unconscious phantasies are experienced—they are, in his mind, ‘internal’ or ‘inner’ objects (1940/1975, p. 345).

The child develops internal relations alongside external relations, and forms both ‘good,’ loving representations of the other and ‘bad,’ persecuting representations. Klien thought
that depression in adulthood resulted from a failure to uphold ‘good,’ internalized objects (1935/1975, p. 266). Such an individual has not integrated a sense that valued others are constant and caring.

With the failure to maintain ‘good’ internalized objects, the child is unable to overcome the depressive position (Klien, 1940/1975, p. 369). In early childhood, the child encounters developmental positions comprising anxieties and defenses that have a connection with similar adult processes yet occur normally throughout development (Klien, 1935/1975, p. 275). Rather than focus on depression in adulthood, Klien primarily addressed childhood processes that are replicated in adult pathology, and she did so by elucidating these developmental positions instead of considering the significance of psychosexual stages such as Freud and Abraham set forth. For Klien, the child originally experiences psychotic anxieties, as typified by the paranoid position, and then later the child confronts an infantile neurosis with the depressive position coming to the fore (1940/1975, p. 347).

Similar to the formulations of Freud and of those who followed, Klien’s belief was that loss plays an important part in depression; yet she reframed loss in terms of the internal object relations constellation of the depressive position. She formulated the depressive position as “those anxiety-contents, distressed feelings and defenses which are connected to the impending loss of the whole loved object” (Klien, 1935/1975, p. 275). Klien was pointing to the similarity between early childhood and adult processes concerning depressed affect: she was specifically underlining the way such internal, emotional processes regard the anticipated loss of a loved one and stem from not having established constant and caring representations of others.
In particular, in the depressive position, Klien held that the ego is anxious that the ‘good’ object will die during the process of introjection, or that if the whole loved object is successfully introjected, the ‘bad’ internalized objects will kill the ‘good’ object (1935/1975, p. 265). The content of anxiety centers on impending loss at this point in development because the child realizes the full extent of his or her aggression (1935/1975, p. 269). Klien understood aggression as essential to her understanding of depression, much like Freud and others before her (Gabbard, 2000. p. 209). Coming to terms with aggression toward a loved one, and coming to terms with the associated thoughts and images, is extremely difficult for the young child and the depressed person alike. Distress emanates from the child’s realization of its aggression and permeates the ego's feelings. The child feels “guilt and remorse” for its aggression toward the ‘good’ object, and pervasive “sadness” and “despair” in presuming inevitable loss (1935/1975, p. 270). The child also feels anxious about its aggression, and defends against this anxiety through an increased introjection of the ‘good’ object and by making reparations (1935/1975, p. 265). The child feels guilt, sadness, and anxiety regarding anticipated loss, and understandably, develops different ways of coping with such painful affect.

Klien’s emphasis on the process of reparation is reminiscent of the prominent place reparation held in Rado’s formulation of depression. The ego’s endeavors at reparation, fueled by love, are centered on the ‘good’ object, whereas the ego’s aggression and hate are centered on the ‘bad’ object (Klien, 1935/1975, p. 266). Klien called this ego process that consists of the “splitting of imagos” into loved and hated objects “ambivalence,” which harkens back to Freud’s precondition of depression, and she saw the process as pivotal in gaining trust and belief in external and internal objects.
Klien explained, “The strengthened ego…make[s] still further steps towards unification of its imago—external, internal, loved and hated—and towards a further mitigation of hatred by means of love, and thus to a general process of integration” (Klien, 1940/1975, p. 353). The child participates in a dialectical process of reconciliation between actual others and his or her representation of others, and between his or her love and hate toward both. The child attempts to come to terms with love and hate for the same significant person who exists both in the world and in his or her thoughts. The process culminates in the child’s securing of a ‘good’ internalized object, thereby overcoming the depressive position and solidifying a more integrated representation of a kind other who cares and provides constancy. Klien held that if the position were not overcome, it would lead to subsequent depressions in adulthood, but that the process could be reinitiated at any point in development and aided by psychological treatment.

2.2.3 Libido Theory

In contrast to the theorists addressed so far, Jung did not write an essay on depression or develop a conceptualization of depression. However, he did address the phenomenon of depression throughout his work; in particular, two writings and a letter provide a good indication of his ideas about depression. Looking at these ideas will show them to contrast drive and object relations theories because Jung focused his writings on what was then called “simple” depression whereas these other theorists wrote about “melancholic” depression.

Jung offered a concise characterization of depression when he wrote a letter to a friend who was depressed wherein he stated that depression literally meant being forced
To understand his statement, Jung’s libido theory needs to be addressed since his ideas about depression are based on this conceptualization (Steinberg, 1989, p. 340). Jung thought that when depressed, a person’s libido withdraws from the conscious world and descends into the individual’s unconscious (Jung, 1916/1953, p. 213). Depression is the ego’s experience of exhaustion of libido: the person does not invest energy either in relationships with others or in engagements with projects since such energy is depleted. In this light, Jung advised his depressed friend to seek others, to engage in work, and to eat and drink well in an effort to receive energy from outside himself (1959/1976).

In attempting to understand the dynamics behind the depletion of the ego, Jung’s concepts of compensation and introversion, both of which concern the regulation of the psyche, need to be highlighted (Steinberg, 1989, p. 340). An individual can only be conscious of a given number of contents at one moment, and, depending on the attitude of the ego, certain other contents are relegated to the unconscious. Compensation occurs when the contents of which the person is unconscious cohere, in order to maintain balance, in a stance counter to the person’s conscious attitude. For example, a meek-mannered person is attuned to others’ needs in relationships but remains unconscious of her own sense of entitlement. However, after loss or other life changes, the attitude of the ego may become too exclusionary and overly conflicted with its counter orientation in the unconscious. Jung proposed that in this case, involuntary introversion occurs in which libido moves into the unconscious in an attempt to regain stasis (1912/1967, p. 404). Through this process, unconscious contents are made conscious in the individual’s expression of fantasies and images of, for instance, aggressive acts toward others. Once
these unconscious contents are integrated into the attitude of the ego, introversion is not
necessary, and the person no longer feels depleted and depressed. In this regard, Jung
suggested to his depressed friend to penetrate the darkness of depression until light
appears (1959/1976). Even though forced introversion is a primary process of
depression, Steinberg proposed that people vulnerable to depression have an extraverted
personality style and are attuned to the needs of others in order to forestall loss of love

2.2.4 Ego Psychology

As the psychoanalytic movement evolved, psychodynamic theories of depression
began to encompass diverse dynamic models, and issues of self-esteem and self-esteem
regulation were given great precedence in formulations of depression (Karasu, 1990, p.
10). Ego psychology came to the fore with the development of the structural model
(McWilliams, 1994, p. 25). Freud (1923/1961) formulated his theory of the superego,
and ego psychology focused on the structures of the psyche (id, ego, and superego). In
this light, the critical agency (the conscience) that is an extension of the ego yet critically
djudges the ego came to be know as the superego and remains central to the
psychodynamic understanding of depression. The super-ego, literally translated as the
“over-I,” can be envisioned as an exaggerated version of a parent or authority who stands
over one’s shoulder and constantly, critically, judges one’s feelings, thoughts, and
actions. In this regard, ego psychology continued to examine the role aggression plays in
the formation of depression.

Jacobson (1971) elucidated the ego psychology of depressed individuals,
implicating the structures of the psyche in the emergence of the disorder. For Jacobson,
the most significant problem for depressed persons is loss of self-esteem, and excessive dependency is their particular ego deficit (Karasu, 1990, p. 15). With these particular points, he is quite consistent with Rado’s conceptualization. For Jacobson, the person depends solely on other people for self-esteem and becomes depressed when his or her self-esteem decreases due to difficulties in relationships.

Jacobson addressed the developmental antecedents of such unstable self-esteem and highlighted the parents’ tendency to misunderstand the child and have little acceptance of him or her (Busch, Rudden, and Shapiro, 2004, p. 20). This experience lessens the child’s self-esteem and leads to conflicted feelings. The child feels aggression toward the parents and guilt about such aggression, and finally turns aggression inward (p. 20). Jacobson’s underlining of the child’s ambivalence and his or her turning of aggression toward the self is consistent with conceptualizations of Freud, Abraham, and Rado. However, Jacobson contrasted these theorists by asserting that lack of self-esteem provokes aggression toward the self, rather than the reverse.

Jacobson also added to previous formulations by proposing that the formation of the superego and ego ideal are additional ways to protect the parents against aggression by idealizing them. In regard to these structures, Jacobson formulated the structural determinants of precarious self-esteem in adulthood as follows: “superego impairment (very harsh), faulty ego ideal (unrealistic or grandiose idealized love objects), pathological development of self-representations (devalued or distorted body image), immature and self-critical ego functions, and in severe pathology, the dissolution of all these structures” (Karasu, 1990, p. 15). As evident in this formulation, Jacobson placed the locus of depressive pathology in the structures of the psyche and processes therein.
With such a harsh and critical view of him or herself, permeated by negative thoughts about self and idealizations of others, loss of self-esteem and depression seem imminent for such a person.

Bibring (1953) proposed that depression is fundamentally a state of the ego and so believed the phenomenon could best be addressed by ego psychology (p. 21). For Bibring, previous psychodynamic formulations concerning the significance of aggression turned inward and of the oral stage are secondary to an ego psychological understanding of depression. Bibring thought that depression is an affective state and is the “emotional correlate” to the fall in the self-esteem of the ego (p. 26). The collapse of self-esteem is due to the “ego’s shocking awareness” of its helplessness and powerlessness to meet its aspirations (p. 39).

Bibring (1953) elucidated three ego ideals or aspirations that are narcissistically pertinent for the maintenance of self-esteem:

1. the wish to be worthy, to be loved, to be appreciated, not to be inferior or unworthy; 2. the wish to be strong, superior, great, secure, not to be weak and insecure; and 3. the wish to be good, to be loving, not to be aggressive, hateful and destructive. (p. 24)

A person who is striving to reach such aspirations encounters conflict when he or she experiences an incapacity to achieve the aspirations due to personal, interpersonal, or environmental factors. The individual experiences a loss of his or her capacity to actualize his or her ideals and a corresponding loss of self-esteem. Ultimately, self-esteem collapses and depression ensues when a person realizes that he or she is helpless to attain worth, superiority, or goodness. An individual’s sense of such helplessness also leads to feelings of aggression toward him or herself for not living up to his or her
strivings, which contrasts Freud and his predecessors’ conceptualizations of anger as anger intended at another but directed at oneself.

Bibring (1953) thought that in early childhood, a child first experiences a state of powerlessness and fixates on this shocking state. Traumatic experiences in adulthood arise that “regressively reactivate” the state of fundamental helplessness, and the contemporary powerlessness relates to living up to aspirations (Bibring, 1953, p. 39). When the adult encounters his or her own powerlessness, the early childhood helplessness is reawakened. Bibring proposed that the oral stage (and the concomitant fixation) is usually implicated in formulations of depression because states of helplessness abound for the infant during the oral stage (p. 37). Nevertheless, Bibring believed that states of helplessness and fixations on these states could occur during any of the stages of development.

According to Bibring (1953), depression diminishes when the aspirations become attainable, adequately adjusted to be attainable, or when they are abandoned (p. 43). In addition to or in lieu of changes with aspirations, depression decreases via other recovery processes (i.e., introjection), or the person may also simply defend against the state of depression as such. In conclusion, as evident in Bibring’s formulation, “the theoretical tide has increasingly turned away from psychoanalytic metapsychology to notions of depression as a basic affect, and from loss of a love object to the more global erosion of a sense of well-being” (Karasu, 1990, p. 11).

2.2.5 Self Psychology

Instead of following in the direction of ego psychology and examining the structures of the psyche, self psychology enlarged its focus and highlighted the
importance of the development of a sense of self, and connected impediments in this formation with the manifestation of depressive phenomena (Karasu, 1990, p. 15). Even though conflicted anger was not as fully implicated in the formulation, self psychology continued to relate the fall of self-esteem with the emergence of depressed moods as ego psychology had noted before. In particular, Kohut (1971) stressed the child’s need for empathic self-objects during the development of the self and for the continued maintenance of self-esteem. The child requires the primary caregiver to accurately mirror facets of him or herself and thereby to add cohesion to the child’s budding sense of self. The child also needs to idealize the primary care giver as a model of the self toward which to strive. A disorder of the self results from a disruption in this dialogical process; i.e., when the child lacks empathic self-objects. In this case, the child is unable to form a cohesive self. In adulthood, other people then serve as self-objects and perform a primary function in maintaining the sense of self. Galatzer-Levy (2002) pointed out that when these relationships are disrupted the person usually experiences “empty depression” in response to the loss accompanied by feelings of meaninglessness, banality, and a depletion of self-esteem (p. 151).

In addition to an “empty depression” emanating from dissolution of a relationship, a person may experience a “guilt depression” centering on conflicted feelings and hostility toward oneself with self-rejection and self-blame abounding (Karasu, 1990, p. 16). McWilliams (1994) showed from a self psychological perspective that these people have a sense of self as fundamentally bad. She explained, “They lament their greed, their selfishness, their competition, their vanity, their pride, their anger, their envy, their lust” (p. 237). With the sense of badness so apparent, the regularly encountered
hypersensitivity to criticism of these depressed individuals is readily comprehensible. McWilliams concluded that in encountering loss and rejection they deduced that they deserved and caused it (p. 237).

2.2.6 Contemporary Theories

Contemporary psychodynamic theories encapsulate the dominant threads of the movement. In line with the psychodynamic perspective, these theorists highlight the significance of childhood relationships and the formation of the self as well as the significance of adult relationships and one’s sense of self in their formulations of depression. Summers (2002) emphasized, from an object relations perspective, the role that loss of vital aspects of the self plays in the formation of depression. To begin with, he underlined a child’s inherent need to develop attachments and the function these attachments play in the formation of self and in the development of internal object relations. For Summers, adult psychopathology results from early caregivers requiring the child to bury aspects of the self. The child makes a defensive adaptation in order to maintain primary attachments, and, in adulthood, symptoms usually call attention to the sacrifice of the self’s potential (p. 117). Hence, depression is a response to the loss of a facet of oneself. Summers states, “A life that is not authored is the soil in which depression grows…. [Depression] always means that my life does not belong to me” (p. 138). In addition, depression is related to the lack of gratification derived in living cut off from essential aspects of oneself and feeling primarily helpless to modify the defensive adaptation lest an attachment be lost (p. 123).

Arieti and Bemporad (1980) considered depression from an interpersonal perspective, combining facets of drive and ego psychological theories, and they proposed
that depression emerges from the context of a person’s interpersonal relationships. Arieti and Bemporad implicated early interpersonal relationships in the formation of an individual’s personality and his or her vulnerability to depression, yet they focused their explanations on the connection between a person’s personality and depression in adulthood (Blatt, 2004, p. 38). To be specific, they thought that a person’s life ideology predisposed him or her to depression.

A depressed person has a preexisting life ideology of living for a dominant other or dominant goal (Arieti, 1977, p. 865). In other words, the person is not living for him or herself but for another person or for an inaccessible aim. The individual relies on the person or goal as a source of gratification, self-esteem, and purpose. Depression ensues after a loss of a relationship with a significant other or after a change in the attainability of an important goal. The individual feels helpless and hopeless because his or her life ideology limits the envisioning of alternative types of relationships or goals. The person cannot adapt and change his or her strivings after the loss of a valued other or the failure to reach a dominant goal.

Arieti and Bemporad’s formulation manifested two significant trends for understanding depression: depression resulting from a loss or disruption in the development of primary relationships and depression resulting from a loss or disruption in the formation of the self. Blatt (2004) caught sight of this distinction, and from an integration of ego psychology with developmental cognitive psychology, he placed the two issues central in his formulation of personality development and depression. With reference to development, Blatt highlighted “... the normal dialectical interaction of two fundamental developmental lines—the development of mutually satisfying, reciprocal
interpersonal relationships and the development of a differentiated, integrated, essentially positive and realistic sense of self” (1998, p. 746). In other words, two development issues (relatedness and self-definition) arise interdependently during personality formation. Blatt held that psychopathology forms from a disturbance in the developmental process whereby a person acquires an exaggerated preoccupation with one issue while defensively turning away from the other issue.

Blatt (2004) differentiated two types of depression corresponding to an overemphasis on either relatedness or self-definition. First, an “anaclitic” (dependent) depression is typified by feelings of helplessness, loneliness, and being unloved accompanied by persistent fears of abandonment by significant others (p. 31). Anaclitic depression comes to the fore with disruptions in primary interpersonal relationships. Anaclitic issues emerge during the oral stage, and the child experiences loss of love in early relationships brought about by actual loss or by narcissistic injury. In adulthood, the individual’s object representations are polarized and concern frustrating or gratifying others. Second, an “introjective” (self-critical) depression is developmentally more advanced and is distinguished by feelings of unworthiness, failure, and guilt (p. 32). The person engages in activities to atone and compensate for these feelings and has gnawing fears of criticism from significant others. Introjective depression is permeated by self-scrutiny. Introjective issues arise during the phallic stage and the child encounters hostile childhood relationships that lead to marked ambivalence toward primary care givers. In adulthood, the person’s object representations are more differentiated but still fragmented, and they regard exaggerated depictions of aggressive others. In both types,
the individual did not internalize adequate levels of object representations and achieve a sense of object constancy, which results in vulnerability to depression (p. 51).

The importance of the two developmental issues is not only evident in contemporary theories of depression but also apparent in Freud’s (1917/1957) original conceptualization of depression. Freud connected depression with the oral stage of development and elucidated the person’s tendency to regress after the loss of another on whom he or she depended (anacritic), but he also related depression to the more advanced stage of superego formation and highlighted the individual’s experience of guilt and self-punishment at the hand of the conscience (introjective). Blatt notes these differentiated modes of depression in psychoanalytic theory:

Psychoanalytic theorists differentiate between a depression focused primarily on interpersonal issues such as dependency, helplessness, and feelings of loss and abandonment and a depression derived from a harsh, punitive superego—a depression focused primarily on self-criticism, concerns about self-worth, and feelings of failure and guilt. (1998, p. 734)

The nuances between “anacritic” (dependent) depression and “introjective” (self-critical) depression can be seen in the differing etiologies and phenomenologies emphasized by psychodynamic theorists after Freud, very often underscored by the same theorist.

2.2.7 Summary of Psychodynamic Theories of Depression

After reviewing the psychodynamic literature, eight key issues emerged. These issues are helplessness/hopelessness, disengagement with others/projects, loss, conflict, dependence on others, criticalness toward self, childhood development, and the interpersonal context. The first two issues concern an individual’s experience of being depressed, and the other six issues are relevant to the material addressed in psychodynamic psychotherapy. Therefore, these issues are important for my study of the
client’s experience of effective psychodynamic therapy for depression, and the issues will be related to the results of the study.

Two issues that arose from the literature review concern a person’s experience of being depressed, and these issues are helplessness/hopelessness and disengagement with others/projects. Bibring thought that a person feels helpless to reach his or her aspirations when depressed. In addition, the person feels helpless and hopeless to modify his or her life and strivings because, according to Summers and Arieti and Bemporad, the person is unable to change the way he or she relates to self, significant others, or important goals. As indicated by Freud, Rado, and Jung, a person also invests less energy in relationships with others and engagements with projects when depressed. The individual loses interest in the world, withdraws, and focuses more on his or her personal thoughts, memories, feelings, and fantasies.

The other six issues regard material most likely addressed and explored in some form in psychodynamic psychotherapy. The first two of these issues concern the psychodynamics of depression, and these issues are loss and conflict. Drive and object relations theorists pointed out that depression centers on the loss of a loved one. Freud thought that a depressed person encountered an actual loss such as death but could also have experienced loss through neglect or disappointment. Abraham and Rado highlighted that this adult experience of loss resonates with the person’s feelings about a childhood experience of loss and narcissistic injury at the hands of his or her parents. Ego psychology took as its focus such vulnerable narcissism and looked at the loss of self-esteem that accompanies depression. Contemporary theorists underlined the significance of both external and internal losses in the formation of depression. In this
regard, Summers thought that depression was a response to the loss of a facet of the self whereas Arieti and Bemporad proposed that depression emerged after the loss of a significant other or important goal.

At the center of the psychodynamics of depression is conflict. Drive and object relations theorists stated that a depressed person feels ambivalent toward loved ones, and, with the exception of Freud, these theorists connected such feelings to the individual’s ambivalence toward his or her parents during childhood. The conflict for a depressed person is between conscious love and unconscious anger with frequent experiences of guilt manifesting such anger. Freud, Abraham, and Rado held that the individual defends against aggression by turning it inward rather than toward another and becoming angry with oneself. Jung offered a more general conceptualization of conflict without specifying its content. He thought that a person’s conscious attitude was too exclusionary and overly conflicted with its counter-orientation in the unconscious. Bibring further expanded the notion of conflict and wrote that a person could be in conflict with personal, interpersonal, or even environmental factors that interfere with achieving his or her aspirations.

In addition to addressing loss and conflict, psychodynamic psychotherapy would most likely address the person’s manner of engaging others and self; therefore, these next two issues regard the structure of engagements for the depressed individual. The person’s relationships are characterized by dependence on others. The individual feels narcissistically vulnerable, and Rado and Jacobson showed that he or she depends on another for maintenance of self-esteem. A disruption or disappointment in such a relationship lowers the person’s self-esteem and he or she becomes depressed.
The depressed person is also critical of him or herself. Freud, Abraham, and Rado held that through identification with and introjection of another who was loved and lost, a person’s conscience is formed. Freud and Abraham highlighted the significance of the conscience in the emergence of depression, and this critical agency was later called the superego. Rado showed the way the superego abuses the ego and Jacobson further implicated unrealistic ego ideals in such suffering. The literal translation of the superego as the over-I offers a vivid illustration of the way in which this facet of the person observes his or her experience, and for all these theorists, such observation is characterized by judgment and self-criticism.

The final two issues concern the focus of psychodynamic psychotherapy for depression, which would likely be a developmental and interpersonal focus. Most of the literature reviewed connects a person’s experiences during personal development with the emergence of depression in adulthood. Freud and Rado implicated the oral and the phallic stages of development, and Abraham perceived the anal stage as also relevant. Bibring held that any of these stages could be important given that helplessness in childhood is not restricted to a particular stage and that experiences of helplessness are formative of depression in adulthood. Klien looked at developmental positions rather than at stages and considered an adult susceptible to depression if that adult had not overcome the depressive position as a child. These developmental stages and positions can be seen as metaphors that organize and re-present adult psychological life rather than as stringent claims that developmental conflict in a certain stage actually causes adult pathology. Nevertheless, an individual’s development would be a significant topic to explore in psychodynamic psychotherapy.
The last issue regards the interpersonal focus of theories of depression addressed throughout the survey of literature. For psychodynamic theorists, depression emerges from an interpersonal context, and the interpersonal domain permeates the other seven key issues. When depressed, a person feels helpless to change the way he or she relates with others and thus disengages from those others. The individual experiences loss regarding another and feels conflicted toward the person. The individual is dependent on others, and criticizes him or herself based on past relationships with others. This manner of engaging with others and self has been shaped through the person’s development, including childhood relationships with significant others. In this regard, psychodynamic theory is an interpersonal theory, and the material addressed in the psychodynamic therapy of depression, as well as the process itself, will be interpersonal in kind.

2.3 Psychodynamic Therapy for Depression

The formulation of psychodynamic psychotherapy for depression that follows in this section addresses six facets of therapy, and such an organization is an adaptation of Karasu’s (1990) useful description of the features of psychodynamic therapy for depression. These six features are the goal of therapy, the anticipated outcome of therapy, the therapeutic relationship, the therapist, the techniques used in therapy, and the process of therapy, and each will be discussed in turn. The formulation is important for my study of the client’s experience of the effectiveness of psychodynamic therapy for depression, and the facets will be connected with the results of the study.

Two background issues must first be addressed before delineating the six facets of psychodynamic therapy. First, psychodynamic psychotherapy was not specifically developed to treat depression (Karasu, 1990, p. 21). Second, psychodynamic
psychotherapy includes diverse theories and theorists, as were explored in the previous section (Karasu, 1990, p. 21). These issues result in a range of therapeutic frames from short-term (1 time a week for about 2-3 months) to long-term (1-3 times a week for about 1-3 years); a range of practices from relatively supportive (empathic) to relatively expressive (interpretive); and a range of strategies from a here-and-now (immediate relationship) focus to a depth-oriented (historical) focus. Therefore, this formulation of psychodynamic psychotherapy for depression will draw from a general psychodynamic understanding of psychotherapy while also referencing, both explicitly and implicitly, the varied psychodynamic theories about depression and its treatment.

2.3.1 The Goal of Psychodynamic Therapy

A psychodynamic understanding of change centers on the notion of insight (Karasu, 1990, p. 31). Insight is not meant to denote a purely intellectual endeavor, but rather signifies an emotional/intellectual understanding, which provides an opening for the client to move into something new. The overarching goal of psychodynamic psychotherapy is to gain insight; in particular, the client becomes more aware of the unconscious conflict that led to the formation of his or her depression (Karasu, 1990, p. 31). Malan references the intensity of the conflict: “This mixture of love and hate for the same person is one of the most deep and most painful conflicts that human beings suffer from” (1979, p. 130). To obtain such insight, the therapist’s interventions are intended to help the client better understand his or her early interpersonal relationships and the ways these shaped his or her current experiences with others (Blatt, 2004, p. 256). Through psychotherapy, the client remembers, uncovers, and recreates past conflicts with significant others within the therapeutic relationship (Karasu, 1990, p. 3). In this vein,
the aim of psychotherapy is to resolve the conflict by gaining insight into the client-therapist relationship.

Another look at the conflict between love and hate for the depressed client will serve to deepen an understanding of the overarching goal while also broadening the formulation to include other specific goals. In terms of the general goal of insight, psychodynamic psychotherapy of depression first strives to elucidate the client’s narcissistic wish for love and for support of his or her self-esteem (Karasu, 1990, p. 31). In particular, the client comes to understand the loss of such love in his or her childhood and the unrealistic attempts to obtain that affection and support in current relationships. Psychodynamic psychotherapy then aims to uncover feelings of hostility associated with the experience of rejection of past parental love and with any contemporary disappointments. Malan stated, “A fundamental principle in therapy of almost every case of depression...[is] that what the therapist needs to reach, by every means in his power, is hidden anger against someone whom the patient needs or loves” (1979, p. 130). With this in mind, the client and therapist explore the role depression and defense mechanisms play in keeping aggression at bay (Karasu, 1990, p. 32).

In this light, a specific goal of psychodynamic psychotherapy is to understand the client’s defenses; i.e., his or her ways of (mis)perceiving facets of the world and the self occurring below the scope of awareness. McWilliams (1994) and Busch, Rudden, and Shapiro (2004) implicated introjection as the primary defense in depression, especially the client’s taking on aggressive qualities of another who was loved and lost. McWilliams also referenced the prominence of the more developed form of the defense in the client’s turning against the self. Busch, Rudden, and Shapiro thought that the client
also regularly uses reaction formation as well as archaic defenses such as denial and projection. Once the defenses have been interpreted, another specific goal of psychodynamic psychotherapy is catharsis (Karasu, 1990, p. 32). The client comes to express the feelings of anger and hostility directed toward past and present significant persons. The client also begins to grieve past and present losses of significant others while expressing sadness and despair.

2.3.2 The Outcome of Psychodynamic Therapy

The anticipated outcome of psychodynamic psychotherapy of depression is a change in personality, not only symptom relief. Karasu explained, “The psychodynamic approach—whether long- or short-term—thus aims to modify the structural substrate of depressive disorder, not merely its immediate manifestation” (1990, p. 32). Through psychotherapy, a change is expected to occur in the superego and ego, and Jacobson’s formulation (1971) can be used to predict some of these modifications. First, psychodynamic psychotherapy aims to decrease the hypercritical functions of the superego, lessening the client’s constant disparaging judgments of him or herself. This process serves to simultaneously lower the client’s guilt and to increase self-esteem. A second objective of psychodynamic psychotherapy is the formation of more realistic ego ideals and self-representations; the client comes to see others and the self in a more accurate light, resulting in increased self-esteem. Thus, a likely outcome of psychodynamic psychotherapy is the increase in self-esteem and corresponding decrease in depression, but these changes connect with the primary modification of the personality.
2.3.3 The Relationship in Psychodynamic Therapy

The therapeutic relationship is an explicit focus of psychodynamic psychotherapy for depression (Gabbard, 2000, p. 219). The relationship starts even before the initial encounter with the therapist. When the client first considers going to psychotherapy, first hears the therapist’s voice on the phone, and awaits the initial session, the client engages with the therapist in fantasy and brings this fantasy into psychotherapy.

In the beginning, psychotherapy focuses on the building of rapport between client and therapist. The client’s and therapist’s first interactions concern establishing a therapeutic frame and agreeing on issues such as treatment frequency (Busch, Rudden, and Shapiro, 2004, p. 40). The client may be eager for a relationship that feels stable because of his or her vulnerability to loss, and the client may be ready to identify with a confident therapist due to his or her low self-esteem (p. 45). If the client and therapist are a good match, the client will come to trust the therapist and they will begin to form a therapeutic alliance. The therapeutic alliance is the working relationship between client and therapist, forged through a mutual understanding regarding tasks and goals of psychotherapy, and permeated by the client’s trust of the therapist and therapist’s respect for the client. In short, the therapeutic alliance concerns the client and therapist working together to understand the client and the meaning of his or her depressive symptoms (p. 44). With the alliance formed, the client ideally views the therapist both as an empathic collaborator in understanding and as a knowledgeable authority with experience treating depression (p. 32).

The therapeutic alliance becomes the ground for the configuration of the transference relationship. A traditional psychodynamic conceptualization of transference
points to the client’s transferring of feelings originally directed toward the parents onto the therapist (Gabbard, 2000, p. 12). In other words, the client’s past significant relationships inform his or her current relationships, including the therapeutic relationship. Consequently, the transference relationship allows the client and therapist to gain insight into the client’s past relationships with significant others, and problems therein, and to see how these factors influence current relationships and difficulties (McWilliams, 1994, p. 31). In particular, the depressed client’s feelings and behaviors emanating from transferential facets of the therapeutic relationship inevitably express the early loss, rejection, and/or deprivation of parental affection. The client will attempt to make up for lost love and may become frustrated and angry with the therapist for not offering enough love. According to McWilliams, “Analyzing the client’s underrcurent presumptions about inevitable rejection, and understanding his or her counteractive efforts to be ‘good’ in order to forestall it, constitute much of the work with depressive people” (p. 241). Specifically, McWilliams suggests interpreting client reactions to separations in psychotherapy and letting the client decide when to terminate, an anticipated event that brings to the fore the client’s conflicts around loss (p. 244-245).

McWilliams (1994) also highlighted the two-sided nature of the transference in psychodynamic psychotherapy with depressed clients. McWilliams described one side of the transference: “They attach quickly to the therapist, ascribe benevolence to his or her aims even when fearing criticism, are moved by empathic responsiveness, work hard to be “good” in the patient role, and appreciate bits of insight as if they were morsels of life-sustaining food” (p. 239). However, McWilliams pointed out that depressed clients also transfer onto the therapist their introjected critic; i.e., the harsh superego (p. 239).
Depressed clients anticipate and fear the worst of criticism from the therapist and are astute at perceiving even hints of disapproval. In Arieti’s terms (1977), the therapist is seen as a dominant other, a substitute for a previous dominant other or goal whose loss precipitated the depression (p. 866). Blatt (2004) also gave consideration to the two types of depression and highlighted the different emphasis of transference with anaclitic and introjective clients. Transference with anaclitic clients consists of concerns about the reliability and care of the therapist and of fears of separation and loss (p. 62). On the other hand, transference with introjective clients comprises issues of client autonomy and competition with the therapist, and of fears about anger and criticism (p. 62).

Just as the client’s transference is enacted in the therapeutic relationship, the therapist’s countertransference plays an essential part in psychodynamic psychotherapy of depression. The therapist’s relationship with the client is informed by the therapist’s past relationships with significant others yet the countertransference also reveals facets of the client’s transference. McWilliams (1994) correlated the therapist’s countertransference with two sides of the client’s transference in the therapy of depression (p. 240-241). On the one hand, the therapist may feel like the all-good, benevolent caretaker in response to the client’s praise and strivings to be good. On the other hand, the therapist may feel incompetent and hopeless because the therapist is also subjected to the tyranny of the client’s internal critic. Understanding the countertransference serves as a point of entry into the client’s world and better enables the therapist not to enact toxic relational patterns and behaviors that are unbenefficial for psychotherapy.
2.3.4 The Therapist in Psychodynamic Therapy

Although the therapist is subjected to the influence of the unconscious, the therapist strives toward certain behaviors and attitudes that encompass his or her professional role. Karasu characterized the therapist’s role in the psychodynamic treatment of depression as interpreter/reflector, and he highlighted three components of the role based on psychodynamic formulations (1990, p. 27). First, the therapist is receptive (p. 27). Freud suggested that therapists strive for an evenly hovering presence. The therapist attempts to be open to the whole of the client’s story while at the same time noticing the holes in it. Second, the therapist offers acceptance and assumes a nonjudgmental stance (p. 27). Moreover, Freud proposed that therapists function like a blank screen, which encourages the client to transfer feelings onto the therapist. Third, Freud offered the rule of abstinence (p. 27). The therapist strives for neutrality and stays away from offering direct advice, guidance, or other reassuring behaviors for which the client may wish. This tack serves to evoke the client’s frustration and thus enables him or her to work through the frustration.

2.3.5 The Technique of Psychodynamic Therapy

Psychodynamic techniques are part of the exploratory process of psychotherapy, and the therapist uses these to help the client gain insight into motivations, fantasies, and feelings of which he or she is unaware. Through the gradual process of exploration, the client starts to understand that his or her depressive symptoms are meaningful and that their origins are comprehensible (Busch, Rudden, and Shapiro, 2004, p. 42). Material of which the client is unconscious manifests in the client’s life experiences outside of therapy, in his or her associations during therapy, and in the aforementioned transference
relationship (Blatt, 2004, p. 256). Material also emerges in the client’s dreams, and
dreams are the easiest way for the client to appreciate the significance of the unconscious
for his or her depression (Busch, Rudden, and Shapiro, 2004, p. 55). Psychodynamic
techniques reference these experiences, associations, transference feelings, and dreams to
help the client acquire awareness about him or herself and others.

The psychodynamic techniques initially emphasized in psychotherapy of
depression are in the service of increasing rapport and client trust in order to solidify the
therapeutic alliance. Empathy is the foundation of any repertoire of psychodynamic
techniques. The therapist first needs to listen and comprehend the depth of the client’s
suffering while attempting to understand the client’s thoughts about his or her depression
(Gabbard, 2000, p. 218). Empathy coupled with a nonjudgmental stance is especially
important to calm depressed clients since they greatly fear any sign of criticism from
another person (McWilliams, 1994, p. 241). In addition to empathy, psycho-education is
provided at the beginning of therapy and the therapist educates the client about the nature
of his or her depression (Busch, Rudden, and Shapiro, 2004, p. 55).

Karasu (1990) and Busch, Rudden, and Shapiro (2004) highlighted three other
important psychodynamic techniques in the psychotherapy of depression. First,
clarification through the therapist’s statements or questions encourages the client to
explore significant facets of the material and to articulate his or her thoughts and feelings
about self and others. Second, confrontation through strongly worded statements or
evocative questioning pushes the client toward emotionally laden material, and also has
use in challenging the client’s self-destructive behaviors. Third, interpretation through
the therapist’s stating of hypotheses connects client’s patterns of behaving and thinking
with the underlying factors that contributed to the patterns. Different types of interpretations implicate different factors, and some examples of interpretations are genetic interpretations, conflict interpretations, defense interpretations, superego interpretations, and transference interpretations. Blatt’s (2004) distinction between anaclitic (dependent) and introjective (self-critical) depression is important when considering processes of change and the main techniques to utilize in psychotherapy. Anaclitic clients respond primarily to the facets of the interpersonal relationship while introjective clients do better with therapist interpretation (2004, p. 289). Beyond the consideration of the type of depression, the therapist tailors techniques to the needs of the individual client.

Psychodynamic techniques are used in the middle and late phases of psychotherapy to help the client work through insights. The working through of insights enables the client to incorporate them into his or her life and to thereby create a different life narrative. In this vein, Arieti (1977) thought that the client needs to articulate his or her preexisting life ideology of living for a dominant other or dominant goal (p. 865). The therapist then aids the client with his or her construction of a new ideology that reflects the client's interest in more versatile ways of living (Gabbard, 2000, p. 219). In another light, Bibring (1953) thought that the client unable to reach his aspirations (to be worthy, good, or strong) must reformulate those aspirations, enabling him to be loved and loving in relationships and secure in endeavors (p. 43).

2.3.6 The Process of Psychodynamic Therapy

The process of change in psychodynamic psychotherapy centers on the therapeutic relationship. The client’s experience of the relationship facilitates the
revision of his or her maladaptive representations of self and others, and the client forms
more integrated and differentiated representations (Blatt, 2004, p. 263). The
aforementioned psychodynamic techniques are used to encourage the development and
examination of the process, and in particular, an analysis of resistance and transference
(Karasu, 1990, p. 22). In other words, the process of psychodynamic psychotherapy
encourages the formation of the therapeutic relationship, including an exploration of
blocks to the progression of therapy and insipid distortions of the relationship.

The process of psychodynamic therapy facilitates changes concerning the client’s
relationships with others. As stated earlier, the therapeutic relationship is in part
informed by the client’s past relationships with significant others. By gaining insight into
the transference imbued facets of the therapeutic relationship, the client and therapist
come to elucidate the client’s fundamental relatedness toward others. The
psychodynamic techniques enable the client to gain insight into the therapeutic
relationship, past relationships with primary caregivers, and current significant
relationships, and through this process, the client begins to understand how depression
developed out of the context of these relationships. Moreover, as the transference is
examined and resolved, the client’s maladaptive interpersonal schemas and
representations of others are revised (Blatt, 2004, p. 263).

The process of psychodynamic therapy also facilitates changes regarding the self.
The holding environment provided by the therapist via his or her receptiveness,
acceptance, and empathy enables the client to begin to develop a more cohesive sense of
self, which militates against an experience of “empty” depression after the dissolution of
a significant relationship (Galatzer-Levy, 2002, p. 157). In other cases, the client
ascerts that difficulties with self-acceptance and self-evaluation influenced the emergence of depression. The therapist’s use of interpretation and other techniques helps the client resurrect and accept hitherto buried aspects of the self, originally responsible for depression (Summers, 2002, p. 119). By identifying with the valued facets of the therapist, the client reevaluates and revises his or her negative self-concept, and the client may even identify with valued aspects that the client transferred onto the therapist in the first place (Blatt, 2004, p. 275). In both cases, the process of psychodynamic therapy helps with the maintenance of the client’s sense of self and/or the quality of the client’s representations of self through the client’s internalization of the therapist’s attitudes and functions (Blatt, 2004, p. 275).

In summary, the goal of psychodynamic therapy for depression is to gain insight into the client’s emotional life. To this end, client and therapist engage in a process of exploration based on their acknowledgement of the significance of the client’s depressed moods and other symptoms. In particular, client and therapist examine events in the client’s life, associations in session, as well as the client’s feelings about dreams and the therapeutic relationship.

Throughout the process, the therapist assumes his or her role as interpreter/reflector, and uses techniques such as clarification, confrontation, and interpretation to help the client work through insights. The therapist also assumes a nonjudgmental stance, abstaining from direct advice or guidance, and strives for an evenly hovering presence. The foundation of such techniques and stance is the therapist’s empathy, and the expression of such empathy helps the client form a therapeutic alliance with the therapist. The therapeutic relationship is also informed by
the client’s past relationships, and the client sometimes sees the therapist as similar to a primary caregiver.

Through the exploratory process, the client gains awareness of the therapeutic relationship as well as of past and current relationships, and the client also gains awareness of the self. The client revises representations of self and other, and ultimately internalizes the therapist’s functions and attitudes that were part of the process. The outcome of therapy is a change in the client’s personality, not only symptom relief. In particular, the client develops a realistic and complex sense of self and others, and becomes less critical of him or herself. The preceding formulation of psychodynamic therapy for depression in this section, and summarized in the last few paragraphs, will be related to the results in the Discussions Chapter.

2.4 Summary

Meta-analyses of outcome studies found that therapy for depression, and psychodynamic therapy for depression in particular, works. However, most studies that were meta-analyzed provided a limited analysis of outcome by solely using quantified symptom measures and provided almost no analysis of process by focusing only on the brand of therapy as the main curative ingredient. Process studies provided a better, but still limited, analysis of process by utilizing quantitative process measures in which only researchers rated the process. In addition, outcome and process studies did not examine the client’s perspective on process or outcome, even though common factors research showed that clients contribute significantly to both. In this regard, although psychodynamic therapy for depression has been documented effective, no research has documented the client’s experience of processes that facilitated change or of the effects
of therapy. Therefore, my study examined the client’s experience of effective, long-term psychodynamic for depression, a type of therapy that has received little representation in most meta-analyses. The Method Chapter that follows this Chapter delineates the manner in which data gathering procedures targeted clients who went to psychodynamic therapy for depression and the way in which clients’ experiences were accessed through written descriptions and interviews. Specifically, the study examined both the process and outcome by requesting that clients describe the helpful facets and therapeutic effects of psychodynamic therapy, giving concrete accounts of both. The Method Chapter also highlights the qualitative data analysis procedures utilized and, particularly, the use of the empirical phenomenological method to provide in-depth analysis that did not limit the examination of process and outcome.

In the survey of drive theory, object relations theory, libido theory, ego psychology, and self psychology, eight keys issues emerged regarding these theories of depression. In particular, issues of hopelessness, helplessness, and disengagement with others and projects will be related to the results in the Discussion Chapter in a section concerning Participant’s Experience of Being Depressed. In addition, issues of loss, conflict, dependence on others, criticalness toward self, development, and relationships concern material addressed in some form in psychodynamic therapy and will be connected to the results in the Discussion Chapter in a section concerning the Therapeutic Process. The Discussion Chapter will include a discussion of the ways in which the results converged and diverged with a psychodynamic formulation of these issues.

In the survey of main facets of psychodynamic therapy, the goal of insight into client’s emotions was highlighted as well as the therapist’s use of techniques, such as
clarification, confrontation, and interpretation, to work through insights. The therapist’s role was elucidated and shown in the therapist’s manner of maintaining an evenly hovering presence, of assuming a nonjudgmental stance, and of abstaining from direct guidance. Through the process, the client is assumed to initially develop a therapeutic alliance, to gain awareness of relationships, including the transference relationship, and awareness of self, and to ultimately internalize the aforementioned therapist functions and attitudes. The anticipated outcome is personality modification, in addition to symptom relief, in which the client develops a complex sense of self and others, and cultivates a less critical stance toward self. The Discussion Chapter will compare and contrast results with the facets of psychodynamic therapy in sections concerning the Therapeutic Process and Therapeutic Outcome.
Chapter 3

Method

The focus of the research study was the client’s experience of effective psychodynamic psychotherapy for major depression. The research study did not focus on whether psychodynamic psychotherapy for major depression was effective or whether the psychotherapy was more effective than other therapies. Psychodynamic psychotherapy was assumed helpful and the study was designed to select participants who felt the psychotherapy had worked. The overarching goal of the research study was to arrive at structural descriptions of participants’ experience of the process and outcome of effective psychodynamic psychotherapy for major depression. The research study was guided by two general questions: For those people for whom treatment was experienced as effective, what were the facets of psychodynamic psychotherapy for major depression that helped, and what were the effects of psychodynamic psychotherapy?

I was interested in memories of representative incidents that captured what was helpful, thereby ensuring that participants based the description of process on their own experience of a concrete situation. The research study was also guided by my interest in gaining access to the participants’ experience of being depressed upon entering psychodynamic psychotherapy, and the ways that experience was different after psychotherapy and currently. I wanted to obtain concrete accounts of change thereby making sure the participant situated the description of the differences in his or her
experience. I was interested in acquiring as full a description of change as possible and so I requested that participants elaborate on changes experienced: in a bodily way, with others, in oneself, toward the future and past, and in the various aspects of one’s world. The Method Section that follows illustrates the steps followed to meet these goals and interests, and describes the empirical phenomenological research method used to elucidate participants’ experiences of effective psychodynamic psychotherapy for major depression.

3.1 Data Collection

3.1.1 Step One: Participant Sample and Solicitation

My research study focused on depressed clients who underwent psychodynamic psychotherapy for major depression. I used the term psychodynamic psychotherapy to stay consistent throughout the literature review in light of the predominant use of the term in contemporary research (e.g., Pole & Jones, 1998) and literature reviews (e.g., Karasu, 1990). However, I am not excluding psychoanalytic psychotherapy or any other depth-oriented psychotherapy. Gabbard (2005) explained in the Oxford Textbook of Psychotherapy: “The terms psychoanalytic and psychodynamic have increasingly been used synonymously in discussions of psychotherapy” (p. 1). Thus, my study focused on depressed clients who participated in psychoanalytic-psychodynamic psychotherapy.

Both the terms psychoanalytic and psychodynamic were used when soliciting participants, and a description of such a therapy was provided as follows: a type of therapy that employs an insight-orientation and an emotion focus, and that aims at deep seated change in addition to symptomatic improvement by addressing developmental themes, relational issues, and the significance of the unconscious. After participants had
identified themselves as having participated in psychoanalytic-psychodynamic therapy and had entered my study, I did not perform any further examination of their therapists’ orientation or an investigation into whether their therapists were board certified psychoanalysts. As it turns out, two participants identified their therapists as practicing from a Jungian orientation. A strength of not looking for particularly orthodoxed therapists is that it provided methodological openness in that the results would not be limited to any orthodox form of psychodynamic treatment. Another strength is that my results are directly relevant to many therapists who are not board certified psychoanalysts and who do not identify themselves as practicing from a particular psychoanalytic-psychodynamic orientation.

The research study more specifically addressed clients who participated in long-term treatment (i.e., psychotherapy of at least one-year duration and weekly or twice weekly frequency). Long-term psychotherapy leads to greater and wider therapeutic gains that a focus on short-term therapy might leave out. In addition, to control for positive transference gains at termination that recede after the diminution of the therapeutic relationship, and for gains simply unsustainable without continued psychotherapy, the research study focused on clients who terminated at least one year prior to the study. Focusing on clients who terminated at least one year prior to the study also allowed for therapeutic improvement that comes to fruition when the client is required to rely on structures, insights, and skills acquired in psychotherapy but which are fully actualized only after psychotherapy and the therapeutic relationship have ceased.

My study centers on clients who were depressed; thus, I required that participants retrospectively endorse, according to the DSM-IV-TR, the symptoms of major depression
experienced during the episode that corresponded with their psychodynamic
psychotherapy (American Psychiatric Association, 2000). Participants would be
excluded if they did not meet the criteria for major depression, but there was no exclusion
for other Axis I diagnoses. With these symptom-related endorsements, I used the DSM-
IV-TR to establish construct validity for major depression in order to ensure that I
solicited a group of participants comparable to those in previous studies. However, I did
not focus on symptoms in order to measure psychotherapeutic outcome.

The participants in the research study were clients who participated in once to
twice-weekly psychoanalytic-psychodynamic psychotherapy of at least one year’s
duration for their major depression, terminating no less than one year prior to beginning
the study, and who found therapy helpful. The participant solicitation procedures
targeted clients who were psychologically insightful, self-reflective, and articulate. With
this aim in mind, the particular participants sought for the research study were primarily
psychotherapists who participated in psychodynamic psychotherapy for their major
depression, and their colleagues who underwent such a treatment. Letters were sent out
to different psychological organizations soliciting these potential participants. As word
got around about the study, I was also open to accepting people not in the field who also
met the criteria.

Psychotherapists were suitable participants. Psychotherapists are taught to be
attuned to psychotherapeutic process and trained in the art of describing psychological
life. I therefore thought that psychotherapists were likely to generate rich descriptions. A
challenge of the study was to ensure that psychotherapists would not resort to abstract
theoretical constructs and schemas to describe their experience. To this end, I requested
that participants refrain from using theory. The written request encouraged participants
to describe their experiences concretely and requested specific incidents that captured
what was helpful for them in therapy as well as concrete accounts of changes with their
being depressed.

Psychotherapists were available participants. Depression is a common presenting
problem for psychotherapists entering personal psychotherapy (Norcross et al., 1988).
Psychoanalytic-psychodynamic psychotherapy is the most common choice of treatment
for psychotherapists seeking personal psychotherapy (Norcross et al., 1988). Thus,
psychotherapists who sought their own personal psychodynamic treatment for depression
were an available participant pool. A challenge in soliciting psychotherapists was their
degree of investment in the effectiveness of the therapeutic endeavor because they
presumably have a strong belief that therapy works and so may provide a slanted
description. However, the overall design of the study focused on participants who were
presumably invested in therapy, considering that they had found the experience helpful,
and in fact, I particularly sought descriptions from people who indicated investment in
the process and outcome of their therapy. Therefore, soliciting psychotherapists was
beneficial due to their availability and investment. Another methodological advantage of
soliciting psychotherapists was that they presumably had an understanding of the
diagnosis of major depression, and since solicitation focused on psychotherapists, they
provided an initial filter that ensured an accurate response to the solicitation letter.

After obtaining a training certificate from the National Institutes of Health for
participating in their Human Participant Protection Education for Research Teams online
course and receiving approval from the Duquesne University Institutional Review Board,
I targeted various psychological organizations. The manner of participant solicitation included general psychological organizations and ones more specifically associated with psychodynamic psychotherapy, and ensured that participants were diverse yet appropriate for the study. The various solicitation materials (Appendix 1) contained a brief description of the study and included my name, telephone number, and email address.

I placed an advertisement in the April 2007 edition of the Pennsylvania Psychological Association newsletter, *The Pennsylvania Psychologist*, and in the spring 2007 edition of the Greater Pittsburgh Psychological Association newsletter, *The GPPA Report*. I also sent flyers to the president of the Pittsburgh Psychoanalytic Society and Institute to be distributed to their candidates and faculty. I requested in both the advertisements and flyers that psychotherapists and their colleagues who were interested phone or email me.

I also sent a solicitation letter and research materials to the following: alumni of the Duquesne University Psychology Doctoral Program, via mail and email; professionals on the mailing list of the Pittsburgh Association for Psychoanalytic Thought, via mail; practitioners within a twenty mile radius of the greater Pittsburgh area, via mail, based on information I gathered from public telephone listings; and 550 members of the Pennsylvania Psychological Association listserv, via email. The research material (Appendix 2) consisted of directions, a consent form, research questions, and a request for a written description. In the solicitation letter, I addressed the potential participant by name and instructed him or her to complete the included material and to send it back to me in a self-addressed stamped envelope. I stated my availability by phone or email if the potential participant wanted to discuss any aspect of the research.
study. I also followed up with a telephone call after the mailings and gave the individual the option of mailing back the letter in the self-addressed stamped envelope if he or she did not want further contact. The aforementioned solicitation procedures yielded four participants; their characteristics are listed in Table 3.1.

**Table 3.1: Participant Characteristics**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Name</th>
<th>Gender</th>
<th>Age</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>Kelly</td>
<td>Female</td>
<td>50</td>
<td>Ph.D.</td>
</tr>
<tr>
<td>#2</td>
<td>Zack</td>
<td>Male</td>
<td>27</td>
<td>M.Div.</td>
</tr>
<tr>
<td>#3</td>
<td>Lisa</td>
<td>Female</td>
<td>37</td>
<td>Ph.D.</td>
</tr>
<tr>
<td>#4</td>
<td>Jesse</td>
<td>Female</td>
<td>48</td>
<td>M.Ed.</td>
</tr>
</tbody>
</table>

3.1.2 Step Two: Informed Consent and Confidentiality

The consent form (Appendix 2) outlined the steps taken to ensure confidentiality, which were as follows: use of a pseudonym to identify any of the following—participant’s written description, audiotape of participant’s interview, any transcription of interview, and notes; storage in a locked cabinet of the written description, audiotape of interview, any transcription of interview, and notes; storage of the consent form and list containing participant’s pseudonym in a separate locked cabinet; action to eliminate or alter any identifying information. The form explained that the participant’s description of his or her experience would be included in an appendix and that excerpts might be used within the report. It also informed the potential participant of his or her right to stop participating in the study and to retract his or her data at any time prior to completion of the study. If the potential participant understood the consent form, had no other questions to address to me, and agreed to participate, he or she then signed the consent form.
3.1.3 Step Three: Research Questionnaire

After signing the consent form, the participant completed the research questionnaire (Appendix 2), which began with two orienting questions. The first question addressed two symptoms of major depression, at least one of which needed to be present in order to obtain the diagnosis of major depression according to the DSM-IV-TR; the other question confirmed that psychotherapy helped. The orienting questions were as follows: Did you have a depressed mood and/or loss of interest or pleasure in most activities for two weeks or longer prior to and/or during your psychoanalytic- psychodynamic psychotherapy? Do you feel psychoanalytic-psychodynamic psychotherapy helped you? The questionnaire also contained symptom-related questions with at least five of these symptoms needing to be present during the same two-week period to obtain the diagnosis of major depression according to the DSM-IV-TR (American Psychiatric Association, 2000): depressed mood, diminished interest or pleasure in activities, weight loss or gain, insomnia or hypersomnia, fatigue or loss of energy, feelings of worthlessness or excessive guilt, diminished ability in thinking/concentrating, indecisiveness, or thoughts of death, suicide, plans for suicide, or suicide attempt (Table 3.2).
Table 3.2: Participant Symptoms

<table>
<thead>
<tr>
<th></th>
<th>Kelly</th>
<th>Zack</th>
<th>Lisa</th>
<th>Jesse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressed Mood</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Diminished Interest/Pleasure</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Weight/Appetite Fluctuation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Insomnia/Hypersomnia</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Fatigue/Loss of Energy</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Psychomotor Agitation/Retardation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Feelings of Worthlessness or Guilt</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Diminished Ability to Think/Concentrate or Indecisiveness</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Recurrent Suicidal Ideation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

The questionnaire also addressed the participant’s clinical history. In particular, it contained questions on the following:

- the length of the major depression that corresponded with participation in psychodynamic psychotherapy
- whether the depression was recurrent
- whether the depression was treated with medication
- length of psychotherapy
- frequency in psychotherapy
length since termination, and whether respondent had participated in any previous psychotherapies (Table 3.3).

**Table 3.3: Clinical History**

<table>
<thead>
<tr>
<th></th>
<th>Kelly</th>
<th>Zack</th>
<th>Lisa</th>
<th>Jesse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of depression</td>
<td>6 months</td>
<td>2 months</td>
<td>4 years</td>
<td>1-2 years</td>
</tr>
<tr>
<td>Medication</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Recurrent Depression</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Length of Therapy</td>
<td>1 ½ years</td>
<td>4 years</td>
<td>4 years</td>
<td>1 year</td>
</tr>
<tr>
<td>Frequency of Therapy</td>
<td>1 x week</td>
<td>1 x week</td>
<td>2 x week</td>
<td>1 x week</td>
</tr>
<tr>
<td>Years Terminated</td>
<td>17 years</td>
<td>5 years</td>
<td>10 years</td>
<td>8 years</td>
</tr>
<tr>
<td>Previous Therapy</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### 3.1.4 Step Four: Written Descriptions

After completing the research questionnaire, the participant responded to the request for a written description about his or her experience. Each participant wrote a description (three were typed and one hand-written) and returned it via mail. The request for a description was based on my research interests, and read verbatim as follows:

When responding to these questions, please refrain from using conceptual schemas as best you can and write in everyday language about your experience as a person involved in psychotherapy in as much detail as possible. As you look back,

- Please describe in concrete terms what your depression was like before entering psychotherapy, at the end of psychotherapy, and how you are different now
• Please describe several representative incidents that exemplify what was helpful for you in psychodynamic-psychotherapy and how it helped

• If not addressed above, please describe any changes experienced: in a bodily way, with other people, in yourself, toward your future and past, and in the various aspects of your world

3.1.5 Step Five: Interviews

Before conducting the interviews, I read the written descriptions to familiarize myself with each description and I wrote down my reflections and questions. My reading of the written descriptions helped focus the interview. I conducted individual interviews with each participant at his or her home or office. The interviews were audiotaped. I assumed an empathic and interested stance throughout the interview. I conducted the interview with the aim of clarifying and deepening the participant’s written description based on my reading of the document and on my research questions.

3.2 Data Analysis

An empirical phenomenological method was used for data analysis. The method of analysis was outlined by Giorgi (1975 & 1985) and expounded upon by Wertz (1983 & 1985). The data analysis consists of the following overlapping phases:

3.2.1 Step Six: Creation of Master Psychological Text

I transcribed the participant interviews. The interview with each participant was an elaboration of that person’s written description, so I further synthesized each transcribed interview segment with the corresponding portion of the written description to form a master psychological text for each participant. In particular, I placed the interview segment after the part of the written description it elaborated and used bold font
for the written description to differentiate it from the interview. The focus of data analysis was the participant’s master psychological text.

3.2.2. Step Seven: Demarcation of Master Text into Units

I read and re-read the master psychological text to familiarize myself with it and to grasp a sense of it holistically. I dwelt with the participant’s description, immersed myself in it, and maintained a maximum openness to what was meaningful for the participant. In the description, the participant shared memories of the process and outcome of psychodynamic psychotherapy: representative incidents that captured the helpfulness of psychotherapy and experiences of change in the participant’s being depressed and existence. The research was retrospective, and these memories were not interpreted as empirical events. These memories represented moments in a story, significant for the participant’s psychological life. They were images that revealed something qualitatively important, perhaps even essential, in the process and outcome of therapy for that person. In this first step, I was entering the hermeneutical circle. I was getting a feel for the narrative as a whole that informed my reading of the different parts, and my reading of the different parts of the narrative contributed to my sense of the whole.

I demarcated the many transitions that emerged within the description by breaking the narrative into meaning units. These transitions were qualitative changes in the narrative and places where I perceived a shift in meaning. I marked these transitions with a slash on the master psychological text. I noted the changes by paying particular attention to passages that revealed what helped the participant in psychodynamic
psychotherapy and what changed with the participant’s being depressed and in his or her existence.

3.2.3 Step Eight: Formulation of Central Themes of Units

I stated the theme of the transition in my own terms using a name, phrase, or sentence that I thought captured what the participant expressed. The theme was a restatement of the unit that encapsulated it in a clear and succinct manner. It was formulated with my grasp of the text as a whole in the background. I attempted to articulate the way in which self-others-body-world were implicated in each unit.

3.2.4 Step Nine: Integration of Central Themes

I interrogated the description according to my guiding questions. These questions were formed in line with my guiding interests and were as follows: What was the experience of being depressed before psychotherapy and after psychotherapy? What was the experience of representatively helpful incidents and how did these help? What were other changes experienced in the dimensions of existence? In light of these questions, I analyzed the narrative to arrive at central themes and I thoroughly examined each of these. I also identified the relations among themes, reflected upon these relations, and identified recurrent themes.

In particular, I discerned the relevant themes while eliminating nonessential ones and redundant ones by using imaginative free variation. I imagined whether the description would be fundamentally altered and whether my guiding questions would be unanswered if I did not include the theme. I determined that a theme was essential if its inclusion was necessary for understanding of the description and for answering my guiding questions. In this way, I looked at each theme and each relation among themes,
determining whether each was essential for an understanding of the helpful facets and therapeutic effects of psychodynamic psychotherapy for the participant. I eliminated themes that were not essential and sometimes modified themes to better express what was essential. Finally, I placed the themes in temporal order.

3.2.5 Step Ten: Formulation of the Situated Structure

I integrated the essential themes to form a structural description for each participant and developed situated structural descriptions of effective psychodynamic psychotherapy for major depression. Each structural description is my understanding of what helped the participant in psychodynamic psychotherapy and what happened with his or her being depressed and in his or her existence. The structural description included only the essential themes and highlighted the interconnected relationships among themes. The situated structure is a holistic description that emphasized the way in which past-present-future, self-other-body, and dimensions of the participant’s lived world were evident in moments that helped the person to change.

3.2.6 Step Eleven: Formulation of the General Structure

I compared themes common among the various structural descriptions. Sometimes these common themes were evident while at other times the common themes were implicit or came to light when compared under a more inclusive theme. For example, unlike other participants, one participant did not explicitly describe feeling hopeless before therapy, but she did describe feeling positive and hopeful about the future after therapy. The theme of hopelessness before therapy was implicit but made apparent when her description about the way she felt after therapy was analyzed in light of her description as a whole and in light of the other participants’ descriptions. I also
differentiated divergent themes specific to each particular description. I performed a further integration and created a general structural description that left out the particulars of the specific descriptions and synthesized the essential themes concerning the helpful facets and therapeutic effects of psychodynamic psychotherapy that transcended the specific descriptions.
Chapter 4

Results

This Chapter presents the results in the form of four situated structural descriptions. Each situated structure is divided into three parts, organized as follows: depression and other presenting problems, therapeutic process, and therapeutic outcome. The general structure concludes this chapter.

4.1 Situated Structure #1: “Kelly”

Kelly felt depressed and contemplated suicide while married to a man who was controlling and narcissistic, and she experienced severe depression after she divorced him. Feeling grief and sadness regarding the failed relationship, she saw her entire life as a failure as well. Even though she still found work meaningful, Kelly felt empty and felt like she was starting her life over again after the divorce. She felt alone and estranged from family and friends from whom she had isolated herself. Kelly also encountered difficulty sleeping and typically awoke at 3 a.m. unable to fall back asleep. Kelly entered psychodynamic therapy in light of her psychological difficulties, basing her choice of therapist on another’s recommendation and on reassurance of the therapist’s competence with women’s issues.
Therapeutic Process

In this manner, therapeutic work helped Kelly to become aware of the way in which her diminished sense of power influenced her ensnarement in the relationship with her controlling ex-husband, and to become empowered by developing more defensive and assertive facets of herself. Kelly consciously developed these facets of herself by engaging in academic projects such as studying for college courses and by participating in egalitarian relations with males in class. She acquired additional skills by reading books that helped her develop the ability to say ‘no’ in relationships.

Therapeutic work on dreams evoking various emotional qualities helped Kelly by developing her awareness of the unconscious meanings of those dreams. Kelly experienced a particular, frightening dream involving women with no appearance of femininity, appearing as if they were in a concentration camp with shaved heads and naked bodies. She found the dream to imply that she was detached from her femininity, and she apprehended her ex-husband’s detrimental influence on that feeling of disconnection. Kelly learned to reconnect with feminine facets of herself and to appreciate herself as a woman. Stemming from her interpretation of the dream, Kelly became more interested in adorning herself with nice clothes and make-up, and in nurturing others with a friendly and sociable demeanor, which she considered to be feminine traits. Thus, through therapeutic process that centered on her personality and dreams, Kelly’s sense of self and imaginative life developed as she cultivated and reconnected with assertive and feminine facets of herself of which she had been unaware before therapy.
Grief work also occurred throughout the process of therapy. After emotional encounters and altercations with her parents, Kelly usually experienced grief, and she tended to process it privately. However, specific work in therapy centered on family dynamics. In the course of therapy, Kelly grieved over her parents’ past shortcomings and started to accept present limitations such as her mother’s tendency to be controlling and her father’s tendency to react in anger. After therapy, Kelly had an upsetting encounter with her father in which he said something mean to her. In light of her therapeutic work, she was able to identify and accept the reality of unchanged relational dynamics regarding her father’s aggressive behavior.

Kelly also grieved the loss of both the past and a future relationship with her ex-husband. To facilitate working through this grief, her therapist provided a specific psycho-educational intervention utilizing a manual for the diagnosis of her ex-husband, and Kelly endorsed all criteria of narcissistic personality disorder. After Kelly expressed curiosity about a cure, her therapist taught her about the necessity of the ex-husband’s acknowledging his problems and engaging in long-term therapy. As Kelly knew he would not do this, she realized the magnitude of her ex-husband’s problems and the impossibility of any solution, which enabled her to let go of the emotional attachment and move on. That is, the intervention gave her insight into the impossibility of a future relationship, which served to solidify the dissolution of the past relationship, thereby enabling her to grieve and let go.

Kelly experienced other specific interventions that proved helpful. Firstly, her therapist offered an interpretation that placed Kelly’s mother and ex-husband in the same category (controlling) and that highlighted Kelly’s choice to marry her ex-husband in
relation to his similarities with her mother. Her therapist’s interpretation encouraged reflection and helped Kelly to develop insight. She came to see her mother as controlling, thus similar to her ex-husband, and to re-vision the way in which history with her mother shaped her choice of ex-husband. Secondly, her therapist confronted Kelly in a nonjudgmental way when she chose unhealthy dating relationships. She encouraged Kelly to look at her experience, draw connections between current and past males, and formulate her own understanding. Kelly reflected on her experience to draw a connection between her boyfriend and ex-husband. These interventions encouraged her to develop insight into the influence of past relationships so not to perpetuate the same types of relationships in the future.

The therapist’s presence and the atmosphere of her office were important because Kelly felt vulnerable in therapy. Her therapist had an electric hearth beside two wingback chairs, and her therapist sometimes offered her tea. The maternal-like warmth and comfort her therapist intentionally offered, both interpersonally and environmentally, provided Kelly with a sense of safety that enabled her to trust the therapist with ever more private realms of thought, fantasy, and memory.

Throughout the process of therapy, Kelly also sensed a general helpfulness from her therapist in that the therapist sometimes deviated from a theoretically orthodox stance but still maintained definitive boundaries. For example, when Kelly was reserved and felt self-conscious, her therapist was more active and directive during these sessions. In short, Kelly felt cared for: she felt her therapist cared on a professional level, based on the therapist’s emotional participation in the therapeutic work, and on a personal level when her therapist bestowed a gift related to their work. The therapist’s presence and care were
therefore foundational to and intertwined with specific therapeutic work that flourished within a responsive therapeutic frame.

The therapist’s role was also significant to the process of therapy. Kelly idealized the therapist in her role as a parent. She perceived the therapist as mother, grandmother, and even father and received validation and guidance not acquired from her own parents. In addition, vis-à-vis Kelly’s own potential to know, Kelly believed in the therapist in her role as the one who knows. She perceived the therapist to be her teacher who intuitively knew her problems and their solution, and so Kelly assumed the student role and was eager to learn. The therapist also served to model behaviors contrary to Kelly’s typical style of engagement. For instance, self-acceptance was modeled when her therapist made a lighthearted comment regarding a mistake the therapist had made, which served to contrast Kelly’s tendency to approach with the utmost seriousness any error she herself made. In general, Kelly’s participation with a therapist who provided validation and guidance led Kelly to experience care that had been lacking in past relationships with parents and that was lacking in the present relationship with herself. This novel encounter with her therapist stimulated growth in therapy. Specifically, Kelly took in qualities and care consistent with the therapist’s role such as her therapist’s validation and guidance, and in turn, Kelly started to validate her own emotions and to guide herself when making life decisions. Through the process of imagining the therapist’s perspective on issues, she learned to perform the function of therapist for herself. Kelly chose to end the process after sensing that she was able to deal with issues without her therapist and that the work was complete.
Therapeutic Outcome

Many aspects of Kelly’s life improved through the process of therapy. After therapy, Kelly no longer felt depressed or empty, but felt positive about her life and experienced her life as full of people and activities. She did experience a dysphoric mood at times, but it was more akin to lingering grief or sadness than to the emptiness Kelly had experienced before therapy. Prior to therapy, she had felt lost because she did not thoroughly know herself or understand the interpersonal context from which her depressed moods emerged, and she had felt shame in relating her feelings to others. After therapy, however, she identified signs of depressed mood earlier and understood how those signs related to her feelings and world; she also communicated her experience better with others.

Through the process of therapy, Kelly’s awareness enlarged as she learned to appreciate the nuances of her own experience and to apprehend the various facets of self and others. Kelly acquired more self-knowledge and self-confidence, and she learned to be nurturing toward her potentials and accepting of her mistakes. Kelly therefore sensed a significant change in selfhood. Kelly also felt more open with others and experienced a greater capability of forming close connections with people. Before therapy, Kelly had isolated herself from others due to the severity of being depressed and to her husband’s control. In particular, Kelly experienced ambivalence during therapy about reinitiating contact with her cousin and his family. However, after therapy, she developed close relationships with her cousin, his wife, and their children and assumed the important role of godmother to their third child, which enabled her to participate in their lives. With the help of suggestions during therapy about ways to initiate engagements by, for example,
going hiking or joining a social group, Kelly’s life became fuller after therapy as she increased engagements with enjoyable and with other people.

As a result of therapy, Kelly felt hopeful about the future. She still regretted her past choice of spouse, as it had precipitated much suffering. However, Kelly discovered the meaning of her suffering in her work as a therapist insofar as it helped her understand and work with her own clients, and she discovered a divine purpose for her suffering. Kelly also sensed divine purpose in finding this particular therapist and imagined her therapist to be an angel. She felt a sense of gratitude toward her therapist for the immense impact of therapy in transforming her life. Kelly’s personal development through the process of therapy contributed to her decision and commitment to become a therapist. Kelly’s experiences in her own therapy made her a better therapist and informed her formulation of therapy.

4.2 Situated Structure #2: “Zack”

Before he became depressed, Zack suffered from panic attacks. He started having panic attacks when he was entering a transition phase in his life. Specifically, he was beginning a romantic relationship with his new girlfriend and thinking about employment after college. Zack had experienced a looming anxiety concerning the unknownness of these engagements and a sadness over his longing for old ones.

With the increase in occurrences of panic attacks, Zack did not want to leave the safety of his home and began to feel sad and weak, as the sphere of meaningful engagements in his life shrank. Moreover, Zack felt frustrated about the recurrence of panic attacks and discouraged by the possibility of having to endure them throughout his
life. Zack began to feel depressed. He suffered a sense of emptiness as if there were a hole in his heart.

Encountering intense feelings of depression and emptiness without an understanding of these feelings, Zack’s sense of trust in his own capability was shaken. He felt anxious. He worried that such dark feelings indicated he was crazy and would kill himself. He then felt more depressed. Feelings of anxiety and depression arose in a cyclical relationship, perpetuated by Zack’s thoughts about each.

Zack primarily formulated his experience of the emergence of depressed moods in terms of temporality. Zack’s present felt unbearable because his experience of anxiety was so intense. Zack’s future seemed hopeless since he was unable to posit a pathway out of his suffering and to anticipate a future without it. He sensed that his future held no potential, as feelings of anxiety interfered with significant relationships and a meaningful career; he felt depressed, not wanting to engage in such an existence. Zack then took refuge in his past and reminisced over the relationship with his ex-girlfriend to escape dysphoric feelings in the present and his anticipation of their continuation in the future. Zack’s past became glorified, and as the past was no longer, he felt further depressed.

Zack distrusted others with whom he was in a relationship. Zack fantasized that if he chose to describe his experience of being depressed, his girlfriend would consider him crazy and reject him. Such fantasies of others’ reactions were an extension of his own fears for his sanity, and the underside was his desire for another to provide him a sense of definitive stability to relieve such fears. Nonetheless, because his description often provoked his girlfriend’s worry, given that she did not understand his experience, he in turn felt more anxious, especially in her presence. Zack isolated himself from her. In
addition, when Zack talked with friends about his depressed moods, friends would either acknowledge his experience but not fully attend to his emptiness or offer him advice that could not bring emotional relief. He also felt alone as they appeared to not understand his struggles with such moods and so kept their distance.

One night stood out for Zack as the culmination of his suffering. He was in his room praying for relief, yet even in these efforts, he continued to feel weaker and weaker. Sensing that all his engagements provided him no hope to hold onto, Zach felt helpless. At that point, he made the decision to drive to an old and empty church to pray. He screamed and questioned God about his suffering, his faith, and God’s sovereignty. Feeling abandoned even by God, Zach laid his head in exhaustion on an open Bible, only to fix his gaze on a Psalm concerning trusting God and God’s providing solace. Zach began to feel a sense of hope, and he found an engagement with something solid outside of himself to hold onto.

Therapeutic Process

In therapy, Zack identified the transition he was going through, specifically his starting a romantic relationship and considering employment after college. He also identified the way the transition related to his sadness about leaving part of his life behind. Zack went on to highlight a life-long pattern of anxiety and sadness coming to the fore during transitions from middle school to high school and from high school to college.

Zack also identified thought patterns that contributed to feelings of panic and depressed moods, and then brought to light the original situations that were of actual concern. For example, he traced an experience of panic back to conflicted thoughts he
had experienced moments earlier about speaking in front of a group of people. In particular, Zack highlighted the recurrent themes of helplessness, hopelessness, frustration, and anger that permeated his thoughts and factored into his depressed moods. He also came to realize that his parents had thought patterns similar to his, evident in the way both he and his father tended to think catastrophically regarding everyday stresses, and Zack came to appreciate that others might think differently in similar situations.

The process of therapy provided Zack with another person with whom he could articulate his feelings of depression. The act of simply talking significantly helped him to feel less isolated. For Zack, expressing his feelings of anxiety and depression was therapeutic insofar as he found stability in the therapeutic discussions between himself and his therapist. By bringing his feelings to light, he came to learn that his experience was not that dark, disturbing, or bad, but rather, an experience of a transitory nature. Zack then began to imagine his future apart from his present experiences of anxiety and depression, and to feel that his future was calling him.

Via his therapist’s stance, Zack learned that his depressed moods were of a transitory nature. Learning about his depressed moods occurred on three levels in therapy: First, when Zack articulated his thoughts, feelings, and fantasies to his therapist, his therapist assumed a stance that showed he understood. His therapist had an attentive and empathic presence. He was also neutral in that he did not react in an anxious manner when Zack expressed his concerns. Second, his therapist’s professional role evoked Zack’s confidence that his experience would be understood and that his therapist would view that experience as commonplace since he had likely seen similar cases. His therapist also highlighted that Zack was not exhibiting psychotic or suicidal behavior,
which provided Zack further relief. Third, his therapist on a few occasions disclosed his own personal experiences in an appropriate and well-modulated fashion, conveying a sense that Zack’s experiences were understood and not out of the ordinary. With regard to the latter two levels, his therapist normalized Zack’s experience, and thus lifted Zack’s burden of suffering alone.

Zack elucidated three specific interventions that he found helpful. First, his therapist encouraged Zack to associate to different imagined worst-case scenarios regarding particular worries and anxieties. For example, Zack worried about fainting after experiencing panic attacks. After reflecting upon scenarios involving fainting, he associated to a fantasy of someone caring for him after regaining consciousness, which brought to light a theme of distrusting others’ care. Zack also worried about his potential for committing suicide after being depressed, which elucidated a theme of distrusting his own care. Moreover, he was thrown back upon his authentic will to live because he could not imagine a scenario of actually attempting or even considering suicide, and so delineated this possibility as merely a thought stemming from anxiety. Zack thereby gained trust in his own capability.

Second, when he felt depressed, Zack’s thoughts had a ruminative quality and a cyclical movement wherein he worried about his depressed feelings and then lamented them, only to finally feel more depressed. This reflective engagement with himself created an abysmal spiraling downward. To address this problem initially, his therapist suggested he engage in activities such as playing guitar and eating. For instance, playing guitar required that he engage to some degree automatically during his focus on that engagement. These activities cultivated his attending to prereflective engagements with
the world and others rather than further attending to the problematic reflective engagement with himself. Zack thus felt less helpless and more able to bear his feelings because he acquired a sense of trust in his own ability to deal with his situation.

Third, when his experiences of anxiety initially intensified, Zack felt frustrated and hopeless, and he came to feel depressed. During therapy, his therapist highlighted the possibility that he might encounter such a period in the future and approximated the potential frequency and duration, while also pointing out the possibility of Zack’s acceptance of these periods. While processing this statement after session, Zack initially reacted oppositionally as he never wanted to encounter feelings of anxiety and depression again. However, with further processing, Zack concluded that he had the ability to handle another period and ascertained the positive function these painful feelings provided for him to reconnect with his world. Through these considerations, Zack came to accept his experiences of anxiety and being depressed, and to surrender his fight against such feelings, a process that brought him a sense of hope and peace.

Other areas, such as dreams, were addressed during the course of therapy. Zack had a series of dreams concerning his ex-girlfriend where he felt perfect, feeling both love and longing, but something prevented him from contacting her. He interpreted the image to mean that she was the ideal of something safe and stable from his past, but that he felt stuck in his miserable present unable to secure a sense of safety and stability. He also interpreted the function of his daydreaming and reminiscing about this particular ex-girlfriend as a means of temporarily feeling such safety and stability, and his therapist confronted him about his embellished memories of his ex-girlfriend. In this way, Zack came to see his past in a realistic light.
Zack also realized the extent of his parents’ struggles with anxiety, as evident in the way his mother attempted to protect him from the dangers of the world and contrasted by his father’s hypochondriacal and withdrawn manner. Not only did Zack better understand his parents, the impact that his parents had on his development, and family dynamics, he became more aware of himself. Zack found comfort in their shared struggles as well as a greater sense of acceptance of his own proclivity toward anxious experiences.

Zack studied scripture on his own over the course of therapy. Discovering that he shared similar experiences with its authors and characters, he identified themes in Christianity apparent in his life. In particular, he experienced abandonment by God, but found his faith nevertheless. Zack also felt redemption, as if a part of him had died when depressed, but through rectifying his faith, he had arisen to truly live. Thus, faith became an overarching theme. Zack was suffering; he did not completely trust himself, others, or the world, and so his existence felt out of his control; however, he maintained a faith in a sovereign God who provided refuge and stability. In this light, faith and trust are similar for Zack in that both qualities concern a belief in the other’s supportive response.

Just as Zack had faith in God to provide refuge and stability, he found stability in the therapeutic discussions and found refuge in the therapeutic milieu. The atmosphere of Zack’s therapy was permeated by an air of comfort, from his therapist’s casual attire to the office itself with its calming pictures and relaxing couch. Zack felt the atmosphere was an invitation to speak freely, and in turn, he felt safe to talk about ever more personal thoughts and fantasies.
A sense of safety was vital to therapy because he initially had not trusted the manner in which his therapist would react, which reflected an overall difficulty trusting others. The intensity of his experiences of panic and anxiety necessitated a certain kind of basic trust in his therapist as a professional care provider at the beginning of therapy. Nonetheless, when opportunities to express his anxious ruminations about insanity or suicidality were presented in therapy, Zack initially did not trust that his therapist would react in a neutral way and fantasized that he might be judged. As he expressed worries such as the intrusive thought about his potential to run his car off the road, his therapist did not react in the anticipated manner, which disconfirmed his fears. Thus, Zack gained a sense of trust in his therapist.

In regard to the relationship, Zack desired at times for his therapist to respond to him like a friend, father, mother, or even pastor. He fantasized that his therapist could provide some ultimate stability to his existence, stability he had previously sought from others, but to no avail. However, his therapist either avoided responding in such a way or questioned Zack about his fantasized response, thereby frustrating his desire. Zack learned that his therapist was not aversely impacted by his desire or his feelings, and his therapist kept the relationship professional. In general, Zack felt positive about the relationship and thought it was therapeutic.

Therapeutic Outcome

After therapy, Zack did not feel depressed. Through learning about himself in therapy, Zack had become better able to deal with his feelings of depression and to trust his own capability and ability. The intensity of his depressed moods had lessened as Zack had come to understand and tolerate his experience of anxiety and panic, and such
anxiety had lessened as well. In a basic sense, Zack came to understand that his experience of anxiety consisted of just thoughts and feelings and that these were transient. In a larger sense, the process of therapy helped Zack to create a life narrative that provided a perspective for understanding his experience of being depressed and that further helped him articulate themes inherent in that experience. In short, Zack became more aware of himself.

Zack also became more trusting of others in addition to depending less on them for stability. With his understanding formulated, he did not panic when depressed moods arose during the course of therapy, and so did not need his girlfriend to stay calm to provide support. He was able to confidently express more personal thoughts and feelings to her, and she came to better understand his experience. Nor did Zack need his friends to attend to his feelings or to offer appropriate solutions. He felt more confident holding back disquieting thoughts and feelings, and was able to reestablish everyday contact with friends.

Through enduring anxiety and depressed moods, Zack solidified his faith in God and saw his faith as a holding onto something beyond these experiences. After his suffering, Zack acquired a sense of God’s presence in his life, knowledge of the degree of suffering involved in living, and a capacity to empathize with others who are suffering.

In conclusion, the process of therapy helped Zack be more attentive to his engagements in the present with the world and others, offered him the perspective from which to envision a future without debilitating anxiety or depressed moods, and enabled him to keep memories of his ex-girlfriend as part of his past. Now able to feel a future beckoning to him, Zach felt hope. He realized his call to become a pastor, and the
realization helped him to delineate a definitive career potential from the abounding possibilities that had emerged in college and had contributed to his panic attacks.

After therapy, Zack encountered for a shorter duration a few periods of more intensified experiences of depressed moods and/or anxious feelings, which wound up consolidating the growth he had achieved through therapy. For instance, Zack was about to graduate from his master’s program and suffered a loss of a loved one, too. He initially experienced panic attacks accompanied by instances of crying, but his thoughts no longer filled with worry. Instead, he recognized his dysphoric feelings, knew they were transitory, and understood their connection to his apprehension about graduating and starting a career. Zack had previously developed, in therapy, specific ways to endure these moods; thus, during this transition, he played guitar and maintained contact with family and friends. Zack continued to trust others and God, and he experienced much less of a sense of isolation and aloneness. As he surrendered to this phase with its accompanied mood, Zack found he felt better. Zack even managed to envision his being in the future after graduation and imagined caring for children, working at a job, and engaging in leisurely pursuits.

4.3 Situated Structure #3: “Lisa”

During her senior year in college, Lisa first became depressed for a few weeks. Her body felt heavy and she lost the ability to smile. She also experienced hypersomnia. In an intentional manner, Lisa disengaged with others, and she carried a walkman and wore headphones around campus to discourage people from speaking with her. One year later, Lisa started graduate school and encountered a longer period of depression in which she experienced lethargy and despair. Around the time of these episodes, Lisa felt aimless
since she did not have personal goals concerning her career path and doubted her ability to establish or reach any goals. Lisa also felt stuck in a relationship wherein she experienced instances of physical and verbal abuse.

During the latter episode, Lisa attended therapy only in regard to relationship difficulties, but not for her depressed moods since she had not yet recognized that she was depressed. Her first therapist insisted she confront her boyfriend despite Lisa’s voicing concerns. Lisa was unwilling to confront him and left therapy after one session. Her second therapist appeared pleasant and cheerful, but Lisa felt no sense of connection with her. Lisa thought that the therapist had nothing to offer and left after several sessions.

One year later, Lisa moved back home. She encountered a severe depression for a long duration in which she experienced significant sleep disturbances and a sense of self-loathing. For periods, Lisa ate compulsively and neglected to engage in self-care such as bathing. In regard to precipitating factors, she still felt aimless and was consequently frustrated. Lisa also continued in the abusive relationship and felt even more stuck. Hence, both personally and relationally, Lisa existed in a dissatisfying present, yet was unable to posit a pathway toward a different future or to anticipate its possibility.

At the start of this episode, Lisa attended cognitive behavioral therapy for a year, but found this therapist unhelpful, too. Her therapist used labels on her and her problems, which felt invalidating and confining. He approached her suffering in a pragmatic manner based on the assumption that Lisa merely had to stop engaging in problematic behaviors by will alone. However, before taking any practical measures to change, Lisa
first had to want to change and to believe that change toward a worthy life was deserved and possible. Her therapist failed to engage her in a more fundamental way.

Lisa had a poorly developed sense of identity and therefore experienced a poorly differentiated sense of self and others, which contributed to her feeling aimless in projects and relationships. In regard to herself, when she attended to her prereflective experience, Lisa could not clearly recognize, identify, or express emotions, such as anger, and so could not articulate her wants and beliefs. In regard to others, when she encountered an unsatisfactory relationship, Lisa assumed that another’s ill-treatment, such as her boyfriend’s, indicated that she was bad.

Therapeutic Process

Without a developed sense of identity, Lisa felt fragile and confused at the beginning of psychodynamic therapy. Lisa had a prethematic sense that she was wanting and her therapist was providing, as if the process was feeding some unarticulated hunger. Over the course, she came to articulate this experience and others. Lisa discovered and acquired the words necessary to recognize and identify themes in her experience, and she cultivated a well-developed, adult sense of identity.

The most significant facet of therapy was her therapist’s analytic stance, which ameliorated a core issue for which Lisa sought therapy. Rather than pathologizing Lisa, her therapist acknowledged Lisa’s feelings, such as anger, and thereby let her be, in the fullness of her being, who she was. Her therapist approached her with respectful curiosity and questioned Lisa about her feelings to help her learn more about herself (e.g., her wants), which facilitated the differentiation of her sense of self. Lisa came to understand that, in addition to her parents’ and boyfriend’s invalidating her, she, too, was
rejecting her feelings. She realized that such a manner of attending to her experience contributed to her feeling lost with little sense of identity.

Another important aspect of therapy was her therapist’s receptive presence, which occurred on three levels. First, her therapist provided constancy as Lisa weekly encountered a consistent presence for several years. Second, her therapist exuded openness insofar as the therapist was attentive to Lisa and accepting of her, yet was also reserved and nondirective. Third, her therapist was responsive, and patiently engaged with her at the pace Lisa set. When Lisa felt threatened by interpretations based on her previous experiences of manipulation by others and on her limited identity formation, her therapist was adaptable and modified the treatment. In general, Lisa sensed that her therapist was trying to help, and such a helpful, caring presence was more significant to the process than was the correctness of the content of treatment.

The significance of her therapist’s constancy came to the fore during a particular session. Lisa was isolated and deprived of feeling valued by another, but she wanted to feel worthy, and her therapist’s treatment of her offered such a potential. Lisa had arrived late to session, as she had for other sessions, and upon seeing that the office light was off, Lisa became faint. Her body broke down when she encountered a disruption in the therapeutic relationship and her reaction embodied her unmet relational need. However, her therapist was still in the office and Lisa experienced a great sense of relief. Her therapist’s presence indicated that her therapist was reliable, that she could handle such a disruptive behavior as lateness, and that Lisa was worth waiting for.

An example of the therapist’s openness and responsiveness was her modification of the therapeutic frame. When depressed, Lisa suffered significant sleep disturbances.
When awake, her existence had slowed as she was both moving and thinking slowly. Her existence had also become more limited in scope since her vocabulary had shrunk and she had difficulty remembering. Lisa found that she was only able to speak about something important, or to even speak at all, after a significant portion of the session had elapsed. Therefore, at the beginning of the course of therapy, her therapist scheduled two sessions in a row, which enabled Lisa’s participation.

Her therapist also addressed specific relationships. Before therapy, Lisa had felt a sense of being stuck, as she was unable to end her dating relationship in two regards. First, Lisa feared her boyfriend and was frightened to leave him because of his threats and abuse; consequently, she entered into a survival mode of existence in which she attempted to endure his behavior. Second, Lisa longed for her boyfriend since she idealized him and wanted to obtain his validation, yet she could never obtain it. Throughout the course of therapy, her therapist helped her to articulate the unhealthy effects of the relationship, such as her tendency to become withdrawn in therapy during periods when her boyfriend was visiting her, and Lisa began to feel more of a sense of movement in her life. Lisa gained knowledge about and perspective on the relationship and herself, and she saw, for instance, that her boyfriend’s devaluation of her mirrored her own devaluation of herself. Such perspective helped to counter her rigid assumption that his ill-treatment solely indicated her badness. In addition to this more cognitive understanding, she continued to experience her therapist’s constant attentiveness, respect, and interest. Lisa started to believe that she was worthy of such treatment, and so felt that the way she treated herself and the way she was treated by her boyfriend were both
unacceptable. In other words, Lisa developed a belief in her own worthiness through integrating her experience of her therapist’s care.

Her therapist also explored family dynamics and helped Lisa discern problems that had previously been unclear and unarticulated, which facilitated the differentiation of her sense of significant others. Her therapist discussed particular concepts such as mirroring, which helped Lisa to better understand her development. Specifically, her therapist helped Lisa to articulate the limitations of her parents’ care. Lisa came to understand that, rather than seeing and validating her more personal qualities and potential, her parents recognized and valued her only in terms of her appearing in line with their expectations. During childhood and adolescence, her parents’ lack of recognition of her feelings and potentials contributed to Lisa’s difficulty in forming her own sense of identity, and, during young adulthood, her therapist’s care and respectful curiosity regarding these feelings and potentials were important processes in stimulating the development of Lisa’s sense of identity.

Her therapist also helped Lisa to articulate her feelings of rage and grief toward her parents’ limitations. Lisa had assumed that objectionable feelings such as shame signified a personal deficit and so had taken her hatred of her parents to mean that she was a bad person. Via her therapist’s analytic stance and respectful curiosity concerning Lisa’s feelings, Lisa found help in working through such hatred and found that, beyond her experiences of anger, feelings of grief and sadness emerged on the horizon. Because of her parents’ inability to validate Lisa’s personal attributes, she felt grief for deficits in the quality of care she received throughout her development. Lisa further felt sad for her parents, who had presumably received similarly deficient care, treatment that contributed
to deficiencies in the care of their daughter. Lisa ultimately felt a sense of empathy for them, which showed her burgeoning capacity to feel differing emotions toward the same person.

Her therapist also explained the significance of goodness of fit between parents and child, and Lisa acquired some perspective on their parenting that enabled her to feel more compassion toward her parents. Lisa came to understand that her parents were providing the only kind of care they were able to offer, and that in light of her more sensitive constitution, she simply needed additional guidance from them, which was a more complex understanding of family relationships.

When such family issues were addressed, the therapist focused on the complexity of Lisa’s experience, highlighting that issues are multiperspectival, not black and white, and that she could feel many different ways toward the same person. She came to see that she could both love and hate her parents, and that experiencing a strong emotion such as anger did not indicate her own badness.

**Therapeutic Outcome**

After therapy, Lisa did not feel depressed. She felt as if something had broken open, allowing in air, and she experienced a certain rawness of being. As opposed to her previous withdrawal and schizoid focus on herself, Lisa more fully engaged herself in a less defended manner with the world and others, and she felt truly alive.

For one year after therapy, Lisa often cried and felt sad for the difficulties inherent in living as she acquired a shared sense of humanity. In addition, Lisa felt grateful that she had endured her own difficulties during therapy to participate more fully in life, since life had become beautiful as well, and she felt particularly grateful for her
therapist’s constant presence throughout such demanding therapeutic work. Her tears in response to such incongruous emotions as sadness and gratitude were evidence of her development from perceiving the world in a rigid, dichotomous manner to seeing the world in its complexity and richness. Such a description was more accurate and such a world more inhabitable.

Lisa thus acquired and integrated a lived sense of the complexity of experience. Lisa came to understand that in a shared world, issues are multifaceted and so she could feel a multitude of contradictory emotions toward the same person. Furthermore, she learned that her identity consisted of her differing feelings and that she persisted throughout these feelings. Lisa assumed a stance of respectful curiosity toward her experiences and integrated her therapist’s stance into her own manner of attending to her feelings. Rather than rejecting her experiences and becoming angry with herself for them, Lisa believed that her thoughts, feelings, and reactions were valuable to her sense of identity and meaningful for her understanding of the world.

In this way, Lisa attained a more developed sense of identity than before therapy and continued to cultivate her interests, for example, by reading books that excited her curiosity. She articulated her wants and found that her identity was reflected in her engagements with the things of her world. Rather than ignoring or rejecting these, she let herself intentionally engage with more and more things she had found meaningful during therapy. For instance, Lisa bought an item that she found humorous at a store and purchased it only for the sake of its comic appeal. Since her therapist had cared enough to provide a therapeutic space for her to be in her fullness of being, Lisa felt motivated to care about herself and gave herself room to develop.
In line with this development, Lisa felt more integrated with her body, as her body was incorporated in her sense of identity. When severely depressed, she had felt detached from her body as if her body were an oppressive object that she loathed. When depressed, Lisa had also been unable to produce anything creative since she was not grounded in a sense of identity and embodiment, nor in terms of relationships with others. As Lisa established such a ground from which to create, she once again engaged in painting: a creative endeavor she had enjoyed prior to becoming depressed.

As for relations with others, Lisa developed a greater sense of empathy for her parents. In addition, she began to relate better with people in general. She initiated interactions with others and they reciprocated by doing the same. Beforehand, Lisa’s world had dwindled with her only engagement consisting of buying groceries and she felt as if she did not exist with others. Nonetheless, during therapy, Lisa had experienced a positive encounter at the grocery store when she mumbled aloud an insignificant thought directed toward herself. Another person in the store responded assuming that Lisa was speaking to her, and Lisa felt reconnected with others and the world. The process of therapy, along with this experience, elucidated the possibility of relatedness with others and the potential for relationships to be benevolent and reciprocal; therefore, the process modified her beliefs about others.

Lisa also formulated personal goals for her future and was engaging in academic course work. In light of her experiences, including the therapeutic effects of treatment, Lisa felt impelled to pursue studies in psychology, and ultimately completed graduate school. The process of therapy enabled the envisioning of such new potentials in her future. Through therapy, Lisa learned to foster curiosity rather than animosity toward her
feelings, others, and the world, which opened up new possibilities of engagement with each. She also learned to be receptive toward novel possibilities rather than anticipating only negative ones.

4.4 Situated Structure #4: “Jesse”

Jesse started a new job when pregnant. She was directing a program that necessitated a lot of local travel, while working another part-time job as well as performing household tasks, such as cooking and cleaning house. When her child was born, Jesse began taking care of her son as well. Jesse felt anxious, as she might or might not manage to fulfill these commitments. She suffered from acid reflux. She worried about her job, and awoke at 3 a.m. She felt exhausted, and eventually became less efficient at work.

Jesse felt negative toward and detached from her life. She had little quality time for her husband or for her son, and consequently, she and her husband frequently argued. Jesse had even less time to engage in activities such as writing poetry for relaxation and enjoyment since she had allocated more time for the care of her son and still attempted to spend the same amount of time at work. She felt depressed about the design of her world of engagements, yet did not want to acknowledge being depressed or that her moods indicated the need to modify the scope of her involvement with these engagements.

About two years after her son’s birth, Jesse took a medical leave of absence from her job. Assuming that her symptoms could be explained medically, Jesse sought assistance from her primary care physician. Her physician prescribed a tricyclic antidepressant to treat her insomnia, which she took for six months. In addition, Jesse saw a psychiatrist who diagnosed her with major depressive disorder. She then went to a
cognitive behavioral therapist through her work but felt too depressed and anxious for the therapy to be of help and left after two sessions.

**Therapeutic Process**

Jesse went back to a psychodynamic therapist she had seen ten years previously, and the therapist highlighted that Jesse was presenting with the same pattern: caring for significant others and work projects at the expense of caring for herself. The psychodynamic therapy helped Jesse to address such patterns and to avert subsequent symptom formation through an in-depth exploration of her development, including the unpleasant aspects of her development and her self that Jesse did not want to acknowledge. In addition, psychodynamic therapy helped her grow through exploring and developing assertive and creative facets of her personality that had been denied when Jesse cared for others but failed to care for herself.

Jesse appreciated the focus on dreams throughout the therapeutic work, which helped her develop a sense of personal and emotional complexity. Jesse analyzed a dream in which she descended into a swamp-like basement and felt disgusted, as she did not want to look at the repulsive sites. Jesse interpreted the dream to mean that she did not desire to acknowledge her depressed moods and other unpleasant feelings about herself or about her over-involvement with work, household tasks, and childcare, and such a dream made her more aware of these feelings. Jesse analyzed another dream wherein she was a prominent Nazi figure. Such a female figure was powerful yet undesirable. Jesse interpreted the image to mean that she was denying the more assertive facets of herself and that she needed to be more assertive. In this way, as opposed to her previously accommodating style, Jesse realized that she had the right to say no to
employers, to refuse to engage in an unrealistic amount of work, and to take better care of herself.

When Jesse presented dreams, her therapist did not over-analyze them, but instead questioned Jesse about her feelings concerning particular aspects of or figures in the dream. The discussions stimulated Jesse’s interest and she searched for books to supplement the therapeutic work. The dreams as well as the books provided a novel perspective from which to understand herself. From her reading of a particular book, Jesse concluded that life transitions, like parenthood, and challenging experiences, like being depressed, call forth a personal, emotional examination and a descent into undesirable feelings, fantasies, and images in order to become better aware of oneself and to grow as a person.

Jesse also appreciated the therapeutic focus on a particular symbol. Her therapist had organic items such as seashells throughout her office and Jesse found herself prereflectively focusing on a specific figure, a dragonfly. Later in therapy, Jesse articulated the way it had represented her need to change as an individual and to accept life’s change. Specifically, Jesse felt emotionally unprepared for the difficult transition from engaging mostly with work and leisurely projects to also caring for a child. The dragonfly was also a symbol of hope when Jesse felt significantly depressed. After therapy, Jesse adorned herself with a pair of dragonfly earrings and her home with a dragonfly figure to remind herself to allow change.

In light of therapeutic work concerning dreams and the symbol, Jesse came to see her experience of being depressed as a reminder to take care of herself, and in general, as an indication to attend to herself in the fullness of her being. To this end, given that Jesse
initially felt anxiety and shame concerning her experience of certain feelings such as sadness, her therapist instructed Jesse to allow these feelings to move her after an event and to be curious about what the feelings taught her. Jesse therefore arranged a time and place to attend to her experience of feelings when needed, and she found this process cathartic. She would further discern the significance of her feelings and what they disclosed about the event and about herself.

The therapy also addressed her pattern of commitments concerning work and family responsibilities in order to facilitate change regarding that pattern. As she integrated her perception of parenthood into her sense of identity and started to accept the changes that parenthood entailed, Jesse came to realize that child-care required self-care, and so she learned to end certain commitments and to share responsibilities with her husband. In particular, Jesse realized that she needed to change and that she could not possibly direct affairs at her full-time job as well as care for a child while still attempting to participate in enjoyable activities without feeling significantly stressed. Jesse thus focused on part-time private practice work, and constructed a flexible schedule that allocated adequate time to engage with work, with her husband, and with her son. Jesse also built time for herself into her schedule, which initially consisted simply of being without commitments; e.g., sleeping, listening to music.

Concerning time for herself, Jesse had played in a band for about a decade and had written songs that espoused feminine strength based on images from her dreams. She had also written poetry. During and after her pregnancy, in order to allocate more time for childcare, Jesse no longer engaged with music or creative writing. Through therapy, Jesse articulated the way in which this choice was informed by her ideal of the self-
sacrificing mother, based on her experiences with her own mother who, in order to care for the children, had not worked outside the home. Jesse’s therapist highlighted that her well had run dry, and Jesse understood this to mean that she was not nurturing herself. She started to allow time for writing down her dreams and poetry, which stimulated her love of music and creation of songs. Jesse reconnected with this more creative facet of herself and reintegrated such engagements into her life.

The therapeutic work also centered on the significance of particular interactions between Jesse and her therapist. Jesse sometimes felt angry and reacted firmly when her therapist would point out that she had not paid when she was required to pay, and her therapist’s assertions stood in stark contrast to Jesse’s more self-sacrificing style. Her therapist interpreted some of these reactions as stemming from the transference, and Jesse articulated her feelings and fantasies regarding her therapist at these times. Jesse found such work interesting in light of its significance for the acquisition of self-knowledge.

In general, the therapeutic relationship consisted of a felt bond between Jesse and her therapist. Jesse’s therapist had a rather eccentric demeanor and a less medically oriented or authoritarian approach than may be typical. On occasion, Jesse’s therapist made personal disclosures, which seemed appropriate at the end of therapy and after their chance meetings in the community.

Her therapist also had an attentive and caring presence. Jesse sensed that her therapist understood her suffering and that her therapist was nurturing and guided her. Her therapist’s understanding and nurturing facilitated her own understanding and growing throughout the process of therapy. Jesse thought this process unfolded in a
prereflexive manner and was subsequently reflected upon in their therapeutic discussions centering on dreams and symbols.

**Therapeutic Outcome**

Before therapy, Jesse had felt depressed, but toward the end, she felt better. At the beginning of the work, Jesse came to acknowledge that she was depressed and to trust that she would feel better and could make changes in her life to this end. In this manner, Jesse felt hopeful by the end of therapy. She also felt more positive about her life and felt less of a sense of depletion, after she quit her full-time job.

After therapy, Jesse felt happier and was more able to enjoy her work. Although she had to adjust to working only part-time, Jesse felt a greater sense of control in her private practice work and felt a significant decrease in the severity of anxiety. She also obtained more sleep and so felt more energized when interacting with her husband and son. Jesse argued less with her husband, and in general experienced a lesser degree and frequency of anger.

Through therapy and her struggles with being depressed, Jesse had learned to engage more carefully with others and with work, and to refrain from over-involving or over-stressing herself in this new phase of life. To this end, Jesse continued to work only part-time after discontinuing therapy, as her husband worked full-time and acquired health insurance. She consequently had more time to be involved with her son and his schooling. Jesse kept an empty bottle of her antidepressant as a reminder not to over-involve herself with too many personal and professional responsibilities. She thus designed both her world of engagements and her environment in such a way as to avert subsequent depressed moods.
After therapy, Jesse also had more time for herself and did meditation, yoga, and tai chi for relaxation and well-being. She performed these practices or just sat quietly in order to attend to herself and become more aware of feelings that were significant yet prethematic. Jesse also re-integrated engagements into her life that she enjoyed, such as music, and attempted to stay optimistic about her life in general.

Jesse now viewed her past struggles with being depressed as a learning experience, which helped in her work as a therapist. She felt pleased and encouraged about the present relationships with her work and with her child. Jesse also felt more accepting of and more ready for future life changes.

4.5 General Structure

Before Therapy

Before entering therapy, the participant feels depressed. The depressed moods disclose a situation concerning oneself, others, or the world that is a source of suffering, but she is unable to change her involvement with the situation in two regards. First, the participant has an unsophisticated understanding of depressed moods. She furthermore encounters difficulty when making her experience of emotions thematic and also takes any experience of unwanted feelings to indicate that something is wrong with her. Therefore, she cannot attend to what her feelings and depressed moods disclose about the situation in order to begin to change her involvement. Second, the participant has a poorly developed sense of self that contributes to the co-creation of the situation and to her not shaping it differently.

Throughout the General Structure, I use “she” or “her” when referencing participants, rather than “he or she” or “him or her,” because the former reads better and three out of four participants were female. In addition, there were no essential differences regarding process and outcome found between the one male participant and the other female participants.
The person disengages in response to the situation and also in an attempt to deal with it. She experiences diminished relatedness with significant and insignificant others, and diminished engagement with meaningful projects as well as with everyday ones. These experiences contribute to the depressed moods and are also a consequence of the participant disengaging when depressed.

The participant experiences a change in her life that solidifies the particular constitution of the situation. The person is discouraged about her present situation but unable to posit a way of changing her involvement with it. The participant anticipates future suffering on the horizon and feels hopeless. In such a situation, the person feels “stuck” and depressed.

Therapeutic Process

When the person enters psychodynamic therapy, she feels vulnerable regarding the therapist’s potential actions or reactions, and the therapist assumes an analytic stance toward her presentation of emotion-laden experiences. The therapist acknowledges the participant’s feelings, approaches them with curiosity, and teaches the person to do the same. The participant makes thematic her experiences and comes to learn more about the depressed moods, other feelings, and herself. She also becomes more aware of the relationship between such feelings and the situation that is a source of suffering.

Therapy centers on the participant’s sense of self, and she becomes aware of the way in which negation of potentials of being have contributed to the situation. She develops hitherto negated facets of self through her engagements with activities, projects, or relationships. She thereby changes her manner of involvement in the situation or is prepared to involve herself differently in similar situations in the future.
An important way to address the person’s sense of self is through exploration of emotion-laden dreams. The participant formulates an interpretation where a figure or aspect of the dream represents something of significance for her situation. She becomes more self-aware regarding negated feelings, fantasies, or potentials, and self-development follows as she attends to herself or others in a different manner.

The therapist also helps the participant to identify particular patterns of thinking, reacting, behaving, or relating that contribute to her involvement in the situation. The therapist’s manner of intervening provides the participant with an experience that more fully elucidates the pattern, and she comes to some realization about it. The participant is then better able to modify the pattern and the way she is involved in the situation.

Therapy also addresses individual psychodynamics, and, in particular, the participant’s longing for and fantasies about a remembered past or imagined future that contribute to the person’s not facing the actual present situation. The therapist confronts her about the ways in which such a past never was or such a future never will be. As she processes this contrast, the participant comes to see the present as it is and to experience a sense of movement in her life.

The therapy focuses on relational dynamics. The participant makes thematic her experience of relations with family members, and she comes to a more complex understanding of family dynamics and family members. Therapy further involves an exploration of the participant’s development, and she critically assesses her parents’ care to better understand early relationships. She articulates the way these early relationships with her parents shaped her co-constitution of the situation, and she becomes more aware of herself. The therapist also helps the participant to see relationships with
acquaintances, friends, or significant others in a different light, and she gains insight about relationships, other people, and herself.

Therapy also explicitly addresses the therapeutic relationship. The person sometimes views the therapist as a parental or authority figure and interacts with the therapist in an idiosyncratic manner based on these perceptions. The therapist either makes an intervention that highlights the quality of the participant’s interaction, in that understanding her fantasy helps the person gain insight about her relationships and herself, or the therapist makes no intervention because the participant’s benign and positive fantasy facilitates her participation in the process of therapy.

The therapy touches upon loss. The participant is disheartened with a personal, professional, and/or relational issue that entails the potential loss of a differently imagined future or an actually remembered past. The therapist makes an intervention that aims to highlight the definitive nature of the issue and loss. The person sees the issue more clearly and works through anger or grief about loss. The participant thereby comes to accept the issue and to feel differently about it.

Between sessions, the participant engages in activities, such as reading books, which stimulate additional learning. She intentionally cultivates her interests in, for example, music, art, or academics, which fosters personal growth.

During the process of therapy, the therapist intervenes in three different ways. First, the therapist questions the participant about feelings and fantasies regarding an aspect of her experience, or asks about another variable that the person has not yet articulated in order to encourage reflection. Second, the therapist highlights an aspect of the participant’s experience to bring it into the foreground, or interprets the person’s
behaviors and reactions to explain the way these were shaped by past experiences. Third, the therapist provides psychoeducation to help the participant better understand her experience and relationships, or makes suggestions about different potential ways for the person to engage with herself, others, and the world.

The atmosphere of therapy is also important to the process and consists of the comfortable furniture, appealing decorations, and even the therapist. The atmosphere provides a sense of safety or consistency that helps the person to talk about private feelings, fantasies, and memories.

The therapist is attentive to the participant’s articulations and empathic toward her emotions. The therapist is responsive to the person’s needs and sometimes modifies the analytic frame or stance to help the participant. The person’s therapy experience is unique insofar as therapist flexibility and individually tailored responses are designed to meet the specific needs of the participant. The participant senses that the therapist cares about her. The way the therapist cares for the person contrasts with the ways others have cared for her and the way the participant cares for herself. The participant’s encounter with the therapist’s care facilitates the participant’s understanding of her experience as well as her appropriation of such care into her own manner of attending to her experience. The person appreciates the therapist, the deep sense of therapist care she encountered in the therapeutic relationship, and the centrality of the relationship to the process of therapy.

Therapeutic Outcome

After therapy, the participant no longer feels depressed, and has modified her involvement with the situation concerning herself, others, and/or the world.
therapy, the participant discerns the nuances of her experiences and emotional life, and comes to better understand these. She also acquires a more complex sense of herself and others, and becomes more aware of both.

The participant thus develops personally and engages differently with herself, others, and the world. She assumes a caring stance when attending to her experiences, which allows her feelings and potentials to appear more clearly and fully. The person interacts more and relates better with others as well. She feels trusting of others, and in return, they offer more to her. The participant also engages more and is more engaged with the world and with enjoyable activities or significant projects. Specifically, the participant makes important choices regarding her career, and ultimately, her experiences inform her work.

The participant feels better about her life in the present. She also apprehends the purpose of her past suffering for her life. The participant envisions new potential ways of relating and of engaging in the future and feels hopeful. The participant has learned to identify the signs of any depressed moods, to understand the personal and interpersonal significance of the moods, and to handle such moods and talk about them with trusted others.

4.6 Summary of Findings

The following is a summary of the main findings of the study:

- Therapy helped to relieve the intensity and duration of participants’ depressive episodes, to improve the quality of participants’ engagements with others and projects, and to encourage their resiliency and continued psychological growth after termination.
• The process of therapy facilitated participants gaining awareness of self and others. Participants acquired insight about and developed facets of self. They also gained insight about contemporary relationships with family, friends, and significant others, and about the importance of their development in shaping their present situations.

• The process of therapy also focused on participants’ grief and anger about loss, and on their conflicted feelings about facing their present situations, as well as on participants’ dreams and their perceptions of therapists as a parental figure.

• Therapists questioned participants about their feelings to clarify or to confront, made statements to highlight or to interpret, and provided psychoeducation or suggestions.

• The comfortable therapeutic atmosphere offered a sense of safety. Regarding therapists’ presence, therapists were attentive and responsive to participants, and showed empathy for them. Concerning their analytic stance, therapists acknowledged participants’ feelings and were curious about the significance of such feelings for their lives.

• The deep sense of therapist care encountered in the genuinely personal therapeutic relationship facilitated the participants’ integration of such care into their own manner of attending to their experiences.

• Therapy helped participants to modify their involvement in a situation that was a source of suffering by teaching them to attend to their feelings in a caring manner and by facilitating their development of a complex sense of self. After therapy,
participants felt better about their lives in the present and felt hopeful about the future.
Chapter 5

Elaboration of the General Structure\textsuperscript{2}

Before Therapy

*Before entering therapy, the participant feels depressed.*

**Kelly-** My depression at this time was pretty severe.

**Zack-** It was an emptiness that I had never felt before. It was as if there was a hole in my heart and I had fallen through that hole.

**Lisa-** I grew increasingly self-loathing and entered a vicious depression.

**Jesse-** I was very tired, had low energy would sit at my desk at work, unable to function.

*The depressed moods disclose a situation concerning oneself, others, or the world that is a source of suffering, but she is unable to change her involvement with the situation in two regards.*

**Kelly-** The person that I was before therapy was young, naive, undefended in the world, which is what allowed me to get sucked up into a relationship that was very bad for me.

**Zack-** The symptoms of anxiety and panic were back with vengeance.

\textsuperscript{2} In this Chapter, the General Structure is italicized. Each italicized common theme is followed by examples taken from participants’ descriptions. The examples have been indented and include the name of the participant from which they have been taken.
Lisa- There had been three brief episodes of physical violence from him toward me, as well as verbal intimidation. I felt both trapped in the relationship and a tremendous longing for him to love me. I felt despair, lethargy, was at a loss personally— with no goals.

Jesse- I had had little time for myself or fun, and felt that I had to leave my child at day care, work all day, was very busy at work running a program, and then would come home, have to cook dinner, clean up. I had no time to spend with my husband.

First, the participant has an unsophisticated understanding of depressed moods. She furthermore encounters difficulty when making her experience of emotions thematic and also takes any experience of unwanted feelings to indicate that something is wrong with her. Therefore, she cannot attend to what her feelings and depressed moods disclose about the situation in order to begin to change her involvement. Second, the participant has a less developed sense of self that contributes to the co-creation of the situation and to her not shaping it differently.

Kelly- [Depression] had a quality of shame, emptiness, and lostness. There’s a feeling of lostness, not knowing who you are and not really having a context for understanding myself or other people.

Zack- I got so depressed, so vacant, so dark...My inner dialogue would say, “Oh my God, I’m going to kill myself... I’m going to go crazy and kill myself...” Before I knew it I was in a full blown panic situation because I was afraid I couldn’t trust myself to myself.
Lisa- I think a lot of it had to do with identifying and expressing emotions. I didn’t learn how to say I feel this, I believe this, I want this, I hate this. I was just aimless, and coupled with that bad relationship, started getting on this track of I’m bad, I’m not good enough, I’m wrong...I think I was pretty foggy. I think I was undifferentiated. I didn’t know how to be a person or a grown up or have an identity.

Jesse- I think that is what kind of personality I had functioned with prior to this period where it was just like...I can do everything without paying attention to my inner needs or to my health.

The person disengages in response to the situation and also in an attempt to deal with it. She experiences diminished relatedness with significant and insignificant others,

Kelly- I did not want to socialize with my family and had lost contact with all of my friends from the past, so I felt very alone.

Zack- I felt completely alone and isolated from everyone around me. No one seemed to understand what I was going through. I felt so remote from my family, friends, and girlfriend (now wife).

Lisa- I wore a Walkman, often with nothing playing, in order to avoid interacting with people.

Jesse- I had no time to spend with my husband and we were both tired, stressed, and argued a lot. I worried that I did not have enough energy to enjoy my son. and diminished engagement with meaningful projects as well as with everyday ones.

Kelly- It seemed like I was starting life over again and my life felt very empty.
Zack- I started to become agoraphobic, not wanting to go out of the house as much. And as this started happening, just this overwhelming sense of weakness just started to creep over me and sadness.

Lisa- I only left the house to buy food or something like that. I wouldn’t meet or have any other experiences any other places. I was standing in the checkout line. I think at that point feeling like a non-entity, practically invisible.

Jesse- I felt very negative and detached from life...I had to quit my job and go on medical leave.

These experiences contribute to the depressed moods and are also a consequence of the participant disengaging when depressed.

The participant experiences a change in her life that solidifies the particular constitution of the situation. The person is discouraged about her present situation but unable to posit a way of changing her involvement with it. The participant anticipates future suffering on the horizon and feels hopeless. In such a situation, the person feels “stuck” and depressed.

Kelly- I had been having a very hard time breaking the attachment to my ex-husband, even though I knew that I could not return and that he was very bad for me.

Zack- I was unable to posit a way out. Because my present was so hellish I was unable to imagine any future.

Lisa- I felt both trapped in the relationship and a tremendous longing for him to love me. I felt despair, lethargy, was at a loss personally- with no goals, and with significant doubt in my ability to find a goal or achieve anything of substance.
Therapeutic Process

When the person enters psychodynamic therapy, she feels vulnerable regarding the therapist’s potential actions or reactions,

Kelly- I felt so vulnerable.

Zack- But there was a sense too though when I had those scary thoughts, where I didn’t trust him with those, because I was afraid he’d judge me or 302 me.

Lisa- I was just so fragile and confused.

and the therapist assumes an analytic stance toward her presentation of emotion-laden experiences. The therapist acknowledges the participant’s feelings, approaches them with curiosity, and teaches the person to do the same. The participant makes thematic her experiences and comes to learn more about the depressed moods, other feelings, and herself. She also becomes more aware of the relationship between such feelings and the situation that is a source of suffering.

Zack- Knowing for the next hour that I would be able to talk through these thoughts with someone who not only understood my pain, but also saw it as “no big deal” lifted a tremendous yoke off my shoulders.

Lisa- [My therapist] did not engage me as though I was wrong or crazy. At the same time, she acknowledged my tremendous anger and sadness...But also the added layer of not only is it fine that you feel what you feel, but there may very well be something important here that you can learn from that can show you something about yourself...there was a kind of respectful curiosity.

Jesse- One of the phrases that the woman I saw used was what does it teach you or let the information come to you from a body-feeling sense that can either tell
you what the origins of some of those emotions are or how it feels to allow them
to move through you.

*Therapy centers on the participant’s sense of self, and she becomes aware of the*
*way in which negation of potentials of being have contributed to the situation. She*
*develops hitherto negated facets of self through her engagements with activities, projects,*
*or relationships. She thereby changes her manner of involvement in the situation or is*
*prepared to involve herself differently in similar situations in the future.*

**Kelly**- The person that I was before therapy was young, naive, undefended in the
world, which is what allowed me to get sucked up into a relationship that was
very bad for me. So, working on becoming better defended...and not just more
assertive in a consciousness way, but better defended in terms of being able to
say no to things, being able to take a stand, being able to be more empowered.

**Lisa**- I was totally lost and had nowhere to go internally or no sense of home
within myself because I was rejecting what I was feeling and hating myself for
what I was feeling. And to learn that these feeling are exactly what you need to
be exploring to find your home, to find yourself. So, it was really a tremendous
relief to just be allowed to be. But it was also discovering this map that could
really help me.

**Jesse**- I started to allow myself to have time to write. I had these dreams and I’d
get up and write them down in the morning. Sometimes I’d try to make songs
out of them, just to revisit, regain that part of myself...Another aspect of this is I
had to put these parts of myself aside or at least I thought I did. I thought I don’t
have time for this anymore. I think it was my image of what I thought parenthood should be.

An important way to address the person’s sense of self is through exploration of emotion-laden dreams. The participant formulates an interpretation where a figure or aspect of the dream represents something of significance for her situation. She becomes more self-aware regarding negated feelings, fantasies, or potentials, and self-development follows as she attends to herself or others in a different manner.

**Kelly**- Their femininity all signs and traces of it were erased, almost like a concentration camp quality to the dream...The way it was interpreted was being cut off from the feminine side of myself...I learned to reconnect with my femininity and embrace it more...I became more interested in clothes, make up...I guess too being more open and friendly with other people.

**Zack**- I’d be...with my ex-girlfriend...I would feel perfect. I would feel this sense of warmth and this sense of love that I hadn’t experienced in such a long time. I experienced excitement and longing. But something would happen in this dream that would prevent me from seeing her...[the dream was] indicative of what I was going through...she was an embodiment of something that seemed more stable and safe.

**Jesse**- I had a dream that I was Ilsa of the SS...For me, it was not paying attention to the bitch sort of part of myself. Because I’m one of these people-pleasing, pleasant, accommodating, oldest child kind of things. So, I had to allow my bitch self to come through or my stronger self...in the sense of self-care, assertiveness, that it’s okay to say no more, that I can’t do everything, that I’m not superwoman.
The therapist also helps the participant to identify particular patterns of thinking, reacting, behaving, or relating that contribute to her involvement in the situation.

**Kelly**- [My therapist] would never come right out and say something like, “He’s just like your ex-husband.” She would never do that. She would make me figure it out.

**Zack**- Therapy did many other things like leading me to an understanding of certain...thought patterns.

**Lisa**- I remember [my therapist] pointing out to me that whenever [my boyfriend] would be in town that I would get withdrawn and I would stop talking, and be incredibly defended. Her pointing that out, that’s stuff that I didn’t even see, no perspective, no self-awareness.

**Jesse**- I had developed a pattern of superwoman and not being able to be superwoman, thinking that you can expend all this energy without self-nurturing.

The therapist’s manner of intervening provides the participant with an experience that more fully elucidates the pattern, and she comes to some realization about it. The participant is then better able to modify the pattern and the way she is involved in the situation.

**Kelly**- When I made poor choices in dating, my therapist would confront me, but in a way that showed restraint and made me figure things out on my own...if I would say, “I feel like I’ve seen him before or I feel I’ve known him before.” She would say, “Listen to your words.” And, of course, if you listen to the words, well you have [known him].
Zack- Understanding where those bad thought trains start and sort of being able to derail them...one of the things I noticed is this is my inner dialogue: “Oh I’m anxious right now. Aw is this my future? This is it. Aw I don’t want to go through this again. Oh I don’t have the strength to deal with this”...And then before you know it I’m crying my eyes out.

Lisa- I think that’s how the therapy worked in terms of that relationship too. It gave me a different perspective or it contrasted with [my boyfriend’s] way of relating. And I kind of questioned what I was accepting as okay or as tolerable.

Jesse- I began to realize that I couldn’t “run” things at work, be a parent and still have a fun life without getting over-stressed...I began to work part-time, focus on my private practice more, have a flexible schedule that worked with time for my son, for my work, and for my husband.

Therapy also addresses individual psychodynamics, and, in particular, the participant’s longing for and fantasies about a remembered past or imagined future that contribute to the person’s not facing the actual present situation. The therapist confronts her about the ways in which such a past never was or such a future never will be. As she processes this contrast, the participant comes to see the present as it is and to experience a sense of movement in her life.

Kelly- I had been having a very hard time breaking the attachment to my ex-husband...My therapist...pulled out a copy of the DSM-III. She opened to the section on Narcissistic Personality Disorder and read off the criteria asking me which ones fit my knowledge of my ex-husband...Suddenly I realized the gravity of the problems I had been dealing with and the impossibility of fixing
things...This one intervention made a huge difference in my being able to "fall out of love" with this person and move on.

**Zack**- I just wanted so bad to be somewhere else and the only somewhere else I could imagine was that past. So, it was thinking and longing for [my ex-girlfriend], but she was an embodiment of something that seemed more stable and safe...But [my therapist] was like, “Do you remember your relationship with you ex?” It was horrible...There was a sense of looking at things as they really were.

**Lisa**- Over the years she helped me to move beyond immobilized fear and longing in the dating relationship by articulating it's poisonousness.

**Jesse**- I began to realize that I couldn’t “run” things at work, be a parent and still have a fun life...at the beginning it was like, “Oh my god. I can’t do this. This is what I’ve always done.” I was clinging to my old ways and not really wanting to let go of that.

*The therapy focuses on relational dynamics. The participant makes thematic her experience of relations with family members, and she comes to a more complex understanding of family dynamics and family members.*

**Kelly**- The limitations of my own parenting set me up for this [relationship with my ex-husband].

**Zack**- Therapy did many other things like leading me to an understanding of certain family struggles.

**Lisa**- [My therapist] unfolding the concept of the designated patient and exploring family dynamics, rules and expectations with me was tremendously helpful
throughout the therapy. She helped me articulate what had initially been only a troubling fog in my relationships with family.

*Therapy further involves an exploration of the participant’s development, and she critically assesses her parents’ care to better understand early relationships. She articulates the way these early relationships with her parents shaped her co-constitution of the situation, and she becomes more aware of herself.*

**Kelly**- I remember an important interpretation that [my therapist] made one day that stopped me in my tracks and made me re-vision my history in a new way. She said something like, "so you traded a controlling mother for a controlling husband." This made me look at my mother in a whole new light and understand how my history had more or less prepared me for the fate of making such a poor marriage choice.

**Zack**- [My father] goes to the worst case scenario...With my mom, seeing her worst case scenario thinking but also seeing her always trying to protect dad or always protect me from dad or always trying to protect us from something else or constantly assuming this role of protective bear from us and the world. Seeing where that prevented me from having some real life experiences and seeing the way I try to run back to that comfort.

**Lisa**- [My therapist] also helped me articulate my parents' limitations and the fury and grief I felt toward those limitations...I felt like they just couldn’t see me and there was a certain way that I was supposed to be and a certain way that I had to look. The surface was what they saw and there wasn’t sort of a curiosity about who was inside. That really infuriated me and broke my heart.
Jesse- I think it was my image of what I thought parenthood should be, similar to self-sacrificing mothers of the fifties and sixties. Because my mom didn’t work outside the house, never went to college...I think when I became a parent I think I sort of adopted some of that aspect of like, “Well, I have to put myself aside.”

The therapist also helps the participant to see relationships with acquaintances, friends, or significant others in a different light, and she gains insight about relationships, other people, and herself.

Kelly- My therapist...pulled out a copy of the DSM-III. She opened to the section on Narcissistic Personality Disorder and read off the criteria asking me which ones fit my knowledge of my ex-husband....Suddenly I realized the gravity of the problems I had been dealing with and the impossibility of fixing things.

Zack- One of my anxieties was that I might faint. [My therapist would say] let’s explore that. What is the worst case scenario? You faint, you wake up two seconds later and somebody might be taking care of you. So, of course, that reveals not trusting the other.

Lisa- Over the years [my therapist] helped me to move beyond immobilized fear and longing in the dating relationship by articulating it's poisonousness.

Therapy also explicitly addresses the therapeutic relationship. The person sometimes views the therapist as a parental or authority figure and interacts with the therapist in an idiosyncratic manner based on these perceptions. The therapist either makes an intervention that highlights the quality of the participant’s interaction, in that understanding her fantasy helps the person gain insight about her relationships and
herself, or the therapist makes no intervention because the participant’s benign and positive fantasy facilitates her participation in the process of therapy.

**Kelly**- There was a parental aspect to the therapy in that I feel like I got things from [my therapist] that I didn’t get from my own parents. It wasn’t just from my mother...It felt like a parent guiding you in the right direction, like something your father would say.

**Zack**- There are times you confuse [your therapist] for your father and therapy doesn’t work too well that day. And there are times you want him to be your mother and you want him to comfort you...He would be like, “What do you want me to tell you?”

**Jesse**- I still remember [my therapist] saying to me, “That’s the transference”...It’d usually be about money for some weird reason. I remember one time she said to me, “You didn’t give me the check.” I was like, “Oh.” For some reason, I got mad at her.

*The therapy touches upon loss. The participant is disheartened with a personal, professional, and/or relational issue that entails the potential loss of a differently imagined future or an actually remembered past.*

**Kelly**- The limitations of my own parenting set me up for this [relationship with my ex-husband]...The loss of time that was spent in that relationship because I got stuck there and couldn’t get out. The loss of the dreams that I had for it that didn’t materialize, the things I wanted that relationship to be that it wasn’t and never would be.
Zack- One of the reasons I began to become so intensely depressed during times of acute anxiety was because of my inner dialogue. I would often say to myself...“Is this going to be my future? Is this all I have to look forward to?”

Lisa- There was a period where I absolutely hated my parents...what was behind that anger was a lot of sadness. I think for what my life wasn’t like and what my relationships with them weren’t like, and also for...the lacks that they experienced.

Jesse- I waited to long to see that I couldn’t do all these things at once: be a parent, work full time, and do all these things without some damage to myself.

The therapist makes an intervention that aims to highlight the definitive nature of the issue and loss. The person sees the issue more clearly and works through anger or grief about loss. The participant thereby comes to accept the present issue and to feel differently about it.

Kelly- Through the process of therapy...I came to know myself better and grieve and accept some of the disappointments in my life.

Zack- [My therapist] said something like, “So what, you are probably going to have to deal with these bouts of acute anxiety from time to time”...In the acceptance of my anxiety and depression I stopped fighting the reality of it and just accepted it for what it was. I was able to surrender.

Lisa- [My therapist] would work with me to unpack that [hatred]...pushing through this anger to this sadness to a kind of bitter-sweat compassion.

Jesse- In her office, she had shells, [a dragonfly], and organic type things...I saw the dragonfly as fitting my changes from an independent person, a person who saw herself mostly in terms of work and fun stuff, and changing to a parent...I
came to see the dragonfly as it being okay to change, as the fact that all these changes were very natural, and as a point of acceptance of that change.

*Between sessions, the participant engages in activities, such as reading books,* which stimulate additional learning.

**Kelly**- Reading was a big part of the therapy and allowed me to keep my therapy going throughout the week.

**Zack**- I also spent a lot of time reading the Psalms... just catching yourself in this familiar theme that’s throughout scripture of almost abandonment, but then beyond that abandonment there is faith.

**Jesse**- Reading some of those books open you up to a new way of looking at yourself that I might not have done before.

*She intentionally cultivates her interests in, for example, music, art, or academics, which fosters personal growth.*

*During the process of therapy, the therapist intervenes in three different ways. First, the therapist questions the participant about feelings and fantasies regarding an aspect of her experience, or asks about another variable that the person has not yet articulated in order to encourage reflection.*

**Zack**- When I tried to get [my therapist] to be my mom and to tell me that everything’s going to be okay...He would be like, “What do you want me to tell you?”

**Jesse**- There were some discussions of [dreams], but not discussion in the over-analytic way, more discussion about how did I feel about particular aspects of the dream.
Second, the therapist highlights an aspect of the participant’s experience to bring it into the foreground,

Zack- [My therapist] said something like, “So what, you are probably going to have to deal with these bouts of acute anxiety from time to time.”

Lisa- I remember [my therapist] pointing out to me that whenever [my boyfriend] would be in town that I would get withdrawn and I would stop talking, and be incredibly defended. Her pointing that out, that’s stuff that I didn’t even see, no perspective, no self-awareness.

or interprets the person’s behaviors and reactions to explain the way these were shaped by past experiences.

Kelly- I remember an important interpretation that she made one day that stopped me in my tracks and made me re-vision my history in a new way. She said something like, "so you traded a controlling mother for a controlling husband."

Jesse- I still remember [my therapist] saying to me, “That’s the transference”...It’d usually be about money.

Third, the therapist provides psychoeducation to help the participant better understand her experience and relationships,

Kelly- [My therapist] pulled out a copy of the DSM-III. She opened to the section on Narcissistic Personality Disorder and read off the criteria...When we noticed [my ex-husband] had nearly all of the criteria, my question to her was, “is that something that could be treated in therapy?” She answered that it would require him acknowledging the problem and spending about five years in
intensive psychotherapy. Suddenly, I realized the gravity of the problems I had been dealing with and the impossibility of fixing things.

Zack- [My therapist]...would say, “Zack first off you are not exhibiting any suicidal behavior. You are exhibiting none of what somebody looks for.” To hear that...There was a relief. Then, being able to see the anxiety and depression for what it really was helped me to know that: “okay, I’m not really going to go crazy, I’m depressed.”

Lisa- [My therapist] talked about things like...good enough parenting, mirroring, and that did a couple things. It helped me understand what I didn’t have, but maybe what they didn’t have, and also what was there.

or makes suggestions about different potential ways for the person to engage with herself, others, and the world.

Kelly- [My therapist] would make suggestions to me about hiking or joining a group, about different ways to meet people or make friends, and very encouraging in that way.

Zack- My therapist suggested engaging in concrete outside-of-myself activities when this downward spiral [of depression and anxiety] would begin. These could include simple things like eating, playing guitar, or praying for others.

Jesse- One of the phrases that the woman I saw used was what does it teach you or let the information come to you from a body-feeling sense...I would go sit somewhere, like in a park, and allow that time to go down within my emotional self to see what was there.
The atmosphere of therapy is also important to the process and consists of the comfortable furniture, appealing decorations, and even the therapist. The atmosphere provides a sense of safety or consistency that helps the person to talk about private feelings, fantasies, and memories.

Kelly- [My therapist] was interested in warmth both personally and in the environment and had an electric hearth beside the two wing-back chairs where she and I sat...I think having the atmosphere in therapy be warm made it welcoming, soft, and gentle. Made it safe place to come, open up, and talk about things.

Zack- Just walking in the door of my therapist’s office was a comfort... My therapist dresses very comfortably...He has a couple of nice pictures from Target and a comfortable couch...his dress and definitely his office really convey safety and sort of like, “You can be open here. You’re not being judged here.”

Jesse- In her office, she had shells, [a dragonfly], and organic type things...When I was in therapy, [the dragonfly] was the thing I focused on when I was going through the process, and as time went by, I was able to see that the dragonfly represented all of these changes.

The therapist is attentive to the participant’s articulations and empathic toward her emotions.

Kelly- Having a sensitive and caring witness to clarify, articulate, and provide a path.

Zack- There was this true sense of empathy...understanding for me is just somebody listening and not necessarily giving you step by step advice on what to do, but being in there in that moment. My therapist did that. He really was there.
Lisa- [My therapist’s] constancy...[was] important...She was clearly paying attention, but also reserved, not emotionally reserved in any way. She was in a position of accepting what I would offer, as opposed to inserting her project into things.

Jesse- I think being heard, especially since I’d been so besieged by these other things...I think too the aspect of like somebody really paying attention.

*The therapist is responsive to the person’s needs and sometimes modifies the analytic frame or stance to help the participant. The person’s therapy experience is unique insofar as therapist flexibility and individually tailored responses are designed to meet the specific needs of the participant.*

Kelly- There was a helpfulness like: we’re going to do this and if it means I’ll carry the ball for a session I’ll do that, if it means I’ll give you information that you need to make smarter choices that’s what we’ll do...but there were definite boundaries.

Zack- [My therapist] let out some personal tidbits...Hearing that even in this guy was a sense of understanding and also normalizing. But he would never go too far into himself where it became like reverse therapy. There was a sense where it was appropriate.

Lisa- I think that [having two sessions in a row] made the psychotherapy possible because literally it would take me forty plus minutes to begin to speak or to be able to talk about anything of any relevance. I’m really grateful that [my therapist] agreed to do that. I think that’s an example of her openness and going at my pace.
Jesse- [My therapist] didn’t have that blank wall...I remember her telling me about her mother dying...[during] nurturing discussions and discussions about parenthood.

The participant senses that the therapist cares about her. The way the therapist cares for the person contrasts with the ways others have cared for her and the way the participant cares for herself. The participant’s encounter with the therapist’s care facilitates the participant’s understanding of her experience as well as her appropriation of such care into her own manner of attending to her experience.

Kelly- I felt that my therapist cared about me as a person...I got things from her that I didn’t get from my own parents...I actually learned to do those things for myself, and I took in those qualities she showed me. The kind of care that she showed me I think it rubbed off on me...I would think, “What would Dr. W say about this?”

Zack- There were connections built on a personal level between [my therapist] and I that really were beneficial and made me trust more...He didn’t react into the fear, and I think of my mother reacting emotionally. That normalized it knowing that you’re not freaking out when I tell you this. That really made it a normal thing.

Lisa- I was motivated to care about myself and to take care of myself, and I think it partly had to do with [my therapist] caring about me...She was respectful and attentive. She took me seriously. What I said mattered and there was something important there to understand. When someone treats you like that and it happens again and again and four-thousand times, you start thinking: I deserve this or I’m
worthy of this. Then, it made me no longer be content with or okay with someone treating me as badly as I treated myself.

**Jesse**- We had a nice bond...there’s a very nurturing quality to it.

*The person appreciates the therapist, the deep sense of therapist care she encountered in the therapeutic relationship, and the centrality of the relationship to the process of therapy.*

**Therapeutic Outcome**

*After therapy, the participant no longer feels depressed, and has modified her involvement with the situation concerning herself, others, and/or the world.*

**Zack**- Therapy thereby lessened my depression.

**Lisa**- By the end of our work together, I was no longer depressed.

**Jesse**- I started to feel happy again.

*Through therapy, the participant discerns the nuances of her experiences and emotional life, and comes to better understand these. She also acquires a more complex sense of herself and others, and becomes more aware of both.*

**Kelly**- Know myself better...understand and appreciate different facets of myself and others in new ways...clarifying my experience through an abbreviated language that was previously unavailable and added depth and breadth to my understanding.

**Zack**- Learning more about myself...finding those themes or concrete expressions, that’s one of the big things that therapy did was to be able to create a narrative or a way of looking.
Lisa- Finding words, being able to first notice, not reject, and then name my experiences.

Jesse- Find more personal and emotional complexity...bringing that negative stuff into the awareness.

The participant thus develops personally and engages differently with herself, others, and the world. She assumes a caring stance when attending to her experiences, which allows her feelings and potentials to appear more clearly and fully.

Kelly- [Therapy] has allowed me to become more nurturing toward myself...I feel...more accepting of myself.

Zack- Depression isn’t this dark secret or the anxiety this dark abyss. It’s just these momentary waves of feeling that take me over. Quite frankly, the thoughts aren’t that disturbing or the feelings aren’t that bad. They’re just fleeting moments.

Lisa- One of the big over-arching things that I took out of the experience...[was] to look at your experience or what you’re thinking, feeling, or doing with this kind of nonjudgmental curiosity of there’s something important here and that somehow it makes sense.

Jesse- [I] came to see...anxiety and depression as a reminder to take care of myself...I try to listen to my deep emotions. I am more aware of my need for quiet and time to de-stress with meditation.

The person interacts more and relates better with as well. She feels trusting of others, and in return, they offer more to her.
**Kelly**- [Therapy] has allowed me to become more nurturing toward...others...I feel more open to other people... My cousin and his wife had a son and I remember having such mixed emotions about going to visit her in the hospital because I felt bad about where I was at and had been out of touch with them for a long time yet I wanted to reconnect with family. Then, several years later, after therapy, I ended up being godmother to their third child...I just got really close to their family.

**Zack**- I definitely could be more open with my wife, my girlfriend at that time...I was able to express things to her without that sort of ‘ah’ attached to it. So, she began to be able to realize what was going on because I was actually able to express it.

**Lisa**- By the end of our work together...I was...interacting with people...I reached out more but I also felt like people were reaching out to me. I think that was the therapy showing me that there was goodness out in the world.

**Jesse**- Less arguing with my husband and more energy for him...[more] time to spend with my son, his school, and to have fun.

*The participant also engages more and is more engaged with the world and with enjoyable activities or significant projects.*

**Kelly**- I don’t know how to describe the fullness except to say that there’s more people in my life, more activities in my life.

**Lisa**- Before, I would go somewhere and see a book or something that would speak to me. I would ignore it, reject it, or I wouldn’t pursue it. Realizing that part of my project was to gather those things because that was me. That was how...
I became me. That’s how life would mater...[I] made concerted efforts to develop and nourish my interests.

**Jesse**- I started to do tai chi and yoga again for relaxation...I also started to swim again, play music, and to “reclaim” parts of my life that gave me joy.

_Specifically, the participant makes important choices regarding her career, and ultimately, her experiences inform her work._

**Kelly**- I think that the transformation I felt I went through had a lot to do with making the decision to make that commitment [to apply to graduate school for psychology]...I feel that this experience also has allowed me to be a better therapist to others.

**Zack**- Through this, I began to realize my calling and wanting to be a pastor, what I wanted to do with my life.

**Lisa**- My experiences, including having experienced the curative power of psychotherapy, compelled me to return to school for psychology.

**Jesse**- I see my past depression as a learning experience, which has helped me in my own work with patients...The best thing that I ever did was to say that I could run my own practice [part-time].

_The participant feels better about her life in the present._

**Kelly**- My life is full.

**Zack**- Therapy helped me to live in the present.

**Lisa**- It felt like something broke open, and there was air getting into a place that it hadn’t been...It was kind of a rawness of actually being alive and that was
something that I hadn’t been, or that exposed and engaged in the world in a realistic way as opposed to an incredibly defended self-internalized way.

Jesse- I feel very positive about my life, my work, and parenthood. She also apprehends the purpose of her past suffering for her life.

Kelly- Although I regret certain choices made in my past, I feel that they were necessary to fulfill God's purpose for my life... I think I had to go through my own hell to be able to be there with other people and help them find a way out of it. So, I feel it was part of God’s plan for my life because I feel like this profession is what I was meant to do.

Zack- It was the depression and anxiety that brought me to a spot to really live in that religious way and resurrected a faith that had fallen asleep.

Jesse- [I] see my past depression as a learning experience, which has helped me in my own work with patients. The participant envisions new potential ways of relating and of engaging in the future and feels hopeful.

Kelly- I feel positive about the future.

Zack- I was able to see the future again and this gave me hope. No longer was the future this abstract dark enemy that included anxiety and panic; it was now something that welcomed me from a distance...Therapy gave me back my future.

Lisa- [I] had developed a plan for the future...Part of it was the newness of learning new things like that I could have feelings and be curious about them...and new possibilities in that there were things out there that I couldn’t imagine and expectations that I couldn’t predict. They weren’t necessarily bad expectations or
things to come. And being freed to be curious about the world and other people gave me a forward direction.

**Jesse-** [I felt more] hopeful about the future.

*The participant has learned to identify the signs of any depressed moods, to understand the personal and interpersonal significance of the moods, and to handle such moods and talk about them with trusted others.*

**Kelly-** It has a different quality to it now. I am able to recognize it sooner and communicate better with others...there’s not that feeling of emptiness. When I get depressed, it’s more of a sadness. I usually can figure out what’s bringing it about by looking at my feelings and what’s going on in my world.

**Zack-** The sense of aloneness wasn’t there...I grabbed those people who are important in my life and said, “Hey, I’m going through this, pray for me.”...There was a sense of control, but I would start crying at the drop of a hat. So, I was like there, I knew what was going on, I addressed it, and it was there in its place....It felt like there was a wealth of things to draw from. Whether that is advice or the digging through my soul and my past that we did for the four years of therapy, it created a base...I’m actually able to benefit from what the anxiety and/or depression is revealing about my life in the present.
Chapter 6

Discussion

The Discussion chapter is divided into six sections. In the first three sections, the results of the study will be elaborated and compared with the literature that has been reviewed. The sections will be organized according to the unfolding structure of effective psychodynamic psychotherapy of depression. The first three sections are as follows: participants’ experience of being depressed, therapeutic process, and therapeutic outcome. The final three sections examine implications of the study, limitations of the study, and directions for future research.

Before elaborating and comparing the results with the literature, a brief comment will be made about participants who were involved in Jungian therapy and participants who were treated with medication. After examining both process and outcome, there seemed to be no essential differences between the Jungian therapies and the other psychodynamic therapies. In addition, there seemed to be no essential differences between the therapies where participants were taking medication in addition to participating in therapy and the therapy where the client was not taking medication. With this noted, the results will be discussed with regard to the literature.
6.1 Participants’ Experience of Being Depressed

The participants in the study had previously been depressed, and they retrospectively endorsed six or more symptoms of depression from the DSM-IV-TR (American Psychiatric Association, 2000). The study found that depression emerges from a specific context, and the participants’ depressed moods were inextricably bound to a particular type of situation; i.e., one of suffering. The situation was a source of suffering for the participants, and involved three different areas of their lives. First, the situation concerns the self; the person suffers from an illness or psychological disturbance. Second, the situation concerns an important other; the individual suffers in the midst of an unsatisfactory or abusive relationship, or feels attached in a relationship that has dissolved. Third, the situation concerns the person’s world or environment; the person suffers due to his or her meaningful engagements at work or at play, or to a reduction of such engagements. Each participant’s situation related mostly to one particular area, yet each area interrelated with other areas and contributed to the total situation. The study found that the situation in and of itself is not a source of suffering; rather, the way in which the person is involved with the situation co-constitutes that person’s suffering.

The next two results will be compared with issues that arose when reviewing the literature concerning psychodynamic theories of depression. The first of these results centers on the participants’ experience of being depressed and the manner in which being depressed unfolded temporally. In the present, the participant is involved in a situation that is a source of suffering, and he or she feels discouraged about this predicament. However, being depressed did not emerge for that participant due to the situation alone.
For example, a person may be suffering because of sweltering heat, but she can remove herself from the situation and find relief. In contrast, the participants were unable to imagine any means of modifying their involvement in their respective situations. Participants felt helpless in their present situation, and this finding converged with Bibring’s (1953) formulation. Bibring thought that depression emerges when a person feels helpless to attain his or her aspirations of being loved and worthy, strong and secure, or good and loving. Participants’ inability to reach their aspirations was one way they felt helpless and consequently suffered. Some participants felt helpless to realize their strivings of being loved in relationships whereas others felt helpless to meet their goals of being strong in careers. Nonetheless, there were other ways participants felt helpless and suffered due to the limitations of the situation itself, regardless of their aspirations. One participant felt helpless to leave an abusive relationship because of her fear for the safety of her family.

Participants were unable to posit a way of modifying their involvement with the situation, and so they imagined continued suffering in the future. Participants felt hopeless about the future. Arieti and Bemporad (1980) thought that a depressed person feels helpless and hopeless, and they believed this sense was a result of that person’s dominant life ideology. Such an ideology limits the individual’s envisioning of different kinds of relationships or goals, and this conceptualization is consistent with my finding that the participants were unable to imagine engaging differently with significant others or with important projects. A life ideology is a way of looking, and my study found that in addition to their ways of viewing relationships and goals, participants were unable to develop alternative ways of looking at their own experience, which limited their sense of
self. Summers’ (2002) understanding is comparable to this finding; he held that a depressed person is helpless to change the way he or she lives cut off from essential aspects of him or herself. The significance of the participants’ restricted view of self and limited sense of self in regard to their involvement in their respective situations will be discussed in more detail later. For now, the importance of helplessness and hopelessness in the temporal unfolding of the participants’ experience of being depressed is evident in my results as well as in the theories of Arieti and Bemporad, Bibring, and Summers.

The participants’ experience of being depressed was also characterized by their disengagement from relationships and projects. Regarding meaningful engagements, participants experienced diminished relatedness with family, friends, or partners, and diminished involvement with academic or career endeavors. Regarding everyday engagements, participants experienced diminished relatedness with acquaintances or unimportant others, and diminished involvement with functional projects from driving a car to buying groceries. These results are consistent with Freud (1917/1957), Rado (1928), and Jung (1916/1953), all of whom saw that a depressed person invests less energy in his or her relationships and endeavors. They proposed that a process occurs during depression wherein this energy or libido withdraws from the world and into the individual’s unconscious. In a similar manner, my study found that participants disconnected from others and projects when they felt depressed, but it also found that participants’ reduction of engagements contributed to their depressed moods. Therefore, disengagement and depressed moods emerged in a cyclical relationship wherein both factored into each other.
6.2 Therapeutic Process

The next section addresses results significant for understanding effective therapeutic process in psychodynamic therapy and relates these to the literature review. This section is organized into three subsections based on Lambert’s division of common factors (Asay & Lambert, 1999), which are: model and technique factors, relationship factors, and client factors. First, the section examines model and technique factors and compares the results with six issues that arose in the survey of the literature concerning the psychodynamic model of depression. The material explored in therapy as well as the techniques used are related to the literature on the psychodynamic therapy of depression. Second, the section addresses relationship factors and looks at the therapeutic atmosphere, the therapist’s presence, and the therapeutic relationship as these emerged both in the results and in the literature. Third, the section examines client factors and highlights two ways to differentiate participants that are relevant to the literature: depression with grief versus depression with anxiety, and anaclitic depression versus introjective depression.

6.2.1 Model and Technique Factors

Participants were incapable, before therapy, of modifying their involvement with a situation that was a source of suffering because they were unable to attend to what their depressed moods and other feelings revealed about the situation in two regards. First, participants met with difficulty when making their experiences thematic. They were unable to identify their depressed moods and other feelings and to express their feelings and experience of needs to others. Second, participants sensed that depressed moods and
other unwanted feelings signified that something was wrong with them as people rather than seeing that the feelings also indicated something about the situation.

Regarding the latter, the participants took unwanted feelings and depressed moods to signify that something was wrong with them, and the particular form this assumption took for most participants was that they were wrong for having these feelings. That is, participants were critical of themselves and their unwanted feelings; this finding is consistent with most psychodynamic theories of depression. Freud (1917/1957) and Abraham (1924/1953) highlighted the importance of the conscience in the emergence of depression, a critical agency that Freud (1923/1961) later called the superego. Rado (1928) and Jacobson (1971) underlined the harsh quality of the superego’s judgments and self-criticisms. The processes of the superego are evident in most participants’ shame about their depressed moods, as if they were wrong for being depressed. In contrast, one participant took his depressed moods to indicate that something about him was wrong or disordered, which is a different form of assumption, and this participant took his depressed moods to mean that he was crazy. Nonetheless, these two different forms can be reconciled under a more general conceptualization of the superego. That is, all participants judged their feelings to mean that something was wrong with them. One form of judging was characterized by critical judgments about the self (e.g., I’m at fault) whereas another form was characterized by apprehensive judgments about the self (e.g., I’m crazy).

In therapy, therapists took a different stance toward the participants’ presentation of feelings, and, through the process, participants learned to assume an analytic stance when attending to their feelings. Therapists acknowledged participants’ experiences,
which helped participants to start to better identify their feelings for themselves.

Therapists also approached participants’ experiences with a sense of curiosity, which countered participants’ tendency to judge their feelings as signifying that something was wrong with them. Participants thereby learned more about their feelings throughout the process, and became more aware of the relevance of depressed moods to the situation that occasioned suffering. This awareness was the participants’ first step toward changing their involvement with the situation.

Participants were also incapable, before therapy, of modifying their involvement with a situation that produced suffering because of their poorly developed sense of self. The two reasons for participants’ inability to change their involvement are connected. That is to say, when a person does not attend to feelings vital to the self, the individual may have a poorly developed sense of self. In therapy, therapists and participants focused on the participants’ sense of self, and, through the process, participants became aware of negated facets of self and got in touch with, for instance, their assertive or creative sides. Participants did not acquire such awareness through abstract, intellectual discussions but rather through discussions about the ways in which negating facets of self co-constituted the situation and contributed to participants’ depressed moods.

These results regarding the significance of absent or lost facets of self converge with Summers’ (2002) understanding of depression. Summers believed that depression is a response to the loss of a facet of self, and that an individual originally buries facets to maintain attachments with primary care givers. Summers explained, “A life that is not authored is the soil in which depression grows. . . [Depression] always means that my life does not belong to me” (p. 138). Participants’ awareness of the loss of self played an
important role in the process of therapy. Most participants acquired a sense of different parts of themselves that had been lost, and one participant, Lisa, gained a more fundamental and holistic sense of herself than she had previously experienced.

In therapy, self-development followed self-awareness. Sometimes participants reconnected with facets of self from which they had felt detached before developing these facets, and other times they cultivated parts of the self that had not been discovered earlier. Participants did not develop through artificial, mechanical practicing of skills but through their meaningful engagements with the world. This development of facets of self was the means by which some participants modified their involvement with the situation that brought about suffering; for others, the development helped to prevent future involvement in similar situations. Beyond the particular therapeutic focus on the loss of a facet of self, loss is a major issue in the psychodynamic therapy of depression as well as a major issue for most psychodynamic theories of depression. Freud (1917/1957), Abraham (1924/1952), and Rado (1928) held that a depressed person suffered the loss of a relationship with another who was loved, and that the person encountered an actual loss through death or neglect. Whereas Freud focused on loss in adulthood, Abraham and Rado also wrote about the relevance of loss in childhood. Summers (2002), Jacobson (1971) and Bibring (1953) all wrote about the significance of the loss of self for depressed persons, with the difference that they focused on loss of self-esteem. Bibring’s formulation is similar to that of Arieti and Bemporad (1980); these theorists all believed that the loss of an important goal was just as important as the loss of an important other, and they were concerned with such losses as they occurred in adulthood. These theorists also believed that depression emerges when an individual encounters a potential loss in
which the person realizes that he or she might not be able to meet aspirations regarding
an important relationship or goal.

From the psychodynamic literature cited in the previous paragraph, six variables
emerge that are pertinent to an understanding of the nature of loss for participants:
relational or professional loss, adulthood or childhood loss, and actual or potential loss.
First, some of my participants experienced loss within the context of relationships with
significant others or family members, whereas others suffered the loss of professional
aspirations. Second, most participants encountered loss in adulthood in their
engagements with significant others or careers, but some participants also had suffered
childhood loss in their relationships with family members. Third, most participants
suffered an actual loss through, for instance, divorce or leave of absence from a job.
More importantly, participants felt disheartened and depressed about potential loss. Most
felt disheartened about potential loss of a future in which they imagined their lives and
relationships differently, and, in some cases, the potential for this imagined future held
the promise of modifying the loss of the remembered past.

In therapy, therapists and clients strove to elucidate the nature of the loss, and
participants came to perceive the loss as definite and discrete, thereby enabling the
process of coming to terms with loss. As long as participants had imagined a future
without loss, the loss had remained a lingering potential and they were unable to work
through anger and/or grief; however, working in therapy, participants processed the loss
and their feelings, and ultimately came to accept the loss.

Conflict is another issue in the psychodynamic therapy for depression as well as
in psychodynamic theories of depression. Drive theory, object relations theory, and ego
psychology highlight the way ambivalence permeates a depressed person’s being-toward-others, and the theories emphasize the individual’s latent aggression toward others.

Freud (1917/1957), Abraham (1924/1952), Rado (1928), and Jacobson (1971) believed that in depression a conflict occurs between a person’s conscious love toward primary care givers or significant others and an individual’s unconscious anger toward them. They proposed that the anger is manifest in the guilt commonly experienced in depression and in the defensive turning of such anger toward the self.

Conflict was found to be an issue for participants; however, aggression was not necessarily part of the conflict. Ambivalence was manifest temporally. For participants, a conflict occurred between their longing for a remembered past or wishing for an imagined future and their ignoring the call to face the actual present situation that was a source of suffering. Participants longed and wished for different types of relationships, for instance, with partners or ex-partners, and for different sorts of engagements, for example, at work. Whereas most drive and object relations theories held that a person is motivated to turn anger away from another and inward toward self in order to maintain a relationship, participants were motivated to turn their attention toward the past or future and away from the present to avoid taking notice of the situation as being depressed disclosed it. In therapy, just as a therapist following these psychodynamic theories interprets the defense of turning anger inward, these therapists confronted participants about the ways in which the remembered past never was or the imagined future never will be. Through the process, the participant came to see the present situation as it was and experienced a sense of movement, as this perception opened the possibility of changing his or her involvement with the situation.
Therapists also helped participants identify specific patterns of thinking, behaving, or relating, as these contributed to participants’ involvement in a situation that gave rise to suffering. Cognitive, behavioral, and interpersonal were aspects present in all psychodynamic therapies, but each therapy tended to focus primarily on one particular aspect. Psychodynamic therapists intervened in a non-exclusionary and flexible manner to meet the needs of participants. These results regarding cognitive aspects present in therapies are consistent with the findings of Jones, Ghannam, Nigg, and Dyer (1993) who conducted a single-case study of long-term psychodynamic therapy for depression. The researchers used the Psychotherapy Process Q Set (PQS), an instrument designed for quantification and analysis of therapy, to assess videotaped sessions, and found that the therapist characteristically highlighted recurrent themes in the client’s life and that discussions focused significantly on cognitive themes.

With respect to my findings, one therapy explored the participant’s cognitive patterns and the way in which these patterns contributed to his situation and depressed moods, whereas another therapy examined the participant’s behavioral patterns and the manner in which these patterns played a role in her work situation and depressed moods. Two therapies addressed participants’ patterns of relating, and one particular pattern was the participant’s dependence on a current or ex-partner. Excessive dependence on others also emerged as a significant theme in the review of psychodynamic theories of depression. In this regard, Rado (1928) and Jacobson (1971) believed that a depressed person primarily depends on others for the maintenance of self-esteem. Through the process of therapy, participants arrived at some type of realization about their patterns;
they were thus able to begin to modify such patterns and to modify their involvement in the situation.

Some therapies tended to center more on interpersonal patterns than did other therapies, but all therapies focused on participants’ relationships and interpersonal dynamics. As evident in the Discussion chapter thus far, in therapy, participants talked about relationships with acquaintances, friends, significant others, and/or family members. Through the process, therapists helped participants acquire insight, and participants developed a complex understanding of themselves, other people, and relationships. These findings converge with the previously mentioned findings of Jones, Ghannam, Nigg, and Dyer (1993), and they found that interpersonal relationships were a major theme throughout therapy. Both findings are congruent with psychodynamic theories of depression, which consistently formulated that depression emerges from an interpersonal context. Psychodynamic models of depression are interpersonal, and psychodynamic therapy for depression follows suit.

Participants and therapists not only examined contemporary relationships, they also explored developmental themes. In particular, participants critically assessed the quality of their parents’ care and the impact of such manner of care on their development, and, through this assessment, gained awareness of themselves. Just as this result highlights the significance of participants’ development for the process of therapy, development also arose as an important issue throughout the review of psychodynamic theories of depression. On the one hand, Freud (1917/1957) and Rado (1928) connected the oral and phallic stages of development with the emergence of depression in adulthood, and Abraham (1924/1952) believed that the anal stage was pertinent as well.
On the other hand, Bibring (1953) proposed that, since childhood experiences of helplessness are formative of depression, any stage could be significant. My results showed that participants had felt helpless to modify their involvement with a situation that led to suffering. In addition, rather than addressing stages of development, the therapeutic discourse concerned the manner in which the participant’s development shaped his or her co-constitution of the situation. Parent care was an important topic in the process of therapy insofar as it contributed to participants’ involvement in the situation and to their depressed moods.

In addition to contemporary and past relationships, psychodynamic therapy explicitly addresses the therapeutic relationship. The participants sometimes viewed the therapists as parental or authority figures and responded to them as such. This result is quite consistent with psychodynamic formulations of therapy, which hold that clients direct feelings originally aimed at parents toward the therapist (Gabbard, 2000). For depressed clients, such feelings and corresponding behaviors reflected parental loss, rejection, or deprivation. In this regard, one participant stated that through the process of therapy she received care that she had not received from her parents.

McWilliams (1994) delineated two sides of the transference with depressed clients. On one side, clients ascribe benevolence to the therapist’s intentions and are grateful for the therapist’s empathy and insights. The aforementioned participant described this side of the transference in which she viewed her therapist as an angel. On the other side, clients fear criticism from the therapist and are sensitive to even hints of disapproval. In this vein, another participant felt angry and reacted firmly when her therapist mentioned that she had not paid the fee when she was required to pay. In
therapy, when participants’ perceptions did not facilitate the process of therapy, and when those perceptions became an opportunity for participants to acquire insight into the therapeutic relationship, therapists made interventions to elucidate the participants’ manner of relating.

Psychodynamic therapy addresses an individual’s sense of self through dreams. In particular, participants explored their emotion-laden dreams, focusing on a specific facet of the dreams, and articulated an interpretation pertinent to their situation. Participants became conscious of negated feelings, fantasies, or facets of self. In turn, they developed, for instance, either their assertive or feminine sides, as they attended to themselves and others in different ways. Busch, Rudden, and Shapiro (2004) collaborated on a book that serves as a step toward manualization of psychodynamic therapy for depression, and they proposed that a client’s dreams are the simplest means for a client to appreciate the importance of the unconscious. In other words, clients easily understand that they have dreams and that they are not consciously producing them. With reference to my results, through therapeutic work on dreams, participants gained awareness of feelings, fantasies, and/or facets of self of which they were unconscious.

In this subsection thus far, results regarding important material explored in the process of therapy were compared with the review of the literature concerning psychodynamic models of depression and of therapy, with particular attention paid to six key issues that emerged in the review. In the remainder of this subsection, technique factors will be addressed, and results a propos to three different ways in which therapists intervened in therapy will be related to the literature.
First, therapists questioned participants about their thoughts and feeling regarding facets of their experiences or regarding other unarticulated facets related to their experiences. In other words, therapists asked participants for clarification of their experiences as a means to stimulate reflection. In literature relevant to a psychodynamic formulation of therapy, clarification is a technique a therapist uses frequently in therapy (Busch, Rudden, & Shapiro, 2004; Karasu, 1990). However, technique seems like a misnomer when used to describe clarification. Rather than assuming a technical stance, therapists approached participants’ experiences with a sense of interest and curiosity, and their questions stemmed from such an approach.

Second, therapists made statements that elucidated facets of participants’ experiences or that interpreted the significance of their experiences. Some therapists confronted participants about aspects of their experiences that they did not see or that they did not want to see in order to bring the aspects into view. According to the literature, such confrontation is a technique that therapists use to challenge clients’ defenses and behaviors (Busch, Rudden, & Shapiro, 2004; Karasu, 1990). Other therapists went further than confronting participants and made statements that interpreted participants’ behaviors to explain the manner in which those behaviors had been shaped by the past. As indicated in the literature, such interpretation is another technique that therapists use to relate manifest client patterns with latent variables that contribute to these patterns (Busch, Rudden, & Shapiro, 2004; Karasu, 1990).

A further look at psychodynamic theory and research will shed light on these findings. Busch, Rudden, and Shapiro (2004) delineated different types of therapist interpretations. With reference to these types, in my study, one therapist used genetic
interpretations to point out the familial origins of interpersonal patterns and another therapist used transference interpretations to highlight the transferential components of emotional patterns. In a single-case study of psychodynamic therapy for depression, Jones, Ghannam, Nigg, and Dyer (1993) also found that the therapist characteristically made interpretations, and arrived at these and other process items that most characterized therapy by using the PQS, a process measure, to assess sessions. In addition, the researchers subjected these process items to a factor analysis and yielded a process factor entitled psychodynamic technique. This factor seems comparable to therapists’ use of confrontation and interpretation in my study in that these statements went beyond therapists’ use of clarification of experiences to an attempt at deepening participants’ understanding of experiences.

Third, therapists provided psychoeducation. In some cases, therapists offered their knowledge about, for instance, psychopathology or child development. Participants thereby gained a better comprehension of their experiences or relationships and came to see those experiences or relationships as they were and not as they imagined them to be. In other cases, therapists offered concrete suggestions about possible ways for participants to engage with self and others, suggesting activities such as playing guitar or joining a group. These results converge with contemporary psychodynamic theory and research. Busch, Rudden, and Shapiro (2004) believed that psychoeducation plays a role early in psychodynamic therapy for depression. Jones, Ghannam, Nigg, and Dyer (1993) found, in the study that was previously mentioned, that the therapist behaved in a didactic fashion throughout the entire course of therapy. The results of my study diverge from a traditional psychodynamic understanding of therapist as interpreter/reflector (Karasu,
1990) in that therapists were also found to be teachers at times. However, the didactic function of the therapist was nuanced. Therapists drew from their expertise to provide knowledge specifically when participants did not possess such knowledge and when such knowledge was pivotal to clients’ modification of their understanding and behavior.

6.2.2 Relationship Factors

This next subsection highlights the centrality of the therapeutic relationship to the process of therapy and relates results pertinent to the relationship with the literature. In particular, this subsection examines the therapist’s presence and care as well as the participant’s appropriation of such care. To begin with, the backdrop of the relationship between participant and therapist is the therapeutic milieu, and participants in the study described the atmosphere of therapy as warm and comfortable. Such a physiognomy appeared to the participants in the furniture and in the decorations and, for one participant, even in the therapist’s attire. The atmosphere was important to the therapeutic relationship and process insofar as participants experienced a sense of consistency or safety, and thereby felt invited to open up and discuss their private fantasies and feelings. In the literature, the significance of the therapeutic climate for the development of trust and safety was likewise emphasized (Bachelor & Horowitz, 1999). Since the therapist chooses the décor, the environment of therapy seems to be an extension of the therapist’s presence and one way the therapist provides comfort and safety to gain the participant’s trust and to facilitate the process.

Against the background of the therapeutic environment, the therapist’s presence comes to the fore in his or her comportment toward the client. The therapist’s presence is an attentive, empathic presence. Participants felt that such attentiveness indicated that
therapists understood them and/or accepted them. Participants sensed therapists’ empathy in their attentiveness as well as in their communications.

Three aspects of these results regarding the therapist’s presence confirm a psychodynamic understanding of therapy for depression. First, according to such theories, psychodynamic therapists assume an evenly hovering presence and are receptive toward clients (Karasu, 1990). Second, psychodynamic therapists assume a nonjudgmental stance and are accepting of clients (1990). Third, psychodynamic therapists display empathy for clients (Gabbard, 2000). Receptivity, acceptance, and empathy are three aspects of a unified therapist presence, and the significance of these was verified by the results of my study.

The results are also consistent with contemporary therapy research, which highlighted the contribution of therapist characteristics to the therapeutic relationship (Ackerman & Hilsenroth, 2003; Bachelor & Horowitz, 1999). Therapists were attentive, interested, respectful, and understanding, and they communicated such understanding and respect. With reference to contemporary research that specifically addressed psychodynamic therapy for depression, Jones, Ghannan, Nigg, and Dyer (1993) arrived at process items that most characterized therapy by assessing sessions using a process measurement, the PQS, and further arrived at process factors through factor analysis of those items. The study yielded a factor termed “therapist acceptance/neutrality,” which comprises items such as therapist acceptance, therapist neutrality, and therapist empathy. With the exception of therapist neutrality, aspects of this factor seem comparable to results regarding the therapist’s presence in my study.
According to a psychodynamic formulation, a therapist aims for neutrality in the treatment of depression. The therapist adheres to the rule of abstinence, abstaining from reassuring behaviors such as direct advice or guidance, and functions like a blank screen (Karasu, 1990). The results of my study sometimes diverged from such a characterization of a psychodynamic therapist. Most therapists modified their analytic stance and disclosed their own personal losses or suffering. One therapist even modified the analytic frame and scheduled two sessions in a row rather than intermittently throughout the week. Although therapists responded neutrally regarding participants’ specific choices about careers or relationships or regarding their fleeting desires, therapists did not respond neutrally regarding the participants’ needs when meeting their needs were congruent with the process of therapy. For instance, Zack’s therapist remained abstinent when Zack wanted reassurance that everything in his life would be alright, and his therapist did not provide such reassurance. On the other hand, Zack’s therapist did not remain abstinent when Zack felt depressed and isolated, and his therapist disclosed that he had endured his own suffering earlier in his life. As illustrated in this example, a therapist remains neutral when a participant wants the therapist to collude in a way that distorts the participant’s experience or the therapeutic process such as by reassurance that everything will be alright. However, a therapist does not remain neutral when a participant needs something from the therapist to facilitate the process of therapy such as a disclosure that he is not alone in his suffering. In this way, therapists were responsive to the participants and to the unfolding process of therapy. This finding is consistent with contemporary therapy research (Ackerman & Hilsenroth, 2003). Such research found that therapist openness and flexibility contributed to the therapeutic
relationship. In my study, therapists’ responsiveness contributed to the relationship and to the process itself.

Participants described a therapeutic relationship characterized by therapists’ attentiveness, empathy, and responsiveness, and, based on their experience of the therapists’ presence, participants believed that their therapists cared about them. The manner in which therapists cared for participants contrasted with the manner in which others, such as parents or partners, cared for them and the manner in which participants cared for themselves. Blatt (2004) held that, through the client’s experience of the therapeutic relationship, the client revised representations of self and others, and my study highlighted the role that the therapist served as a contrast in this process of revision.

Participants’ encounters with therapists’ care facilitated their appropriation of such care into their own manner of attending to their experiences. Participants adopted their therapists’ manner of care and started to approach their experiences as their therapists had: with respect, interest, and a desire to understand. Psychodynamic theories underlined the significance of the child’s internalization of parental care, and Klien, for instance, believed that depression results from a failure to uphold ‘good,’ internalized objects (1935/1975). Blatt proposed that internalization is also an important process in psychodynamic therapy for depression, and he highlighted the significance of the client’s internalization of the therapist’s attitudes and functions (2004). In their effectiveness study, Freedman, Hoffenburg, Vorus, and Frosch (1999) found gains in effectiveness with increases in duration and/or frequency of psychodynamic therapy, and the researchers hypothesized that gains were due to the internalization of the growth-enhancing qualities of therapists and that internalization was facilitated by the prolonged
and intensified exposure to the therapeutic relationship unique to long-term therapy. In light of my findings and their convergence with psychodynamic theory and research, the therapeutic relationship and the accompanied client appropriation of therapist’s care as one’s own seem central to the process of effective long-term psychodynamic therapy of depression, and these aspects of the process distinguish it from other short-term therapies for depression.

6.2.3 Client Factors

This subsection looks at client factors and their role in the process of psychodynamic therapy for depression. In particular, two ways to distinguish participants that are relevant to the literature will be addressed. Freedman, Hoffenberg, Vorus, and Frosch (1999) conducted an effectiveness study, and asked ninety-nine participants to endorse any of twelve problems for which they had sought psychodynamic therapy. Participants endorsed problems such as depression, low mood, grief, generalized anxiety, child/familial concerns, and job problems; and researchers identified two types of depressed clients: depression with anxiety and depression with grief. Likewise, in my study, two participants experienced depression with anxiety; one of these participants suffered from panic attacks with agoraphobia, while the other suffered from generalized anxiety. The other two participants experienced depression with grief; one participant suffered from grief after her divorce, while the other suffered from grief about her rejecting boyfriend. Both of these participants also experienced grief about the limitations of their parenting. Although two participants suffered from grief, all participants dealt with the issue of loss, as discussed earlier. The latter two participants suffered from grief in contending with present and past losses, and the former two
participants experienced anxiety in anticipating potential future losses. Unfortunately, depressed clients with anxiety would most likely be excluded by researchers conducting controlled clinical trials on therapy for depression due to researchers’ aim of no co-morbidity. Although my study was not designed to assess diagnoses other than depression, and strictly relied on participants’ descriptions about any such suffering, my study supports the argument that the assumption of no co-morbidity in psychotherapy research is unsound (Elliot, 1998).

These two types of depression, accompanied by two different problems—grief and anxiety—reflect two personality styles. Blatt (2004) identified two types of depression based on personality factors. First, an anaclitic personality is characterized by an exaggerated preoccupation with relatedness and a dependent interpersonal style. Anaclitic depression comes to the fore with disruptions in relationships. Second, an introjective personality is characterized by an exaggerated preoccupation with self-definition and a self-critical style. Introjective depression comes to the fore when efforts to obtain a goal pertinent to self-esteem maintenance are thwarted. Although my study was not designed to assess types of depression, participants seemed to be experiencing anaclitic or introjective depressions. Two participants were involved in situations concerning others that were sources of suffering: one participant was attached to her ex-husband although divorced, while another was attached to her boyfriend although he was abusive. The other two participants were involved in situations concerning self that were sources of suffering: one participant was unable to overcome personal suffering, while another was unable to continue as a fulltime professional. The significant point is that the process of the therapies centered on participants’ relationships or self, depending on
whether participants had presented with anaclitic or introjective issues. In fact, two
participants, Kelly and Zack, described three helpful therapist interventions that
exclusively focused on dealing with either relational or personal issues, respectively.
Although focuses were different, all participants’ therapies addressed relational and self
issues, as discussed earlier. Thus, therapists responded based on the specific presentation
of participants’ being depressed to help clients change their manner of involvement in
their particular situations.

6.3 Therapeutic Outcome

The next section examines results relevant to the outcome of effective
psychodynamic therapy of depression, and compares these results with literature
concerning psychodynamic formulations and assessments of outcome. In particular,
participants described changes taking place with regard to the following: depressed
moods, involvement with situations that gave rise to suffering, personalities, awareness of
self and others, and engagements with others and projects.

After psychodynamic therapy, participants no longer felt depressed; thus, the
psychodynamic therapies provided participants with symptom relief. Symptomatic
improvement is one, though not the sole, anticipated outcome of psychodynamic therapy
for depression (Karasu, 1990), and participants obtained such improvement. Participants
were more engaged with the world and felt better about their lives in the present.
Through the process of therapy, they changed their involvement with a situation
concerning self, others, or world that was a source of suffering. Participants were not
suffering in the same way and no longer felt helpless because they had been able to
modify their involvement with the situation. As such, participants felt hopeful about the
future. They did not anticipate the continuation of their suffering and imagined different possibilities of relating and engaging. With regard to hope, Synder, Michael, and Cheavens (1999) believed that clients become hopeful in therapy by developing a pathway toward a goal and/or a sense of agency about reaching a goal. Within this framework, in my study, participants felt hopeful as they had developed a way in which to change their involvement with their situation and had developed a belief in their ability to change their involvement in such a manner.

Through the process of psychodynamic therapy, participants learned to attend to and to articulate their emotional lives, and thereby differentiated the nuances of their experiences. After therapy, participants had a better understanding of their experiences and were more aware of themselves. These results regarding outcome converge with the goal of psychodynamic therapy for depression; namely, to gain insight into one’s emotional life (Karasu, 1990). In addition to their increased awareness of self, participants became more aware of others, and ultimately developed a complex sense of others and of self. Using Jacobson’s (1971) psychodynamic formulation of depression, a modification of the ego occurred, and participants formed more differentiated and realistic ego ideals and self-representations. After therapy, participants also assumed a nurturing stance toward themselves and attended to their experiences with a sense of care and curiosity. Again, using Jacobson’s formulation, a change of the superego occurred, and participants approached their experience more positively, lessening the criticizing or pathologizing of themselves. Ego and superego modifications represent changes in psychological structure. Changes in the client’s personality are the primary anticipated
outcome of psychodynamic therapy for depression (Jones, 2002; Karasu, 1990), and participants described such developments.

Psychodynamic therapy aims to produce, and participants described, symptomatic improvement and personality changes (Jones, 2002; Karasu, 1990). However, studies that were sampled by most meta-analyses of therapy for depression (Dobson, 1989; Gaffan et al., 1995; Gloaguen et al., 1998; Nietzel et al., 1987; Thase et al., 1997) exclusively used symptom measures such as the Beck Depression Inventory and the Hamilton Rating Scale of Depression to assess outcome and thereby left out other important changes with regard to personality and general functioning. In my study, with reference to functioning, participants described changes concerning the frequency and quality of their interactions and engagements. After therapy, participants were interacting more with people such as significant others or family members. They were also relating better with others and described less arguing or more trust occurring in relationships. Participants believed developments in relationships were reciprocal in that they trusted others and others offered more to them in return.

After therapy, participants engaged and participated more in enjoyable activities such as reading, swimming, or playing music, or in significant projects such as attending a university or starting a practice. Through these activities or projects, participants reconnected with old interests or developed new ones. Regarding significant projects, during therapy, participants had made important choices about their careers, and had, for example, realized their calling or made a commitment to pursue their calling. After therapy, participants believed that their experiences with depressed moods or with psychodynamic therapy helped in their work, for instance, as a pastor or therapist. In this
way, participants formulated the meaning that their past suffering had for their lives, as they attributed a religious or humanistic value to it. In other words, participants described the divine purpose for their suffering or the meaning they found in their suffering.

6.4 Contributions of the Study

My empirical phenomenological study of effective psychodynamic therapy for depression contributed to the field in regard to both psychotherapy research and clinical psychology. General contributions of my study will first be addressed with respect to the method and to the breadth and depth of results. My study filled the gap in the literature by documenting the qualities of clients’ experiences in effective psychodynamic therapy for depression, as the literature had only documented that psychodynamic therapy for depression was effective (Leichsenring & Rabung, 2008). Concerning its breadth, the study addressed both the process and outcome of psychodynamic therapy for depression, in contrast to meta-analyses of outcome studies that do not examine process variables other than the type of therapy. For instance, my study found that, during the process of therapy, therapists were attentive and curious about participants’ feelings and that participants appropriated their therapists’ analytic stance. In turn, at outcome, participants attended to their feelings differently and thereby modified their involvement with a situation that occasioned suffering. Thus, the study highlighted interpersonal and intrapersonal aspects of the therapeutic process and connected these with significant changes at outcome. Concerning depth of the study, the qualitative method allowed for the analysis of detailed descriptions of the process and outcome of psychodynamic therapy, in contrast to quantitative studies that limit such description. For example,
participants described reciprocal changes in relationships with others after therapy, wherein they felt more trusting of other people and believed that other people offered them more in return. Thus, the study elucidated changes in participants’ relationships and described the two-sided nature of such change between participants and other people.

Specific contributions of my study to the practice of psychodynamic therapy for depression will next be addressed. The study highlighted the significance of participants’ involvement in a situation that concerned the self, others, or the world, and that was a source of suffering. It elucidated the connection between participants’ helplessness to modify their involvement in the situation, their hopelessness about the future, and their depressed moods. In light of these results, when a client presents with depression, psychodynamic therapists might conduct a thorough assessment and determine places in the client’s life where the client is suffering but unable to change, such as in a relationship, at work, or as a result of an illness. The study also highlighted the main therapeutic outcome regarding participants’ involvement in the situation. It elucidated the relationship between the participants’ development of a different manner of attending to their experiences, the corresponding development of a complex sense of self, and the change in their involvement with the situation. In light of these findings, psychodynamic therapists treating a client with depressed moods might focus on the client’s emotional life and sense of self, especially facets of which the client is unconscious, to help the client change his or her manner of suffering.

Another contribution to the practice of psychodynamic therapy for depression is that the study showed the importance of the therapeutic relationship to the process of therapy. The results highlighted the therapists’ presence and manner of care for
participants; therapists were attentive and responsive to participants, and showed empathy for them. The results also elucidated therapists’ analytic stance toward participants’ presentation of their experiences and emotions; therapists acknowledged participants’ feelings and were curious about the significance of such feelings for their lives. Ultimately, participants adopted their therapists’ manner of care and analytic stance, and started to attend to their experiences in a similar way. With respect to these findings, rather than focusing on delineating a hidden impulse or making a correct interpretation, psychodynamic therapists should be aware of the significance of relational processes. They might strive to be present to the fullness of the client’s emotional life and to approach the client’s experience with a desire to understand.

6.5 Limitations of the Study

Methodological limitations of my study will be addressed with regard to the sample, focus, results, and data analysis.

The first methodological limitation regards the sample. Participant solicitation procedures targeted, and ultimately recruited, clients who were psychologically insightful, self-reflective, and articulate. Solicitation materials (i.e., advertisements, flyers, letters, and emails) were distributed to practitioners, mostly focusing on different psychological organizations, and the solicitation procedures yielded four client participants. Three out of four of the participants were psychologists and all participants had acquired at least a master’s degree. Solicitation procedures introduced sample bias into the study in that participants were insightful and articulate, had obtained a graduate degree, and were mostly psychologists, which does not reflect the general population. In addition, with a small sample, one does not know what the results may look like with
other participants. Nevertheless, participants generated rich descriptions, which were the aim of these particular solicitation procedures. With a small sample, the study was able to gather such data through written descriptions and lengthy interviews and to analyze the data in great depth. Plus, participants were diverse with respect to other variables such as age.

Data gathering procedures were also limited because participants’ therapists were not enlisted to disclose diagnoses they had made when participants presented for psychodynamic therapy. That notwithstanding, therapists would have been unlikely to contact clients whom they diagnosed with major depression. In addition, the aim of obtaining descriptions of stable therapeutic gains from clients who had terminated at least one year prior was more important than was obtaining therapists’ diagnoses.

The second methodological limitation concerns the focus of the study. The study centered on the participants’ descriptions of an entire course of effective psychodynamic therapy for depression, and addressed both the process and outcome of therapy. Unfortunately, the scope of the study made it difficult, during interviews, to focus on any one part of the process or outcome and therefore limited a fuller examination of either. For example, participants reported that they perceived therapists as parental or authority figures at times, yet interviews did not center on this theme in as much depth as desired because many other themes had to be addressed. The situations from which these particular perceptions arose, including therapists’ behaviors and participants’ fantasies about such behaviors, should have been explored.

Participants’ descriptions were retrospective accounts of the process of therapy from which they had terminated five to seventeen years earlier. Participants’ accounts of
process were rich and descriptive. However, these accounts were solidified impressions of therapy made several years earlier, which made providing additional details of the process sometimes difficult for participants during interviews. Nevertheless, the scope of the study allowed for an examination of both process and outcome, and of relationships between both.

The third methodological limitation regards the results. The results of my study concerned participants’ experience of effective psychodynamic therapy for depression. However, other types of therapy may be conducted similarly to psychodynamic therapy and have a similar effect. Hence, until other empirical phenomenological studies are performed on other types of therapy, one cannot definitively state which results are specific to psychodynamic therapy. Nonetheless, such a limitation does not invalidate the results of my study. Empirical phenomenological studies on other therapies may support that my results are specific or that my results speak more to common factors; either way, my results are still legitimate.

It follows that the study was also not designed to assess whether or not psychodynamic therapy was more effective than other therapies. Thus, the results of the study did not provide support for the conclusion that psychodynamic therapy is the treatment of choice for depression or that it is a better approach than, for example, cognitive therapy for depression. In short, the design of the study limited the claims that can be made about the effectiveness of psychodynamic therapy. That withstanding, attempts to draw such conclusions from research (e.g., controlled clinical trial comparisons) contain problems empirically, epistemologically, and politically, as was
shown in the literature review. Therefore, this study was designed with the goal of directly informing the practice of clinicians, rather than of convincing researchers.

The fourth methodological limitation concerns the data analysis. An empirical phenomenological method was used for data analysis, in line with the formulations of Giorgi (1975 & 1985) and Wertz (1983 & 1985). This method was used to demarcate meaning units and to articulate situated structures as well as to formulate the general structure. However, an empirical phenomenological method, of course, cannot do what statistical approaches can do because of differences regarding the kind and the amount of data gathered. That notwithstanding, I undertook my analysis to help fill in the gap left by those approaches and so had different research aims guiding my analysis.

An empirical phenomenological research method does not access the social, cultural, and historical facets of clients’ lives. In particular, three out of four participants were women, which reflects the disproportionate prevalence of women to men who are depressed in the general population (American Psychiatric Association, 2000). In addition, two women were in relationships with controlling or abusive men, and the third was employed full-time as well as assuming primary responsibility for childcare and housework. The study did not address the relationship between these women’s depressions, their subordination to the men in their lives, and the social factors that inform such relatedness. Accounting for social, cultural, and historical facets in addition to participants’ experience of effective psychodynamic therapy for depression was well beyond the scope of this study.
6.6 Suggestions for Future Research

Four suggestions for future research will be made: include personality variables, add the therapist’s perspective, change the focus of the research, and modify the research topic.

The first suggestion is to include personality variables when researching the psychodynamic therapy for depression. Personality variables could be assessed at the beginning of the study, and the relationship between these variables and the process and outcome of therapy could be examined during the analysis. The most important personality dimension to be included is the distinction between anaclitic and introjective depression. The significance of this dimension emerged in the literature review (Blatt, 2004), and its relevance to the results of my study was explored in the Discussions chapter. However, the discussion of anaclitic and introjective depression with regard to the results remained tentative because the study did not include an assessment of these variables, and the analysis was not designed to focus on them. Another important dimension to be included is the differentiation of personality structure from a psychodynamic perspective (McWilliams, 1994), especially personalities that increase the likelihood of experiencing major depression. Depressive personality is obviously the most relevant structure, and narcissistic personality, with its frequently accompanied empty depression, is just as important. Obsessive and compulsive personalities are also relevant, as are most personality structures, since depressed moods can be a part of any characterological suffering. By focusing on a few or even many personality structures, future research could examine their place in the process and outcome of psychodynamic therapy for depression.
Another suggestion is to add the therapist’s perspective when researching the psychodynamic therapy for depression. Psychodynamic therapists could be the target of solicitation procedures and could be asked to contact clients they have treated who were depressed. Therapists could also be requested to complete a research questionnaire that lists items relevant to the identification of themselves as psychodynamic therapists and could endorse items such as the following: read psychodynamic literature, member of psychodynamic professional organization, or received formal training. Therapists could lastly be included in the data-gathering phase and requested to write a description of the facets of therapy they perceived to be helpful for clients and the effects therapy had for clients. In this way, both therapists and clients are participants, and therapists’ descriptions could be analyzed to highlight convergences and divergences from participants’ descriptions regarding effective process and outcome.

The third suggestion is to change the focus of the research. My research centered on the process and outcome of an entire course of effective psychodynamic therapy from which participants had terminated five to seventeen years prior to the study. A direction for future research is to focus on one facet of effective process and to examine the particular outcome associated with that process. Such a change in focus could be based on the results of my study. For example, in my study, participants’ appropriating of therapists’ care and thereby modifying the manner in which they attended to their experience was found to be a significant process and outcome. However, because this was one process and outcome among others, the data gathering and analysis did not give this process the depth of focus it called for. Future research focusing on this or another finding could enable a more elaborate examination of particular processes and outcomes.
Another direction for future research is to conduct a process study and to focus on processes and outcomes shortly after they are experienced. Participants could be asked after sessions to describe effective processes and would be more likely able, in that time frame, to provide an in-depth account. Participants could also be requested after sessions to describe mini-outcomes and could thus more likely describe gradual changes that occurred.

The last suggestion is to modify the research topic in order to contrast the results of future research with the results of my study. This modification could take several forms. A direction for future research is to study effective psychoanalysis of depression. The study could elucidate which facets of effective psychoanalysis converged with effective psychodynamic therapy, possibly due to their shared theoretical foundations, and which diverged, possibly due to their different frames. For instance, the therapeutic relationship was found to be important in my study; however, would other processes, such as free association, be found more significant to psychoanalysis? A related direction is to study other effective therapies such as cognitive behavioral therapy for depression since it is the so-called treatment of choice for depression. The study could contrast the results with the results of my study to highlight facets common to both therapies and facets specific to long-term psychodynamic therapy. Another direction for future research is to study ineffective psychodynamic therapy for depression. The study could assess whether ineffective psychodynamic therapy consists of a modification of the effective facets found in my study. For example, would a course of ineffective psychodynamic therapy involve a negative therapeutic relationship, in contrast to my study finding a positive relationship to be important to effective therapy? The final
direction is to study effective psychodynamic therapy for other diagnoses such as
generalized anxiety. The study could compare the results of this future research with my
results to determine processes and outcomes specific to particular diagnoses and ones
pertinent to psychodynamic therapy in general.

6.7 Summary of Findings

The following summary was originally presented after the results and is presented
again to encapsulate the main findings of the study:

- Therapy helped to relieve the intensity and duration of participants’ depressive
  episodes, to improve the quality of participants’ engagements with others and
  projects, and to encourage their resiliency and continued psychological growth
  after termination.

- The process of therapy facilitated participants gaining awareness of self and
  others. Participants acquired insight about and developed facets of self. They
  also gained insight about contemporary relationships with family, friends, and
  significant others, and about the importance of their development in shaping their
  present situations.

- The process of therapy also focused on participants’ grief and anger about loss,
  and on their conflicted feelings about facing their present situations, as well as on
  participants’ dreams and their perceptions of therapists as a parental figure.

- Therapists questioned participants about their feelings to clarify or to confront,
  made statements to highlight or to interpret, and provided psychoeducation or
  suggestions.
• The comfortable therapeutic atmosphere offered a sense of safety. Regarding therapists’ presence, therapists were attentive and responsive to participants, and showed empathy for them. Concerning their analytic stance, therapists acknowledged participants’ feelings and were curious about the significance of such feelings for their lives.

• The deep sense of therapist care encountered in the genuinely personal therapeutic relationship facilitated the participants’ integration of such care into their own manner of attending to their experiences.

• Therapy helped participants to modify their involvement in a situation that was a source of suffering by teaching them to attend to their feelings in a caring manner and by facilitating their development of a complex sense of self. After therapy, participants felt better about their lives in the present and felt hopeful about the future.
References


Appendix 1: Solicitation Material

A1.1 Solicitation Advertisement

---

**Effective Psychoanalytic Psychotherapy of Depression**

**Research participants needed to participate in a qualitative research study.**

- I am seeking therapists and any of their interested colleagues who went to weekly or twice-weekly long-term psychoanalytic-psychodynamic psychotherapy for no less than one year for major depression, found therapy helpful, and have terminated from this treatment at least one year ago.

- The goal of this study is to describe typical features of the processes and outcome of effective psychoanalytic-psychodynamic treatment based on clients' descriptions of their experiences of their own personal psychotherapy.

- Participation consists of writing a short description regarding your experience of the facets of your psychotherapy that helped and its effects on your depression, and taking part in an audiotaped interview that expands on the written description. The interview may be transcribed.

- All data will be securely locked. Some data will be included in an appendix and excerpts may be used within the report. All identifying information you provide will be altered or deleted to protect your and other's anonymity. A consent form detailing confidentiality and your rights as a participant will be provided for you to sign.

*If you have further questions or think you or someone you know might be interested, I am available to be contacted:*

**T. J. Smith, M.A. | C: | H: | @duq.edu**

This study is being conducted in partial fulfillment of the requirements for a Ph.D. in clinical psychology at Duquesne University and has been approved by the University Institutional Review Board for the Protection of Human Subjects.
RESEARCH PARTICIPANTS NEEDED

I am seeking individuals to participate in a qualitative research study concerning the experienced effectiveness of psychoanalytic-psychodynamic psychotherapy for major depression. In particular, I am seeking therapists and any of their interested colleagues who went to weekly or twice-weekly long-term psychoanalytic-psychodynamic psychotherapy for no less than one year for depression, found therapy helpful, and have terminated from this treatment at least one year ago.

The goal of this study is to describe typical features of the processes and outcome of effective psychoanalytic-psychodynamic treatment based on clients’ descriptions of their experiences of their own personal psychotherapy.

Your participation would help understanding in this area, and would provide empirical, qualitative support for psychoanalytically oriented psychotherapy. It is expected that the study will be interesting and useful for therapists as well as for colleagues doing research regarding psychotherapy’s outcomes, but it may be of interest to clients/patients as well.

If you choose to participate, you will be asked to write a description regarding your experience of the facets of your psychotherapy that helped and its effects on your depression. I would like to interview you as well. The interview will be audiotaped and may be transcribed.

All information and data will be securely locked. Some data will be included in an appendix and excerpts from the written descriptions and interviews may be used within the report. All identifying information you provide will be altered or deleted to protect your anonymity and the anonymity of any others you mention. A consent form detailing confidentiality and your rights as a participant will be provided for you and the researcher to sign if you choose to participate.

The study is being conducted in partial fulfillment of the requirements for a Ph.D. in clinical psychology at Duquesne University and has been approved by the University Institutional Review Board for the Protection of Human Subjects.

If you think you might be interested, or if you have further questions, we can set up a time to meet to discuss things further. Also, if you know of someone who meets the criteria and might be interested in participating, please have him or her contact me. At your earliest convenience, please contact:

T. J. Smith, M.A.
C: or H:
@duq.edu

Your interest and participation are greatly appreciated!!
A1.3 Solicitation Letter/Email

Dear:

I am seeking individuals to participate in a qualitative research study concerning the experienced effectiveness of psychoanalytic-psychodynamically informed therapy for depression. I am sending letters to practitioners in the area and I have acquired your name and address from a public telephone listing. In particular, I am seeking therapists and any of their interested colleagues who went to weekly or twice-weekly long-term psychoanalytic-psychodynamically informed psychotherapy for no less than one year for major depression, found therapy helpful, and have terminated from this treatment at least one year ago. By psychoanalytic-psychodynamic, I am referring to a type of therapy that has an insight-orientation, emotion-focus, and aims at deep seated change in addition to symptomatic improvement by addressing development themes, relational issues, and the significance of the unconscious. I am privileging your view of and/or your therapist’s acknowledgement of the therapeutic orientation.

The study is being conducted in partial fulfillment of the requirements for a Ph.D. in clinical psychology at Duquesne University and has been approved by the University Institutional Review Board for the Protection of Human Subjects. The goal of this study is to describe typical features of the processes and outcome of successful psychoanalytic-psychodynamic treatment based on participants’ descriptions of their experiences of their own personal psychotherapy. Your participation would further understanding in this area, and would provide empirical, qualitative support for psychoanalytically oriented psychotherapy. It is expected that the results of the study will be interesting and useful for therapists as well as for colleagues doing research regarding psychotherapy’s outcomes.

If you choose to participate, you will be asked to write a short description regarding your experience of the facets of your psychotherapy that helped and its effects on your depression. I shall be looking for descriptions of actual experiences of the things that made a difference and seemed to help, as well as specifics of what you felt and thought at those times. You will also be asked to participate in an interview to clarify and expand upon your written description. The interview will be audiotaped and may be transcribed.

The written description, tape of the interview, any transcription, and any notes will be stored in a locked cabinet. The written descriptions and interview transcriptions will be included in an appendix and excerpts from the written descriptions and interviews may be used within the report. All identifying information you provide will be altered or deleted to protect your anonymity and the anonymity of any others you mention. You may stop participating and retract your data any time prior to the completion of the research study. If you choose to participate, you and the researcher will sign a consent form detailing confidentiality and your rights as a participant.

I shall follow-up this letter with a phone call at which time we can discuss the study further. In the meantime, if you would like to participate before the initial phone contact, I have included directions on the back of this page along with a consent form, research questions, and a request for a written description to be completed and sent back to me in the self-addressed stamped envelope. If you know of someone who meets the criteria and might be interested in participating, please pass along this material to him or her. I am available to be contacted by phone or email for you and for those you refer. If you do not wish to receive any further contact, please see the directions on the back of this page.

Your interest and participation are greatly appreciated,

T. J. Smith, M.A.

Street      H:              or C:  
Pittsburgh, PA          @duq.edu
Appendix 2: Research Material

A2.1 Directions

- If you do not wish to receive any further contact regarding potential participation in this research study, simply return this letter in the self-addressed stamped envelope within one week from whence you received it.

- If you are interested in potentially participating, I have included an informed consent form, research questions, and a request for a written description for you to look over. Please read this material and make sure you understand it.

- Once you decide to participate, please:
  - Re-read the consent form that addresses the steps taken to ensure confidentiality and that highlights your rights as a participant. If you understand the consent form and want to participate in the study, please sign the form.
  - Answer the research questions that address clinically relevant material
  - Re-read the request for a written description, and on a separate sheet or sheets of paper, write a detailed description that addresses the different facets of the request.
  - Include the signed consent form, answered research questions, and written description in the self-addressed stamped envelope. Also, include a note containing your contact information (phone # or email) or just call/email me with your contact information. Please mail these back to me at:

    T. J. Smith, M.A.
    Street
    Pittsburgh, PA

- After I have reviewed and read the description, I shall contact you to schedule an interview time and location. The interview should take less than an hour and I can easily travel to your home or place of employment if you wish. Your contact information will be shredded after the interview.

- If you have any questions at this point (or any point), I am available for you to call or email.
TITLE: Clients’ Experience of Effective of Psychoanalytic-Psychodynamic Psychotherapy for Major Depression: An Empirical Phenomenological Study

INVESTIGATOR: Thomas J. Smith, M.A. Avenue
Pittsburgh, PA

ADVISOR: Roger Brooke, Ph.D., ABPP
Duquesne University
Psychology Department
412-396-6563

SOURCE OF SUPPORT: This study is being undertaken as partial fulfillment of the requirements for the doctoral degree in Clinical Psychology at Duquesne University.

PURPOSE: You are being asked to participate in a research project that seeks to investigate the effectiveness of psychoanalytic-psychodynamic psychotherapy of major depression. You will be asked to write a description of your experience. In addition, you will be asked to allow me to interview you. The interviews will be taped and may be transcribed.

These are the only requests that will be made of you.

RISKS AND BENEFITS: Your participation in this research has minimal risks. The benefit of participating in this study is that the information obtained will offer the psychology community a better understanding of the effectiveness of psychoanalytic-psychodynamic psychotherapy for major depression and information regarding the process and outcome of psychotherapy.
COMPENSATION: There is no monetary compensation for your participation in this study. However, participation in the project will require no monetary cost to you.

CONFIDENTIALITY: Names will not appear on material, except consent forms. All written materials and tapes will be stored in a locked cabinet and pseudonyms only will appear on this material. A list of each participant’s pseudonym will be kept in a separate locked cabinet with the consent forms and any contact information. The descriptions of your experience will be included in an appendix and excerpts may be used within the report. All identifying information will be altered or deleted to protect your anonymity and the anonymity of others you mention. Following the interview, contact information will be shredded. Following transcription, the tapes will be erased.

RIGHT TO WITHDRAW: You are under no obligation to participate in this study. You are free to withdraw your consent to participate and to retract your contributed data at any time prior to completion of the study.

SUMMARY OF RESULTS: A summary of the results of this research will be supplied to you, at no cost, upon request.

VOLUNTARY CONSENT: I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time prior to completion of the study, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call the researcher Thomas Smith at 412-310-2565, the research advisor Dr. Roger Brooke at 412-396-6563, or the Chair of the Duquesne University Institutional Review Board Dr. Paul Richer at 412-396-6326.

_____________________________    __________________
Participant's Signature    Date

_____________________________    __________________
Researcher's Signature    Date
A3.3 Research Questions

**Age:**

**Gender:**

**Highest Level of Education:**

- Did you have a depressed mood and/or lost of interest or pleasure for at least two weeks or longer prior to and/or during your psychoanalytic-psychodynamic psychotherapy? (yes/no)

- Do you feel psychoanalytic-psychodynamic psychotherapy helped you? (yes/no)

- From which of the following symptoms of depression were you suffering:
  
  - Depressed mood
  - Diminished interest or pleasure in activities
  - Weight loss or weight gain, or a decrease or increase in appetite
  - Insomnia or hypersomnia
  - Fatigue or loss of energy
  - Psychomotor agitation or retardation
  - Feelings of worthlessness, or excessive or inappropriate guilt
  - Diminished ability to think or concentrate, or indecisiveness
  - Recurrent thoughts of death or suicide, plans for suicide, or suicide attempt

- What was the length of your depression?

- Was the depression treated with medication?

- Was the depression recurrent?

- What was the length of psychoanalytic-psychodynamic psychotherapy?

- What was the frequency of the psychotherapy?

- When did you terminate the psychotherapy?

- Did you participate in any psychotherapy before the psychoanalytic-psychodynamic psychotherapy?
A3.4 Request for Written Description

This is a request for you to write a description about your experience. Please take some time to think about and write the description on a separate sheet or sheets of paper.

When responding to these questions, please refrain from using conceptual schemas as best you can and write in everyday language about your experience as a person involved in psychotherapy in as much detail as possible. As you look back:

- Please describe in concrete terms what your depression was like before entering psychotherapy, at the end of psychotherapy, and how you are different now.
- Please describe several representative incidents that exemplify what was helpful for you in psychodynamic psychotherapy and how it helped.
- If not addressed above, please describe any changes experienced: in a bodily way, with other people, in yourself, toward your future and past, and in the various aspects of your world.
Appendix 3: Data and Analysis Participant #1

A3.1 Written Description

I entered psychotherapy in the summer of 1989 due to difficulties I was having adjusting to the end of a 10-year relationship. The psychologist I chose had been recommended to me by my boss who knew that I was going through a divorce. She was described to me as a Jungian psychologist, but I was mainly concerned that she had experience with "women's issues." My depression at this time was pretty severe. I felt a lot of grief and sadness over the failure of this relationship, even though I was the one who left. I felt estranged from my family and as though my life was a total failure. Looking back, I had been depressed for some time and had even contemplated suicide when I was still in the relationship. Work was about the only thing in my life that kept me sane. It took my mind off my problems and made me feel useful and worthwhile. I had difficulty sleeping at night and would often waken at 3:30 or 4:00 a.m. and be unable to fall back asleep. I did not want to socialize with my family and had lost contact with all of my friends from the past, so I felt very alone. It seemed like I was starting life over again and my life felt very empty. The therapy process went on for about a year and a half. During this time, I saw my therapist weekly. I chose to end the therapy when I began to feel that we had done our work and that I could handle my problems on my own.

It is hard to describe what exactly changed for me through the process of therapy. Everything it seems got better. I began to feel more confident in myself and felt that my experience had been validated by someone else in a way that it never had been by anyone else in my life. I came to know myself better and grieve and accept some of the
disappointments in my life. Therapy also taught me to become a better friend/parent to myself. More importantly, I feel that this process allowed me to differentiate or develop parts of myself that were missing before and to recover parts of myself that had become lost during the period of this relationship. I also came to understand my experience in a broader context that made it easier to heal.

What was helpful for me in therapy, I think was my therapist's approach which was Jungian and archetypal. I learned about the archetypes and how they were taken up by modern-day Jungian analysts. Learning about the archetypes allowed me to understand and appreciate different facets of myself and others in new ways that were helpful for me. They offered a way of clarifying my experience through an abbreviated language that was previously unavailable and added depth and breadth to my understanding. The work that we did on the shadow allowed me to better understand underdeveloped or disowned parts of myself and how that had led to my current predicament. Becoming more aware of my unconscious through dreams was also important and helpful. Sometimes the dreams were very stark and scary, but at least I had a guide. When my dream images brought hope, it was exciting to learn what the symbols represented and I felt that my therapist cared and shared in my excitement. I felt that my therapist cared about me as a person. (She actually traveled to Greece during the course of my therapy and brought me a gift—a small sculpture of Athena, which really touched me and is a memento of my therapy that I have to this day.)

As for specific incidents that were helpful, I remember an important interpretation that she made one day that stopped me in my tracks and made me re-vision my history in a new way. She said something like, "so you traded a controlling mother for a
"controlling husband." This made me look at my mother in a whole new light and understand how my history had more or less prepared me for the fate of making such a poor marriage choice. I had been unable to see any comparison between my mother and my ex-husband on my own, but afterwards it made sense to me, and I felt that my therapist knew me better than I knew myself.

Another turning point for me occurred when my therapist provided what I would call some pure and simple "psychoeducational training." I had been having a very hard time breaking the attachment to my ex-husband, even though I knew that I could not return and that he was very bad for me. My therapist knew that I was stuck and during one session, pulled out a copy of the DSM-III. She opened to the section on Narcissistic Personality Disorder and read off the criteria asking me which ones fit my knowledge of my ex-husband. When we noticed he had nearly all of the criteria, my question to her was, "is that something that could be treated in therapy?" She answered that it would require him acknowledging the problem and spending about five years in intensive (once or twice-weekly) psychotherapy. Suddenly I realized the gravity of the problems I had been dealing with and the impossibility of fixing things: first, he would never acknowledge having a problem, and second, I didn't have five years to wait! This one intervention made a huge difference in my being able to "fall out of love" with this person and move on.

When I made poor choices in dating, my therapist would confront me, but in a way that showed restraint and made me figure things out on my own. For example, she would say things like "listen to your words" or "where have you seen this before?" These confrontations always were given in an accepting and loving way, without judgment,
matter-of-factly and recognizing that change is slow and occurs in its own time and space.

In addition to these specific incidents that stand out, I think that the general atmosphere and quality of the relationship had a lot to do with my getting better. She was interested in warmth both personally and in the environment and had an electric hearth beside the two wing-back chairs where she and I sat. She had little figurines in the office representing some of the archetypes and would sometimes point out one or two during our sessions. Sometimes she would offer candy or tea. It was a warm place to come. I had the utmost confidence in her. Especially at the beginning of therapy, I know that I idealized her. I saw her as a grandmother or mother, but also as someone who was very successful at her work (she had an office in a large downtown office building). I felt she was someone who knew and understood my problems and could help me. She always had piles of books on her desk and was always recommending books for me to read. Reading was a big part of the therapy and allowed me to keep my therapy going throughout the week. I think that the confidence that I had in her as "the one who knows" was a very important element to my therapy. When I went to sessions, I felt as if I was going to see my teacher who knew me and where I was at and could help.

The therapy changed me in significant ways and to such a degree that I do not feel I would be the person (or therapist) that I am today without having had this experience. I feel more open to other people and more accepting of myself. I feel positive about the future. Although I regret certain choices made in my past, I feel that they were necessary to fulfill God's purpose for my life. In a sense, I feel that it was all part of a larger plan. The therapy allowed me to recover lost pieces of myself and to become more rooted in
my God-given feminine identity and wisdom. It has allowed me to become more nurturing toward myself and others. At the same time, I feel I have learned to be better defended against evil. Although I still, at times, experience depression, it has a different quality to it now. I am able to recognize it sooner and communicate better with others. And regardless of the depressions I experience, my life is full. I feel that this experience also has allowed me to be a better therapist to others. Although I do not practice from a Jungian or archetypal perspective, I do understand how people can become stuck and how the process of change takes time and is a process often of reparenting, having a sensitive and caring witness to clarify, articulate, provide a path. Someone who knows the terrain toward selfhood and can guide that process.

I felt at the time (and still do) that my therapist was an angel put in my life at just the right time, to help me to get my life back on tract. I know that she would reject the idealization of being called an angel. Nevertheless, for me, the image stands. I feel an enormous sense of gratitude for the way that this therapy changed my life.
A3.2 Interview

R: The first thing I want to start with is that I remember when I was reading the beginning of your description you were writing about how before therapy you were feeling an estrangement from your family [P1: Um hmm] and a loss of contact with your friends [P1: Um hmm] and then you wrote that after therapy you felt that you were more open to other people [P1: Right] and you felt more nurturing toward other people [P1: Right]. I want to know if you have any examples of that change in relatedness or that change you experienced with other people.

P1: Um, yes, I can think of some right off the bat and I, I think that, um, that change had two parts to it. First, was being in a depression, you know, where you tend to pull back anyways [R: Um hmm]. And then the other part of it was I had been in a relationship for 10 years that was a very controlling, abusive kind of relationship where there was, um, a lot of pressure on me to break contact with people [R: Um hmm] that he perceived to be a threat, um, to the relationship [R: Yes] or a support system for me aside from him. So, um, when I got out of the relationship and started in therapy I was, I was still feeling very depressed [R: Um hmm] and, and wanting to isolate from other people. Um, my cousin and his wife had, um, just had a son and I remember, um, having such mixed emotions about going to visit her in the hospital. You know because, um, I just felt so bad about where I was at [R: Um hmmm], and, um, had, had been out of touch with them for a long time and yet, ah, wanted to reconnect with family. And then, um, several years later after therapy, um, I ended up being godmother to their third child [R: Um hmmm], a little boy. So, you know, through that whole period of time, um, you know, there were lots of trips to the zoo with the boys [R: Um hmmm] and overnight sleepovers. And, um, I just got really close to their family, and, um, to the point that they wanted me to be godmother [R: Um hmmm], which was fun [R: Yeah]. So, that’s one, one thing that stands out.

R: And so it sounds like that change with the relationship with their children really, you know, encapsulates the change you experienced.

P1: Um hmmm, just an openness and, um, wanting to be a part of other peoples’ lives [R: Um hmmm] and watch them grow up.

R: That’s great! At the beginning of therapy also you wrote that you were seeing your therapist as, um, as a grandmother or mother [P1: Um hmm] and as a teacher or the one who knows [P1: Right], and even after therapy, you wrote that you held onto that image of your therapist as an angel [R: Um hmm]. I was wondering how was that related to the process of therapy for you?

P1: Um, I, I felt like a student almost [R: Um hmm]. When I would be going to my therapy sessions, I almost felt like I was student going to study or learn about myself [R: Um hmm]. And this was way before grad school, way before I had considered becoming a psychologist. I was very naïve about therapy at the time, but I felt like she knew what was wrong with me [R: Yeah]. I just felt that she instinctively knew what I needed and what was wrong with me and how to, how I would get better [R: Um hmm].

212
R: Um hmm, yeah, so you saw her as, you know, the teacher [P1: Um hmm], the one who knew [P1: Um hmm] about what was going on with you.
P1: And she also, there was a parental side to her too. I use the word grandmotherly because I guess she was maybe in her sixties [R: Um hmm], early sixties. Um, but there was a parental aspect to the therapy in that I feel like I got things from her that I didn’t get from my own parents [R: Um hmm]. Um, you know, it wasn’t just from my mother. It was things I didn’t get from my father too [R: Um hmm]. You know, like, in therapy I remember mentioning I was going to be buying a car. You know, and kind of nervous. It was the first car I was buying. And, um, she, she became, you know, very, ah, matter of fact: and well you’re going to want to get it, you know, the rust proofing on the bottom, you’re going to want to make sure you do that [R: Um hmm]. And, you know, just [R: Yeah] little comments like that. It, it felt like, you know, a parent guiding you like in the right direction, like something your father would say [R: Um hmm].

R: Um hmm, so it wasn’t so much, you know, grandmother or mother or father. It was just sort of like a [P1: Parental] a parental amalgamation of those [P1: Right]. Yeah [P1: yeah], so she was a teacher and a mother and a father and a grandmother [P1: Um hmm]. And how did, how did that develop over the course of therapy too. Is that something that stayed the same for you or is that something that developed? How did that proceed throughout the course of therapy?

P1: Um, I think I actually learned to do those things for myself, like I took in those qualities she gave, she showed me, you know [R: Yeah]. That kind of care that she showed me I think it sort of rubbed off on me (laughs).

R: Yeah, yeah, that makes a lot of sense, so taking that in.

P1: Um hmm, and then, you know, because I would think, you know, what would Dr. W say about this? You know [R: Um hmm], it was just, it would, I could almost imagine what she would say about an issue or you know.

R: Yeah, it’s almost, you know, therapy outside of therapy [P1: Um hmm]. You mentioned too that um, you weren’t in the field at that time [P1: Right]. Was there a relationship between you going through this course of therapy and you getting into the field?

P1: Um, there was but there was a little bit of a gap [T: Um hmm] between. I remember talking in therapy about how I’d like to go back to school and be a therapist. And I remember she didn’t encourage me or discourage me either way. Again, it was kind of a matter of fact like: wow, you must be wanting to study quiet a bit (laughs) or commit a lot of years to study. And she, ah, mentioned the, um, Pennsylvania Licensing Board: and if you really want to know what’s involved, you know, you can check it out with the Pennsylvania Licensing Board and find out what all the requirements are. And just very factual about it [T: Um hmm] you know. Um, and I think that, um, the transformation that I felt I went through, um, had a lot to do with making the decision to make that
commitment [T: Um hmm]. Although I had a lot of doubts over whether I’d be accepted [T: Um hmm] into graduate school because of, you know, I didn’t have a lot of confidence and, ah, questioned, you know, that but [T: Yeah] it was a goal.

R: Okay, your articulation of therapy as (reads segment of participant’s description): understanding that someone becomes stuck and how the process of change takes time [P1: Um hmm] and that it’s often also a process of re-parenting [P1: Um hmm]. That formulation of therapy, was it formulated somewhat based on your own experiences in your own therapy?

P1: Yes, yes

R: Because that was catching my eyes too was the re-parenting, which you also mentioned early today describing your own therapy [P1: Um hmm, um hmm].

R: I have another question. I was wondering about, um, you were writing about the parts of yourself that were discovered or developed [P1: Um hmm] in therapy. I was wondering if you could tell me a bit about that in more detail.

P1: Okay, um, I think it was, um, partly rediscovering parts of myself. Um, you know, kind of like reconnecting with, um, my feelings, my intuition, those kind of, you know [R: Um hmm], parts of myself. Um, and then I think it was, um, developing other parts of myself in the sense of, um, the work we did on the archetypes [R: Um hmm]. Like a lot of the work in therapy, um you know, following the sort of Jungian approach is, um, the move toward individuation and pulling into consciousness, um, latent or unconscious potentialities [R: Um hmm]. So, um, you know, the person that I was before therapy was, um, you know, young, naive, um, undefended in the world, which is what allowed me to get sucked up into, um, a relationship that was very bad for me [R: Um hmm]. So, um, working on becoming better defended, you know [R: Yeah], more Athena like, more mental less feeling, um, and less naive, and, um, would be some [R: Um hmm] of I think the ways I changed you know. And not just, not just, um, like more assertive, you know, in a consciousness kind of way [R: Um hmm], but just better defended in terms of, um, being able to say no to things, being able to take a stand, being able to be more empowered I guess.

R: Yeah, so that would be the development, you know, empowering yourself based on a lot of depth work [P1: Um hmm] and also the, it sounds like the rediscovering of your own intuition [P1: Um hmm] of your feelings [P1: Um hmm]. And you mentioned Athena, I was wondering you wrote that some archetypes [P1: Um hmm] helped you to understand yourself and others [P1: Umm] and was that one of them? Could you tell me [P1: Yes] about that?

P1: Yes, um, Athena goddess of wisdom and, um, she was sort of aligned with, um, the male world [R: Um hmm], you know. But she was very defended. She always had a breast plate over her heart, you know [R: Um hmm], that was, um, so that she couldn’t be
wounded [R: Yeah]. And, um, um, a lot of the work I think involved cultivating those kind of traits in myself [R: Um hmm] through more of a conscious effort.

R: Yeah, what were some of those traits that were developed then, some of the traits that were cultivated?

P1: I think that, um, the interest in, um, learning and studying [R: Um hmm], you know. Um, I certainly needed that to go back to school, you know [R: Yes]. And ah, um, and you know, being able to sort of, um, join with men [R: Um hmm] you know on a mental, you know, rather then having it be power based kind of relationship. Having it be more of like a brother-sister kind of thing or an equal [R: Yeah]. You know, because, ah, that’s, that’s kind of who she was. She was kind of on their level [R: Um hmm]. And you know, but even be involved in, you know, strategizing battles. And, you know, she was part of the male world.

R: Okay, is the any examples off the top of your head concerning how you were able to be better defended, better assertive, more empowered?

P1: Um, I learned to say no (laughs) [R: Um hmm]. I had been raised, you know, to be nice and, um, to be agreeable. And, um, you know, those, those qualities are great but you also have to be able to protect yourself and you have to be able to walk away from evil. And keep yourself, you know, protected and away from it. And, um, so, you know there were books that were assigned reading in therapy that were skills really just basic skills you need to learn like how to say no [R1: Um hmm]. And, um, so I guess that would be one way that I felt better defended. You know that you can hang up on somebody you don’t want to talk to. It’s your phone. You pay the bill for the phone (laughs) [R: laughs]. Those kind of things.

R: I am also wondering too you wrote before therapy you felt some deal of grief over the [P1: Um hmm] end of the relationship with your ex-husband [P1: Um hmm] and then you also wrote that a good deal of therapy was doing grief work and accepting some disappointments in your life [P1: Um hmm]. I was wondering if you could tell me more about the grief work or the accepting of disappointments.

P1: Ah, the limitations, I guess, of my own parenting [R: Um hmm] that kind of, I guess, set me up for this. And um, coming to accept my parents for who they were, which, I mean, I’m still (laughs) working on that [R: Yeah] here and there (laughs) [R: (laughs)]. Um, yeah, I guess that was a big part of it. The loss of time that was spent in that relationship [R: Um hmm], um, because I got stuck there and couldn’t get out. Um, and the loss of, you know, the dreams that I had had for it that didn’t, you know, materialize, [R: Um hmm] the things I wanted that relationship to be that it wasn’t and never would be.

R: That helps me understand. So, it sounds like there was some acceptance of how you were parented and how that influenced the relationship. So, I guess an acceptance of the past, but also then grieving over the loss of what you wanted the relationship with your
ex-husband to be. Was that something that occurred throughout the entire course of therapy or was that something that occurred during a period when most of the grief work was done?

P1: I think a lot of that was done privately [R: Um hmm]. I don’t think that I talked a lot about my parents in therapy. Although I must have for the one example that I gave about something my therapist, an interpretation she made [R: Um hmm] that my mother was controlling and so was my ex-husband and I had never seen that connection before [R: Yeah]. Yeah, so, you know, um I must have been talking about my mother in there. But, um, I don’t remember. It doesn’t stand out for me as, um, something I talked a lot about. And I don’t think I talked much at all about my father. Although I remember her describing him as the absent father [R: Um hmm]. So, I must have talked (laughs) about him too [R: Um hmm].

R: And you were saying that a lot of the work was being done outside the therapy too. What was that like?

P1: Um, like, when I would go visit my parents and, ah, you know, all the same emotions would come up when the family dynamics are the way they always have been [R: Um hmm] you know.

R: Was there anything off the top of your head you were thinking of?

P1: I just, I remember going home to visit, um, and this may have been even after therapy was over [R: Um hmm]. Um, and I remember my father saying something very very mean and it just struck me. You know, when you’re away from your parents for a while. And, you know, there living in Atlanta, I’m living in Pennsylvania [R: Yeah]. And your main contact is by phone and everything is real pleasant and nice. But when you’re back home visiting you’re right back in the soup so to speak [R: Yes], you know. And, um, my father said something very very mean and it just like (whistles) right there [R: Um hmm]. And, um, then I just remember just going into the bedroom and, you know, just being in tears. And then just, you know, kind of realizing you know: this is the way he’s always been, it’s always been painful, you may try to put it out of your mind, but its is mean [R: Um hmm] and it’s just mean. And, um, maybe it’s untreated depression or whatever but I’m his daughter not his therapist (laughs) [R: Um hmm].

R: That interaction was something that happened after therapy. How did therapy prepare you for it? How was it situated in light of the experiences you had in therapy?

P1: Um, I think, I think I worked through it on my own [R: Um hmm]. And the way, it was different. Um, like I said the therapy did not focus so much on the parents [R: Um hmm], more just focusing on myself, you know. So, I don’t know if I’m answering your question.

R: Yes, I think you are. When I was hearing you say that you were able to accept that’s, you know, just the way your father is [P1: Um hmm] and that your father said something mean, I was remembering earlier that you said some of the work of therapy was being
able to accept things [P1: Um hmm]. I was wondering if the ability to accept [P1: Um hmm], you know, was something that developed [P1: Um hmm] in therapy, which made that moment with your father possible [P1: Um hmm] for you.

P1: Yeah, I think that probably the therapy did lay the groundwork for that. Just in the sense of being able to name things for what they are and label them [R: Um hmm]. And in sort of a nonjudgmental way talk about, you know, well this is the way it is.

R: What was coming to my mind as you were speaking was, you know, the taking in [P1: Um hmm] of the therapist. You know, being able to engage in a nonjudgmental way [P1: Um hmm]. What your therapist was doing during the process of therapy is what you were doing [P1: Um hmm] outside of therapy [P1: Um hmm, um hmm]. Another question I have concerns you writing about the different quality depression has now [P1: Um hmm]. I am wondering if you could tell me more about the different quality [P1: Um hmm], what the difference is.

P1: Um, there’s not the emptiness [R: Um hmm], not that feeling of emptiness. Um, now when I get depressed, it’s more of, um, a sadness [R: Um hmm]. Um, and I usually can figure out, you know, what’s bringing it about, you know, by looking at my feelings and what’s going on in my world. Um, and I think before it had a quality of, um, shame, emptiness, um, ah, lostness [R: Um hmm]. You know, there’s a feeling of lost, just not knowing who you are or, um, not really having a context for understanding [R: Um hmm] myself or other people.

R: That’s something I hear coming up today is that before therapy there was a sense of lostness but through your work you were developing a knowledge of yourself [P1: Um hmm], like an understanding that you took with you [P1: Um hmm] and you have with you now [P1: Um hmm]. In your written description you also mention feeling very empty before therapy [P1: Um hmm] but after therapy you wrote you felt full [P1: Um hmm]. I was wondering about that experience. Were there any instances of experiencing that change in a bodily way that sense of fullness versus emptiness?

P1: Um, I think the fullness has to do with my life became fuller [R: Um hmm], you know. Um, but I do remember like a real high, um, that I got running a, um, I don’t know if it was, um, the 10K run in the fall that they do in Pittsburgh or it was one of the races, the Great Race maybe [R: Um hmm] that they do in Pittsburgh. I remember just feeling so high running that race like, you know, reconnecting like: this is my town and this is a neat town and all these different little neighborhoods are, you know, familiar to me [R: An exuberance and a reconnection]. But I don’t, I don’t know how to describe the fullness so much. Um, except to say that there’s more people in my life, more activities in my life. And, and my therapist was a part of helping that bring that about because, you know, she would make suggestions to me about hiking or, you know, joining a group or, um, you know, different ways to meet people or make friends, and very encouraging in that way [R: Um hmm]. You know, kind of, it’s like she knew I was kind of starting over, and thinking of ways that, um, would be helpful.
R: That sounds helpful [P1: Um hmm]. I was also wondering about the atmosphere in therapy [P1: Um hmm]. You wrote that it was very warm [P1: Um hmm], um, both personally and environmentally. How was that helpful?

P1: It just, um, eh, the fact that it was warm, I mean, because I felt so vulnerable I think having the, um, atmosphere in therapy be warm made it welcoming, and soft, and gentle, made it safe [P1: Um hmm]. You know, made it a safe place to come and open up and talk about things.

R: So, the warmth environmentally would be providing a sense of safety personally, which then helped you to open up.

P1: Like a baby would feel wrapped in a blanket, you know, when you’re giving them a bottle [R: Um hmm]. I mean it wasn’t, it wasn’t, I never sat on her lap or anything [R: No]. There was a hearth right by the she had two wing-back chairs. And there was an artificial hearth but it did let out heat [R: Okay]. And, ah, it seemed like a conscious detail that, you know, she put there for a reason [R: Yeah], you know what I mean.

R: From your description, I can feel the warmth there. It seems like a very warm and inviting place. I was wondering about two sentences in your written description that I would like you to elaborate on [P1: Okay]. Um, on the last page, um, you said, “that although I regret certain choices made in my past I feel they were a necessary part to fulfill God’s purpose in my life. In a sense, I feel it was all part of a larger plan.” I was wondering if you would elaborate on this, the situating things within a larger context.

P1: Um hmm, um, well, what I think I was thinking of when I said I regret certain choices, ah, that would be, um, you know, the person that I ended up marrying [R: Um hmm] in my first marriage. Um, and I do regret that choice because there was a lot of time lost in that relationship trying to make it work. And I, I feel like, um, those were a lot of good years in my life when I was young and, um, they were essentially wasted because it was a relationship that never could have worked. Um, the way, the reason I feel it was necessary to fulfill God’s purpose for my life is I don’t think I would have understood, unless I would have gone through what I went through, some of my clients that walk into my office [R: Um hmm], you know. I think if, if I would have gone to graduate school and become a therapist before this happened to me, I would have had the attitude: well, you just need to do this, you just need to do what I’m going to tell you and you’ll be fine [R: Um hmm]. And um, that’s not the way to do therapy (laughs) [R: (laughs)]. But I know that I would have had that shallow of an idea about it [R: Um hmm]. Um, so I think I had to go through my own hell to be able to help, to be there with other people and help them to come out of it and, ah, find a way out of it. And, um, and so I do feel it was part of God’s plan for my life because I do feel like this profession is what I was meant to do.

R: Yeah, so this profession is what you were meant to do and your experiences in your own therapy helped you, enabled you to [P1: Do it better] do it better. Um, also, when you were imagining what you would have been like as a therapist if you did not go to
your own therapy [P1: Um hmm], and you were saying that you probably would just instruct clients to: go and do this [P1: Um hmm]. However, what I was hearing reflected in your description of your own therapy a lot of the time was that your personal therapy was allowed to open up in it’s own time [P1: Um hmm] and that your therapist understood that therapy proceeds in it’s own time [P1: Um hmm]. What was your experience of the way your therapist proceeded and the way your therapy opened up in it’s own time?

P1: Um hmm, um, I remember going to therapy sessions wondering what am I going to talk about today [R: Um hmm] and should I even go. But I would go. I hardly ever missed. And, um, my therapist seemed to have a patience. Um, I don’t know if I should confuse this with grad school jargon but, um, one of our professors would refer to it as: lying fallow when not a lot happens in therapy on the surface but things are going on underneath the surface [R: Okay]. You know, and, um, I just remember feeling a little self-conscious like, you know, maybe not having a lot to say. And I just remember her sort of picking up the ball, you know, and, sort of, chit-chatting about this or that or. You know, that that was okay if I really didn’t have a lot to say [R: Um hmm] that, you know, I could sit back and take a breather and she would sort of carry the session for a while. Um, it wasn’t your typical, um, you know, analytic stance where the therapist doesn’t say anything. It was more of a, there was more of a back and forth [R: Um hmm] you know. And I think that that worked for me and I found it, I was grateful for it on the days that I didn’t have a lot to say [R: Yeah] you know. But I do feel that it was all part of the work [R: Um hmm]. You know that I was changing but I think, you know, um, it wasn’t in leaps and bounds but it was in it’s own course and time.

R: Um hmm, yes, what’s just coming to mind too is it almost seems like a sense of holding, um, holding in the therapy [P1: Um hmm] where she was seeing the, you know, change but able to hold onto that [P1: Um hmm] and let it develop in its own time [P1: Um hmm]. I was wondering could you give an example of any dream that was significant for you in the process of therapy. Is there any one, one that comes to mind or any, anything that comes to mind of that sort?

P1: There was a very scary dream, um, and I think it came from sort of early in the course of therapy. And um, it was scary, there was a lot of water and, um, a lot of woman that were sort of, um, if I’m remembering it correctly they were sort of, um, like their femininity all signs and traces of it were erased [R: Um hmm] like, you know, almost like a concentration camp kind of quality to the dream [R: Um hmm]: shaved heads, naked bodies, you know. Just ah, and it was kind of just a nightmarish kind of atmosphere [R: Um hmm]. And I think that, um, the meaning of that dream and the way it was interpreted was, you know, sort of being cut off from the feminine side of myself. Because having been in this relationship with a man that really essentially hated woman, you know, and, and having that, having been influenced by that and kind of divorced from my own femininity in so many ways [R: Um hmm] that I think that was part of the meaning of what that was about [R: Yeah]. It was very stark and scary [R: Um hmm] kind of a dream.
R: How was that picked up in your therapy? How did that dream have a significance for you in there?

P1: I learned to, um, reconnect with my femininity [R: Um hmm] and embrace it more. And, ah, was able to see more clearly how I had been, um, I don’t want to say brainwashed but affected by being with someone who was, was so negative toward woman [R: Um hmm]. And just, um, coming to accept myself as a woman and, and be happy about that and take the good from that and celebrate it [R: Um hmm].

R: Yes, it seems like a real personal acceptance of your own femininity [R: Um hmm]. Were there expressions of that too? Were there instances you can recall that were manifestations of that internal change?

P1: I became more interested in clothes, make up. Um, I remember having my colors done, you know, where you have a beauty expert tell you what colors look good on you [R: Yes]. I mean I got more involved that way. Um, I’d always like to cook, so I don’t think that was part of it. Um, those are the main ways [R: Yeah]. I guess too being more open and friendly with other people, more interested in other people [R: Um hmm]. You know because I view that as a feminine trait [R: Um hmm] to sort of want to draw people out and find out about people. And I, I think I became more confident doing that.

R: Um hmm, is there anything that stands out for you with reference to the openness towards others you mentioned? Is there any experience after therapy or, you know, currently where you really see that development, that openness towards others, um, being displayed? Is there anything that comes to mind?

P1: Hmm, I think I just speak more freely [R: Um hmm] with people. I don’t hold back as much [R: Yeah]. I can’t think of any like specific, um, people you know.

R: Yes, I do get the picture. It sounds like, you know, in interactions with others [R: Um hmm] they are permeated with a sense of freeness there [R: Um hmm]. I wanted to also talk about something in the one paragraph where you mentioned what you called your therapist’s confrontations. Um, that was on the second page, ah, the smaller paragraph in the middle [P1: (Locates paragraph in written description)]. I was wondering if you could look at that for a second [P1: (silently reads paragraph) Um, um hmm]. I was wondering about how that experience was helpful for you. I got, I was getting a sense of the way she was, um, bringing across these confrontations, but how was, how was that helpful for you?

P1: It made me think [R: Okay]. She would never like come right out and say something like: he’s just like your ex-husband. She would never do that [R: Um hmm]. She would make me figure it out. So, she would say, if I would say: I feel like I’ve seen him before or I feel I’ve known him before. She would say: listen to your words (laughs) you know [R: Yeah]. And, um, of course, you know if you listen to the words well, you know, you have (laughs) [R: Um hmm] with a different face [R: (laughs)] (laughs). Um, so I guess
it, you know, making me figure it out on my own but know that she knew something I didn’t know yet [R: Um hmm], but I had to figure it out.

R: Um hmm, so I see, you were seeing her as having some idea of what was going on, but she helping you, you know, giving it to you to [P1: figure out] figure out.

P1: She was using restraint [R: Yes] and not, not telling me what she saw but she would make me think about it [R: Um hmm].

R: Um hmm, I was also wondering something concerning your therapist’s interpretation you wrote about, um, the paragraph starting a couple sentences above the sentence: so you traded a controlling mother for a controlling husband [P1: Right]. I was wondering what was going on in your life at that moment, like at that time in your life when that interpretation was made.

P1: Um, I really don’t remember [R: Um hmm]. I just remember it stopped me in my tracks [R: Yeah] because I had never heard anyone describe my mother as controlling [R: Um hmm] you know. Everyone saw my mother as such a nice person. Everybody loved her. And, um, so when my therapist gave, you know, labeled her as controlling and likened her to my ex-husband in that way [R: Um hmm] it really made me think a lot [R: Yeah] you know. And, um, and it, it, it rang so true for me. Ah, in the sense that, you know, before I had, had met him it was, it was almost like I would have sort of needed someone as controlling as him to pull me away from her [R: Um hmm], you know. Um, but my mother was very manipulative, she wasn’t controlling in an abusive way [R: Um hmm]. It was more in a guilt-laden, um, ah, motherly kind of way (laughs). And I don’t, I don’t remember what was happening [R: Yeah] at that time in my life. In general I do [R: Um hmm]. In general, I was getting closer to my family and they were very supportive of my relationship ending because they never liked him [R: Um hmm], um.

R: Yeah, so this was coming out at a time in therapy when it sounded like your relationship with your ex-husband had ended and then you were getting closer to your parents [P1: Right]. And the real magnitude that I’m hearing is that it was not just an interpretation about your ex-husband or just an interpretation about your mother but it seems like that interpretation was made in such a way that it was an interpretation concerning both. You know, the therapist interpreted something that stopped you in your tracks for both [P1: Um hmm] people in your life.

P1: Well, I had, I’d come to recognize that he was controlling [R: Um hmm] and, and that he was abusive [R: Yeah]. But I guess that because my mother did it in such a nice way I hadn’t ever pictured the two of them in the same category in relation to myself [R: Yeah] until she said that.

R: And how did that, how did that play out for you, um, within your understanding of your relationship with your ex-husband and your understanding of your relationship with your mother? What were the reverberations after the interpretation? Was that something that was worked through?
P1: It’s still being worked through [R: Yes] (laughs) [R: (laughs)]. You know, um, my mother issues still come up when I see my mother [R: Um hmm].

R: In one paragraph of your written description, you were writing about your therapist’s interpretation and then in the next paragraph you were writing about your therapist’s intervention with the DSM [P1: Oh right]. You were writing in both of them about realizations. Were the realizations for you in therapy more of like an instant ah-ha experience or, um, were they something that would be worked through in the weeks, months, and years to follow or was it a little bit of both? What was your experience of the realizations like?

P1: Um, well I think the initial realization was just the, the, um, depth of the problems I had been dealing with [R: Um hmm] in him. In recognizing that a licensed psychologist given five years could maybe help him, maybe, if he were willing to go, if he were willing to, you know, admit he had a problem. And realizing that was kind of a turning point for me [R: Um hmm] because it just seemed so huge. Here I was this one person trying to make this relationship work that could never work because it is not workable [R: Um hmm] if someone needs therapy to make it work. Five years of therapy, it’s not workable and I didn’t have five years. I had already given it ten [R: Yeah]. Um, so that was kind of an immediate, um, realization that helped me to let go of that attachment that was there. Even though I left and even though I knew I couldn’t go back the attachment was still there. Um, does that answer your question?

R: Yes, it does answer my question. And with that realization, um, of the gravity [R: Um hmm] of your ex-husband’s problems, do you remember what was going on in therapy at that time? Do you remember what the work of therapy was before that experience with the DSM?

P1: Um hmm, um, I remember I just had a really incredibly hard time letting go [R: Um hmm]. And I would walk by his house and see if his lights were on or see if he were home and do stupid stuff I mean. Um, I guess, I guess my therapist just got tired of it. I guess she just got tired of me not being able to let go. And maybe the more I talked about him maybe she realized: ah-oh, I know who he is (laughs) [R: (laughs)]. And, um, decided to, to instead of withholding, being silent to sort of break that analytic neutrality and just give me some honest help [R: Um hmm]. So I think it, it had a huge impact in letting me let go. Beyond sort of just the stickiness, I’m not sure exactly what was going on. I was going to work. And I was living in my apartment, which was, it was very close to where he lived [R: Okay]. Because I didn’t have a car at the time so I didn’t have a lot of, you know, time to get around the city to find a place, um.

R: And it sounds like that within that moment you believed your therapist could have been withholding but it sounds like, sounds like her actually pointing that out was very helpful for you [P1: It was very helpful]. It was just reminding me of what you were saying earlier about in the moments of therapy where it might have been difficult to say something your therapist in that moment wasn’t silent either but she was the one striking
up conversation [P1: Right, right]. I am beginning to get the impression that that was, you know, quintessential to your therapy with her.

P1: Yeah, there was just a helpfulness like just a: we’re going to do this and, um, if it means I’ll carry the ball for a session I’ll do that, if it means I’ll give you information that you need to make smarter choices that’s what we’ll do. You know, in that sense, I guess, you know, she was, um, invested in being helpful in whatever ways she could. Um, but there were boundaries, you know [R: Yeah], definite boundaries. It wasn’t like I, I would call her up if I were lonely one night, you know. It seemed like she knew when to break a rule and when to not break a rule, you know.

R: Yeah, along those lines, what else should I know about the, your therapist’s care and validation that she offered? What else would help me to understand your experience of her presence better?

P1: I felt like she tried to, um, model for me things that were hard for me to do. Like, um, I tend to be serious she would show a playful side. You know, like she would be talking about herself sometimes and, and maybe make a joke about a mistake she made. Or, you know, kind of modeling it’s okay to make mistakes, you know. You can accept yourself if you screw up [R: Yeah], you know. And, um, there was also sort of, um, a quietness about her [R: Um hmm] that made me a little, feel a little bit afraid of her at times. Like, like we never like explored the transference or who I thought she was or any of that [R: Yeah]. But, um, I think that she tapped into some of my authority figures. You know [R: Um hmm], I think she became an authority figure in some way for me and, and so there was a little bit of, of fear at times, um, probably more so earlier in the therapy [R: Um hmm]. Um, I felt, I felt that, um, when I told her I had decided to stop therapy, um, I felt that I had disappointed her. Because, um, I remember she made a reaction like showing disappointment but then catching herself [R: Um hmm] and getting neutral again, you know. And, um, so, so I felt like maybe I disappointed her when, in that, um, she really did have a personal investment [R: Um hmm] in my getting well. Maybe she felt like a needed more therapy (laughs).

R: It seemed like you made that decision to terminate, um, you wrote it felt like your work was done [P1: Um hmm] and you can handle things on your own now. I was just remembering that [P1: Um hmm] and that went into, that was what prompted that decision to terminate then [P1: Um hmm, Um hmm, right]. I was, I’m getting a real sense of the therapy too and I’ll just put out my impressions [P1: Um hmm]. Um, and even with the, you know, layout of the written description it kind of came to my mind. It sounds like in the beginning there was the, you know, you saw your therapist as, you know, a figure maybe a teacher, um, maybe a parent [P1: Um hmm]. And that, that through the process of therapy it seems like, you know, she was actively a part of the therapy and being very helpful. But it seemed like in a way that developed that gave it back to you and that you started to really be, you know, able to handle things and, you know, understand things on your own. And it sounds like that’s what continued after therapy [P1: Um hmm] and what was really the impact of therapy.
P1: Um hmm, right, she kind of helped me find the lost parts of myself and sure up the missing parts of myself, yeah. And I, I did look up to her [R: Um hmm] throughout the therapy. But I think by the end of therapy, even though I still idealize her in some ways, I think it’s more in a, the effect she had on my life than her as a person [R: Um hmm]. And I know she’s fallible as we all are, you now. But, ah, she was definitely the right therapist for me when I need her, and in that sense, um, that was my blessing [R: Yes, yes] from God.

R: I do see it’s getting, it’s almost 4:00. I wanted to say is there anything that we’ve left out, is there anything coming to mind, anything unsaid.

P1: Um, I don’t think so.
A3.3 Master Psychological Text
with Meaning Units and Central Themes

Written Description: Bold Font
Interview: Regular Font
Demarcation of Meaning Units: ||

| I entered psychotherapy in the summer of 1989 due to difficulties I was having adjusting to the end of a 10-year relationship. The psychologist I chose had been recommended to me by my boss who knew that I was going through a divorce. She was described to me as a Jungian psychologist, but I was mainly concerned that she had experience with "women's issues." My depression at this time was pretty severe. I felt a lot of grief and sadness over the failure of this relationship, even though I was the one who left. I felt estranged from my family and as though my life was a total failure. Looking back, I had been depressed for some time and had even contemplated suicide when I was still in the relationship. Work was about the only thing in my life that kept me sane. It took my mind off my problems and made me feel useful and worthwhile. I had difficulty sleeping at night and would often waken at 3:30 or 4:00 a.m. and be unable to fall back asleep. I did not want to socialize with my family and had lost contact with all of my friends from the past, so I felt very alone. It seemed like I was starting life over again and my life felt very empty. The therapy process went on for about a year and a half. During this time, I saw my therapist weekly. I chose to end the therapy when I began to feel that we had done our work and that I could handle my problems on my own. |
| In light of difficulties adjusting after divorce, P1 entered therapy and she based her choice of therapist on other’s recommendation and reassurance of therapist’s competence with women’s issues |
| After divorce, P1 experienced feelings of failure, grief, and severe depression, although depression started and suicidal ideation occurred during relationship |
| Although she found work meaningful, P1 felt loneliness due to lack of relatedness with significant others and felt emptiness as she began to forge a new life |
| P1 engaged in long-term therapy, and she chose to end the process after sensing that the work was complete and that she was able to deal with issues without her therapist |
It is hard to describe what exactly changed for me through the process of therapy. Everything it seems got better. I began to feel more confident in myself and felt that my experience had been validated by someone else in a way that it never had been by anyone else in my life. I came to know myself better and grieve and accept some of the disappointments in my life. Therapy also taught me to become a better friend/parent to myself.

R: I am wondering too you wrote before therapy you felt some degree of grief over the end of the relationship with your ex-husband and then you also wrote that a good deal of therapy was doing grief work and accepting some disappointments in your life. I was wondering if you could tell me more about the grief work or the accepting of disappointments.

P1: The limitations of my own parenting set me up for this. I was coming to accept my parents for who they were. I am still working on that here and there. I guess that was a big part of it. The loss of time that was spent in that relationship because I got stuck there and couldn’t get out. The loss of the dreams that I had had for it that didn’t materialize, the things I wanted that relationship to be that it wasn’t and never would be.

R: That helps me understand. So, it sounds like there was some acceptance of how you were parented and how that influenced the relationship. So, I guess an acceptance of the past, but also then grieving over the loss of what you wanted the relationship with your ex-husband to be. Was that something that occurred throughout the entire course of therapy or was that something that occurred during a

The process of therapy provided unique validation and the opportunity to grieve, and through this, P1’s whole life improved as she developed more self-confidence and self-knowledge and learned to nurture herself and to accept the past.

Through therapy, P1 started to accept parents’ limitations

Through therapy, P1 grieved the loss of both the past and future relationship with her ex-husband
period when most of the grief work was done?

P1: I think a lot of that was done private. I don’t think that I talked a lot about my parents in therapy. Although I must have for the one example that I gave about something my therapist, an interpretation she made that my mother was controlling and so was my ex-husband and I had never seen that connection before. So, I must have been talking about my mother in there, but I don’t remember. It doesn’t stand out for me as something I talked a lot about. I also don’t think I talked much at all about my father. Although I remember her describing him as the absent father. So, I must have talked about him too.

R: You were saying that a lot of the work was being done outside the therapy too. What was that like?

P1: I would go visit my parents and all the same emotions would come up when the family dynamics are the way they always have been, you know?||

R: Was there anything off the top of your head you were thinking of?

P1: I remember going home to visit, and this may have been even after therapy was over. I remember my father saying something very, very mean and it just struck me. You know, when you’re away from your parents for a while. They were living in Atlanta, I’m living in Pennsylvania. Our main contact is by phone and everything is real pleasant and nice. But when you’re back home visiting you’re right back in the soup so to speak. So, my father said something very, very mean and it just hit me right there. Then I just remember going into the bedroom and

Grief work occurred through emotional encounters with parents and was processed privately yet specific work in therapy also centered on family dynamics.

After therapy, P1 had upsetting encounter with father and was able to identify and accept the reality of unchanged relational dynamics in light of therapeutic work.
being in tears. And then I realized, this is the way he’s always been, it’s always been painful. You may try to put it out of your mind, but it is mean, it’s just mean. Maybe it’s untreated depression, but I’m his daughter not his therapist.

R: That interaction was something that happened after therapy. How did therapy prepare you for it? How was it situated in light of the experiences you had in therapy?

P1: I think I worked through it on my own. It was different. Like I said, the therapy did not focus so much on the parents more just focusing on myself. I don’t know if I’m answering your question.

R: Yes, I think you are. When I was hearing you say that you were able to accept just the way your father is and that your father said something mean, I was remembering earlier that you said some of the work of therapy was being able to accept things. I was wondering if the ability to accept was something that developed in therapy, which made that moment with your father possible for you.

P1: Yeah, I think that probably the therapy did lay the groundwork for that. Just in the sense of being able to name things for what they are and label them. And in sort of a nonjudgmental way talk about the way it is.

R: What was coming to my mind as you were speaking was the taking in of the therapist and being able to engage in a nonjudgmental way. What your therapist was doing during the process of therapy is what you were doing outside of therapy. More importantly, I feel that this through depth-oriented therapeutic work,
process allowed me to differentiate or develop parts of myself that were missing before and to recover parts of myself that had become lost during the period of this relationship.

R: I have another question. I was wondering about the parts of yourself that were discovered or developed in therapy. You wrote about it and I was wondering if you could tell me a bit about that in more detail.

P1: Okay, I think it was partly rediscovering parts of myself. Kind of like reconnecting with my feelings, my intuition, those kind of parts of myself. Then I think it was developing other parts of myself in the sense of the work we did on the archetypes. A lot of the work in therapy, following the sort of Jungian approach is the move toward individuation and pulling into consciousness latent or unconscious potentialities. So, the person that I was before therapy was young, naive, undefended in the world, which is what allowed me to get sucked up into a relationship that was very bad for me. Working on becoming better defended, more Athena like, more mental less feeling and less naive, would be some of the ways I changed. And not just more assertive in a consciousness kind of way, but just better defended in terms of being able to say no to things, being able to take a stand, being able to be more empowered I guess.

R: So that would be the development, you know, empowering yourself based on a lot of depth work and also the rediscovering of your own intuition of your feelings.

I also came to understand my experience in a broader context that

P1’s selfhood expanded as she developed and reconnected with facets of herself of which she was unconscious

Before therapy, P1’s lack of power influenced her ensnarement in the relationship with her ex-husband

Through therapy, P1 became more empowered as she developed more defensive and assertive facets of herself

Depth psychological orientation and focus on archetypes helped P1 to appreciate the
made it easier to heal.

What was helpful for me in therapy, I think was my therapist's approach which was Jungian and archetypal. I learned about the archetypes and how they were taken up by modern-day Jungian analysts. Learning about the archetypes allowed me to understand and appreciate different facets of myself and others in new ways that were helpful for me. They offered a way of clarifying my experience through an abbreviated language that was previously unavailable and added depth and breadth to my understanding.

R: You mentioned Athena. I was wondering, you wrote that some archetypes helped you to understand yourself and others and was that one of them? Could you tell me about that?

P1: Yes, Athena goddess of wisdom. She was aligned with the male world, you know? But she was very defended. She always had a breast plate over her heart, so that she couldn’t be wounded. A lot of the work I think involved cultivating those kind of traits in myself through more of a conscious effort.

R: Yeah, what were some of those traits that were developed then, some of the traits that were cultivated?

P1: I think that the interest in learning and studying was cultivated. I certainly needed that to go back to school. I needed to be able to join with men on a mental level, rather than having it be power based kind of relationship. Having it be more of a brother-sister kind of thing or an equal because that’s who Athena was. She was kind of on their level, and even involved

Therapeutic work concerning a particular archetype helped P1 consciously develop facets of herself by encouraging pedagogical projects and egalitarian relations with males.
in, strategizing battles. She was part of the male world.

R: Okay, is there any examples off the top of your head concerning how you were able to be better defended, better assertive, more empowered?

P1: I learned to say no. I had been raised to be nice and to be agreeable. Those qualities are great but you also have to be able to protect yourself and you have to be able to walk away from evil. You have to be able to keep yourself protected and away from it. You know there were books that were assigned reading in therapy that were skills really just basic skills you need to learn how to say no. I guess that would be one way that I felt better defended. You know that you can hang up on somebody you don’t want to talk to. It’s your phone. You pay the bill for the phone. Those kind of things helped.

The work that we did on the shadow allowed me to better understand underdeveloped or disowned parts of myself and how that had led to my current predicament. Becoming more aware of my unconscious through dreams was also important and helpful. Sometimes the dreams were very stark and scary, but at least I had a guide. When my dream images brought hope, it was exciting to learn what the symbols represented and I felt that my therapist cared and shared in my excitement.

R: I was wondering could you give an example of any dream that was significant for you in the process of therapy. Is there any one, one that comes to mind or anything that comes to mind of that sort?

Through therapeutic work concerning a particular archetype and skills training acquired by reading books, P1 developed the ability to say ‘no’ in relationships thereby asserting and defending herself.

Therapeutic work with the shadow helped P1 understand the past and present significance of having facets of herself of which she was unconscious.

Therapeutic work with dreams of different emotional qualities helped P1 by developing her awareness of their unconscious meanings.

P1 felt her therapist cared for her on a professional level and sensed her therapist participated emotionally with her when P1 developed her understanding of dreams.
P1: There was a very scary dream, and I think it came from early in the course of therapy. It was scary, there was a lot of water and a lot of woman. The women, if I’m remembering it correctly, had their femininity and all signs and traces of it erased almost like a concentration camp kind of quality to the dream: shaved heads, naked bodies. It was just a nightmarish kind of an atmosphere. I think that, the meaning of that dream and the way it was interpreted was being cut off from the feminine side of myself. Because having been in this relationship with a man that really essentially hated woman and having been influenced by that and kind of divorced from my own femininity in so many ways that I think that was part of the meaning of what that was about. It was a very stark and scary kind of a dream.

R: How was that picked up in your therapy? How did that dream have a significance for you in there?

P1: I learned to reconnect with my femininity and embrace it more. I was able to see more clearly how I had been. I don’t want to say brainwashed but affected by being with someone who was so negative toward woman. I was coming to accept myself as a woman and be happy about that and take the good from that and celebrate it.

R: Yes, it seems like a real personal acceptance of your own femininity. Were there expressions of that too? Were there instances you can recall that were manifestations of that internal change?

P1: I became more interested in clothes and make up. I remember having my colors done, you know, where you have a beauty expert tell you what colors look

<table>
<thead>
<tr>
<th>Early in the course of therapy, P1 experienced a dream that had an overall scary quality and consisted of women with no appearance of femininity</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1 found the dream to mean she was detached from her femininity</td>
</tr>
<tr>
<td>P1’s prior relationship with her husband who hated the feminine contributed to her detachment from her own femininity</td>
</tr>
<tr>
<td>Through therapeutic work with the dream, P1 learned to reconnect with her femininity and rejoice in it, as well as to apprehend the prior detrimental influence of her husband</td>
</tr>
<tr>
<td>After interpreting the dream, P1 became more interested in adorning herself in a way she considered feminine</td>
</tr>
</tbody>
</table>
good on you. I mean I got more involved that way. I’d always liked to cook, so I don’t think that was part of it. Those are the main ways. I guess too being more open and friendly with other people, more interested in other people. You know because I view that as a feminine trait to sort of want to draw people out and find out about people. I think I became more confident doing that.

R: Is there anything that stands out for you with reference to the openness towards others you mentioned? Is there any experience after therapy or, you know, currently where you really see that development, that openness towards others being displayed? Is there anything that comes to mind?

P1: I think I just speak more freely with people. I don’t hold back as much. I can’t think of any specific people or examples.

R: Yes, I do get the picture. It sounds like, in interactions with others, they are permeated with a sense of freeness there.

I felt that my therapist cared about me as a person. (She actually traveled to Greece during the course of my therapy and brought me a gift—a small sculpture of Athena, which really touched me and is a memento of my therapy that I have to this day.)

As for specific incidents that were helpful, I remember an important interpretation that she made one day that stopped me in my tracks and made me re-vision my history in a new way. She said something like, "so you traded a controlling mother for a controlling husband." This made me look at my

After interpreting the dream, P1 became more open with others, engaging them in a way she considered feminine.

P1 felt her therapist cared for her on a personal level and was moved when her therapist bestowed a gift related to their work with a particular archetype.

Therapist made interpretation that placed P1’s mother and ex-husband in same category (controlling) and highlighted P1’s choice to marry ex-husband in relation to his similarities with mother.

Therapist’s interpretation jolted P1,
mother in a whole new light and understand how my history had more or less prepared me for the fate of making such a poor marriage choice. I had been unable to see any comparison between my mother and my ex-husband on my own, but afterwards it made sense to me, and I felt that my therapist knew me better than I knew myself.

R: I was also wondering something concerning your therapist’s interpretation which you wrote about. The paragraph starting a couple sentences above the sentence: so you traded a controlling mother for a controlling husband. I was wondering what was going on in your life at that moment, like at that time in your life when that interpretation was made.

P1: I really don’t remember. I just remember it stopped me in my tracks because I had never heard anyone describe my mother as controlling. Everyone saw my mother as such a nice person. Everybody loved her. So when my therapist labeled her as controlling and likened her to my ex-husband in that way it really made me think a lot. It rang so true for me. In the sense that before I had met him it was almost like I would have needed someone as controlling as him to pull me away from her. But my mother was very manipulative, she wasn’t controlling in an abusive way. It was more in a guilt-laden, motherly kind of way. I don’t remember what was happening at that time in my life. In general I do. In general, I was getting closer to my family and they were very supportive of my relationship ending because they never liked him.

R: Yeah, so this was coming out at a time in therapy when it sounded like your relationship with your ex-husband had encouraged reflection, and helped her to develop in-sight. She came to see mother as controlling, thus similar to ex-husband, and to re-vision the way history with mother shaped choice of ex-husband.
ended and then you were getting closer to your parents. The real magnitude that I’m hearing is that it was not just an interpretation about your ex-husband or just an interpretation about your mother but it seems like that interpretation was made in such a way that it was an interpretation concerning both. The therapist interpreted something that stopped you in your tracks for both people in your life.

P1: I’d come to recognize that he was controlling and, and that he was abusive. But I guess that because my mother did it in such a nice way I hadn’t ever pictured the two of them in the same category in relation to myself until she said that.

R: How did that play out for you within your understanding of your relationship with your ex-husband and your understanding of your relationship with your mother? What were the reverberations after the interpretation? Was that something that was worked through?

P1: It’s still being worked through. My mother issues still come up when I see my mother.

Another turning point for me occurred when my therapist provided what I would call some pure and simple "psychoeducational training." I had been having a very hard time breaking the attachment to my ex-husband, even though I knew that I could not return and that he was very bad for me. My therapist knew that I was stuck and during one session, pulled out a copy of the DSM-III. She opened to the section on Narcissistic Personality Disorder and read off the criteria asking me which ones fit my knowledge of my ex-

After therapy, P1 continued to work through therapist’s interpretation when issues with mother arose

Therapist provided psycho-educational intervention utilizing a manual for diagnosis of ex-husband. P1 endorsed all criteria of particular personality disorder. After P1 expressed curiosity about cure, therapist taught her about the necessity his acknowledgement of problems and engagement in long-term therapy.
husband. When we noticed he had nearly all of the criteria, my question to her was, "is that something that could be treated in therapy?" She answered that it would require him acknowledging the problem and spending about five years in intensive (once or twice-weekly) psychotherapy. Suddenly I realized the gravity of the problems I had been dealing with and the impossibility of fixing things: first, he would never acknowledge having a problem, and second, I didn't have five years to wait! This one intervention made a huge difference in my being able to "fall out of love" with this person and move on.

R: In one paragraph of your written description, you were writing about your therapist’s interpretation and then in the next paragraph you were writing about your therapist’s intervention with the DSM. You were writing in both of them about realizations. Were the realizations for you in therapy more of like an instant ah-ha experience or were they something that would be worked through in the weeks, months, and years to follow or was it a little bit of both? What was your experience of the realizations like?

P1: I think the initial realization was just the depth of the problems I had been dealing with in him. In recognizing that a licensed psychologist given five years could maybe help him, maybe, if he were willing to go, if he were willing to admit he had a problem. Realizing that was kind of a turning point for me because it seemed so huge. Here I was this one person trying to make this relationship work that could never work because it is not workable if someone needs therapy to make it work. Five years of therapy, is not workable and I didn’t have five years.

After intervention, P1 realized the magnitude of ex-husband’s problems within their relationship and the impossibility of any solution, which enabled her to let go of emotional attachment and move on.
I had already given it ten. So that was kind of an immediate realization that helped me to let go of that attachment that was there. Even though I left and even though I knew I couldn’t go back the attachment was still there. Does that answer your question?

R: Yes, it does answer my question. With the realization of the gravity of your ex-husband’s problems, do you remember what was going on in therapy at that time? Do you remember what the work of therapy was before that experience with the DSM?

P1: I remember I just had a really incredibly hard time letting go. I would walk by his house and see if his lights were on or see if he were home and do stupid stuff I. I guess my therapist just got tired of it. I guess she just got tired of me not being able to let go. Maybe the more I talked about him maybe she realized: ah-oh, I know who he is and decided to instead of be withholding or being silent to sort of break that analytic neutrality and just give me some honest help. So I think it had a huge impact in letting me let go. Beyond sort of just the stuckness, I’m not sure exactly what was going on. I was going to work. I was living in my apartment, which was very close to where he lived. I didn’t have a car at the time so I didn’t have a lot of time to get around the city to find a place.

R: It sounds like that within that moment you believed your therapist could have been withholding but it sounds like her actually pointing that out was very helpful for you. It was just reminding me of what you were saying earlier about in the moments of therapy where it might have been difficult to say something your therapist in that moment wasn’t silent.

Before intervention, P1 experienced difficulty letting go of emotional attachment to ex-husband and felt stuck. P1 saw therapist’s intervention as expression of her knowing about situation offered to help P1 and as deviation from typical analytic stance.
either but she was the one striking up conversation. I am beginning to get the impression that that was quintessential to your therapy with her.

P1: Yeah, there was just a helpfulness like just a: we’re going to do this and if it means I’ll carry the ball for a session I’ll do that, if it means I’ll give you information that you need to make smarter choices that’s what we’ll do. In that sense, I guess, she was invested in being helpful in whatever ways she could. There were boundaries too, definite boundaries. It wasn’t like I would call her up if I were lonely one night. It seemed like she knew when to break a rule and when to not break a rule.

When I made poor choices in dating, my therapist would confront me, but in a way that showed restraint and made me figure things out on my own. For example, she would say things like "listen to your words" or "where have you seen this before?" These confrontations always were given in an accepting and loving way, without judgment, matter-of-factly.

R: I wanted to also talk about something in the one paragraph where you mentioned what you called your therapist’s confrontations. That was on the second page, the smaller paragraph in the middle [P1: (Locates paragraph in written description)]. I was wondering if you could look at that for a second [P1: (silently reads paragraph). I was wondering about how that experience was helpful for you. I was getting a sense of the way she was bringing across these confrontations, but how was that helpful for you?

P1: It made me think. She would never...
come right out and say something like: he’s just like your ex-husband. She would never do that. She would make me figure it out. So, she would say, if I would say: I feel like I’ve seen him before or I feel I’ve known him before. She would say: listen to your words. Of course, if you listen to the words, you have known him, but with a different face. What helped is that she knew something I didn’t know yet, but I had to figure it out on my own.

R: I see, you were seeing her as having some idea of what was going on, but she was helping you by giving it to you to figure out.

P1: She was using restraint and not telling me what she saw, but she would make me think about it.

and recognizing that change is slow and occurs in its own time and space.

R: Also, when you were imagining what you would have been like as a therapist if you did not go to your own therapy, and you were saying that you probably would just instruct clients to: go and do this. However, what I was hearing reflected in your description of your own therapy a lot of the time was that your personal therapy was allowed to open up in its own time and that your therapist understood that therapy proceeds in its own time. What was your experience of the way your therapist proceeded and the way your therapy opened up in its own time?

P1: I remember going to therapy sessions wondering what am I going to talk about today and should I even go. But I would go. I hardly ever missed. My therapist seemed to have a patience. I don’t know if I should confuse this with grad school jargon but one of our professors would vis her own potential to know, and reflected on her experience to make a connection between boyfriend and ex-husband
refer to it as: lying fallow when not a lot happens in therapy on the surface but things are going on underneath the surface. I just remember feeling a little self-conscious like maybe not having a lot to say. I remember her sort of picking up the ball and chit-chatting about this or that. That was okay if I really didn’t have a lot to say. I could sit back and take a breather and she would sort of carry the session for a while. It wasn’t your typical analytic stance where the therapist doesn’t say anything. It was more of a, there was more of a back and forth. I think that that worked for me and I found it, I was grateful for it on the days that I didn’t have a lot to say. But I do feel that it was all part of the work. I was changing but I think it wasn’t in leaps and bounds, but it was in its own course and time.

R: Yes, what’s just coming to mind too is it almost seems like a sense of holding in the therapy, where she was seeing the change but able to hold onto that and let it develop in its own time.||

In addition to these specific incidents that stand out, I think that the general atmosphere and quality of the relationship had a lot to do with my getting better.

R: Yeah, along those lines, what else should I know about your therapist’s care and validation that she offered? What else would help me to understand your experience of her presence better?

P1: I felt like she tried to model for me things that were hard for me to do. For example, I tend to be serious and she would show a playful side. She would be talking about herself sometimes and make a joke about a mistake she made. Or modeling that it’s okay to make mistakes.

The therapist served as a model for particular behaviors and qualities contrary to P1’s typical style of engagement and was thereby modeling areas of growth.
Showing me that you can accept yourself if you screw up. There was a quietness about her that made me feel a little bit afraid of her at times. We never like explored the transference or who I thought she was or any of that, but I think that she tapped into some of my authority figures. I think she became an authority figure in some way for me and so there was a little bit of fear at times, probably more so earlier in the therapy. I felt that when I told her I had decided to stop therapy, I felt that I had disappointed her. I remember she made a reaction like showing disappointment but then catching herself and getting neutral again. So I felt like maybe I disappointed her when she really did have a personal investment in my getting well. Maybe she felt like I needed more therapy.

R: It seemed like you made that decision to terminate and you wrote it felt like your work was done and that you can handle things on your own now. I was just remembering that, and that was what prompted that decision to terminate then.

**She was interested in warmth both personally and in the environment and had an electric hearth beside the two wing-back chairs where she and I sat. She had little figurines in the office representing some of the archetypes and would sometimes point out one or two during our sessions. Sometimes she would offer candy or tea. It was a warm place to come.**

R: I was also wondering about the atmosphere in therapy. You wrote that it was very warm, both personally and environmentally. How was that helpful?

P1: The fact that it was warm, I mean, P1 initially felt vulnerable, and so the
because I felt so vulnerable I think having the atmosphere in therapy be warm made it welcoming, and soft, and gentle, made it safe. It made it a safe place to come and open up and talk about things.

R: So, the warmth environmentally would be providing a sense of safety personally, which then helped you to open up.

P1: Like a baby would feel wrapped in a blanket when you’re giving them a bottle. I mean, I never sat on her lap or anything. There was a hearth right beside her and she had two wing-back chairs. It was an artificial hearth but it did let out heat. It seemed like a conscious detail that she put there for a reason.

R: From your description, I can feel the warmth there. It seems like a very warm and inviting place.

I had the utmost confidence in her. Especially at the beginning of therapy, I know that I idealized her. I saw her as a grandmother or mother, but also as someone who was very successful at her work (she had an office in a large downtown office building). I felt she was someone who knew and understood my problems and could help me. She always had piles of books on her desk and was always recommending books for me to read. Reading was a big part of the therapy and allowed me to keep my therapy going throughout the week. I think that the confidence that I had in her as "the one who knows" was a very important element to my therapy. When I went to sessions, I felt as if I was going to see my teacher who knew me and where I was at and could help.

R: At the beginning of therapy also you wrote that you were seeing your therapist

maternal-like warmth and comfort her therapist intentionally offered provided P1 with a sense of safety that enabled her to open up in therapy

P1 believed in the therapist in her role as the one who knows, and perceived the therapist to be her teacher who intuitively knew her problems and their solution. P1 assumed the student role and engaged with recommended readings
as a grandmother or mother and as a teacher or the one who knows, and even after therapy, you wrote that you held onto that image of your therapist as an angel. I was wondering how was that related to the process of therapy for you?

P1: I felt like a student almost. When I would be going to my therapy sessions, I almost felt like I was student going to study or learn about myself. This was way before grad school, way before I had considered becoming a psychologist. I was very naïve about therapy at the time, but I felt like she knew what was wrong with me. I just felt that she instinctively knew what I needed and what was wrong with me and how I would get better.

R: So you saw her as the teacher, the one who knew about what was going on with you. ||

P1: There was a parental side to her. I use the word grandmotherly because I guess she was maybe in her sixties, early sixties. But there was a parental aspect to the therapy in that I feel like I got things from her that I didn’t get from my own parents. It wasn’t just from my mother. It was things I didn’t get from my father too. For example, in therapy I remember mentioning I was going to be buying a car, and I was kind of nervous. It was the first car I was buying. She became very matter of fact: and well you’re going to want to get the rust proofing on the bottom, you’re going to want to make sure you do that. The little comments like that felt like, a parent guiding you in the right direction, like something your father would say.

R: So it wasn’t so much grandmother or mother or father, but it was like a parental amalgamation of those. So she was a

P1 idealized the therapist in her role as the parent, and perceived the therapist to be a mother, grandmother, and even father providing guidance. P1 felt she received care not acquired from her own parents.
teacher and a mother and a father and a grandmother. How did that develop over the course of therapy too? Is that something that stayed the same for you or is that something that developed? How did that proceed throughout the course of therapy?

P1: I think I actually learned to do those things for myself, like I took in those qualities she gave me and showed me. That kind of care that she showed me I think it sort of rubbed off on me.

R: Yeah, yeah, that makes a lot of sense, so taking that in.

P1: Right, because then I would think, what would Dr. W say about this? I could almost imagine what she would say about an issue.

R: Yeah, it’s almost like therapy outside of therapy.

The therapy changed me in significant ways and to such a degree that I do not feel I would be the person (or therapist) that I am today without having had this experience. I feel more open to other people and more accepting of myself.

R: The first thing I want to start with is that I remember when I was reading the beginning of your description your were writing about how before therapy you were feeling an estrangement from your family and a loss of contact with your friends and then you wrote that after therapy you felt that you were more open to other people and you felt more nurturing toward other people. I want to know if you have any examples of that change in relatedness or that change you experienced with other people.

P1 took in qualities and care consistent with therapist’s role, and through the process of imagining therapist’s perspective on issues, she learned to perform the function of therapist for herself.

P1’s experiences in therapy created significant change in selfhood.

As a result of therapy, P1 experienced increased openness with others.

As a result of therapy, P1 experienced increased acceptance of self.
P1: Yes, I can think of some right off the bat and I think that change had two parts to it. First, was being in a depression where you tend to pull back anyways [R: Um hmm]. And then the other part of it was I had been in a relationship for 10 years that was a very controlling, abusive kind of relationship where there was a lot of pressure on me to break contact with people that he perceived to be a threat to the relationship or a support system for me aside from him. So, when I got out of the relationship and started in therapy I was still feeling very depressed and wanting to isolate from other people. My cousin and his wife had just had a son and I remember having such mixed emotions about going to visit her in the hospital. I just felt so bad about where I was at and had been out of touch with them for a long time and yet I wanted to reconnect with family. And then, several years later after therapy, I ended up being godmother to their third child, a little boy. So, through that whole period of time, there were lots of trips to the zoo with the boys and overnight sleepovers. I just got really close to their family to the point that they wanted me to be godmother, which was fun. So, that’s one thing that stands out.

R: So it sounds like that change with the relationship with their children really encapsulates the change you experienced.

P1: Just an openness and wanting to be a part of other peoples’ lives and watch them grow up.

I feel positive about the future. Although I regret certain choices made in my past, I feel that they were necessary to fulfill God's purpose for my life. In a sense, I feel that it was all part of a larger plan.

Before therapy, P1 isolated herself from others due to quality of depression

Before therapy, P1 severed relations with others due to husband’s control

During therapy, P1 experienced ambivalence toward particular family relations as she had previously isolated from them yet wanted to reinitiate contact

After therapy, P1 developed close relationships with particular family relations and assumed an important role that enabled her to share in their lives

As a result of therapy, P1 felt hopeful about the future

P1 still regretted her past choice of spouse, as it precipitated much suffering. However, P1 discovered the meaning of
R: I was wondering about two sentences in your written description that I would like you to elaborate on. On the last page you said, “that although I regret certain choices made in my past I feel they were a necessary part to fulfill God’s purpose in my life. In a sense, I feel it was all part of a larger plan.” I was wondering if you would elaborate on this, the situating things within a larger context.

P1: What I think I was thinking of when I said I regret certain choices is the person that I ended up marrying in my first marriage. I do regret that choice because there was a lot of time lost in that relationship trying to make it work. I feel like those were a lot of good years in my life when I was young and, they were essentially wasted because it was a relationship that never could have worked. The reason I feel it was necessary to fulfill God’s purpose for my life is I don’t think I would have understood, unless I would have gone through what I went through. I think if I would have gone to graduate school and become a therapist before this happened to me, I would have had the attitude: well, you just need to do this, you just need to do what I’m going to tell you and you’ll be fine. That’s not the way to do therapy. I know that I would have had that shallow of an idea about it. So I think I had to go through my own hell to be able to help, to be there with other people and help them to come out of it and find a way out of it. So I do feel it was part of God’s plan for my life because I do feel like this profession is what I was meant to do.

R: Yeah, so this profession is what you were meant to do and your experiences in your own therapy helped you, enabled you to do it better.
R: You mentioned too that you weren’t in the field at that time. Was there a relationship between you going through this course of therapy and you getting into the field?

P1: There was but there was a little bit of a gap between. I remember talking in therapy about how I’d like to go back to school and be a therapist. I remember she didn’t encourage me or discourage me either way. Again, it was kind of a matter of fact like: wow, you must be wanting to study quiet a bit or commit a lot of years to study. She mentioned the Pennsylvania Licensing Board: and if you really want to know what’s involved, you know, you can check it out with the Pennsylvania Licensing Board and find out what all the requirements are. She was just very factual about it, and I think that the transformation that I felt I went through had a lot to do with making the decision to make that commitment. Although I had a lot of doubts over whether I’d be accepted into graduate school because I didn’t have a lot of confidence and questioned this, but it was a goal.

The therapy allowed me to recover lost pieces of myself and to become more rooted in my God-given feminine identity and wisdom. It has allowed me to become more nurturing toward myself and others. At the same time, I feel I have learned to be better defended against evil. Although I still, at times, experience depression, it has a different quality to it now. I am able to recognize it sooner and communicate.

P1’s personal development through the process of therapy contributed to her making the decision and commitment to become a therapist.

As a result of therapy, P1 developed the ability to better defend herself. She also reconnected with her femininity thereby becoming more nurturing toward herself and others.

After therapy, P1 experienced a different quality to depression, more akin to sadness. She identified depression earlier and understood its relation to her feelings.
**better with others.**

R: Another question I have concerns you writing about the different quality depression has now. I am wondering if you could tell me more about the different quality and what the difference is.

P1: There’s not that feeling of emptiness. Now when I get depressed, it’s more of a sadness, and I usually can figure out what’s bringing it about by looking at my feelings and what’s going on in my world. I think before it had a quality of shame, emptiness, and lostness. There’s a feeling of lost, just not knowing who you are or not really having a context for understanding myself or other people.

R: That’s something I hear coming up today is that before therapy there was a sense of lostness but through your work you were developing a knowledge of yourself, like an understanding that you took with you and you have with you now.

**And regardless of the depressions I experience, my life is full.**

R: In your written description you also mention feeling very empty before therapy but after therapy you wrote you felt full. I was wondering about that experience. Were there any instances of experiencing that change in a bodily way that sense of fullness versus emptiness?

P1: I think the fullness has to do with my life became fuller. I do remember a real high that I got running a 10K run in the fall that they do in Pittsburgh, or it was one of the races, the Great Race maybe that they do in Pittsburgh. I remember just feeling so high running that race, reconnecting like: this is my town and this

Before therapy, P1 experienced emptiness when depressed. She felt lost since she lacked an understanding of depression and knowledge of herself, and felt shame in relation to others.

After therapy, P1’s life was fuller.

As for fullness experienced in a bodily way, P1 participated in a race, and while running, felt a sense of exuberance and a reconnection with the city in which she lived.
is a neat town and all these different little neighborhoods are familiar to me. But I don’t know how to describe the fullness so much except to say that there’s more people in my life, more activities in my life. My therapist was a part of helping bring that about because she would make suggestions to me about hiking or joining a group or different ways to meet people or make friends, and very encouraging in that way. It’s like she knew I was kind of starting over, and thinking of ways that would be helpful.

R: That sounds helpful. 

I feel that this experience also has allowed me to be a better therapist to others. Although I do not practice from a Jungian or archetypal perspective, I do understand how people can become stuck and how the process of change takes time and is a process often of re-parenting, having a sensitive and caring witness to clarify, articulate, provide a path. Someone who knows the terrain toward selfhood and can guide that process.

R: Okay, your articulation of therapy as (reads segment of participant’s description): understanding that someone becomes stuck and how the process of change takes time and that it’s often also a process of re-parenting. That formulation of therapy, was it formulated somewhat based on your own experiences in your own therapy?

P1: Yes, yes

R: Because that was catching my eyes too was the re-parenting, which you also mentioned early today describing your own therapy.

P1’s sense of fullness concerned an increase in engagements with others and projects. In therapy, her therapist helped co-create this increase by making concrete suggestions about ways to initiate engagements.

P1’s personal experiences in her own therapy made her a better therapist and informed her formulation of therapy. For P1, therapy is a process of re-parenting. A client is stuck, and an empathic and knowledgeable therapist guides him or her along the path to selfhood.
I felt at the time (and still do) that my therapist was an angel put in my life at just the right time, to help me to get my life back on track. I know that she would reject the idealization of being called an angel. Nevertheless, for me, the image stands. I feel an enormous sense of gratitude for the way that this therapy changed my life.

R: I was, I’m getting a real sense of the therapy too and I’ll just put out my impressions. Even with the layout of the written description it kind of came to my mind. It sounds like in the beginning that you saw your therapist as a figure maybe a teacher, maybe a parent. And that through the process of therapy it seems like she was actively a part of the therapy and being very helpful. But it seemed like in a way that developed that gave it back to you and that you started to really be able to handle things and understand things on your own. It sounds like that’s what continued after therapy and what was really the impact of therapy.

P1: Right, she kind of helped me find the lost parts of myself and sure up the missing parts of myself. I did look up to her throughout the therapy. But I think by the end of therapy, even though I still idealize her in some ways, I think it’s more in a, the effect she had on my life than her as a person. I know she’s fallible as we all are, you know? But, she was definitely the right therapist for me when I needed her, and in that sense, that was my blessing from God.
A3.4 Integration Central Themes

1. P1 experienced grief and severe depression after her divorce, although the depression and suicidal ideation occurred during the relationship.

2. Even though she still found work meaningful, P1 felt loneliness due to lack of relations with significant others and emptiness as she began to forge a new life.

3. P1 entered therapy in light of her difficulties and based her choice of therapist on another’s recommendation and reassurance of the therapist’s competence with women’s issues.

4. Throughout the process of depth-oriented therapy, P1’s awareness enlarged as she learned to appreciate the nuances of her own experience and to apprehend the various facets of self and others, and her selfhood expanded as she developed and reconnected with facets of herself of which she was unaware.

5. Therapeutic work concerning personality styles helped P1 to become aware of the way her lack of a sense of power influenced her ensnarement in the relationship with her ex-husband and to become empowered by developing more defensive and assertive facets of herself.

6. In the course of therapeutic work concerning a particular style, P1 consciously developed these facets of herself by engaging in academic projects and egalitarian relations with males and acquired additional skills by reading books that helped her develop the ability to say ‘no’ in relationships.

7. Therapeutic work with dreams of different emotional qualities helped P1 by developing her awareness of their unconscious meanings. P1 experienced a particular scary dream consisting of women with no appearance of femininity and she found the dream to mean that she was detached from her femininity.

8. P1 also apprehended the detrimental influence her ex-husband had on her detachment and learned to reconnect with feminine facets of herself and appreciate them. Stemming from her interpretation of the dream, P1 became more interested in adorning herself and nurturing others in ways she considered feminine.

9. After emotional encounters with her parents during the course of therapy, grief usually ensued and P1 processed it privately, but specific work in therapy also centered on family dynamics.

10. In the course of therapy, P1 grieved over her parents’ past shortcomings and started to accept their present limitations.
11. P1 had an upsetting encounter with her father after therapy and was able to identify and accept the reality of unchanged relational dynamics in light of her therapeutic work.

12. P1 also grieved the loss of both the past and a future relationship with her ex-husband.

13. Her therapist provided a specific psycho-educational intervention utilizing a manual for the diagnosis of her ex-husband and P1 endorsed all criteria of a particular personality disorder. After P1 expressed curiosity about a cure, her therapist taught her about the necessity of him acknowledging his problems and engaging in long-term therapy.

14. As P1 knew he would not do this, she realized the magnitude of her ex-husband’s problems and the impossibility of any solution, which enabled her to let go of the emotional attachment and move on.

15. Her therapist made an interpretation that placed P1’s mother and ex-husband in the same category (controlling) and highlighted P1’s choice to marry her ex-husband in relation to his similarities with her mother.

16. Her therapist’s interpretation encouraged reflection and helped P1 to develop insight. She came to see her mother as controlling, thus similar to her ex-husband, and to re-vision the way history with mother shaped her choice of ex-husband.

17. Her therapist also confronted P1 in a nonjudgmental way when she chose unhealthy dating relationships. She encouraged P1 to look at her experience, draw connections between current and past males, and formulate her own understanding.

18. P1 reflected on her experience to make a connection between her boyfriend and ex-husband.

19. P1 felt vulnerable in therapy, and so the maternal-like warmth and comfort her therapist intentionally offered both interpersonally and environmentally provided P1 with a sense of safety that enabled her to open up.

20. Throughout the process of therapy, P1 sensed a general helpfulness from her therapist in which her therapist sometimes deviated from a typical analytic stance but still set definitive boundaries.

21. P1 felt her therapist cared for her on a professional level when her therapist participated emotionally in the therapeutic work and on a personal level when her therapist bestowed a gift related to their work.
22. P1 idealized the therapist in her role as the parent. She perceived the therapist to be a mother, grandmother, and even father and received validation and guidance not acquired from her own parents.

23. P1 believed in the therapist in her role as the one who knows vis-à-vis her own potential to know. She perceived the therapist to be her teacher who intuitively knew her problems and their solution and so P1 assumed the student role.

24. The therapist also served to model behaviors, such as self-acceptance, contrary to P1’s typical style of engagement.

25. P1 took in qualities and care consistent with the therapist’s role, and through the process of imagining the therapist’s perspective on issues, she learned to perform the function of therapist for herself.

26. P1 chose to end the process after sensing that she was able to deal with issues without her therapist and that the work was complete.

27. All aspects of P1’s life improved through the process of therapy. She acquired more self-knowledge and self-confidence and she learned to nurture herself.

28. P1 learned to accept herself. P1 sensed a significant change in selfhood. P1 also felt more open with others.

29. Before therapy, P1 isolated herself from others due to quality of the depression and her husband’s control.

30. P1 experienced ambivalence during therapy about reinitiating contact with certain family relations. She developed close relationships with them after therapy and assumed an important role that enabled her to share in their lives.

31. P1’s life was fuller after therapy as she increased engagements with others and projects, and during therapy, her therapist encouraged this change by making suggestions about ways to initiate engagements.

32. P1 still experienced depression at times but it had a different quality more akin to sadness. She identified depression earlier and understood its relation to her feelings and world, while also communicating it better with others.

33. P1 experienced emptiness when depressed before therapy. She felt lost since she lacked an understanding of depression and knowledge of herself, and felt shame in relating it to others.

34. As a result of therapy, P1 felt hopeful about the future.
35. P1 still regretted her past choice of spouse, as it precipitated much suffering. However, P1 discovered the meaning of her suffering in her work as a therapist and apprehended a divine purpose for it.

36. P1 also sensed divine purpose in finding this particular therapist and imagined her therapist to be an angel. She felt a sense of gratitude toward her therapist for the immense effect therapy had in transforming her life.

37. P1’s personal development through the process of therapy contributed to her making the decision and commitment to become a therapist.

38. P1’s experiences in her own therapy made her a better therapist and informed her formulation of therapy. For P1, therapy is a process of re-parenting. A client is stuck, and an empathic and knowledgeable therapist guides him or her along the path to selfhood.
Appendix 4: Data and Analysis Participant #2

A4.1 Written Description

Please describe in concrete terms what your depression was like before entering psychotherapy, at the end of psychotherapy, and how you are different now.

There I was on my knees praying for relief from a pain I had never felt before. It had been almost exactly a year since I was diagnosed with Panic Disorder. Things had gotten better over time, but now the symptoms of anxiety and panic were back with vengeance. What surprised me about this acute period was the emptiness that accompanied it. It was an emptiness that I had never felt before. It was as if there was a hole in my heart and I had fallen through that hole. It also produced quite a nasty cycle. I got so depressed, so vacant, so dark that I had no idea what I was capable of. I never dwelt on suicidal thoughts, but with the emptiness I had no idea how far it (the emptiness) could go. Naturally after that the panic would kick in. My inner dialogue would say, “Oh my God, I’m going to kill myself… I’m going to go crazy and kill myself…” Before I knew it I was in a full blown panic situation because I was afraid I couldn’t trust myself to myself. And of course after that, I would be more depressed because the situation seemed more bleak than when the hopeless feelings began to emerge and thus the whole cycle would begin again. This is what brought me to my knees on that evening in March when I had no idea what I would do. “God please help me! Please, please, please, please…”

The night of that prayer was at the peak of my depression. I felt completely alone and isolated from everyone around me. No one seemed to understand what I was going through. I felt so remote from my family, friends, and girlfriend (now wife). People kept
their distance and did not address the big issue in my life. I liked it that way. Alone to deal with this unknown darkness.

That night I tried to open up to my girlfriend about what I was feeling, but I couldn’t. The second I started to express the darkness and felt as though she would reject me and consider me crazy for having such terrible thoughts. Thus, panic set in and I fled from the situation. She was also terrified that I was going off to kill myself, but I tried to assure her I wasn’t. I called my mother and asked her to take me to an empty church where I could have it out with God.

With tears streaming down my face I screamed to God. “Why, why, why, is there such pain!?!?” “How can I even believe in you, when my heart is so empty!?!?” “Why are you allowing this!?!?” “Why are you doing this!?!?” Bent down, feeling abandoned even by God I laid my head upon the alter sobbing. Opened in front of me was the alter Bible and looked to see what it was turned to. It read, “He who dwells in the shelter of the Most High will abide in the shadow of the Almighty. I will say to the Lord, ‘My refuge and my fortress, my God, in whom I trust’” (Psalm 91). At that moment I felt in my heart something that had been missing for quite some time: hope.

Upon expressing these thoughts in psychotherapy I began to feel a burden lift off my shoulders. For reasons that will be described in the next section, psychotherapy took the burden off my shoulders. I no longer had to hold this depression all by myself. The sense of extreme isolation began to lift. Through learning more about myself, I began to be better able to handle the depression.

Along with this, as my period of acute anxiety decreased I was able to see the future again and this gave me hope. No longer was the future this abstract dark enemy
that included anxiety and panic; it was now something that welcomed me from a
distance. When I was in the heap of my anxiety, I was unable to posit a way out.
Because my present was so hellish I was unable to imagine any future. Along with this I
would begin to glorify the past and when I realized that the past was no longer, that
would be cause for despair. So in short, therapy by helping me cope with my anxiety
thereby lessened my depression.

In the present now, reflecting on what transpired then, I feel a sense of awe
regarding where I came from. Since then I have had a couple spells of acute anxiety and
depression. When it returns the pain is still nearly unbearable. Although this is the case
something is different. The depression is no longer the monster waiting to swallow
whole. In spite of the pain, psychotherapy has given me the tools to be able to handle
these acute instances of depression. These, for lack of a better word, tools have
prevented the depression from being able completely destroy my life. With this said we
shall now look at several instances that describe what I’m talking about.

Please describe several representative incidents that exemplify what was helpful for you
in psychodynamic-psychotherapy and how it helped.

The first way in which therapy was of benefit to me is rather simple. In short, it
gave me another to share my pain with. One of the most terrifying aspects of depression
was the sense of extreme existential isolation. As I mentioned in my previous
description, the despair was so intense that I felt as if no one either wanted or could
understand what I was experiencing. Combine that with the anxiety and it creates a
deadly combination. I was afraid that the thoughts of despair would take me over and
officially throw me into some dark abyss with no escape.
Just walking into the door of my therapist office was a comfort. Knowing for the next hour that I would be able to talk through these thoughts with someone who not only understood my pain, but also saw it as “no big deal” lifted a tremendous yoke off my shoulders. Through therapy I began to understand that the pain and thoughts I was carrying around were rather normal in today’s society. I wasn’t some unique case that was going to go off the deep end of inescapable tragedy; I was rather someone who was afflicted with a temporary acute sense of despair.

The second way that therapy helped me was that it brought me out of myself. When anxious and depressed it felt as if the center of me was a large black hole that was sucking me into myself. Thoughts of anxiety and depression would push me further into that hole and would amplify the sense of emptiness that was already there. It was horrible cycle!

Therapy helped me to not fall prey to this. My therapist suggested engaging in concrete outside-of-myself activities when this downward spiral would begin. These could include simple things like eating, playing guitar, or praying for others. In this way it got me in touch with my being-in-the-world and my being-in-the-world-with-others (forgive my heidegerian), which would in turn pull me out of myself. This strategy proved to be of immense benefit in dealing with my anxiety and depression. Preventing me from being sucked into the dark abyss helped me to realize that the depression was not a large monster, but rather the outworking of a secession of thoughts that led me needlessly in to an abyss that appeared bigger than it really was.

The third way that therapy helped me handle my depression was teaching me how to accept and in a sense surrender. One of the reasons I began to become so intensely
depressed during times of acute anxiety was because of my inner dialogue. I would often say to myself, “I can’t believe this is happening again,” or, “Is this going to be my future? Is this all I have to look forward to?” From these thoughts I would proceed to slide down into the pit of despair.

I remember expressing these thoughts to my therapist and getting the most shocking answer. He said something like, “So what, you are probably going to have to deal with these bouts of acute anxiety from time to time. What’s the big deal? You might have to accept that fact.” At first I was appalled at the thought. I wanted this ordeal to be over. I wanted nothing more than to never have to deal with this again. My therapist insight though began to feel like a great comfort. In the acceptance of my anxiety and depression I stopped fighting the reality of it and just accept it for what it was. I was able to surrender. In some paradoxical way it was when I did this that some rays of light began to creep in.

In Scripture the Apostle Paul is inflicted with what he calls a thorn in the flesh. Concerning this thorn he writes, “Three times I pleaded with the Lord about this, that it should leave me” (1 Corinthians 12:8). So often I was like St. Paul pleading to God to be relieved of this pain. I often did the same thing to my therapist. Wishing he would just remove this thorn. This being the case, God often has different plans than what we often think is best. To St. Paul’s cries for relief God replied, “My grace is sufficient for you, for my power is made perfect in weakness” (12:9). God brought St. Paul to the point of acceptance and surrender and in that acceptance he felt the grace of God in ways he could never imagine. That’s the way it was with my anxiety. When I stopped fighting and despairing it, a sense of peace and healing crept through my body. Because of my
constant fighting this peace and healing was not able to exist there before. Through acceptance and surrender healing was now able to flow through my body.

As a mentioned before, I have had relapses of anxiety and depression since the period I am describing, but with the help of these three experiences I no longer fall into the deep pit. Recovery time is shorter and I’m actually able to benefit from what the anxiety and/or depression is revealing about my life in the present. Of course therapy did many other like leading me to an understanding of certain family struggles, thought patterns, and internal dissentions; but when I really reflect upon it, these three elements described above are the most helpful.

If not addressed above, please describe any changes experienced: in a bodily way, with other people, in yourself, toward your future and past, and in various aspects of your world.

These were mentioned above, but I’ll briefly recap. Therapy helped my being-in-the-world and my being-in-the-world-with-others. My therapist taught me how to do this in concrete ways so not to get caught in the never ending cycles of depression and anxiety.

As far as time goes, therapy gave me back my future. As I said before, when the anxiety came my future became hopeless, my present became unbearable, and my past became glorified; thus spiraling me further into anxiety and depression. In giving me back my future, therapy helped to live in the present and put the past where it belonged.
A4.2 Interview

R: I was wondering what was going on in your life around the increase in your anxiety and depression.

P2: Um, I think it was the beginning of a transition, sort of in the middle of a transition I was having. I was in my junior year in college. Eh, I just started dating my girlfriend, now wife. You know, we were in the beginning stages of our relationship then. Um, you know, I started to have to start thinking about the future. You know, what am I going to have to do after college? So, those questions become more, um, more pertinent as, eh, the year went on. So, there was sort of just this, um, you know, looming anxiety over everything, you know, all the new things and all the unknowns. So, um [R: Um hmm], that’s sort of the context of where I was. I was sort of just in a shift in my life almost, if that makes sense.

R: That definitely makes sense. It was definitely a time of transition. There was a part concerning things that were coming up with you with your future and also things specifically with your relationship with your girlfriend.

P2: Not specifically with her, that was just one of many [R: Yeah], many things.

R: Yeah, were these things then contributing to your sense of anxiety and depression at that time?

P2: I would definitely say anxiety and I would say sadness. I wouldn’t say depression quite yet. Because there was, you know, the unknowing causing a sense of sadness in me. I think, um, as I mentioned in the one part of the written description too, um, you know, where I was sad that the past was no longer too because I was so anxious about the future, you know [R: Um hmm], and the present was sort of shaky. And I sort of looked to the past in a sad longing way, so there was a little bit of that too.

R: I was wondering too were these things you were coming to see in therapy? The way the situation in your life, the transition, was this something you came to see in therapy as contributing to your anxiety?

P2: Yeah [R: Okay], and sort of, you know, in therapy there was pretty much revealed a life-long pattern of that too. You know, pretty much every transition I went through all my life, it might not have been a depression, but there was always a sense of, of a melancholy, you know [R: Um hmm], leaving things behind. So, I think there’s a pattern there that can probably stretch all the way back to going to kindergarten.

R: Okay, could you tell me more about that? Is there specific things that were, specific instances that were highlighted in therapy?

P2: Well, going from elementary to middle school that was hard on me. You know [R: Um hmm], I went through a situation then. Um, leaving high school, I didn’t really enjoy
that either [R: Um hmm]. You know, of course, leaving college there was a little bit of anxiety there but not much because I was happy to get out of there. And then even most recently leaving grad school and, eh, going into the unknown of the future there too. There was an awful lot of depression and anxiety around that [R: Um hmm]. Only I was able to identify that a lot better, you know, and address that, as opposed to before where it was just so automatic that I couldn’t, you know, control, I don’t want to say control, but I couldn’t address it.

R: Um hmm, and that was one of things I was sensing from your written description. You were saying that in the subsequent episodes of anxiety and depression you were able to see what it revealed about your life and your world. Is that what you were referring to then, um, that it was related to you leaving graduate school and entering, um, the new phase in your life?

P2: Um, I’d say that was definitely part of it. Could you re-ask that question again?

R: Definitely, I was seeing, I was seeing that in your description you said that at one point, eh, in subsequent depressions what is different about it now you can identify [P2: Oh, yeah] you can really see what it is saying about your life and world [P2: Okay, yeah, now I remember]. Is that um [P2: true or is it true or how is it true]. In what ways

P2: Well, I think the one I mentioned is adapting is definitely one [R: Um hmm]. Um, you know, in another way it sucks and it is really painful to go through. But there is an essence where it is the, eh, almost like it is the great opener. Where, sort of, even though it is not healthy, it pries open your soul and forces you to stop for two seconds and say, “What am I doing,” you know [R: Um hmm]. And part of the sadness and part of the depression is looking in there and not really liking what you see, you know [R: Um hmm]. And, eh, so in that sense, you know, the depressive episodes were always, there is somewhat a positive aspect in the long run [R: Um hmm]. But through therapy though, it helps me in the sense, and I mentioned this in the written description too, that I don’t get swallowed by it [R: Okay] where it’s. You know, before I would fall in that hole, where I would be like, “God, what am I going to do?” [R: Um hmm] And that would be, that would be sort of the way the anxiety and depression would communicate. But now I am at a point where I can recognize it for what it is [R: Um hmm]. You know, there’s the bio stuff, the patterns that are contributing to it, the way I’m seeing the world through a transitory period of time. I can look at those for what those are [R: Um hmm]. And, um, there’s even a sense of with therapy of just being able to, um, just really be able to talk it out and realize there’s, there’s an extent where it’s not that bad [R: Okay]. Where being so involved and so swallowed up in your hole that it just builds upon each other and gets worse. Then when you just have the chance to express it sort with a person who isn’t as emotionally invested in you per se, you know, it really makes you say, “It’s really not that huge of deal.” [R: Um hmm, um hmm] So, definitely a perspective is put on the whole, whole thing.

R: Yeah, and you said there was subsequent episodes of depression when you were able to see what it revealed about your life. Um, what was it revealing in subsequent
episodes? You mentioned the transition you went through finishing graduate school [R: Um hmm]. What was that transition like? What did your previous work in therapy help reveal about the more recent transition?

P2: Well, again there was an onslaught of anxiety first, um, panic. And, but the more recent time symptom wise the depression was the worse [R: Okay], but not, not despairing wise. Does that make sense? Like, in my head, there was a sense of control on it, you know, there was, eh, but I would start crying at the drop of a hat, you know [R: Yeah]. So, I was like there, I knew what was going on and I addressed it and it was there in its place. But the physical symptoms and manifestations of it were a lot more than I was used to. Crying at a life insurance commercial one morning is my funny experience that I always talk about. But it felt good just to cry [R: Um hmm]. You know, but in the subsequent episode the first thing was again the anxiety, just being so depressed that it was pushing you back to square one. I just kept on going, “Not again, not again, not again, not again,” just feeling almost pinned [R: Um hmm]. You know, and then, eh, sort of a depressiveness toward, um, towards God almost and just life in general. Both feeling, feeling like I was being thrown into this sort of a, sort of dark patch that I, I did not want to go through [R: Um hmm]. You know, when I closed my eyes, I got this, I got this image of this sort of big hand sort of pushing me and I’m kind of leaning back against that not wanting to go. But [R: Um hmm] it was almost something that I had to go through, you know. And it was sort of, um, that was sort of like what it felt like the more recent time. Of course, there was the transition of leaving school and not knowing what was going on, um, and life, life just being so busy, you know, losing a loved one a month before it started. You know, just having that collective experience just hit me all at once [R: Um hmm]. It was sort of big. You know one of the things I, eh, did in the more recent episode that really got me out was I, almost um, surrender too it [R: Um hmm], if that makes sense. You know, surrender to that hand that was pushing me. You know, sometimes I think of it like consciousness being a river, you know, that just keeps on going whether you want it to or not [R: Um hmm]. Um, as opposed to swimming against it, sort of letting go and floating with the stream [R: Yeah]. So, sure I cried a lot, but, you know, it just was sort of interesting to see how that dynamic worked and how it slowly started getting better [R: Um hmm] after that.

R: Yeah, so the pain itself, the more symptomatic aspects of it, crying [P2: Um hmm] was rather intense this time [P2: a lot more intense] a lot more intense and [P2: Yeah] you were really able to make sense of it differently.

P2: Um, I, I think I thought of a better way to distinguish the two episodes. The pain was, the physical pain was awful, you know, and just the symptoms, and the anguish, but there wasn’t as much mental anguish about it [R: Um hmm], you know. You know, I knew this, I don’t want to even, you know, it’s clichéd, but it’s, you know, I thought that it’s sort of a season. You know, I knew it was going to be temporary [R: Um hmm]. You know, so, there wasn’t that mental anguish of: is this all there really is? You know, I mean, of course that thought came every now and then, but that wasn’t as, as present as that had been in the past episode, if that makes sense.
R: Um hmm, um, was, was therapy, was the previous course of therapy sort of preparing you for this subsequent depression? Did you feel what you gained previously [P2: yeah] helped you

P2: It felt like, it felt like there was, eh, wealth of things to draw from, you know, and whether that is advice or actual just, you know, the, the digging through my, my soul and the digging through my past that we did for the three or four years of therapy [R: Um hmm] created a base. And when the depression hit, and I think it hits everybody every now and then, but when it hit, I wasn’t, you know, I didn’t go as low into the hopelessness [R: Um hmm]. I recognized things for what they were as opposed to things being much bigger than they, you know.

R: In paragraph one, um, you started your description writing about a night that occurred at the peak of your depression [P2: Um hmm] and that was a very vivid description [P2: Um hmm]. And I was wondering what was significant about this night. I see you chose to write about it first and so I was assuming it had significance. So, I was wondering about the significance concerning what it manifested, what it was showing you or me about your experience of the nature of depression.

P2: Well, it was sort of the water shed moment of, eh, I’d say almost my life, but of that particular episode, you know, of depression, of acute anxiety and depression. Um, you know, I, anxiety, my panic attacks had started the year before and I started therapy for them. They had since decreased and um, a lot, I wasn’t having a problem. And then all of a sudden the spring of that year it just started popping up again, the panic attacks [R: Um hmm]. And, um, you know, before I knew it, it started taking parts of my life again. You know, I started to become agoraphobic, you know, not wanting to go out of the house as much. And as this started happening, just this overwhelming sense of weakness just started to creep over me and sadness, sort of in a similar way to the more recent episode. Just, “Oh my God, I thought I was done with this, not again, not again, not again, not again,” you know. But this time it was like, it was like, “Holy shit, is this going to be my life, for the rest of my life?” [Um hmm] And I started getting really depressed about that. And then what would happen is I would get so depressed that the depression would feed the anxiety, the anxiety would slowly feed the depression, and it would just become, you know, really bad. And what started happening the day before or two days before this night was the depression and darkness was getting so great that I started becoming anxious of what I, of what I could do with that darkness. And, you know, I tried, it wasn’t like suicidal thoughts, I wasn’t looking at things thinking, “I could do this to kill myself.” It was: “Oh my God I’m so depressed, I’m going to kill myself. What if I kill myself?” Sort of [R: Um hmm], but not, you know, it was typical anxiety. But then that would feed the depression [R: Um hmm]. And then I had no idea of what I was going to do. And my girlfriend and I were rather new [R: Um hmm] seeing each other, so she wasn’t quite as used to this anxiety as other people in my life were. So, sort of my anxiety, um, almost attached itself to her in some weird way [R: Um hmm]. And it was, I got anxious when I was by her, and not just anxious like nerves, but panic attack symptoms when I was around her. And, um, so I started to avoid seeing her [R: Yeah]. And, um, and I became pretty damn depressed about that too. And, eh, so that night, that
sort of brings you up to date, I was in the heat of that. So that night, I went out to meet my wife, on a, a bench at the University. And we’re talking and it hit again. And I was just like, “Honey, I got to go. I’m sorry. This is hitting me real hard.” And she was sincerely afraid that I was going to go somewhere to kill myself [R: Um hmm]. And, um, you know, her saying that, you know, only upend that fear in me and only upend the depression. And it was just really, you know, a horrible feeling of helplessness: what am I going to do? And, you know, every constant in my life just seemed to mean nothing. Um, everything just seemed to be swept under my feet. And, eh, sort of what I’d do at those points is, you know, I really feel a strong urge and call to pray because for some reason when things go crazy in my life that is the only thing that remains standing. You know, that’s the only thing that’s there. And even that, you know, of course was shaky at that moment. So, I called my mom and, eh, had her drive us, drive us, drive me to, eh, my grandmother’s church where we had the keys to. And it was just sort of this empty, old, dingy sanctuary where I just sat and prayed and just let out these, let it out [R: Um hmm]. And almost in the latter episode when I surrendered to the depression it was a very similar thing. I just let it out. You know, and screaming at God in the sanctuary, “Why, why is this so painful, you know, this unknown darkness? Why is this so, so bad?” [R: Yeah] You know, I just had it out. And, um, you know, I was just completely in this honest moment where it was like, you know, where it was like, “Either you show up or this is over,” you know [R: Um hmm]. And, um, there’s an old church set up so there’s alter with one of those big pew alter Bibles and I just put my head on it because I was completely exhausted. And I looked up and there was that one verse that I wrote in the description, you know, “The Lord is my refuge, my fortress, my God in whom I trust.” And it was just sort of weird at that moment it was just like beyond any comprehension there was just this sense of peace [R: Yeah]. You know, the sadness was there, the anxiety was there. But the reality that something was solid beyond me really, really helped [R: Um hmm], you know. And that’s, you know, just being able to, um, to grab onto something [R: Yeah]. That was, I was thinking of the episode of Lost last night where Desmond was trying to find a constant to keep his brain from blowing up. It was very similar. It was just, you know, and with the latter struggle you can even say that there, there’s, I recognized a lot more constants in the world. Where at that point at that day that I wrote and described everything felt as if it was failing me. And because I didn’t have the experience yet in therapy, because I didn’t have the experience dealing with my panic disorder or depression I, I didn’t have the tools necessary in me to grab onto things in the world [R: Yeah]. So, that is why that is sort of a big moment for me because I don’t know what would have happened in my life if that wouldn’t have happened.

R: Um hmm, yeah, so that thing I’m really hearing is something beyond you [P2: Um hmm] you were able to grab onto as a constant [P2: Yeah]. And, and something that was standing out when you were saying that to me and I’ll see if this resonates with your experience. So, internally the anxiety and depression were feeding one another [P2: Yeah]. So, internally there wasn’t this sense of something to grab a hold of [P2: Yeah]. Um, relationally there wasn’t a sense of something to grab a hold of [P2: Yeah] at that moment. And then in the church there was a sense of even can I grab a hold of God,
something outside myself. [P2: Complete abandonment at first]. And then you were able to [P2: Yeah] reach a hold of something outside yourself [P2: Yeah].

P2: And it was sort of freaky that it was turned to the verse that spoke to that, you know, dwelling and abiding, refuging, trusting. So, it was kind of one of those moments where you were just like, “Hello.” But, um, but yeah that’s a really good way to put it. It was very, you know, finding something to hang onto in that moment. Because, you know, I said it before and I’ll say it again just in case I’ll miss something, I didn’t have yet what was necessary [R: Yeah] to be able to know that, to be able to separate almost, and this could be unhealthy too, to be able to separate my feelings from reality [R: Um hmm]. And I felt so sad and I felt so anxious, but was that necessarily reality at that time: no [Yeah]. You know, things weren’t going to go completely, I wasn’t going to go completely bonkers, you know [R: Yeah]. And sort of like that’s where in therapy we started going into that and looking, you know, you know, “what are some things you can do to really put yourself in reality in those moments?” You know [R: Um hmm], playing guitar or eating a sandwich or, you know, just doing something like that really getting a sense almost of your being-in-the-world [R: Um hmm], you know.

R: So, if I was hearing you right there, in therapy there was a developing of, there was a developing of a part of yourself that was separate from what you were feeling in the moment, I guess sort of a different part of yourself. Like, you were saying that what you were feeling was connected with what you thought reality was. But was therapy then a developing of a further distinction in yourself between what you were experiencing and what you were observing?

P2: Um, sort of, I might use different words [R: Yeah]. I don’t want to separate it, that’s the thing like I don’t want to separate it too much [R: Yeah]. But it was sort of a, um, just sort of to grab onto something that makes you realize you’re not going to get sucked into yourself [R: Yes, yes], you’re not going to go into some sort of. You know, and that time I wasn’t so familiar with the symptoms of panic so I thought I was going crazy. Um, you know, so, um, one of the things my therapist did was in making me grab onto that outwardness [R: Um hmm] I didn’t suck into myself. You know, that’s where, you know, the circle or whatever goes so fast. The feeding between the depression and anxiety starts to really speed up.

R: Yeah, yeah, so that was, there was this development of something internally that you were able to become rooted with and grab onto.

P2: It would be more like almost external though because [R: Okay, yeah] because I’m grabbing onto something outside of myself [R: Okay] because the internal was so, such a mess [R: Yeah].

R: Since we’re on this line of discussion, I was wondering about that. Specifically, in paragraph eleven, um, what was your experience of playing guitar? You gave that as one example of grabbing onto something outside yourself. What was your experience of playing guitar and how it helped?
P2: Um, well first, um, doing something automatic, you know, it was something that was so, so automatic that it sort of just takes you out of yourself [R: Um hmm]. Um, but also not just automatic but, you know, it’s challenging, you know. And so, you know, I had to pay attention to what my fingers were doing. You know, the way I used to do it back then was play the songs I like. You know, so I’m sitting there paying attention to what the song’s doing and at the same time paying attention to my fingers. So, again it’s just a putting myself, attaching myself to just an activity that, you know, gets me out of that loop [R: Um hmm] and, you know, puts me into something that’s automatic. And, you know, how a person might to avoid a depressive situation or to feel better might build something or, or, you know, might, I don’t want to say read a book, but might, you know cook. But it was just something that had no stress, no value, attached to an activity [R: Um hmm] completely outside of me.

R: So, in focusing outside of yourself [R: Yeah] that helped you

P2: Well, you know, I’m depressed so that thought stream would be: oh my God, this is so bad, I am so sad. And then the anxiety would be: oh my gosh, you’re so sad, you’re so sad. You know [R: Um hmm], and where, when I’m playing guitar the thoughts are: oh my gosh, this, oh, fret five, finger one [R: Um hmm]. You know [R: Yeah], and thinking automatically it prevented, the thoughts were still there, but, you know, there was something else that needed to be done at that point, at that moment. And that was to rock! (laughs)

P2: Yes, so the depressive-anxious loop that was going on internally [P2: Yeah] was, was then being handled by focusing outwardly in an activity in playing guitar [P2: Yeah] or something.

R: Or even like I mentioned eating too [R: Um hmm], you know, same thing. And it wasn’t like depressive eating [R: Yeah]. And was just, you know, feeling something, (laughs) this is going to sound weird, feeling something, smelling it, putting it in your mouth, chewing, you know, those normal everyday functions, you know, just reminds you sort of how automatic everything is, you know [R: Yeah]. You know, and that was one of the first big lessons that my therapist taught me was, you know, sitting there talking about anxiety and depression when I was sitting there in the car and I was afraid I might do something, you know, drive off the road, but I ended up at the destination. And my therapist was like, “How did you end up there?” You know, he was like, “Somewhere on you, you know, even though you feel like everything is going crazy, there’s a part of you that is automatically breathing and, and, you know, existing and driving to the destination. There’s a part of you that’s connecting neurons, you know, to get from the one place to the other, you know, there’s an internal map in you.” And just, you know, I think therapy and, you know, playing guitar, but also these other things that my therapist was trying to do for at least the initial symptom was to help me get in touch with that part of me that was very, I don’t want to say mechanical, but I guess that’d be the best way to describe it [R: Yeah]. Very just, crafty [R: Yeah, very automatic]. Yeah, yeah, that’s the best way.
R: I was wondering. What were you expressing in your description when you typed the, eh, “please” in lower fonts?

P2: That’s sort of the way I, I kind of felt. I was like, “Please, please, please” (Voice Trails Off), you know. And as the anxiety and depression increased, you know, kind of felt smaller and smaller and smaller [R: Um hmm] and weaker and weaker and weaker, you know [R: Yeah]. That’s sort of what I was expressing there.

R: So, you were, it was you were feeling smaller.

P2: Yeah and weaker and just like. You know, if you were in that dream that classic nightmare of somebody’s chasing you, you know, and you can’t like run away. You know, you’re stuck there. You’re just like, “Please.” Then you’re stuck in the dream and you can’t wake up. It’s sort of like that [R: Yeah] sort of phenomenon almost. I never had any of those dreams during those episodes. But just, you know [R: Yeah], sort of those childhood dreams you used to have.

R: Um, I was wondering about something concerning paragraph two and three. In the midst of your depression, you said you felt isolated from others [R: Um hmm]. And I was wondering after this depression and course of therapy, what was your experience of relatedness to others?

P2: Um, I think the best way to do that would really, um, would really be to use my wife as an example [R: Um hmm], you know, who was then a girlfriend. And the episode I’m sharing [R: Yeah] is when that all sort of fell apart. Um, she didn’t know what was going on with me [R: Um hmm]. You know, as much as I tried to describe it, she didn’t understand it. You know, that was pretty much endemic of everybody except for my therapist at that time [R: Um hmm]. They all had their thoughts and ideas of what was going on. But the dark abyss that I was feeling and having was like I felt was so dark at that time that oh my gosh if I were even to let a tidbit of this out, you know [R: Um hmm], she would completely reject me. You know, and, eh, so, again just like everything else that builds on top of each other. You know, you worry, you isolate yourself, just it’s again circular [R: Um hmm] that, you know, oh gosh keep on. And I’d explain it to her, but she was rather, I don’t want to say freaked out, she was supportive, but there was, there was a sense where she didn’t know what was happening at that time [R: Yeah]. Whereas now she has much better understanding where it’s like, “Oh P2 stop it.” Where now, but before it was like she got sucked into the fear, you know [R: Um hmm], of what was going on. So, so, there was just this sense of isolation from, you know, the person I sort of felt closest to before [R: Yeah]. You know, and I think that contributed to the fear and depression of that moment. But even with normal relationships and friendships, you know, eh, nobody really wants to hear your crap all the time, you know. So, it’s like my roommate in college at that time, you know, “Aw, that sucks man.” But then you’re onto something else [R: Um hmm]. And that, that vacant area is left unattended to when you just sort of feel worse and worse and worse [R: Yeah]. And people that you come to for advice they have answers, but it’s just again it’s worse and worse and worse. And no amount of pick yourself up by the bootstraps or any of that sort of talk could really get
you out of that, that spiral that you’re in [R: Um hmm]. So, um, you know, the second part of that, you know, what after this depression and course, I mean course of therapy, you know, and I mentioned this sort of in the written description paper again with just, you know, walking into that room and knowing that for fifty minutes [R: Um hmm] that this person was going be able to maybe not even understand your experience, but you’d be able to express your experience to this person [R: Um hmm]. And in that, you know, as I mentioned right in the beginning, puts it where it is. You know, all of a sudden depression isn’t this dark secret or the anxiety this dark abyss. It’s just these momentary waves of feeling that take me over [R: Um hmm]. You know, and quite frankly the thoughts aren’t that disturbing or, or the feelings really aren’t that bad. There just, there fleeting moments, you know. And just being able to talk those out, you know. My therapist could not have said anything, you know, and that would have, that only would have been healing, you know, maybe not as completely as if he did talk. But, you know, just being able to, to put it out there just makes you see things for what is. I think that’s a theme if you’re noticing: seeing it for what it is [R: Yeah], as opposed to seeing it in the sort of exaggerated, emotive state.

R: So, during the depression, there was the experience going on with the anxiety and depression, and then you couldn’t, you feared to express that to your girlfriend.

P2: Even when I did there wasn’t the connection [R: Yeah] because it was so foreign to her or to anybody else.

R: Then in therapy, you came to see the isness of it [R: Yeah], you came to see it for what it is. And then afterwards within the relationship then was that something that changed in the way you articulated it outside of therapy like, um, was that something you could share more easily?

P2: Well, I definitely could be more open with my wife [R: Yes], my girlfriend at that time, you know, about what was going on because there wasn’t that ‘ah’ attached to it even though, even if she would get sort of freaked out, you know, I, her freaking out didn’t feed mine because I knew, I knew it for what it was because I knew it for its isness, you know. And so I was able to express things more to her without that sort of ‘ah’ attached to it. So, um, and, you know, soon she began to be able to realize what was going on because I was actually able to express it [R: Yeah]. So, then a positive circle began [R: Um hmm], you know. And, um, you know, normal, normalcy was, um, resumed in our relationship. You know, and then with others beyond that, you know, friends [R: Um hmm] or, you know, that just became easier because I didn’t have to express everything to them, but it was okay that they didn’t understand or they didn’t know what to do or they didn’t want to understand because I knew it, I knew it for what it was. So, I was able to resume sort of, you know, normalcy with them. It wasn’t so isolating.

R: Yeah, there’s something really important with what you said there. I could see a self-other dynamic going on there where you were able to feel confident to share this and articulate it with others [P2: Um hmm], and regardless of their response, you were able
then to stand confident [P2: Yeah] within what you know about this experience [P2: Yeah]. And it was not isolating [P2: Yeah], but there was an opening [P2: Yeah]. How about in the subsequent depression you mentioned? What was a, what was the difference, um, in your relationships with others, let’s say your wife? In this subsequent episode, how did the relations differ?

P2: Well, definitely the sense of aloneness wasn’t there [R: Okay]. There, there’s always a slight sense of aloneness, just because that’s depression, but, you know, it wasn’t all encompassing. Um, and of course she understood what I was going through so she was, she was completely solid during the whole time as opposed to. You know, one of the things that happen when you’re together with people who do not know is they get sucked into not knowing what’s going on, you know. And they, they almost catch the anxiety bug [R: Yeah]. But she sort of didn’t catch the depression bug because she knew, “Alright, whatever this is it’s happening and it’s just an it. And, you know, it’s depression. It’s temporary, it’ll pass. And, you know, I’ll be here for him. You know, and, eh, I won’t be completely freaked out. Yeah, I’ll have pain when I see him crying his eyes out, but, you know, so.” So, she was much more solid. Internally, I was just much more confident in the fact that she could handle whatever I could throw at her [R: Um hmm]. You know, I was confident that she wasn’t afraid that I was going to kill myself if, you know, I would mention all the despair [R: Um hmm]. You know, that was a lot easier and, you know, the fact that it was five years after that first experience [R: Yeah] so, you know, our relationship had grown, you know. And one of the things I did do that I hadn’t done in the past was, um, you know, I reached out and grabbed people, you know [R: Yeah, yeah]. I grabbed resources around me so, you know, it wasn’t, I guess this is one of the hopes of therapy is that you’re able to, you know, do it to yourself and grab other people to do it to you. But, you know, I grabbed those people who are important in my life and said, “Hey, I’m going through this, pray for me” or “Hey, just so you know” (Yeah). And they were able to offer their advice, but just the fact that they knew was a big thing. And one of the neat things I found when I, you know, reached out and grabbed was just the universality that everybody has, a lot of people have this: my sister has this, my wife has this, my brother has this. You know, and just really getting a sense of, you know, camaraderie with others. Even if they never had it themselves, they had been very close to somebody that had it. So, you know, when I came out of my last one, I was very frank about it. And it’s just really a blessing to be able to know that you’re not alone in that pain [R: Um hmm] and that other people are there.

R: Um hmm, so you were open, you were able to grab onto others, and then you were actually able to see your experience as somewhat validated [P2: Um hmm] by others who were having similar experiences [P2: Yeah].

R: Um, my next question addresses paragraph four and I think an underlying theme in, in the whole description [P2: Um hmm]. But, specifically I was wondering in what ways did your relationship with God change after this course of therapy, eh, through the process of dealing with anxiety and depression.
Um hmm, much like, eh, the other things too was, eh, looking for a reality beyond your experience, you know, and what you, um, everything you’re experiencing at that moment. So, you know, knowing that God is something beyond that. That necessarily, you know, that faith isn’t necessarily a feeling you have in your, in your stomach in your gut or something you intellectually know. It’s almost something you, I don’t know how, I say this word a lot, but you got to hang onto, um, when everything else is saying no just this complete b.s.. And, you know, hang onto that was just, you know, the payoff afterwards was just there because then, you know, when things weren’t crazy the sense of God or presence in my life was a lot more [R: Um hmm]. You know, and it was also gave me a sense to know that it’s not all peaches and roses. You know, and to know that there’s a lot, a lot of suffering in life regardless of whether you’re a Christian or not, you know [R: Um hmm]. And then being able to be there for other people who are, you know, going through similar experiences. But, um, let me think about that question, um, you know, and I also spent a lot of time reading the Psalms, um, during these experiences, you know, that one and subsequent ones especially in the more recent episode. And, um, there’s a universality of experience there. I mean these guys who made it into the Bible or whatever were writing poetry that almost seems to sometimes insult God because of how empty they feel. You know, my God my God why have you forsaken me, you know, you are so far from my groanings. You know, just catching yourself sort of in this familiar theme that’s throughout scripture of almost abandonment, but then know that beyond that abandonment that there is faith. You know, and that faith, it wouldn’t be faith if you could see. But what I learned and also, you know, in Christian world redemption is a big thing. You know, Christ on the cross redemption of your sins. You know, redemptive, the redemptive elements of life are throughout, especially in the Christian life. You know, and just, you know, part of me died in that depression. But through my faith something else was risen again. And, you know, I always say this in any interviews or any, anything like that it’s just if it wasn’t for that anxiety and depression I would, I would be dead because I wouldn’t have been [R: Um hmm] dead in a bad way because I wouldn’t have been killed and risen to life, you know [R: Yeah]. And, so, it was sort of the depression and anxiety that brought me to a spot to really live [R: Yeah] in that religious way and sort of resurrected a faith that had fallen asleep.

R: Um hmm, so there was a faith that was sleeping [P2: Um hmm] that was there but that through this experience.

Yeah, reawakened, um, became a lot more essential, you know. I mean, one of my, eh, pastors says an awesome thing, one of my mentors I guess I would call him, you know. People never really change unless control is rested from them [R: Um hmm]. And, you know, faith is easy when things are going alright. But when control is rested from you and you are completely at the mercy of the other in a sense, you know, or that really it, it purifies or radicalizes your faith a lot more [R: Yeah] because, you know, for me in my experience, you know, that’s all I have. That time, you know, seven years ago that I described in paragraph one or whatever [R: Um hmm] I mean everything fell: my self fell, my wife fell, my family fell, my relationships fell, my world was falling apart. And only one thing stood through that test and that was sort the spiritual lesson [R: Um
hmm], you know, that, you know, God is my rock and my fortress and even though reality might seemingly be crushing around me, you know, there, there is, there’s something solid there [R: Yeah]. You know, it’s, it’s one of the big common Bible stories that I always think of about this. There’s the, um, where Jesus and the disciples are in the boat and, um, there’s a storm outside and Jesus is just sitting there sleeping. And disciples are freaking out because there’s a storm and they wake Jesus up and say, you know, “Jesus there’s a storm happening and we’re going to die.” And Jesus says, “Why do guys have such little faith?” And, of course, he just, you know, flicks the waters and they’re still or whatever. But, you know, Jesus was sleeping, but there was still a storm going on outside. You know, reality surrounding those disciples was a complete mess [R: Um hmm] and that’s not denied in that story. What, what is, um, what is affirmed though is the fact that, you know, God is sovereign over all of that and that there is, eh, there is something beyond what appears [R: Um hmm] and it is that you have to believe in when everything else seems to be falling apart. So that’s kind of [R: Yeah], that, those, it’s that area that sort of relationship, you know, definitely got better and definitely, um, changed after my dealings with anxiety and depression. And it’s definitely what I described in the description was the beginning of that journey [R: Um hmm] definitely, you know, definitely not the end, definitely the beginning.

R: I find myself trying to pull together what you said but I do not feel the need to because you’re pointing it out so clearly.

P2: And that’s therapy. I mean that is being able to find those themes or concrete expressions. And that’s what all those, that’s one of the big things that therapy did was to be able to create almost sort of a narrative [R: Um hmm] or a way of looking at that, you know [R: Yeah] to be able to squeeze the marrow out of the depression almost.

R: You said in the written description that before therapy you were afraid you could not trust yourself to yourself, not knowing your capability or the extent of the depression. However, in paragraph five you said that through therapy you learned more about yourself and were better able to handle the depression. Um, wondering about this relationship, eh, of yourself to yourself. How did your relationship to yourself change?

P2: Well, in the top of the question sort of the I could not trust myself to myself, um, and that was mainly a symptom of my anxiety and the depression exaggerated that [R: Um hmm]. Um, you know, especially in this particular moment I am describing, um, I had very limited experiences with panic attacks [R: Yeah] and so there was still that mystery surrounding it. So, it was like, you know, I’m sitting there and this dizziness or this feeling of depersonalization, you know, all the classic DSM terms, you know, would happen. And, eh, I would have no idea of what’s going on so naturally that would lead to an almost behavioral change, you know, of like, “Oh crap, this happened. What if this happened?” You know, I just the what if train of thought: “What if I go crazy?” I mean my whole world felt like it was falling apart so the deductive answer was you’re nuts (laughs). So, then, you know, when the depression started to kick in it’s like, “Boy, I never felt this sadness before.” And it’s like, “You’re nuts. You’re going to kill yourself.” So, that sort of, eh, you know, then you have that thought and you’re like, “I
don’t want to express that to anybody [R: Yeah]. They’re going to 302 me.” Is that the number? [R: Um hmm] You know, “They’re going to lock me up. It’s going to be like one of those movies like that Jack Nicholson one, you know, um, but it’ll be like that and my whole life will be like that story because of these thoughts.” And so that was sort of the inexperience of not knowing what I was going through [R: Yeah]. So, therapy it helped me to see things for what they were. You know, of course my therapist being a very trained and very experienced first off would say, “P2 first off you are not exhibiting any suicidal behavior, you know. You are exhibiting none of what somebody looks for, you know.” And so first of all to hear that I was like, “Oh okay” [R: Um hmm]. There was a relief. And then, but then being able to see the anxiety and depression for what it really was, you know, helped me to know that: “okay, I’m not really going to go crazy [R: Yeah], you know, I’m depressed but.” You know, I’ll get to, there’s a cool thought I just had so hang onto that. But, “I’m depressed and I think I’m going to kill myself.” One of the things my therapist said to which is a really one of the really cool exercises was, um, and, you, you’d think that it wouldn’t be. But in anxiety and depression what is the worst case scenario in this moment. So, let’s just think anxious wise. Like, um, I’m having a anxious, let’s say one of my anxieties that I might faint or something [R: Um hmm]. You know, so let’s explore that. What is the worst case scenario? You faint, you wake up two seconds later and somebody might be taking care of you. So, then of course that reveals sort of a not trusting the other [R: Um hmm]. But, you know, so in the depression what’s the worst case scenario? So, I would think about that. What is the worst case scenario? Sadness, well, I grab bottle of pills and I swallow all of them. And right there instantly when I thought that. I don’t want to do that [R: Um hmm]. You know, so I became aware of almost of my will to want to live [R: Yeah]. You know, so, then that whole idea of suicide being afraid that I’d commit suicide seemed preposterous because it’s like, you know, when I actually really think about it this voice would be like, “you don’t want to do that.” You know, almost like smacking me in the head saying, “You know that.” So, it, so being able to trust myself and that I, I wasn’t all of a sudden going to blackout and wake up in a bathtub with my wrists split or something [R: Um hmm] like that. Like it was, “You don’t really want to do that. You know that. [R: Yeah] Don’t let your anxiety take you there.” So, so, again I mean the others and yourself thing is so, um, there’s a thin line, you know [R: Yeah]. So, almost like my anxiety being able to trust myself into another’s hands and almost the depression being able to trust myself into my own hands [R: Yeah, yeah] and knowing that I had a want to live.

R: With the anxiety, you did not trust yourself, but with this line of questioning you are thrown back upon yourself in a radical way and you’re thrown back upon your own will to live.

P2: Almost, I don’t want to say real or fake but it’s almost just your, your thrown upon, remember we were talking about guitar or with driving, your thrown upon, your thrown to that part of yourself that is breathing and existing right there [R: Um hmm] while the other part of yourself just seems to be going nuts. But in all actuality you’re fine it’s just that you’re swallowing yourself up in some really stupid thoughts almost [R: Um hmm]. So, that exercise would almost put me back again to that real self in that moment, you
know, the self that was actually breathing and respirating and heart beating and all that
good stuff.

P2: One thing that just came to my mind, this has been really beneficial too in a healing
way, now that I, you know, past couple days when I’ve been focusing on this. Because it
really helps to see the threads and it helps to actually examine where, where you came
from [R: Yeah]. I was able to see that there has been a lot of help and a lot of growth
during this journey [R: Yeah], so.

R: I’m glad to hear that.

P2: It’s been a positive!

R: And I can definitely see that in the care you took to write the description and in the
way you were able to articulate what helped, how it helped, and the effects of therapy and
also the relationships between these!

P2: One of the good things participating helped me to do is, um, you know, one of the
experiences I had was three days after my therapy I’d be like, “What the hell did I just
do?” When you have no idea and it is frustrating and you feel like you’re actually not
accomplishing anything [R: Um hmm]. But to really sit and reflect upon the whole, the
thing as a whole almost and all these things popped up like [R: Yeah] to be poetic it was
like looking at the night sky on a clear summer night so you look up and see a couple
stars but then when you keep on staring these new stars start to pop up [R: Yeah] (laughs)
[R: (laughs)]. So, that’s sort of the way it happened when I looked up and I thought,
“How the heck am I going to write about this?” But then all of a sudden it’s like, “Bloop,
bloop, bloop, bloop, bloop (Voice Intonating Stars Appearance). And I remembered all
these things and it was really cool to [R: Yeah] to reflect on that.

R: And that showed in the description too.

R: In paragraph six, what, what were some of the things welcoming you in the future
after this depression? You said that there were things welcoming you [R: Um hmm].
What were some of these things, specific things calling you?

P2: Um, yeah, eh, well, I mean if I were to think if I were to explain my depression to
anybody in the most basic terms it would have been sort of in the future-past, um, um,
sort of not diagram, but the future-past thing. Because it’s like my anxiety became so
severe that that’s all I can see at that moment [R: Um hmm]. You know, and again it’s
experience. I can’t say it enough and just dealing with it in general is the best thing. But
at that time when I was so inexperienced it was like, “Is this my future?” If it is my
future, then there is no way I can ever hold any relationship [R: Um hmm] like with my
wife or my family or my friends. You know, if this is my future, then there is no way I
can hold a job. And of course then I had no idea what I wanted to be when I grow up.
So, I think there was a little bit of that too [R: Um hmm]. You know, but if this is my
future, damn, I don’t want to live this [R: Um hmm]. So, that’s sort of what I meant was

274
the future wasn’t welcoming, you know, and when that happens, that’s another kicker for the depression [R: Yeah], you know. And then again the cycle starts: The depression feeds the anxiety and the anxiety depression. Your future becomes more and more cloudy, you know. And, eh, you know, so, you, you cannot in that moment especially when I was inexperienced dealing with it, you cannot in that moment envision any future without that degree of pain [R: Um hmm] and without that degree of anxiety and that’s, that makes you even more depressed. So, um, so, eh, you know, through therapy and again seeing, seeing it for what it was, made me realize that even though this might happen again in the future there is a future separate from this and even with it. But the future isn’t unbearable, you know [R: Um hmm]. The future is something that is welcoming me. So, slowly through this I began to realize sort of almost my calling of, you know, wanting to be a pastor [R: Yeah], you know, what I wanted to do with my life. So, again that made things a little better [R: Yeah]. I was like, “Oh, I actually have some idea of what I want to do with my life.” You know, so then when sad-anxious thoughts would come I’d be like, “Oh, this is that. This is now. This is, you know, this isn’t necessarily the future.” You know, and I think about again with the subsequent episode, um, it hit hard. And thoughts would come where it was like, “Is this it? You know, am I going to have to do this every so many years for the rest of my life?” But even though I felt like shit in the moment, there was that sense that this isn’t all there is. You know, I could close my eyes and picture myself at a job in six month [R: Um hmm]. Or I could close my eyes and picture myself on a, on a road trip, you know, where anxiety or depression wasn’t really an issues [R: Yeah]. You know, so I was able to even though the present was a malefactor, you know, I was still able to picture a future opening me with open arms, as opposed to, you know, wanting to, eh, tear me apart.

R: Yeah, so you were able to see an opening there and in that opening [P2: Yeah] the future was able to welcome you.

P2: I mean like, you know, in the more recent episode, you know, I was having anxiety attacks and my wife and I were thinking about having kids in a year or two. And shockingly in the midst of these crippling panic attacks I was still able to picture me taking care of a kid [R: Um], you know, which is shocking. Because that’s, that’s, that’s, you know, I was able to picture reality [R: Yes] apart from what I was experiencing [R: Yeah].

R: So, not just a picture of your doings, also a picture of you yourself being able to.

P2: Yeah, being in the future, being in the world in a health way [R: Yes] and not, not in that anxiety, not in that depression. But being in, being able to picture myself, my wife and I were planning a cross country trip at the time, being able to picture myself going up the Rockies, being in the car. And not being like, “I’m too far way from home.” You know, being able to really picture myself being free. You know, and knowing that isn’t, that’s not an unrealistic thing to, because it was, because it was, eh, you know, because I was able to find my way out of the episode by that trip. You know, so I guess I attribute that to both therapy and seeing what it is, but also experience and knowing my, this will pass. You know, it might happen again in the future, but it will pass again.
R: You also were mentioning in that paragraph about, eh, some of the things you were glorifying from the past. What were you glorifying from the past during this, eh, the, eh, initial episode?

P2: I had this girlfriend and I would have these weird dreams, it was a reoccurring one, of like I’d be in the room with my ex-girlfriend in a crowd of people and the second we would start talking I would feel perfect. And I would feel this sense of warmth and this sense of like love [R: Yeah] that I hadn’t experienced in such a long time, you know. And I experienced excitement and longing. And, but then something would happen in this dream that would prevent me from seeing her or I would try to kiss her and something would happen. I remember one I was, eh, in a high school parking lot [R: Um hmm] and my ex-girlfriend was in my car. And I’m sitting there trying to get in the car but I can’t. And all I want to do is get in that car, but I can’t [R: Yeah]. And that dream, those series of dreams I almost, they’re almost indicative of what I was going through at that moment. I just wanted so bad to be somewhere else and the only somewhere else I could imagine was, was that past [R: Um hmm]. So, it was thinking and longing for, um, for her, but she was an embodiment of a, a, something that seemed more stable [R: Yeah] and something that seemed safe. And you know even, um, in the subsequent struggle, you know, thoughts about another old girlfriend would pop up in my head. And I would think, “Oh that was nice with her.” And not that there was anything wrong with my marriage, but it was just that my mind would want to think of something that seemed safe [R: Yeah] and seemed tantalizing at that moment. And it didn’t happen to anywhere the same degree, you know [R: Yeah], because it was just something that seemed to naturally happen [R: Yeah] almost.

R: Yeah, so this thinking of the past, thinking of a past relationship [P2: Yeah], one that would provide a sense of security or a sense of safety that you were.

P2: And I can think of a direct instance in therapy because I remember I was pissed off at my therapist for saying this. But he was like, “Do you remember your relationship with you ex?” It was horrible, you know. And then again, I mean, just really getting me in touch with reality [R: Um hmm] and it was [R: Um hmm]. I mean there was a sense of looking for things as they really were [R: Yeah] and seeing, “Oh that was smelly too,” you know [R: Yeah], just in a different way.

R: Did you end up looking at that dream in therapy at all?

P2: Eh, yeah, I think I did.

R: Do you remember any of that, eh, how that looked, eh, the work with the dream?

P2: I’m pretty sure it was the same thing that I just said.

R: Okay
P2: What was really striking me there too was in the initial episode it was the future in imaging anxiety just imaging an anxious future would feed the depression [P2: Um hmm] and then the past you said when you realized the past was past and you couldn’t get back to this secure emotion that would feed the depression. So, like both [P2: Yeah] realms were like.

R: I think the future affected me more than the past [R: Yeah]. But still the past because the past too, you know, whether it was reminiscing over my ex-girlfriend or, you know, thinking about experiences with my other ex-girlfriend, it offered a, a, an initial escape [R: Um hmm]. You know, it offered me an escape from what I was feeling in the present [R: Yeah] so I didn’t have to think about the future. So, I mean. It was an unhealthy escape, but it offered an escape [R: Yeah] nonetheless. So, I mean, I don’t want to say that helped me with my depression. But it was an escape just like if somebody would, you know, turn to alcohol during this time or somebody would turn to, eh, any sort of narcotic or something [R: Yeah] to really just try to, eh: this present sucks I need to get out of here [R: Yeah]. And the only place I could go was the, eh, past at that time [R: Um hmm].

R: Could you please say more about the way your relationship with yourself changed during the subsequent depression?

P2: It was almost functional I would say, you know, it wasn’t something shocking. You’d expect that to be the deepest one, but for me it was almost more functional. Once I understood what was going on with my anxiety [R: Um hmm] I was able to trust myself to myself [R: Yeah]. You know, when I didn’t understand what was going on with the anxiety and depression I, I wasn’t able to do that [R: Um hmm] and that only increased the anxiety. It wasn’t like. Where with others, you know, it was more of a learning to trust them [R: Um hmm], you know. And it was a lot more deeper issue with trust [R: Yeah] as opposed to with trusting myself. And also with God, there’s a deeper issue with trust that got revealed too [R: Yeah] in that.

R: Yes, makes sense, almost more of a knowledge based.

P2: Yeah, so the other one, knowledge and experience and just sort of, eh, I think knowledge and experience would be the best way to, eh. It wasn’t some, it wasn’t an existential like trusting myself to myself [R: Yeah].

R: With reference to paragraph nine, in what ways did your therapist convey that he understood your pain while also normalizing this? And how did, how did you end up processing and integrating that?

P2: Well, I think a good thing was he normalized by never dismissing, you know. You know, it was never other people go through this, you know, you’re alright [R: Um hmm]. You know, it was never that. There was, there was this true sense of empathy from the other side of the chair [R: Yeah] or whatever you call it from, from my therapist, um. But, but understanding it in the sense that, understanding for me is just somebody
listening [R: Okay], you know, and not necessarily giving you step by step advice on what to do, but being in there in that moment. And my therapist did that. You know, he really was there and let me express. And, you know, didn’t flinch [R: Um hmm], you know. You know, he offered, “Wow that really sounds, you know, hard,” you know [R: Um hmm]. But at the same time, so I mean that, that for me was understanding, you know. And then in the back of your head, you know, just, just knowing that he is a psychologist, he’s trained to do this, you know [R: Um hmm]. There is that confidence, you know. He sees a lot of people like me a day, you know [R: Yes]. So, there’s that sense where, where you knew that he understood it more than your wife could or more than your mother could or more than your father could or more than a pastor could or any of that [R: Yeah]. Just knowing the fact that he was said psychologist gave you a confidence that this is his area. You know, I go to a proctologist for my hemorrhoids, you know (laughs), you know, because he knows the butt. But I go to a psychologist because he knows my experience and, um. But also normalizing it, again, situating it, um, you know, again as I said before revealing the thoughts for what they were [R: Yeah]. And, um, knowing that this isn’t crazy and knowing, hearing from a professional of the brain saying, “P2, you know, this is going to be alright. You know, you’re not going to go crazy. You’re not exhibiting any of those things whether it was crazy or with the depression suicide. You’re not doing that.” But also, um, the fact that he didn’t react into the fear [R: Yes], or I think of my mother reacting emotionally, you know. You know, that, that sort of normalized it knowing that: “you’re not freaking out when I tell you this [R: Um hmm].” You know, that, that really made it a normal thing, you know, so that was good. Um, and, and even every now and then, you know, my therapist was really, you know, I don’t know if he did this just for me, I’d imagined he do it otherwise too, but he would let out some personal tidbits...So, so hearing that even in this guy, you know [R: Yeah], was a sense of understanding and also normalizing. But, um, he would never go too far into himself [R: Um hmm] where it became like reverse therapy. But there was a sense where when it was appropriate, you know, there were connections built on a personal level between him and I that really were beneficial and made me trust more. But one of the funniest things was, you know, I’d be stewing over a thought that I thought was disgusting, you know [R: Um hmm], and whether that was a suicidal thought or an anxious thought of like, “Oh my God I’m going to go crazy and kill somebody,” you know, like, you know. Because you’re, when you’re having those especially in the early time nothing seems out of the realm of possibility for your brain to do. And, and I would sit there and just ruminate on a thought for a week: “Oh my God, I’m going to do this.” And by the time I got my therapist I’d get halfway through therapy and finally have to confess this sinful thought or something to him and he’d be like, “Oh yeah” (laughs). He’s like, you know, and he would do, and a lot of times he did the run with it exercise: “Run with it, what are you going to kill that person with?” (laughs) I really hadn’t thought of that and then you realized it for what it was, a fleeting anxious thought [R: Yeah] that was really provoked. So, so again normalizing that situation and really, you know, and making you, making you know the fact that you think it doesn’t mean you’re going to do it [R: Yeah]. And it wasn’t like I was thinking, “Aw, I’m going to kill that person.” It was like, “What if I kill somebody? What if I go crazy?” you know, blank out with the person’s blood on my hands because I’m so going to go crazy because I didn’t understand my panic disorder yet.
R: Yeah, so there was the this foundation of understanding exuding through his listening [P2: Yeah] and his empathy [P2: Yeah]. Um, there was this other level he’s the one who knows [P2: Yeah] he’s the doctor [P2: Yeah]. And also, you know, another level where he’s normalizing it through not reacting in fear [P2: Yeah], um, reacting in confidence [P2: Yeah] and going with it [P2: Yeah] and then also teaching you about it [P2: Yeah] the experience of anxiety and depression [P2: Yeah]

P2: It’s like a trust tree (laughs) [R: (laughs)]. Yeah, I think about, um, my time in Florida doing missions work and I was having trouble in front of those people. And I think that’s the antithesis of therapy was they got sucked in bigger than anybody in my fear [R: Um]. They thought something was really wrong with me in those moments and that’s what really made me go into a deep not so much depression but a deep anxiety spiral there because there wasn’t that objective person saying, “P2 you’re alright.” You know, everybody was reacting to me and feeding that reactivity. Sort of having the therapist normalize that because he was that non-reactive presence, he was reactive but, you know, non-reactive, you know [R: Um hmm], not feeding into what was happening. In fact, he was extracting it (laughs).

R: So, so, part of the depression-anxiety loop was, you know, falling back into yourself. But it sounds like you were able to in this relationship, um, reach out [P2: Yeah] and grab onto him.

P2: Yeah, very much in the same way I did with God, you know, or my guitar, but, you know, just grabbing onto a concrete constant.

R: Coming off that question, one of the things you were writing about was trust. I’d already referenced trusting yourself to yourself. Did the process of therapy then initially consist of developing that trust in your therapist then? If so, could you please describe the process a bit or does that not stand out?

P2: Eh, um, I’d have to say yes/no. Um, I was so desperate when I came to therapy with anxiety that I had no choice but to trust [R: Yes]. It was sort of, eh, I’m just all about the bad metaphors today, it was sort of like I was a baby and I almost had no chance, no choice because I was so completely in the mercy of everything that was around me because my anxiety had gone to such an extreme level the first time. So, you know, it wasn’t like I was having some marital problems where I had to go and face this guy who would judge me or I was feeling sad with life. No, I was completely on my ass and I really had no choice but to trust him [R: Um hmm]. That’s really how it worked [R: Yeah]. You know, I just first session (coughs) first session I just clearly remember word vomiting out my life story (laughs), you know. So, I don’t think there really was that. I mean definitely in any relationship [R: Um hmm] there was a natural trust building. But there was never a moment where I didn’t know about my therapist [R: Yeah]. There was always a sense of being able to trust him because of the position I was brought to him in [R: I understand]. But as the relationship increased it increased of course. But I’m just going to completely contradict everything I said if that’s okay [R: Um hmm] (laughs). But there was a sense too though when I had those scary thoughts, you know, where I
didn’t trust him with those [R: Yeah] because I was afraid he’d judge me or 302 me. But, you know, letting those out and seeing his non-reactivity towards those I guess you could say they increased the trust. So, I guess in that way there was a trust building. But there wasn’t any thoughts of I don’t trust him. But maybe on an unconscious level [R: Um hmm] there was definitely a trust building.

R: Sounds like there’s a basic trust you had [P2: Yeah] when you were coming to him and more of a relational trust [P2: Yes, yes] was building.

P2: It’s like having a heart attack and you get sent in the ambulance. It doesn’t give a shit, it doesn’t matter if you trust the doctor or not he’s going to have to work on you [R: Yeah] and you have to trust him to work on you [R: Yeah]. You know, it was that sort of trust initially, you know, acute I need to trust that person now or else I’m going to die.

R: My next question is just expanding upon what you already started to say. What was your experience of the therapeutic relationship like? Um, and please tell me more about how it helped.

P2: Um, I’d have to say it was almost like, eh, this is almost like a stereotype, you kind of want to be his friend at first, you know [R: Um hmm], and you want him to be one of your boys. You know, so I kind, there was kind of that. Um, walking, just walking into the office and getting the handshake, you know, as much as I love him as much as I’m comfortable with him that was still awkward because, you know, it’s like this guy isn’t your friend this is a professional set relationship [R: Yeah]. But once, you know, after the first set two minutes you start to get into the flow of telling him your story and, you know, he sort of responds and then your, then your relationship what the therapeutic relationship is intended to be starts to click [R: Yeah], you know. So, um, to answer that question, um, it was definitely a good one, it was a therapeutic relationship [R: Um hmm]. Um, you know, there are times you confuse him for your father and therapy doesn’t work too well that day [R: Um hmm]. And there are times you want him to be your mother and you want him to comfort you and to. I think, I don’t know because I’m not a therapist but I’m guessing he probably felt those times, you know, when I tried to get him to be my mom [R: Yes] and try to get him to tell me that everything’s going to be okay because then he wouldn’t [R: Yeah]. He would be like, “What, what do you want me to tell you?” You know, and so or maybe make a decision for me and those kinds of things. He was very crafty, you know, avoiding doing that [R: Yeah] and being very keeping it in the therapeutic realm [R: Um hmm]. So, that’s of course when it’s the most effective because if I confused him for my mom that’d be a bad thing.

R: Yeah, so there was, it sounded like there was this, you know, for you there were times when you desired him to be your friend or mother or father [P2: Yeah] and he acted in such a way that he, he didn’t, he didn’t respond like that.

P2: Yeah, yeah, eh, like again didn’t get sucked up in what I wanted [R: Yeah] or get sucked up in my thing, you know. You know, even like a pastor I could say probably tried to make him a few times [R: Um hmm]. You know, without saying he never ever
said, “No I’m not your mother I’m your therapist,” you know [R: Um hmm]. But it was just, you know, a gentle guiding of the conversation or even sometimes I can’t make that decision or I can’t do that, you know. You know, it was a good reminder or wake up like, “Oh yeah, this is this relationship,” you know [R: Yeah].

R: Is there anything more with your experience of the therapist’s presence that you haven’t mentioned yet? Um, and if there is something more about his presence, eh, could you please, eh, tell me how it helped?

P2: My therapist dresses very comfortably [R: Um hmm], you know what I mean. He’s not too suited up [R: Yeah]. He’s not, he’s not too, he’s very, um, eh, very comfortably, um, I’m trying to think, the only way I can think is to contrast him. I think you mentioned about his office too or something [R: Um hmm] like well that’s the thing. I was seeing a psychiatrist too at the same time. Like, you know, you could make them the antithesis of each other. You know, the psychiatrist, you know, had this cold waiting room. You go into an office that looks very much like a medical doctor’s examining room. And, you know, he comes in and very formal. You know, asks you questions, you feel like you’re being raped, um, and then, you know, he leaves. You know, there’s no sort of comfort in that. And that makes my anxiousness, anxiety rise. But where my therapist on the other hand you’re walking into a, eh, you’re walking into an office, you know, that is really nicely lit, you know, has a couple nice pictures from Target. Sometimes when I’m at Target I see those pictures and get really calm (laughs). But he has a couple of nice pictures from Target, you know, comfortable couch. And it’s almost like his office is like another outfit he’s wearing [R: Um hmm], you know, it’s very, very easy, you know, not too sophisticated, just very comfortable. You know, you just feel like you could just sink yourself in there and talk, you know [R: Yes]. You know, so there’s that sense where you’re just, your defenses are brought done by just sort of the way he is, you know, just a man of a certain stature. But I, I think there’s some validation for that, you know, when I really reflect on that I do think in his dress and definitely his office really convey safety and sort of like, “You can be open here [R: Yeah]. And you’re not being judged here [R: Yes].” You know, the psychiatrist I’m seeing currently has the same sort of rapport where you’re like just not so much, you know, his office has a whole bunch of little artifacts around, you know what I mean. So, I’m going in there and it is not like I’m being examined or raped, you know. This guy’s here to help me [R: Yeah].

R: So, just the set up of the room itself [P2: Yep] the [P2: Ambience] ambience and that comfort helped you to, um. How did it help you then?

P2: Well, your blood pressure drops (laughs). You’re, you’re a lot more just able to get out what you want to say [R: Yes]. That’s the best way I can describe it. You weren’t, never felt probed. I don’t like to feel probed and I never felt probed in therapy. You know, just everything seemed so natural and it seemed to happen in a very natural way.
P2: In paragraph thirteen you mention your therapist’s insight concerning acceptance. What did it look like the process of you coming to understand his insight and ultimately accepting your depression and, eh, surrendering?

R: Um, well, what sticks out to me is when the anxiety started again and I got depressed I was saying, “I can’t believe this is happening. I can’t believe this is happening. I can’t believe this is starting. I thought this was over.” And my therapist said to me, “You know, it might be a real possibility that you have to live with this for the rest of your life.” And not, when I’m depressed that’s one of my thoughts that causes a lot of depression [R: Um hmm] because I think about it in sort of an unrealistic way. But he was like, you know, “It might just be every three or four years you’re going to have a couple weeks to a month where you really get hit hard.” You know, and at first the gut, the gut reaction was, um, one of how dare you [R: Um hmm]. You know, this is supposed to give me hope and you’re tearing hope from me: how dare you? I mean I have to live with this for the rest of my life. You know, and then the battle ensued, you know (laughs) [R: Um hmm]. And, eh, not between him and I but in my head [R: Yeah], you know. And, eh, and of course I sort of placated. I was like, “Yeah I guess you’re right.” But in my head I was like, “No.” And the battle in the coming weeks, you know, it was just sort of realizing, realistically saying, “Yeah, I might have to deal with this.” And again seeing it for what it is you sort of were like, “I could deal with this if this actually comes every three to four years,” you know [R: Um hmm]. And then you almost start thinking positives like, “Well, it’s sort of like a self-checker [R: Yeah].” You know, it keeps me humble. It keeps me from losing touch with myself, you know. Because of this sort of reoccurring depression and panic every now and then, and each time of course it gets a lot less worse, but I’m not going to wake up twenty years from now in a job that I hate and a life that I hate and not know my wife because every three to four years I’m forced to have this breakdown where I’m forced to reexamine everything and I’m like, “Oh yeah.” You know, it’s almost like a maintenance or an oil change [R: Um hmm]. But, um, that was, that was sort of the battle of acceptance, so it was really sort of looking at it in the face and seeing it for what it was. You know, being able to surrender. And just, I think even in that moment when I was on the, in the church, you know, when I was praying and sitting there fighting God, you know: “Why? Why? Why does this hurt so bad? Why?” You know, and just crying my eyes out. That was me fighting. That was me sort of exerting so much energy on that depression and exerting so much of myself. And of course that fed to me getting more depressed and more anxious and getting more worn out [R: Um hmm]. And, um, me just lying my head on the alter and going, “This is yours. You deal with it,” you know (laughs) [R: Um hmm]. That in itself even though that weird spooky verse thing happened at the same time (laughs) but that was a moment of surrender and saying you deal with it. And when you sort of let go and I used the, the sort of the example of the river before too. I’m sitting there swimming against the tide or the current and I’m fighting against myself and the only way to really live is just to let go and float with it [R: Um hmm], you know. In there there’s almost a sense of hope that begins to creep in. And I think I remember reading during that time, you know, I read The Road Less Traveled. You know, one of the things that Scott said, Scott Peck, was, you know, life is hard and the second you realize it is the second you begin to actually have some hope [R: Um hmm]. You know, it was sort of realizing that, you know. I
think we’re raised with the lie by our parents that life there’s going to come a moment in your life where you get it, you know, where you understand or that’s even the American thing where you get such and such a thing then you’re going to be alright or you made it. And sort of depression is almost a reaction against it. I know life is really hard, you know. Only when you realize it then you’re able to actually, you know, instead of fighting it, yeah, so that was sort of the way the process was.

R: Yeah, so the acceptance, the surrendering let some light in, some hope there’s almost an opening of the future [R: Yeah]

P2: Yeah, in a religious way the apostle Paul, St. Paul, his apostles are so big, so big. And I mentioned it in the written description and so I don’t have to retell that story. But even again he was just talking about and another thing he was just talking about contradicting thoughts [R: Um hmm]. And he comes to the point and he says, “Who will save me from this body of death?” You know, that’s his point of I can’t do this anymore. And it’s right when he says that he says, “Thank God for Jesus Christ,” you know what I mean [R: Um hmm]. It is just sort of the second he says I’m through, I can’t do it, my self is emptied is the second that sort of hope comes in [R: Um hmm]. And there is a huge religious element to that.

R: With that, with the scripture you were mentioning in the written description [P2: Um hmm], um, was, was and this depends on when you read it [P2: Um hmm], could you please tell me more about the way it helped you accept and surrender or the way your accepting and surrendering helped you to understand the scripture?

P2: Um, when that scripture popped out to me there’s two instances where I felt God truly talked to me through scripture, actually there’s a couple more, but two huge. And the one was that day that I described with the Psalm in the church. And this was the second time. This was, um, um, I had graduated college and it was that summer and I was about to go away to Florida to do that mission project [R: Um hmm]. And, um, like two weeks before I was to go down I, eh, I had a little a couple of panic attacks. And again I was doing the classic: “Why? I can’t do this,” you know. And I was fighting and fighting it. And, you know, um, there’s a stream in Christianity that believes if you truly believe things you would be healed. And so that’s a fight that I have to have because there’s a lot of Christians that I would talk to that would say to me, “P2 you’re not healed yet, you know, you don’t have enough faith or something.” So, you know, you’re, you’re battling out with this or then you start to doubt your faith and then you start to doubt God and. So, I just randomly reading this passage and, you know, it was just on my reading for that day. And I’m reading it and Paul’s just talking about these amazing revelations he’s had. And he says, “To keep me from becoming concended because of these revelations there was a thorn given to me, you know, a thorn in my flesh.” And then, you know, he’s, and then right there I sort of became part of the story, you know. I was like, “Yeah. This is kind of like a thorn in my flesh.” And then I kept on reading and I was like, “Three times I pleaded to God to relieve me or to remove this thorn.” And I, I thought about myself again. You know, I’m pleading, “God get rid of this thing,” you know [R: Um hmm]. And then, you know, God said to me, I can’t quote verbatim, but,
you know, “My strength is sufficient for you, you know. My power is made perfect in weakness.” And that was one of those moments where I almost got thrown back into my chair because it was like, “Wow it is,” (laughs) you know [R: Um hmm]. And you will get me through this. And the Apostle Paul, you know, almost like a therapist somebody that, you know, is renowned in Christianity, you know, had this experience of pain not being lifted and pain being a present reality and experience. And not only that, but being something that was almost given to him by God to experience God in a more, you know, intense way, you know, really spoke to me and just allowed me to go, “Okay. I trust for your power to remain perfect in my weakness. I trust that your grace is sufficient.” But that was sort of the experience there.

R: And then was that, that was helping you.

P2: That was the only way I was able to go to Florida was because of that experience. I was like, “Okay. I trust you and I surrender.” And of course that experienced has been replayed and replayed and replayed, again and again and again.

R: And so then in accepting and surrendering to the anxiety in this instance and accepting and surrendering to the anxiety and depression in the more recent episode you were drawing on a previous experience in therapy then.

P2: Oh, yeah, yeah, I had a freaky dream over the summer that preceded the episode. I was walking on a sidewalk. It was sort of one of those dark, dark summer nights, you know. I’m walking with some guy I didn’t know, and I’ve identified him as Jesus right now (laughs). But it was just some guy and we were just talking and I was having this really good feeling and then all of a sudden the sidewalk and the road just end and in front of me is nothing but complete darkness. And the guy beside me is saying, “Go just keep going.” And part of me wants to, but I can’t. And a voice comes from the darkness, “Do you trust me? Do you trust me? Do you trust me to let go? Do you trust me?” I imagine sort of the trust fall exercise [R: Yeah]. Just sort of like falling back into that darkness [R: Yes]. And I woke up screaming [R: Um hmm]. But the dream was so real that I was like, “What is this trying to tell me?” And it almost, that’s was my experience during that following academic year of: “Do you trust me in this depression? Do you trust me in this anxiety? That although everything is pointing contrary to what your belief is, do you still trust me? Or do you trust me with your future that is complete smoke?” Yeah, so, so I mean that is, I think especially in Christianity more than other religions where most religions are what can I do to climb the ladder, Christianity is I need to die to myself and just sort of completely be at the mercy of God and trust, you know. And that mostly can only be occurred through immensely painful experiences [R: Um hmm], you know, like depression, anxiety, tragedy, any of that stuff.

R: In paragraph fifteen, you were mentioning some other things. I was wondering if you could tell me a bit more about coming to understand family struggles in therapy and what that looked like?
P2: If you would ask me before I went into therapy if my dad had an anxiety disorder I
would have said no. After therapy I would say yes. Seeing the way he deals with when
he’s sick. But seeing the way his thoughts he gets so internal focused or his heart
problems he doesn’t really have that many but if he feels pain wrap around his back a
little he goes to the worst case scenario [R: Um hmm]. So, although it doesn’t exhibit
itself in symptoms of an anxiety attack per se he always instantly goes to worst case
scenario thinking [R: Um hmm]. I think that has an effect and I think therapy sort of
helped me to realize that, you know. And sort of there is a, a learned behavior there [R:
Um hmm], you know. I mean, you know, it’s snowing outside right now, you know,
what in going outside anywhere in the snow the first thing they would say is be careful
and always worry. That’s one thing I really notice about my dad is just seeing whoa I got
a lot of that in me. So, like understanding origins [R: Yeah]. When learning about
family systems stuff I can go back to my paternal grandmother. But then with my mom
and just seeing, you know, her worst case scenario thinking but also seeing her always
trying to protect dad or always protect me from dad or always trying to protect us from
something else or constantly, you know, assuming this role of, eh, protective bear from us
and the world, you know [R: Um hmm]. And just trying seeing where that prevented me
from having some real life experiences to sort of, you know. And, and seeing the way I
try to run back to that comfort [R: Yeah] when I’m having panic whether, whatever is
representing a mom at that point, you know [R: Yes]. And, um, so I think those are two
big things and seeing how those really went into defining the voice. And, you know, just
really learning how my, um, anxiety didn’t come out of a vacuum [R: Yeah], obviously.
But just seeing, you know, as a family and you could even throw it as the extended
family, you know, how these anxious patterns exist [R: Um hmm]. You know, so it
wasn’t to place blame on any family members [R: No]. But it was to be able to realize
there was just and it helps me with acceptance too [R: Yeah] to realize that, where it
comes from.

R: So, part of the therapeutic work you were able to then see where the anxiety came
from [P2: Yeah], your father’s anxious, your mother’s anxious [P2: Yeah] and then you
were able to see another thing.

P2: Well, they’re both different kinds of anxiousness though, you now, my mom and dad.
I, I would say [R: Um hmm] like my mom is protecting and dad is a lot more internal [R:
Um hmm] a lot more withdrawn.

R: Yeah, so you were able to see their different anxieties [R: Yeah] and how that
contributed to.

P2: I noticed that I know more of my patterns. First, I would say it’s all from my mom.
But then when I walked out I’d say, “Some of it’s from my mom and a good deal from
my dad,” [R: Yeah] you know. I’m trying to think of another thing about the family that
we dealt with well.

R: The one thing was there own anxiety patterns and the second thing was, um, your own
tendency to want to come back to mother in light of the safety she provided when anxious
or depressed. And how, I’m hearing how that helped was it helped you to see it for what it was.

P2: Yeah, what it was and it also helped with acceptance [R: Um hmm]. Um, it’s comforting to know it didn’t come out of a vacuum, you know, to know that in some weird way mom and dad experience this not to the same degree, you know. When learning about family systems theory to see that part of my anxiety is just a product of that chronic anxiety that is manifest in my family as a whole really had also really been cool to look at that. And I think that’s part of the same thing just a different way of saying it, you know. Just knowing it doesn’t come out of a vacuum is a great comfort when you feel completely alone too [R: Yeah]. But then being, it sort of made me aware better aware of those patterns within myself [R: Yes], you know. And so when I start doing things like my dad I can go, “Oh wait a second that is dad and not me” [R: Um hmm]. When I start being my mother or trying to go back to mother, I’m like “Oh yeah.”

R: So, it was understanding these other’s your mother and father [P2: Yeah] that enabled you to better understand yourself.

P2: Better understand myself and where they are in myself kind of [R: Yeah], you know.

R: You also were talking about at the end of the written description, um, coming to understand your thought patterns more in therapy. Could you please tell me more about that?

P2: That focused more on the cognitive aspect of my problems. I think we dealt with some of that. Um, one of the things, you know, like the, um, exercise of really, eh, run with that thought I would say is understanding [R: Yeah] those. Um, and knowing that, you know, I could think one thought right now and thirty minutes later that thought could be a panic attack [R: Um hmm] but I might not even realize that. It might just be I think one anxious thought and then thirty minutes later I might have a heart palpitation because of that one thought I had [R: Yeah]. Sort of, I’d say it’s more in the mechanics of just understanding that oh this came from that. And sort of so again that’s the theme you’re going to write a million times in your paper is that seeing it for what it is, you know [R: Um hmm] and just going, “So that came from that, oh. What am I really worried about here? Oh I’m really worried about going in front of people and talking or something,” you know. Just that’s sort of an example but just understanding where those bad thought trains start and sort of being able to derail them whether that’s through, um, you know, doing something like playing guitar [R: Yeah] or doing something like making love to my wife, you know. But just doing things like that or just touching a table or just doing that so that’s part of the thought pattern just getting out of yourself. Being able to realize where they are and where they begin and what they start. So, it’s more dealing with symptoms as opposed to dealing with the, with the, um, root of the problem [R: Um hmm]. I’m, and you can say those do deal with the patterns too, but I think those would be a lot harder to articulate.
R: Yeah, and can you think of any one off the top of your, a thought pattern that contributed to your sense of depression or despair at that time or that you looked at in therapy?

P2: Well, I definitely would say going into myself and getting swallowed in my hole [R: Yeah], you know. And in the subsequent episode, um, one of the things I would do to get out of that would be to watch comedy sitcoms on television and laugh my head off. But that would get me out of myself. You know, and just I think one of the things I notice is just this is my inner dialogue: “Oh I’m anxious right now. Aw is this my future? This is it. Aw I don’t want to go through this again. Oh I don’t have the strength to deal with this. God, why are you making me deal with this again? Aw I can’t do this. Oh I don’t want to do this. Oh, oh” (accompanies dialogue with hand gestures and changing intonation to indicate moving and feeling down). And then before you know it I’m crying my eyes out. You know, here we go again. So, I started being, “Oh I’m depressed right now oh,” and I think it’s good to reflect on that but it’s not good to sit in that cesspool [R: Yeah], “Oh let’s watch a comedy” or if I’m not there “Let’s play guitar or let’s maybe think about something good in the future, you know [R: Um hmm].” Or, let’s, let’s do something that takes me out of that cycle. So, I think that’s one of the biggest functional thought pattern things I would notice in depression [R: Um hmm]. I mean they’re so similar to anxiety. I mean they’re such the same monster in my head [R: Yeah], you know. They’re separate in a sense, but, you know, it’s the same internal dialogue happening [R: Yeah] just what provokes anxiety while the other provokes depression.

R: Yeah, and the one that provokes depression it sounded like that one was just one that would bring you down.

P2: Yeah and it’s provoked from outside panic circumstances or outside circumstances [R: Um hmm], but it’s the same, you know what I mean: “Oh my heart just palpitated. Oh I’m going to have a panic attack, oh this panic,” and then before you know it I had a panic attack, you know, “Oh this really sucks right now, oh blah,” and then I get sad. And the cool thing is you can even notice it in everyday non-depressive circumstances [R: Um hmm], you know. Like and that’s one of the things connecting me to my parents, you know. Like my dad if something went wrong with the house you would see this thought pattern before you know it like it’s the worst thing that, that pipe is leaking: “Oh my goodness this pipe is leaking. I’m going to be stressed off and pissed off about this for the rest of the day.” You know, where I would visit another house and the pipe was leaking: “Oh the pipe’s leaking that’s a project to be accomplished,” you know [R: Um hmm]. And so noticing that stuff in myself in normal days: “Oh I got to do this paper right now. Oh this really sucks I got to do this. This is the rest of the semester,” you know [R: Um hmm]. Or, right now I’m sick: “Oh I’m sick right now this really stinks, aw,” you know [R: Yeah]. But just noticing those thoughts in my everyday life, you know, almost anxiety and depression is just an exaggerated version of my everyday thinking [R: Um hmm]. So, being able to address those everyday thinking patterns too [R: Yeah] was a really big thing. And, you know, that’s, again that works for the parents, that’s a learned behavior. And that was all around both mom and dad had that
catastrophic, giganticizing thinking is it, [R: Catastrophizing] yeah thanks, where it’s like
something that could just be a mere task to be accomplished is this chore to be done.
And I think that there’s, there’s something to say there [R: Um hmm]. And therapy
helped me to realize there are other ways to think [R: Um hmm] and that that isn’t
necessarily the way everybody thinks.

R: Yeah, yeah, so learning the way you were thinking in the therapy you were also
developing [P2: Yeah] different ways of thinking.

P2: Yeah, different ways of being in the world [R: Um hmm], you know, and ways to
observe the way other people think, you know. Ways to see the way my wife thinks
that’s a lot better than me, you know, and ways to see where she thinks that’s a lot worse
than me. Or, you know, ways to see how other people think and trying to adopt those and
make those your own. I mean it’s really hard to break those huge massive habits [R: Um
hmm] and they’ll never be completely broken until the day I die. You know, there’s a
sense that that’s always going to be with me. But just the fact that you’re aware of them
you can go, “Oh my gosh,” and just laugh at yourself [R: Yeah].

R: Also, toward the end of your written description I was wondering if you could tell me
about coming to understand internal dissentions in therapy. Um, what did that look like?

P2: What I just described [R: Okay], that’s what I just described. Um, just, you know,
how I would fall into myself [R: Um hmm] and, you know, get to the point, you know,
like that thought pattern was like, “Oh this, oh this, oh this.” You know, how I would
pretty much just put myself there sometimes [R: Yeah]. I don’t want to say it was always
just me. Just how I would take random given challenges and descend into myself [R:
Yeah]. And therapy through whether through recognizing it for what it is, through
touching things, just through all those things we’ve discussed already helped me to not do
that [R: Yeah]. And helped me to recognize that for what that was.

R: Um hmm, is there anything else off the top of your head that you feel we left out
today?

P2: No, this is all good!

R: Sounds good, excellent!
**Please describe in concrete terms what your depression was like before entering psychotherapy, at the end of psychotherapy, and how you are different now.**

There I was on my knees praying for relief from a pain I had never felt before. It had been almost exactly a year since I was diagnosed with Panic Disorder. Things had gotten better over time, but now the symptoms of anxiety and panic were back with vengeance.

R: I was wondering what was going on in your life around the increase in your anxiety and depression.

P2: I would have to say was that it was the beginning of a transition, sort of in the middle of a transition that I was having. I was in my junior year in college. I just started dating my girlfriend, now wife. We were in the beginning stages of our relationship then. I started to think about the future. You know, what am I going to have to do after college? So, those questions become more pertinent as the year went on. So, there was this looming anxiety over everything, all the new things and all the unknowns. That’s sort of the context of where I was. I was sort of in a shift in my life almost, if that makes sense.

R: That definitely makes sense. It was definitely a time of transition. There was a part concerning things that were coming up with you with your future and also things specifically with your relationship.

P2 experienced panic attacks and entered psychodynamic therapy. P2 felt his panic attacks were no longer an issue, as these occurrences had decreased, but one year later his experiences of panic and associated anxiety increased in frequency and intensity.

P2 was entering a transition phase in his life. He was beginning a new romantic relationship with his girlfriend and thinking about employment after college. P2 had experienced a looming anxiety concerning the unknownness of these engagements and sadness over longing for old ones.
with your girlfriend.

P2: Not specifically with her, that was just one of many, many things.

R: Were these things then contributing to your sense of anxiety and depression at that time?

P2: I would definitely say anxiety and I would say sadness. I wouldn’t say depression quite yet. Because there was the unknowing causing a sense of sadness in me. I think, as I mentioned in the one part of the written description too, where I was sad that the past was no longer too because I was so anxious about the future, and the present was sort of shaky. I sort of looked to the past in a sad longing way, so there was a little bit of that too.

R: I was wondering too were these things you were coming to see in therapy? The way the situation in your life, the transition, was this something you came to see in therapy as contributing to your anxiety?

P2: Yeah, and in therapy it revealed a life-long pattern of that too. Pretty much every transition I went through all my life, it might not have been a depression, but there was always a sense of a melancholy, you know, leaving things behind. So, I think there’s a pattern there that can probably stretch all the way back to going to kindergarten.

R: Okay, could you tell me more about that? Is there specific things that were, specific instances that were highlighted in therapy?

P2: Well, going from elementary to middle school that was hard on me. I went through a situation then. Leaving high school, I

In therapy, P2 identified this transition and its relationship to his feelings. He moreover articulated a life-long pattern of feelings of anxiety and sadness, and sometimes depressed moods as well, coming to the fore during transitions. After therapy, P2 was able to identify and address such feelings when they arose upon leaving graduate school.
didn’t really enjoy that either. Of course, leaving college there was a little bit of anxiety there but not much because I was happy to get out of there. Then even most recently leaving grad school and going into the unknown of the future there too. There was an awful lot of depression and anxiety around that. Only I was able to identify that a lot better and address that, as opposed to before where it was just so automatic that I couldn’t control. I don’t want to say control, but I couldn’t address it.]

What surprised me about this acute period was the emptiness that accompanied it. It was an emptiness that I had never felt before. It was as if there was a hole in my heart and I had fallen through that hole.

R: In paragraph one, you started your description writing about a night that occurred at the peak of your depression and that was a very vivid description. I was wondering what was significant about this night. I see you chose to write about it first and so I was assuming it had significance. So, I was wondering about the significance concerning what it manifested, what it was showing you or me about your experience of the nature of depression.

P2: Well, it was sort of the water shed moment of, I’d say almost my life, but of that particular episode of depression, of acute anxiety and depression. I, anxiety, my panic attacks had started the year before and I started therapy for them. They had since decreased and I wasn’t having a problem. Then all of a sudden the spring of that year it just started popping up again, the panic attacks. Before I knew it, it started taking parts of my life again. I started to become

With the increase in occurrences of panic attacks, P2 did not want to leave the safety of his home and felt sad and weak as the sphere of meaningful engagements in his life shrunk. Moreover, P2 felt frustrated about the reoccurrence of panic attacks and discouraged about the possibility of having to endure them throughout his entire life span. P2 began to feel depressed and felt a sense of emptiness like there was a hole in his heart.
agoraphobic, not wanting to go out of the house as much. As this started happening, just this overwhelming sense of weakness just started to creep over me and sadness, sort of in a similar way to the more recent episode. Just, “Oh my God, I thought I was done with this, not again, not again, not again, not again,” you know. But this time it was like, it was like, “Holy shit, is this going to be my life, for the rest of my life?” And I started getting really depressed about that. Then what would happen is I would get so depressed that the depression would feed the anxiety, the anxiety would slowly feed the depression, and it would just become really bad. What started happening the day before or two days before this night was the depression and darkness was getting so great that I started becoming anxious of what I could do with that darkness. It wasn’t like suicidal thoughts, I wasn’t looking at things thinking, “I could do this to kill myself.” It was: “Oh my God I’m so depressed, I’m going to kill myself. What if I kill myself?” It was sort of typical anxiety. But then that would feed the depression and then I had no idea of what I was going to do. It also produced quite a nasty cycle. I got so depressed, so vacant, so dark that I had no idea what I was capable of. I never dwelt on suicidal thoughts, but with the emptiness I had no idea how far it (the emptiness) could go. Naturally after that the panic would kick in. My inner dialogue would say, “Oh my God, I’m going to kill myself… I’m going to go crazy and kill myself…” Before I knew it I was in a full blown panic situation because I was afraid I couldn’t trust myself to myself. And of course after that, I would be more depressed because the situation seemed more bleak than when the hopeless

When P2 encountered intense feelings of depression and emptiness without an understanding of these feelings, his sense of trust in his own capability was shook. He felt anxious and worried that such dark feelings indicated that he was crazy and would kill himself. P1 then felt more depressed, as feelings of anxiety and depression arose in a cyclical relationship.
feelings began to emerge and thus the whole cycle would begin again. This is what brought me to my knees on that evening in March when I had no idea what I would do. “God please help me! Please, please, please…”

R: I was wondering. What were you expressing in your description when you typed the “please” in lower fonts?

P2: That’s sort of the way I felt. I was like, “Please, please, please” (Voice Trails Off), you know? As the anxiety and depression increased, I kind of felt smaller and smaller and smaller and weaker and weaker and weaker. That’s sort of what I was expressing there.

R: So, it was you were feeling smaller.

P2: Yeah and weaker and like you were in that dream that classic nightmare of somebody’s chasing you and you can’t run away. You know, you’re stuck there. You’re just like, “Please.” Then you’re stuck in the dream and you can’t wake up. It’s sort of like that sort of phenomenon almost. I never had any of those dreams during those episodes. But just like those childhood dreams you used to have.

The night of that prayer was at the peak of my depression. I felt completely alone and isolated from everyone around me. No one seemed to understand what I was going through. I felt so remote from my family, friends, and girlfriend (now wife). People kept their distance and did not address the big issue in my life. I liked it that way. Alone to deal with this unknown darkness.

That night I tried to open up to my girlfriend about what I was feeling, but I couldn’t. The second I started to express the darkness and felt as though

| One night stood out for P2 as the culmination of his suffering. He was in his room praying for relief, yet even in these efforts, he continued to feel weaker and weaker. |

| P2 felt alone and isolated from significant others, as they appeared to lack an understanding of his struggles and so kept their distance. |

| P2 was beginning a new romantic relationship and such feelings of anxiety and panic were novel to his girlfriend. In a perplexing turn, he experienced more |
she would reject me and consider me crazy for having such terrible thoughts. Thus, panic set in and I fled from the situation. She was also terrified that I was going off to kill myself, but I tried to assure her I wasn’t. I called my mother and asked her to take me to an empty church where I could have it out with God.

P2: And my girlfriend and I were rather new seeing each other, so she wasn’t quite as used to this anxiety as other people in my life were. So, my anxiety almost attached itself to her in some weird way. I got anxious when I was by her, and not just anxious like nerves, but panic attack symptoms when I was around her. So I started to avoid seeing her. I became pretty damn depressed about that too. So that night, that sort of brings you up to date, I was in the heat of that. So that night, I went out to meet my wife, on a, a bench at the University. And we’re talking and it hit again. I was just like, “Honey, I got to go. I’m sorry. This is hitting me real hard.” She was sincerely afraid that I was going to go somewhere to kill myself. Her saying that only upend that fear in me and only upend the depression. It was really a horrible feeling of helplessness: what am I going to do? Every constant in my life just seemed to mean nothing. Everything just seemed to be swept under my feet. What I’d do at those points is I would really feel a strong urge and call to pray because for some reason when things go crazy in my life that is the only thing that remains standing. That’s the only thing that’s there. Even that, of course was shaky at that moment. So, I called my mom and had her drive us, drive me to, my grandmother’s church where we had the keys to. It was just sort of this empty, old, dingy sanctuary where I just sat and prayed and just let out these,

anxiety and panic in her presence and so avoided contact with her, which contributed to his feelings of depression.

On a bench outside his residence hall, P2 attempted to trust his girlfriend and shared his struggles with her in the face of his fantasy that she would consider him crazy and reject him, but in the midst of his attempt, he felt panic. As P2 started to flee from her, his girlfriend worried he was suicidal, thereby validating his fantasy of her response, exacerbating his own anxiety, and contributing to further feelings of depression.

P2 sensed that all his engagements provided him no hope to hold onto and he felt helpless. P2 still felt a call to pray and went to an old and empty church. He screamed and questioned God about his suffering, his faith, and God’s sovereignty. P2 felt abandoned even by God and he laid his head in exhaustion on an open Bible only to see a Psalm concerning trusting God and God providing solace. He felt hope and found an engagement with something solid outside himself to hold onto.
let it out. Almost in the latter episode when I surrendered to the depression it was a very similar thing. I just let it out screaming at God in the sanctuary, “Why, why is this so painful, this unknown darkness? Why is this so, so bad?” I just had it out. I was just completely in this honest moment where it was like, “Either you show up or this is over,” you know.

With tears streaming down my face I screamed to God. “Why, why, why, is there such pain!?!?” “How can I even believe in you, when my heart is so empty!?!?” “Why are you allowing this!?!?” “Why are you doing this!?!?” Bent down, feeling abandoned even by God I laid my head upon the alter sobbing. Opened in front of me was the alter Bible and looked to see what it was turned to. It read, “He who dwells in the shelter of the Most High will abide in the shadow of the Almighty. I will say to the Lord, ‘My refuge and my fortress, my God, in whom I trust’” (Psalm 91). At that moment I felt in my heart something that had been missing for quite some time: hope.

P2: There’s an old church set up so there’s an alter with one of those big pew alter Bibles and I just put my head on it because I was completely exhausted. I looked up and there was that one verse that I wrote in the description, “The Lord is my refuge, my fortress, my God in whom I trust.” It was weird at that moment. It was just like beyond any comprehension there was just this sense of peace. The sadness was there, the anxiety was there. But the reality that something was solid beyond me really, really helped. That’s just being able to grab onto something. That was, I was thinking of the episode of Lost last night where Desmond was trying to find a constant to keep his brain from blowing
up. It was very similar. It was just with the latter struggle you can even say that there, there’s, I recognized a lot more constants in the world. Where at that point at that day that I wrote and described everything felt as if it was failing me. And because I didn’t have the experience yet in therapy, because I didn’t have the experience dealing with my panic disorder or depression I, I didn’t have the tools necessary in me to grab onto things in the world. So, that is why that is sort of a big moment for me because I don’t know what would have happened in my life if that wouldn’t have happened.

R: So that thing I’m really hearing is something beyond you, you were able to grab onto as a constant. And something that was standing out when you were saying that to me and I’ll see if this resonates with your experience. So, internally the anxiety and depression were feeding one another. So, internally there wasn’t this sense of something to grab a hold of. Relationally there wasn’t a sense of something to grab a hold of at that moment. Then in the church there was a sense of even can I grab a hold of God, something outside myself. Then you were able to reach a hold of something outside yourself.

P2: It was freaky that it was turned to the verse that spoke to dwelling and abiding, refuging, and trusting. So, it was kind of one of those moments where you were just like, “Hello.” But that’s a really good way to put it. It was finding something to hang onto in that moment.|| I said it before and I’ll say it again just in case I’ll miss something, I didn’t have yet what was necessary to be able to know that, to be able to separate almost, and this could be unhealthy too, to be able to separate my feelings from reality. I felt so sad and I

P2’s prereflective experience of panic and also depressed moods led to reflective conclusions that he was becoming insane. To rectify this, he developed a repertoire of prereflective engagements with activities in the world, such as playing guitar, to provide stability.
felt so anxious, but was that necessarily reality at that time: no. You know, things weren’t going to go completely, I wasn’t going to go completely bonkers. That’s where in therapy we started going into that and looking, “what are some things you can do to really put yourself in reality in those moments?” You know, playing guitar or eating a sandwich or, just doing something like that really getting a sense almost of your being-in-the-world, you know?

R: So, if I was hearing you right there, in therapy there was a developing of a part of yourself that was separate from what you were feeling in the moment, I guess sort of a different part of yourself. Like, you were saying that what you were feeling was connected with what you thought reality was. But was therapy then a developing of a further distinction in yourself between what you were experiencing and what you were observing?

P2: I might use different words. I don’t want to separate it, that’s the thing, I don’t want to separate it too much. But it was something to grab onto that makes you realize you’re not going to get sucked into yourself, you’re not going to go into some sort of. At that time I wasn’t so familiar with the symptoms of panic so I thought I was going crazy. One of the things my therapist did was in making me grab onto that outwardness. I didn’t suck into myself. That’s where the circle or whatever goes so fast. The feeding between the depression and anxiety starts to really speed up.

R: Yeah, yeah, so there was this development of something internally that you were able to become rooted with and grab onto.
P2: It would be more almost external though because I’m grabbing onto something outside of myself because the internal was such a mess.

Upon expressing these thoughts in psychotherapy I began to feel a burden lift off my shoulders. For reasons that will be described in the next section, psychotherapy took the burden off my shoulders. I no longer had to hold this depression all by myself. The sense of extreme isolation began to lift.

R: I was wondering about something concerning paragraph two and three. In the midst of your depression, you said you felt isolated from others. I was wondering after this depression and course of therapy, what was your experience of relatedness to others?

P2: I think the best way to do that would really, be to use my wife as an example, who was then a girlfriend. The episode I’m sharing is when that all sort of fell apart. She didn’t know what was going on with me. As much as I tried to describe it, she didn’t understand it. You know, that was pretty much endemic of everybody except for my therapist at that time. They all had their thoughts and ideas of what was going on. But the dark abyss that I was feeling and having was so dark at that time that oh my gosh if I were even to let a tidbit of this out, she would completely reject me. So, again just like everything else that builds on top of each other. You know, you worry, you isolate yourself, just it’s again circular. I’d explain it to her, but she was rather, I don’t want to say freaked out, she was supportive, but there was a sense where she didn’t know what was happening at that time. Whereas now she has a much better understanding where it’s

In therapy, P2 did not have to keep his experience of depression to himself any longer, but he expressed his thoughts and feelings to his therapist, which left him feeling less burdened and isolated.

P2 fantasized that if he would describe his experience of depression, his girlfriend would reject him. When he did, his description provoked her worry because she did not understand his experience, and he in turn felt more anxious, especially in her presence. P2 isolated himself from her, which further contributed to the intensity of his feelings of depression.
like, “Oh P2 stop it.” Where now, but before it was like she got sucked into the fear of what was going on. So, there was just this sense of isolation from the person I felt closest to before. I think that contributed to the fear and depression of that moment. But even with normal relationships and friendships nobody really wants to hear your crap all the time. So, it’s like my roommate in college at that time would say, “Aw, that sucks man.” But then you’re onto something else. That vacant area is left unattended to when you feel worse and worse and worse. People that you come to for advice they have answers, but it’s just again it’s worse and worse and worse. And no amount of pick yourself up by the bootstraps or any of that sort of talk could really get you out of that, that spiral that you’re in. The second part of that, what after this depression and course of therapy, and I mentioned this sort of in the written description paper again with just, walking into that room and knowing that for fifty minutes that this person was going be able to maybe not even understand your experience, but you’d be able to express your experience to this person. In that, as I mentioned right in the beginning, puts it where it is. All of a sudden depression isn’t this dark secret or the anxiety this dark abyss. It’s just these momentary waves of feeling that take me over, and quite frankly the thoughts aren’t that disturbing or the feelings really aren’t that bad. They’re just, there fleeting moments, you know. Just being able to talk those out. My therapist could not have said anything, you know, and that would have been healing, you know, maybe not as completely as if he did talk. But, just being able to, to put it out there just makes you see things for what is. I think that’s a theme if you’re noticing: seeing it for what it is, as opposed to seeing it in the sort of

When P2 would express his feelings in friendships, friends would either acknowledge his experience, but not fully attend to his emptiness, or offer him advice that could not bring emotional relief.

For P2, expressing his feelings of anxiety and depression to his therapist was therapeutic insofar as he co-constituted his experience outside himself in the in-between of the therapeutic discourse. By bringing it to light, he came to learn that his experience was not that dark, disturbing, or bad, but just feelings of a transitory nature.
exaggerated, emotive state.

<table>
<thead>
<tr>
<th>R: So, during the depression, there was the experience going on with the anxiety and depression, and then you couldn’t, you feared to express that to your girlfriend.</th>
</tr>
</thead>
<tbody>
<tr>
<td>P2: Even when I did there wasn’t the connection because it was so foreign to her or to anybody else.</td>
</tr>
<tr>
<td>R: Then in therapy, you came to see the isness of it, you came to see it for what it is. And then afterwards within the relationship then was that something that changed in the way you articulated it outside of therapy, was that something you could share more easily?</td>
</tr>
<tr>
<td>P2: Well, I definitely could be more open with my wife, my girlfriend at that time, you about what was going on because there wasn’t that ‘ah’ attached to it even though, even if she would get sort of freaked out, I, her freaking out didn’t feed mine because I knew it for what it was because I knew it for its isness, you know? And so I was able to express things more to her without that sort of ‘ah’ attached to it. So, soon she began to be able to realize what was going on because I was actually able to express it. So, then a positive circle began. You know, normalcy was resumed in our relationship. Then with others beyond that, like friends, that just became easier because I didn’t have to express everything to them, but it was okay that they didn’t understand or they didn’t know what to do or they didn’t want to understand because I knew it, I knew it for what it was. So, I was able to resume normalcy with them. It wasn’t so isolating.</td>
</tr>
<tr>
<td>R: Yeah, there’s something really important with what you said there. I</td>
</tr>
<tr>
<td>With his understanding of his experience of depression formulated in therapy, he did not panic every time depressed moods arose, and so did not need his girlfriend to stay calm to provide support. He was able to confidently express more personal thoughts and feelings to her, and she came to better understand his experience.</td>
</tr>
<tr>
<td>P2 also did not need his friends to attend to his feelings or to offer appropriate solutions. He felt more confident holding back disquieting thoughts and feelings, and was able to reestablish everyday contact with friends.</td>
</tr>
</tbody>
</table>
could see a self-other dynamic going on there where you were able to feel confident to share this and articulate it with others, and regardless of their response, you were able then to stand confident within what you know about this experience. And it was not isolating, but there was an opening. How about in the subsequent depression you mentioned? What was a, what was the difference in your relationships with others, let’s say your wife? In this subsequent episode, how did the relations differ?

P2: Well, definitely the sense of aloneness wasn’t there. There’s always a slight sense of aloneness, just because that’s depression, but, it wasn’t all encompassing. Of course now she understood what I was going through so she was completely solid during the whole time as opposed to, one of the things that happen when you’re together with people who do not know is they get sucked into not knowing what’s going on. They almost catch the anxiety bug. But she sort of didn’t catch the depression bug because she knew, “Alright, whatever this is it’s happening and it’s just an it. And it’s depression. It’s temporary, it’ll pass. And I’ll be here for him. I won’t be completely freaked out. Yeah, I’ll have pain when I see him crying his eyes out, but so what.” So, she was much more solid. Internally, I was just much more confident in the fact that she could handle whatever I could throw at her. I was confident that she wasn’t afraid that I was going to kill myself if I would mention all the despair. You know, that was a lot easier and the fact that it was five years after that first experience so, our relationship had grown.

P2 also shared with other important people that he was suffering, and in return, some of these people offered him stories of personal suffering they or their

When P2 encountered depressed moods for a short duration years after therapy, he experienced much less of a sense of aloneness or isolation. He felt confident in his wife’s capacity to maintain her composure in the face of him disclosing his feelings. She in turn appeared solid and demonstrated an understanding of his moods.
It wasn’t, I guess this is one of the hopes of therapy is that you’re able to do it to yourself and grab other people to do it to you. But, I grabbed those people who are important in my life and said, “Hey, I’m going through this, pray for me” or “Hey, just so you know”. And they were able to offer their advice, but just the fact that they knew was a big thing. And one of the neat things I found when I reached out and grabbed was just the universality that everybody, a lot of people have this: my sister has this, my wife has this, my brother has this. I was just really getting a sense of camaraderie with others. Even if they never had it themselves, they had been very close to somebody that had it. So, when I came out of my last one, I was very frank about it. And it’s just really a blessing to be able to know that you’re not alone in that pain and that other people are there.

R: So you were open up and to grab onto others, and then you were actually able to see your experience as somewhat validated by others who were having similar experiences.

Through learning more about myself, I began to be better able to handle the depression.

R: You said in the written description that before therapy you were afraid you could not trust yourself to yourself, not knowing your capability or the extent of the depression. However, in paragraph five you said that through therapy you learned more about yourself and were better able to handle the depression. I am wondering about this relationship of yourself to yourself. How did your relationship to yourself change?

P2: Well, in the top of the question, I could

family members endured. From these interactions, P2 gained a sense that he was not alone.

Through learning about himself, P2 was able to deal with his feelings of depression.

When he experienced symptoms of panic,
not trust myself to myself, that was mainly a symptom of my anxiety and the depression exaggerated that. Especially in this particular moment I am describing, I had very limited experiences with panic attacks and so there was still that mystery surrounding it. So, it was like, I’m sitting there and this dizziness or this feeling of depersonalization, all the classic DSM terms, would happen. I would have no idea of what’s going on so naturally that would lead to an almost behavioral change of like, “Oh crap, this happened. What if this happened?” You know, I just the what if train of thought: “What if I go crazy?” I mean my whole world felt like it was falling apart so the deductive answer was you’re nuts. So, then, when the depression started to kick in it’s like, “Boy, I never felt this sadness before.” And it’s like, “You’re nuts. You’re going to kill yourself.” So, then you have that thought and you’re like, “I don’t want to express that to anybody. They’re going to 302 me.” Is that the number? “They’re going to lock me up. It’s going to be like one of those movies like that Jack Nicholson one, but it’ll be like that and my whole life will be like that story because of these thoughts.” And so that was sort of the inexperience of not knowing what I was going through. So, therapy it helped me to see things for what they were. Of course my therapist being a very trained and very experienced first off would say, “P2 first off you are not exhibiting any suicidal behavior. You are exhibiting none of what somebody looks for.” And so first of all to hear that I was like, “Oh okay”. There was a relief. And then, but then being able to see the anxiety and depression for what it really was, helped me to know that: “okay, I’m not really going to go crazy. I’m depressed.” There’s a cool thought I just had so hang onto that. But, “I’m depressed and I think I’m going P2 anxiously questioned whether it marked the beginnings of insanity. When P2 also experienced feelings of depression, he anxiously thought it meant he may commit suicide. In both cases, P2 did not trust himself. In addition, P2 did not trust others and feared that if he were to express his worries to another they would commit him.

In therapy, his therapist highlighted that P2 was not exhibiting suicidal behavior, which provided initial relief, and then encouraged P2 to associate to imagined worst case scenarios. P2 worried about fainting after experiencing panic attacks and associated to a fantasy of somebody caring for him after regaining consciousness, which brought to light a theme of not trusting others’ care. P2 also worried about his potential for committing suicide after feeling depressed, which elucidated another theme of not trusting his own care. Moreover, he was thrown back upon his
“to kill myself.” One of the things my therapist said to which is a really one of the really cool exercises was you’d think that it wouldn’t be. But in anxiety and depression what is the worst case scenario in this moment. So, let’s just think anxious wise. I’m having an anxious, let’s say one of my anxieties that I might faint or something. So let’s explore that. What is the worst case scenario? You faint, you wake up two seconds later and somebody might be taking care of you. So, then of course that reveals not trusting the other. So in the depression what’s the worst case scenario. So, I would think about that. What is the worst case scenario? Sadness, well, I grab bottle of pills and I swallow all of them. And right there instantly when I thought that. I don’t want to do that. So I became aware of almost of my will to want to live. You know, so, then that whole idea of suicide being afraid that I’d commit suicide seemed preposterous because when I actually really think about it this voice would be like, “you don’t want to do that.” Almost like smacking me in the head saying, “You know that.” So, being able to trust myself and that I, I wasn’t all of a sudden going to blackout and wake up in a bathtub with my wrists split or something like that. Like it was, “You don’t really want to do that. You know that. Don’t let your anxiety take you there.” So, again I mean the others and yourself thing is so, um, there’s a thin line, you know. So, almost like my anxiety being able to trust myself into another’s hands and almost the depression being able to trust myself into my own hands and knowing that I had a want to live.

R: With the anxiety, you did not trust yourself, but with this line of questioning you are thrown back upon yourself in a radical way and you’re thrown back upon your own will to live.

authentic will to live because he could not imagine the possibility of actually considering suicide.
P2: Almost, I don’t want to say real or fake but it’s almost just you’re thrown upon, remember we were talking about guitar or with driving, you’re thrown upon that part of yourself that is breathing and existing right there while the other part of yourself just seems to be going nuts. But in all actuality you’re fine it’s just that you’re swallowing yourself up in some really stupid thoughts almost. So, that exercise would almost put me back again to that real self in that moment, the self that was actually breathing and respirating and heart beating and all that good stuff.

Along with this, as my period of acute anxiety decreased I was able to see the future again and this gave me hope. No longer was the future this abstract dark enemy that included anxiety and panic; it was now something that welcomed me from a distance. When I was in the heap of my anxiety, I was unable to posit a way out. Because my present was so hellish I was unable to imagine any future.

R: In paragraph six, what were some of the things welcoming you in the future after this depression? You said that there were things welcoming you. What were some of these things, specific things calling you?

P2: If I were to explain my depression to anybody in the most basic terms it would have been sort of in the future-past, sort of not diagram, but the future-past thing. Because it’s like my anxiety became so severe that that’s all I can see at that moment. And again it’s experience. I can’t say it enough and just dealing with it in general is the best thing. But at that time when I was so inexperienced it was like, “Is this my future?” If it is my future, then there is no way I can ever hold any

As the intensity of anxiety lessened, P2 was able to anticipate a future that was calling him and he felt hope.

P2’s present felt unbearable because his present experience of anxiety was so intense. P2’s future seemed hopeless since he was unable to posit a pathway out of his suffering and anticipate a future without it. He sensed his future held no potential as feelings of anxiety would interfere with significant relationships and a meaningful career and so he felt depressed as he did not want to engage in such an existence.
relationship with my wife or my family or my friends. If this is my future, then there is no way I can hold a job. And of course then I had no idea what I wanted to be when I grow up. So, I think there was a little bit of that too. But if this is my future, damn, I don’t want to live this. So, that’s sort of what I meant was the future wasn’t welcoming, and when that happens, that’s another kicker for the depression. And then again the cycle starts: The depression feeds the anxiety and the anxiety depression. Your future becomes more and more cloudy, and you cannot in that moment especially when I was inexperienced dealing with it, you cannot in that moment envision any future without that degree of pain and without that degree of anxiety and that makes you even more depressed. So, through therapy and again seeing it for what it was, made me realize that even though this might happen again in the future there is a future separate from this and even with it. But the future isn’t unbearable. The future is something that is welcoming me. So, slowly through this I began to realize sort of almost my calling of wanting to be a pastor, you know, what I wanted to do with my life. So, again that made things a little better. I was like, “Oh, I actually have some idea of what I want to do with my life.” So then when sad-anxious thoughts would come I’d be like, “Oh, this is that. This is now. This isn’t necessarily the future.” I think about again with the subsequent episode, it hit hard. And thoughts would come where it was like, “Is this it? Am I going to have to do this every so many years for the rest of my life?” But even though I felt like shit in the moment, there was that sense that this isn’t all there is. I could close my eyes and picture myself at a job in six months. Or I could close my eyes and picture myself on a road trip, where anxiety or depression weren’t really an issues. So I

Through therapy, P2 came to understand the transitory nature of his feelings of anxiety. He was able to imagine his future apart from his present experiences and, for instance, realized his call to become a pastor. When P2 encountered panic attacks and depressed moods for a short duration years after therapy, he was nonetheless able to envision his being in the future (e.g., caring for children, working at a job, and engaging in leisurely pursuits) with such feelings not at the fore.
was able to even though the present was a malefactor, you know, I was still able to picture a future opening me with open arms, as opposed to, wanting to tear me apart.

R: Yeah, so you were able to see an opening there and in that opening the future was able to welcome you.

P2: In the more recent episode, you know, I was having anxiety attacks and my wife and I were thinking about having kids in a year or two. And shockingly in the midst of these crippling panic attacks I was still able to picture me taking care of a kid, which is shocking. Because I was able to picture reality apart from what I was experiencing.

R: So, not just a picture of your doings, also a picture of you yourself being able to.

P2: Yeah, being in the future, being in the world in a healthy way and not, not in that anxiety, not in that depression. But being in, being able to picture myself, my wife and I were planning a cross country trip at the time, being able to picture myself going up the Rockies, being in the car. And not being like, “I’m too far way from home.” Being able to really picture myself being free and knowing that isn’t an unrealistic thing, because I was able to find my way out of the episode by that trip. I guess I attribute that to both therapy and seeing what it is, but also experience and knowing this will pass. It might happen again in the future, but it will pass again.

Along with this I would begin to glorify the past and when I realized that the past was no longer, that would be cause for despair.
R: You also were mentioning in that paragraph about some of the things you were glorifying from the past. What were you glorifying from the past during this initial episode?

P2: I had this girlfriend and I would have these weird dreams, it was a reoccurring one. I’d be in the room with my ex-girlfriend in a crowd of people and the second we would start talking I would feel perfect. I would feel this sense of warmth and this sense of like love that I hadn’t experienced in such a long time. And I experienced excitement and longing. But then something would happen in this dream that would prevent me from seeing her or I would try to kiss her and something would happen. I remember one time I was in a high school parking lot and my ex-girlfriend was in my car. I’m sitting there trying to get in the car but I can’t. And all I want to do is get in that car, but I can’t. And that dream, those series of dreams, they’re almost indicative of what I was going through at that moment. I just wanted so bad to be somewhere else and the only somewhere else I could imagine was that past. So, it was thinking and longing for her, but she was an embodiment of something that seemed more stable and something that seemed safe. In the subsequent struggle, thoughts about another old girlfriend would pop up in my head. And I would think, “Oh that was nice with her.” And not that there was anything wrong with my marriage, but it was just that my mind would want to think of something that seemed safe and seemed tantalizing at that moment. And it didn’t happen to the same degree, because it was just something that seemed to naturally happen almost.

R: Yeah, so this thinking of the past, thinking of a past relationship, one that

P2 had a series of dreams concerning his ex-girlfriend where he felt perfect, feeling both love and longing, but something prevented him from contacting her. In therapy, he interpreted the image to mean that she was the ideal of something safe and stable from his past. His therapist also confronted him about his embellished memories of his ex-girlfriend and P2 came to see his past in a different light. During his short struggle years after therapy, P2 again thought about another ex-girlfriend to a lesser extent.
would provide a sense of security or a sense of safety that you were in.

P2: And I can think of a direct instance in therapy because I remember I was pissed off at my therapist for saying this. But he was like, “Do you remember your relationship with your ex?” It was horrible. He just really got me in touch with reality and it was. I mean there was a sense of looking for things as they really were and seeing, “Oh that was smelly too,” you know, just in a different way.

R: Did you end up looking at that dream in therapy at all?

P2: I think I did.

R: Do you remember how that looked, the work with the dream?

P2: I’m pretty sure it was the same thing that I just said.

R: Okay

P2: What was really striking me there too was so in the initial episode it was the future in imaging anxiety just imaging an anxious future would feed the depression and then the past you said when you realized the past was past and you couldn’t get back to this secure emotion that would feed the depression. So, like both realms were like.

R: I think the future affected me more than the past. But still the past because the past too, whether it was reminiscing over my ex-girlfriend or thinking about experiences with my other ex-girlfriend, it offered an initial escape. It offered me an escape from what I was feeling in the present so I didn’t have to think about the future. It was an unhealthy escape, but it offered an
escape nonetheless. So, I don’t want to say that helped me with my depression. But it was an escape just like if somebody would turn to alcohol during this time or somebody would turn to any sort of narcotic or something to really just try to, eh: this present sucks I need to get out of here. And the only place I could go was the past at that time.

So in short, by helping me cope with my anxiety therapy thereby lessened my depression.

In the present now, reflecting on what transpired then, I feel a sense of awe regarding where I came from.

R: My next question addresses paragraph four and I think an underlying theme in the whole description. But, specifically I was wondering in what ways did your relationship with God change after this course of therapy, through the process of dealing with anxiety and depression.

P2: Much like the other things too was looking for a reality beyond your experience and what you, everything you’re experiencing at that moment. So, knowing that God is something beyond that. That necessarily, that faith isn’t necessarily a feeling you have in your, in your stomach in your gut or something you intellectually know. It’s almost something you, I say this word a lot, but you got to hang onto, when everything else is saying no just this complete b.s.. Hang onto that was the payoff afterwards was just there because then, when things weren’t crazy the sense of God or presence in my life was a lot more. It also gave me a sense to know that it’s not all peaches and roses. You know, and to know that there’s a lot of suffering in life regardless of whether you’re a Christian or not. And then being

The intensity of his depressed moods lessened as P2 came to understand and tolerate his feelings of anxiety through the process of therapeutic work. He felt a sense of wonder reflecting on the process and his progress.

Through experiencing anxiety and depressed moods, P2 solidified his faith in God as something to hold onto beyond these experiences. After his suffering, P2 acquired a sense of God’s presence in his life, knowledge of the degree of suffering involved in living, and a capability to empathize with others who are suffering.
able to be there for other people who are, going through similar experiences. But, let me think about that question. I also spent a lot of time reading the Psalms during these experiences that one and subsequent ones especially in the more recent episode. There’s a universality of experience there. I mean these guys who made it into the Bible or whatever were writing poetry that almost seems to sometimes insult God because of how empty they feel. You know, my God my God why have you forsaken me, you are so far from my groanings. Just catching yourself in this familiar theme that’s throughout scripture of almost abandonment, but then know that beyond that abandonment that there is faith. You know, and that faith, it wouldn’t be faith if you could see. But what I learned and also know, in Christian world redemption is a big thing. Christ on the cross redemption of your sins. The redemptive elements of life are throughout, especially in the Christian life. Part of me died in that depression. But through my faith something else was risen again. I always say this in any interviews or any, anything like that it’s just if it wasn’t for that anxiety and depression I would be dead because I wouldn’t have been dead in a bad way because I wouldn’t have been killed and risen to life. And, so, it was sort of the depression and anxiety that brought me to a spot to really live in that religious way and sort of resurrected a faith that had fallen asleep.

R: So there was a faith that was sleeping that was there but that through this experience.

P2: Yeah, reawakened became a lot more essential, you know. I mean, one of my pastors says an awesome thing, one of my mentors I guess I would call him. People through studying scripture, P2 discovered he shared similar experiences with the authors and characters and identified themes in Christianity apparent in his life. He experienced abandonment by God, but found his faith. P2 felt redemption like a part of him died when depressed, but through rectifying his faith, he had arisen to truly live. Thus, faith was an overarching theme. P2 was suffering, he did not completely trust himself, others, and the world and so his existence felt out of his control; however, he maintained a faith in a sovereign God who provided refuge and stability.
never really change unless control is rested from them. Faith is easy when things are going alright. But when control is rested from you and you are completely at the mercy of the other in a sense, or that really it, it purifies or radicalizes your faith a lot more because, you know, for me in my experience, you know, that’s all I have. That time, seven years ago that I described in paragraph one or whatever I mean everything fell: my self fell, my wife fell, my family fell, my relationships fell, my world was falling apart. And only one thing stood through that test and that was sort the spiritual lesson that God is my rock and my fortress and even though reality might seemingly be crushing around me there is, there’s something solid there. It’s one of the big common Bible stories that I always think of about this. Where Jesus and the disciples are in the boat and there’s a storm outside and Jesus is just sitting there sleeping. The disciples are freaking out because there’s a storm and they wake Jesus up and say, “Jesus there’s a storm happening and we’re going to die.” And Jesus says, “Why do guys have such little faith?” And, of course, he just flicks the waters and they’re still or whatever. Jesus was sleeping, but there was still a storm going on outside. You know, reality surrounding those disciples was a complete mess and that’s not denied in that story. What is affirmed though is the fact that God is sovereign over all and there is something beyond what appears and it is that you have to believe in when everything else seems to be falling apart. So that’s kind of that, those, it’s that area that sort of relationship, definitely got better and definitely, changed after my dealings with anxiety and depression. And it’s definitely what I described in the description was the beginning of that journey definitely, you know, definitely not the end, definitely the beginning.
R: I find myself trying to pull together what you said but I do not feel the need to because you’re pointing it out so clearly.

P2: And that’s therapy. I mean that is being able to find those themes or concrete expressions. And that’s what all those, that’s one of the big things that therapy did was to be able to create almost sort of a narrative or a way of looking at that, to be able to squeeze the marrow out of the depression almost.

Since then I have had a couple spells of acute anxiety and depression.

R: Could you please say more about the way your relationship with yourself changed during the subsequent depression?

P2: It was almost functional I would say it wasn’t something shocking. You’d expect that to be the deepest one, but for me it was almost more functional. Once I understood what was going on with my anxiety I was able to trust myself to myself. Where when I didn’t understand what was going on with the anxiety and depression I wasn’t able to do that and that only increased the anxiety. Where with others, it was more of a learning to trust them. It was a lot deeper issue with trust as opposed to with trusting myself. And also with God, there’s a deeper issue with trust that got revealed too in that.

R: Yes, makes sense, almost more of a knowledge based.

P2: Yeah, so the other one, knowledge and experience and I think knowledge and experience would be the best way to, eh. It wasn’t some, it wasn’t an existential like trusting myself to myself.

P2 thought the process of therapy helped him to create a life narrative that provided a way to understand his experience of depression and helped him articulate themes inherent in that experience.

After therapy, P2 encountered for a shorter duration a few periods of intensified experiences of depressed moods and/or anxious feelings. During the more contemporary period, P2 trusted himself and his capability due to an understanding of such feelings acquired in therapy. He further sensed a more significant development of a different kind in his ability to trust others and God.
When it returns the pain is still nearly unbearable. Although this is the case something is different. The depression is no longer the monster waiting to swallow whole.

R: You said there were subsequent episodes of depression when you were able to see what it revealed about your life. What was it revealing in subsequent episodes? You mentioned the transition you went through finishing graduate school. What was that transition like? What did your previous work in therapy help reveal about the more recent transition?

P2: Well, again there was an onslaught of anxiety first, panic. But the more recent time symptom wise the depression was the worse, but not despairing wise. Does that make sense? Like, in my head, there was a sense of control on it there was, eh, but I would start crying at the drop of a hat. So, I was like there, I knew what was going on and I addressed it and it was there in its place. But the physical symptoms and manifestations of it were a lot more than I was used to. Crying at a life insurance commercial one morning is my funny experience that I always talk about. But it felt good just to cry. In the subsequent episode the first thing was again the anxiety, just being so depressed that it was pushing you back to square one. I just kept on going, “Not again, not again, not again, not again,” just feeling almost pinned. Then sort of a depressiveness towards God almost and just life in general. Both feeling like I was being thrown into this sort of dark patch that I did not want to go through. When I closed my eyes, I got this image of this big hand sort of pushing me and I’m kind of leaning back against that not wanting to go. But it was almost something that I had to go

P2 was going through a transition as he was on his way to graduate from his masters program and he also suffered the loss of a beloved other. He initially experienced panic attacks, and felt depressed about their reoccurrence and resistance toward anticipated sad feelings on the horizon. For a period, P2 experienced dysphoric feelings accompanied by occasions of crying, but his thoughts were not filled with worry. Instead, he identified his feelings, knew they were transitory, and understood their psychological significance for this transition in his life. P2 had previously established a perspective for understanding depressed moods in therapy and had also developed specific ways to endure these moods. As he surrendered to this phase with its accompanied moodedness, P2 found he felt better.
through, you know. And that was sort of like what it felt like the more recent time. Of course, there was the transition of leaving school and not knowing what was going on and life just being so busy, you know, losing a loved one a month before it started. Just having that collective experience just hit me all at once. It was sort of big. You know one of the things I did in the more recent episode that really got me out was I, almost um, surrender too it, if that makes sense. You know, surrender to that hand that was pushing me. Sometimes I think of it like consciousness being a river that just keeps on going whether you want it to or not as opposed to swimming against it, sort of letting go and floating with the stream. So, sure I cried a lot, but it just was sort of interesting to see how that dynamic worked and how it slowly started getting better after that.

R: Yeah, so the pain itself, the more symptomatic aspects of it, crying was rather intense this time a lot more intense and were really able to make sense of it differently.

P2: I think I thought of a better way to distinguish the two episodes. The pain was, the physical pain was awful, and just the symptoms, and the anguish, but there wasn’t as much mental anguish about it. You know, I knew this, I don’t want to even, you know, it’s clichéd, but I thought that it’s sort of a season. I knew it was going to be temporary, so there wasn’t that mental anguish of: is this all there really is? I mean, of course that thought came every now and then, but that wasn’t as present as that had been in the past episode, if that makes sense.

R: Was therapy, was the previous course of therapy, sort of preparing you for this
subsequent depression? Did you feel what you gained previously helped you?

P2: It felt like there was a wealth of things to draw from and whether that is advice or actual just the digging through my, my soul and the digging through my past that we did for the three or four years of therapy created a base. And when the depression hit, and I think it hits everybody every now and then, but when it hit, I didn’t go as low into the hopelessness. I recognized things for what they were as opposed to things being much bigger than they, you know.

*In spite of the pain, psychotherapy has given me the tools to be able to handle these acute instances of depression. These, for lack of a better word, tools have prevented the depression from being able completely destroy my life. With this said we shall now look at several instances that describe what I’m talking about.*

*Please describe several representative incidents that exemplify what was helpful for you in psychodynamic-psychotherapy and how it helped.*

| The first way in which therapy was of benefit to me is rather simple. In short, it gave me another to share my pain with. One of the most terrifying aspects of depression was the sense of extreme existential isolation. As I mentioned in my previous description, the despair was so intense that I felt as if no one either wanted or could understand what I was experiencing. Combine that with the anxiety and it creates a deadly combination. I was afraid that the thoughts of despair would take me over and officially throw me into some dark abyss with no |

| When depressed, P2 felt there was no potential for another to understand his experience, which left him alone to deal with his feelings of anxiety and his worry that the depressed moods would intensify and never cease. The process of therapy provided P2 with another person with whom he could articulate his feelings of depression, and significantly helped him feel less isolated. |
R: My next question is just expanding upon what you already started to say. What was your experience of the therapeutic relationship like? Please tell me more about how it helped.

P2: I’d have to say it was almost like a stereotype, you kind of want to be his friend at first, and you want him to be one of your boys. So there was kind of that. Just walking into the office and getting the handshake, as much as I love him as much as I’m comfortable with him that was still awkward because, it’s like this guy isn’t your friend this is a professional set relationship. But after the first set two minutes you start to get into the flow of telling him your story and he sort of responds and then your relationship, what the therapeutic relationship is intended to be, starts to click. So, to answer that question, it was definitely a good one, it was a therapeutic relationship. There are times you confuse him for your father and therapy doesn’t work too well that day. And there are times you want him to be your mother and you want him to comfort you. I think, I don’t know because I’m not a therapist but I’m guessing he probably felt those times when I tried to get him to be my mom and try to get him to tell me that everything’s going to be okay because then he wouldn’t. He would be like, “What, what do you want me to tell you?”

You know, and so or maybe make a decision for me and those kinds of things. He was very crafty, avoiding doing that and being very keeping it in the therapeutic realm. So, that’s of course when it’s the most effective because if I confused him for my mom that’d be a bad thing.

R: Yeah, so, it sounded like for you there

At times throughout the course of therapy, P2 desired for his therapist to respond to him like a friend, father, mother, or even pastor. However, his therapist avoided responding in such a way and sometimes questioned P2 about his desired response. P2 learned that his therapist was not adversely impacted by his desire, or his feelings for that matter, and his therapist kept the relationship professional. In general, P2 felt positively about the relationship and thought it was therapeutic.
were times when you desired him to be your friend or mother or father and he acted in such a way that he, he didn’t respond like that.

P2: Yeah, yeah, again didn’t get sucked up in what I wanted or get sucked up in my thing. Even like a pastor I could say probably tried to make him a few times. He never ever said, “No I’m not your mother I’m your therapist”. But it was just a gentle guiding of the conversation or even sometimes I can’t make that decision or I can’t do that. It was a good reminder or wake up like, “Oh yeah, this is this relationship.”.

Just walking into the door of my therapist office was a comfort.

R: Is there anything more with your experience of the therapist’s presence that you haven’t mentioned yet? And if there is something more about his presence could you please tell me how it helped?

P2: My therapist dresses very comfortably, you know what I mean. He’s not too suited up. He’s not, he’s not too, he’s very, um, eh, very comfortably, um, I’m trying to think, the only way I can think is to contrast him. I think you mentioned about his office too or something, well that’s the thing. I was seeing a psychiatrist too at the same time. You could make them the antithesis of each other. The psychiatrist had this cold waiting room. You go into an office that looks very much like a medical doctor’s examining room. He comes in and very formally asks you questions, you feel like you’re being raped, and then he leaves. There’s no sort of comfort in that. And that makes my anxiousness, anxiety rise. But where my therapist on the other hand you’re walking into an office that is really nicely lit and

The atmosphere of P2’s therapy was permeated by an air of comfort from his therapist’s attire to the office itself with its calming pictures and relaxing couch. P2 felt the atmosphere was an invitation to speak freely, and in turn, he felt safe to talk about ever more personal thoughts and fantasies.
has a couple nice pictures from Target. Sometimes when I’m at Target I see those pictures and get really calm. But he has a couple of nice pictures from Target and a comfortable couch. It’s almost like his office is like another outfit he’s wearing, it’s very, very easy, not too sophisticated, just very comfortable. You know, you just feel like you could just sink yourself in there and talk. So there’s that sense where your defenses are brought done by just sort of the way he is, just a man of a certain stature. I think there’s some validation for that when I really reflect on that. I do think in his dress and definitely his office really convey safety and sort of like, “You can be open here, you’re not being judged here.” You know, the psychiatrist I’m seeing currently has the same sort of rapport where you’re not, his office has a whole bunch of little artifacts around, you know what I mean. So, I’m going in there and it is not like I’m being examined or raped. This guy’s here to help me.

R: So, just the set up of the room itself the ambience and that comfort helped you to, um. How did it help you then?

P2: Well, your blood pressure drops. You’re a lot more just able to get out what you want to say. That’s the best way I can describe it. You weren’t, never felt probed. I don’t like to feel probed and I never felt probed in therapy. You know, just everything seemed so natural and it seemed to happen in a very natural way.

Knowing for the next hour that I would be able to talk through these thoughts with someone who not only understood my pain, but also saw it as “no big deal” lifted a tremendous yoke off my shoulders. Through therapy I began to understand that the pain and thoughts I was carrying around were rather

P2 came to understand that his depressed moods were just feelings of a transitory nature via his therapist’s stance. When he articulated his thoughts, feelings, fantasies to his therapist, his therapist assumed a stance that showed he understood, normalized P2’s experience, and consequently lifted the burden of
normal in today’s society. I wasn’t some unique case that was going to go off the deep end of inescapable tragedy; I was rather someone who was afflicted with a temporary acute sense of despair.

R: With reference to paragraph nine, in what ways did your therapist convey that he understood your pain while also normalizing this? And how did you end up processing and integrating that?

P2: Well, I think a good thing was he normalized by never dismissing. It was never other people go through this, you’re alright. It was never that. There was this true sense of empathy from the other side of the chair or whatever you call it from my therapist. But, understanding it in the sense that, understanding for me is just somebody listening and not necessarily giving you step by step advice on what to do, but being in there in that moment. And my therapist did that. You know, he really was there and let me express. He didn’t flinch. He offered, “Wow that really sounds hard”. But at the same time, so I mean that for me was understanding. And then in the back of your head just knowing that he is a psychologist, he’s trained to do this. There is that confidence. He sees a lot of people like me a day. So, there’s that sense where you knew that he understood it more than your wife could or more than your mother could or more than your father could or more than a pastor could or any of that. Just knowing the fact that he was said psychologist gave you a confidence that this is his area. I go to a proctologist for my hemorrhoids because he knows the butt. But I go to a psychologist because he knows my experience. But also normalizing it, again, situating it, again as I said before revealing the thoughts for what they were. Knowing that this isn’t crazy and knowing, hearing suffering alone, and this occurred on three levels. First, his therapist had an attentive and empathic presence. He was also neutral in that he did not react in an anxious manner when P2 expressed his worries. Second, his therapist’s professional role evoked P2’s confidence that his experience would be understood. When P2 articulated ruminations concerning his feelings of depression indicating his potential for insanity or suicidality, his therapist confidently asserted that P2 was not exhibiting signs of such behavior and also encouraged him to explore his fantasies, which helped him to delineate these as simply anxious thoughts. Third, his therapist on a few occasions disclosed his own personal experiences in an appropriate and well-modulated fashion that conveyed a sense P2’s experiences were understood and not out of the ordinary and that further developed his felt sense of relatedness with his therapist.
from a professional of the brain saying, “P2, you know, this is going to be alright. You know, you’re not going to go crazy. You’re not exhibiting any of those things whether it was crazy or with the depression suicide. You’re not doing that.” But also the fact that he didn’t react into the fear, or I think of my mother reacting emotionally. That sort of normalized it knowing that: “you’re not freaking out when I tell you this.” You know that really made it a normal thing, so that was good. And even every now and then, my therapist was really, I don’t know if he did this just for me, I’d imagined he do it otherwise too, but he would let out some personal tidbits...So, hearing that even in this guy, was a sense of understanding and also normalizing. He would never go too far into himself where it became like reverse therapy. But there was a sense where when it was appropriate, there were connections built on a personal level between him and I that really were beneficial and made me trust more. But one of the funniest things was, I’d be stewing over a thought that I thought was disgusting, and whether that was a suicidal thought or an anxious thought of like, “Oh my God I’m going to go crazy and kill somebody”. Because when you’re having those especially in the early time nothing seems out of the realm of possibility for your brain to do. And I would sit there and just ruminate on a thought for a week: “Oh my God, I’m going to do this.” And by the time I got my therapist I’d get halfway through therapy and finally have to confess this sinful thought or something to him and he’d be like, “Oh yeah”. And a lot of times he did the run with it exercise: “Run with it, what are you going to kill that person with?” I really hadn’t thought of that and then you realized it for what it was, a fleeting anxious thought that was
really provoked. So again normalizing that situation and really making you know the fact that just because you think it doesn’t mean you’re going to do it. And it wasn’t like I was thinking, “Aw, I’m going to kill that person.” It was like, “What if I kill somebody? What if I go crazy?” blank out with the person’s blood on my hands because I’m so going to go crazy because I didn’t understand my panic disorder yet.

R: Yeah, so there was this foundation of understanding exuding through his listening and his empathy. There was this other level he’s the one who knows, he’s the doctor. And also, another level where he’s normalizing it through not reacting in fear, but reacting in confidence and going with it and then also teaching you about it, the experience of anxiety and depression.

P2: It’s like a trust tree. Yeah, I think about my time in Florida doing missions work and I was having trouble in front of those people. And I think that’s the antithesis of therapy was they got sucked in bigger than anybody in my fear. They thought something was really wrong with me in those moments and that’s what really made me go into a deep not so much depression but a deep anxiety spiral there because there wasn’t that objective person saying, “P2 you’re alright.” Everybody was reacting to me and feeding that reactivity. Sort of having the therapist normalize that because he was that non-reactive presence, he was reactive but non-reactive, not feeding into what was happening. In fact, he was extracting it.

R: So, part of the depression-anxiety loop was falling back into yourself. But it sounds like you were able to in this relationship and reach out and grab onto him.
P2: Yeah, very much in the same way I did with God, or my guitar, but just grabbing onto a concrete constant.

R: Coming off that question, one of the things you were writing about was trust. I’d already referenced trusting yourself to yourself. Did the process of therapy then initially consist of developing that trust in your therapist then? If so, could you please describe the process a bit or does that not stand out?

P2: I’d have to say yes/no. I was so desperate when I came to therapy with anxiety that I had no choice but to trust. It was sort of, eh, I’m just all about the bad metaphors today, it was sort of like I was a baby and I almost had no chance, no choice because I was so completely in the mercy of everything that was around me because my anxiety had gone to such an extreme level the first time. So, it wasn’t like I was having some marital problems where I had to go and face this guy who would judge me or I was feeling sad with life. No, I was completely on my ass and I really had no choice but to trust him. That’s really how it worked. First session I just clearly remember word vomiting out my life story. So, I don’t think there really was that. I mean definitely in any relationship there was a natural trust building. But there was never a moment where I didn’t know about my therapist. There was always a sense of being able to trust him because of the position I was brought to him in. But as the relationship increased it increased of course. But I’m just going to completely contradict everything I said if that’s okay. But there was a sense too though when I had those scary thoughts, where I didn’t trust him with those because I was afraid he’d judge me or 302 me. But, letting those out and seeing his non-reactivity towards those I

The intensity of his experiences of panic and anxiety necessitated a basic trust in his therapist as a professional care provider at the beginning of therapy. Nonetheless, when opportunities to express his anxious ruminations about insanity or suicidality were presented in therapy, P2 initially did not trust his therapist would react in a neutral way and fantasized that he might be judged. As he expressed such thoughts and his therapist did not react in the anticipated manner, P2 gained a sense of trust in his therapist and the therapeutic relationship.
guess you could say they increased the trust. So, I guess in that way there was a trust building. But there wasn’t any thoughts of I don’t trust him. But maybe on an unconscious level there was definitely a trust building.

R: Sounds like there’s a basic trust you had when you were coming to him and more of a relational trust was building.

P2: It’s like having a heart attack and you get sent in the ambulance. It doesn’t give a shit, it doesn’t matter if you trust the doctor or not he’s going to have to work on you and you have to trust in him to work on you. It was that trust initially, you know, acute I need to trust that person now or else I’m going to die.

The second way that therapy helped me was that it brought me out of myself. When anxious and depressed it felt as if the center of me was a large black hole that was sucking me into myself. Thoughts of anxiety and depression would push me further into that hole and would amplify the sense of emptiness that was already there. It was horrible cycle!

Therapy helped me to not fall prey to this. My therapist suggested engaging in concrete outside-of-myself activities when this downward spiral would begin. These could include simple things like eating, playing guitar, or praying for others. In this way it got me in touch with my being-in-the-world and my being-in-the-world-with-others (forgive my heidegerian), which would in turn pull me out of myself. This strategy proved to be of immense benefit in dealing with my anxiety and depression. Preventing me from being sucked into the dark abyss helped me to realize that the depression was not a

When he felt depressed, P2’s thoughts had a ruminative quality and a cyclical relationship between them where he lamented about his dysphoric feelings and then worried about them, only to finally feel more depressed. This reflective engagement with himself had an abysmal character of spiraling downward for him. To initially address this problem, his therapist suggested he engage in activities such as playing guitar, eating, and praying for others. For instance, playing guitar required he engage with something more automatically while paying attention to that engagement. These activities cultivated his attending to prereflective engagements with the world and others, rather than further attending to the problematic reflective engagement with himself.
large monster, but rather the outworking of a secession of thoughts that led me needlessly in to an abyss that appeared bigger than it really was.

R: Since we’re on this line of discussion, I was wondering about that. Specifically, in paragraph eleven, what was your experience of playing guitar? You gave that as one example of grabbing onto something outside yourself. What was your experience of playing guitar and how it helped?

P2: Well first, doing something automatic, it was something that was so automatic that it sort of just takes you out of yourself. But also not just automatic but it’s challenging you. And so, I had to pay attention to what my fingers were doing. The way I used to do it back then was play the songs I like. So I’m sitting there paying attention to what the song’s doing and at the same time paying attention to my fingers. So, again it’s just a putting myself, attaching myself to just an activity that gets me out of that loop and puts me into something that’s automatic. You know, how a person might to avoid a depressive situation or to feel better might build something or I don’t want to say read a book, but might cook. But it was just something that had no stress, no value, attached to an activity completely outside of me.

R: So, in focusing outside of yourself that helped you

P2: Well, I’m depressed so that thought stream would be: “Oh my God, this is so bad, I am so sad.” And then the anxiety would be: “Oh my gosh, you’re so sad, you’re so sad.” And where, when I’m playing guitar the thoughts are: “Oh my gosh, this, oh, fret five, finger one,” and
thinking automatically it prevented the thoughts although they were still there. There was something else that needed to be done at that point, at that moment. And that was to rock!

P2: Yes, so the depressive-anxious loop that was going on internally was then being handled by focusing outwardly in an activity in playing guitar or something.

R: Or even like I mentioned eating too, same thing. And it wasn’t like depressive eating. It was just feeling something. This is going to sound weird, feeling something, smelling it, putting it in your mouth, chewing, you know, those normal everyday functions, just reminds you sort of how automatic everything is. That was one of the first big lessons that my therapist taught me was sitting there talking about anxiety and depression when I was sitting there in the car and I was afraid I might do something like drive off the road, but I ended up at the destination. And my therapist was like, “How did you end up there?” He was like, “Somewhere on you, even though you feel like everything is going crazy, there’s a part of you that is automatically breathing and existing and driving to the destination. There’s a part of you that’s connecting neurons to get from the one place to the other, there’s an internal map in you.” I think therapy and playing guitar, but also these other things that my therapist was trying to do for at least the initial symptom was to help me get in touch with that part of me that was very, I don’t want to say mechanical, but I guess that’d be the best way to describe it. Very just, crafty. Yeah, yeah, that’s the best way.

The third way that therapy helped me handle my depression was teaching me how to accept and in a

When P2’s experiences of anxiety intensified, his thoughts contained themes of frustration and hopelessness, and he
sense surrender. One of the reasons I began to become so intensely depressed during times of acute anxiety was because of my inner dialogue. I would often say to myself, “I can’t believe this is happening again,” or, “Is this going to be my future? Is this all I have to look forward to?” From these thoughts I would proceed to slide down into the pit of despair.

I remember expressing these thoughts to my therapist and getting the most shocking answer. He said something like, “So what, you are probably going to have to deal with these bouts of acute anxiety from time to time. What’s the big deal? You might have to accept that fact.” At first I was appalled at the thought. I wanted this ordeal to be over. I wanted nothing more than to never have to deal with this again. My therapist insight though began to feel like a great comfort. In the acceptance of my anxiety and depression I stopped fighting the reality of it and just accept it for what it was. I was able to surrender. In some paradoxical way it was when I did this that some rays of light began to creep in.

P2: In paragraph thirteen you mention your therapist’s insight concerning acceptance. What did it look like the process of you coming to understand his insight and ultimately accepting your depression and surrendering?

R: Well, what sticks out to me is when the anxiety started again and I got depressed I was saying, “I can’t believe this is happening. I can’t believe this is happening. I can’t believe this is starting. I thought this was over.” And my therapist said to me, “You know, it might be a real possibility that you have to live with this for the rest of your life.” And not, when came to feel depressed. P2 expressed such thoughts during therapy. Based on past therapeutic dialogue, his therapist highlighted the possibility he may encounter such a period in the future and temporalized the potential frequency and duration, while also pointing out the possibility of his acceptance. While processing his therapist’s statement after session, P2 initially reacted oppositionally as he never wanted to encounter feelings of anxiety and depression again. But with further processing, P2 concluded that he had the ability to handle another period and ascertained the positive function these feelings provided for him to reconnect with his world. P2 came to accept his current difficult experiences and to surrender to the course, which paradoxically brought him a sense of peace and hope.
I’m depressed that’s one of my thoughts that causes a lot of depression because I think about it in sort of an unrealistic way. But he was like, “It might just be every three or four years you’re going to have a couple weeks to a month where you really get hit hard.” My first gut reaction was one of how dare you. This is supposed to give me hope and you’re tearing hope from me: how dare you? I mean I have to live with this for the rest of my life. You know, and then the battle ensued. Not between him and I but in my head. I sort of placated. I was like, “Yeah I guess you’re right.” But in my head I was like, “No.” And the battle in the coming weeks, it was just sort of realizing, realistically saying, “Yeah, I might have to deal with this.” And again seeing it for what it is you sort of were like, “I could deal with this if this actually comes every three to four years”. And then you almost start thinking positives like, “Well, it’s sort of like a self-checker.” It keeps me humble. It keeps me from losing touch with myself. Because of this sort of reoccurring depression and panic every now and then, and each time of course it gets a lot less worse, but I’m not going to wake up twenty years from now in a job that I hate and a life that I hate and not know my wife because every three to four years I’m forced to have this breakdown where I’m forced to reexamine everything and I’m like, “Oh yeah.” You know, it’s almost like a maintenance or an oil change. That was the battle of acceptance, so it was really sort of looking at it in the face and seeing it for what it was. Being able to surrender. I think even in that moment when I was on the, in the church when I was praying and sitting there fighting God: “Why? Why? Why does this hurt so bad? Why?”, and just crying my eyes out. That was me fighting. That was me sort of exerting so much energy on that
depression and exerting so much of myself. And of course that fed to me getting more depressed and more anxious and getting more worn out. Me just lying my head on the alter and going, “This is yours. You deal with it.” That in itself even though that weird spooky verse thing happened at the same time but that was a moment of surrender and saying you deal with it. And when you sort of let go and I used the, the sort of the example of the river before too. I’m sitting there swimming against the tide or the current and I’m fighting against myself and the only way to really live is just to let go and float with it. In there there’s almost a sense of hope that begins to creep in. And I think I remember reading during that time, I read The Road Less Traveled. One of the things that Scott Peck said was life is hard and the second you realize it is the second you begin to actually have some hope. You know, it was sort of realizing that. I think we’re raised with the lie by our parents that life there’s going to come a moment in your life where you get it, where you understand or that’s even the American thing where you get such a thing then you’re going to be alright or you made it. And sort of depression is almost a reaction against it. I know life is really hard. Only when you realize it, then you’re able to actualize it instead of fighting it, yeah, so that was sort of the way the process was.

R: Yeah, so the acceptance, the surrendering let some light in, some hope there’s almost an opening of the future.

P2: Yeah, in a religious way the apostle Paul, St. Paul, his apostles are so big, so big. And I mentioned it in the written description and so I don’t have to retell that story. But even again he was just talking about and another thing he was just
talking about contradicting thoughts He comes to the point and he says, “Who will save me from this body of death?” That’s his point of I can’t do this anymore. And its right when he says, “Thank God for Jesus Christ,” you know what I mean. It is just sort of the second he says I’m through, I can’t do it, my self is emptied is the second that sort of hope comes in. And there is a huge religious element to that.

In Scripture the Apostle Paul is inflicted with what he calls a thorn in the flesh. Concerning this thorn he writes, “Three times I pleaded with the Lord about this, that it should leave me” (1 Corinthians 12:8). So often I was like St. Paul pleading to God to be relieved of this pain. I often did the same thing to my therapist. Wishing he would just remove this thorn. This being the case, God often has different plans than what we often think is best. To St. Paul’s cries for relief God replied, “My grace is sufficient for you, for my power is made perfect in weakness” (12:9). God brought St. Paul to the point of acceptance and surrender and in that acceptance he felt the grace of God in ways he could never imagine. That’s the way it was with my anxiety. When I stopped fighting and despairing it, a sense of peace and healing crept through my body. Because of my constant fighting this peace and healing was not able to exist there before. Through acceptance and surrender healing was now able to flow through my body.

R: With the scripture you were mentioning in the written description, and this depends on when you read it, could you please tell me more about the way it helped you accept and surrender or the way your accepting and surrendering helped you to understand the scripture?

After therapy, P2 experienced a few panic attacks before moving out of state for a mission trip, and initially felt frustrated and doubted his faith in God. He read a scripture concerning an apostle pleading with God to relieve his pain, God responding that all the apostle need was his grace and power, and the apostle surrendering to receive these. P2 recognized a like struggle occurring when he felt anxious and depressed and a similar way acceptance and surrender in the face of his suffering were a precondition for feeling hopeful. In light of his past experiences and reading of scripture, P2 took a similar approach concerning his panic attacks, trusted God’s power and grace, and went on the trip.
P2: When that scripture popped out to me there are two instances where I felt God truly talked to me through scripture, actually there’s a couple more, but two huge. And the one was that day that I described with the Psalm in the church. And this was the second time. I had graduated college and it was that summer and I was about to go away to Florida to do that mission project. About two weeks before I was to go down I had a little a couple of panic attacks. And again I was doing the classic: “Why? I can’t do this.” I was fighting and fighting it. There’s a stream in Christianity that believes if you truly believe things you would be healed. And so that’s a fight that I have to have because there’s a lot of Christians that I would talk to that would say to me, “P2 you’re not healed yet, you don’t have enough faith or something.” So, you’re battling out with this or then you start to doubt your faith and then you start to doubt God and. So, I just randomly reading this passage and, it was just on my reading for that day. And I’m reading it and Paul’s just talking about these amazing revelations he’s had. And he says, “To keep me from becoming conceded because of these revelations there was a thorn given to me, a thorn in my flesh.” Right there I sort of became part of the story. I was like, “Yeah. This is kind of like a thorn in my flesh.” And then I kept on reading and I was like, “Three times I pleaded to God to relieve me or to remove this thorn.” And I thought about myself again. You know, I’m pleading, “God get rid of this thing.” And then, God said to me, I can’t quote verbatim, but, “My strength is sufficient for you. My power is made perfect in weakness.” And that was one of those moments where I almost got thrown back into my chair because it was like, “Wow it is.” And you will get me
through this. And the Apostle Paul, almost like a therapist somebody that is renowned in Christianity, had this experience of pain not being lifted and pain being a present reality and experience. And not only that, but being something that was almost given to him by God to experience God in a more intense way, really spoke to me and just allowed me to go, “Okay. I trust for your power to remain perfect in my weakness. I trust that your grace is sufficient.” But that was sort of the experience there.

R: And then that was helping you.

P2: That was the only way I was able to go to Florida was because of that experience. I was like, “Okay. I trust you and I surrender.” And of course that experienced has been replayed and replayed and replayed, again and again and again.

R: And so then in accepting and surrendering to the anxiety in this instance and accepting and surrendering to the anxiety and depression in the more recent episode you were drawing on a previous experience in therapy then.

P2: Oh, yeah, yeah, I had a freaky dream over the summer that preceded the episode. I was walking on a sidewalk. It was sort of one of those dark, dark summer nights. I’m walking with some guy I didn’t know, and I’ve identified him as Jesus right now. But it was just some guy and we were just talking and I was having this really good feeling and then all of a sudden the sidewalk and the road just end and in front of me is nothing but complete darkness. And the guy beside me is saying, “Go just keep going.” And part of me wants to, but I can’t. And a voice comes from the darkness, “Do you trust
me? Do you trust me? Do you trust me to let go? Do you trust me?” I imagine sort of the trust fall exercise. Just sort of like falling back into that darkness. And I woke up screaming. But the dream was so real that I was like, “What is this trying to tell me?” And it almost, that’s was my experience during that following academic year of: “Do you trust me in this depression? Do you trust me in this anxiety? That although everything is pointing contrary to what your belief is, do you still trust me? Or do you trust me with your future that is complete smoke?” So, I think especially in Christianity more than other religions where most religions are what can I do to climb the ladder, Christianity is I need to die to myself and just sort of completely be at the mercy of God and trust. And that mostly can only be occurred through immensely painful experiences like depression, anxiety, tragedy, any of that stuff.

As a mentioned before, I have had relapses of anxiety and depression since the period I am describing, but with the help of these three experiences I no longer fall into the deep pit. Recovery time is shorter and I’m actually able to benefit from what the anxiety and/or depression is revealing about my life in the present.

R: That was one of things I was sensing from your written description. You were saying that in the subsequent episodes of anxiety and depression you were able to see what it revealed about your life and your world. Is that what you were referring to then, that it was related to you leaving graduate school and entering the new phase in your life?

P2: I’d say that was definitely part of it. Could you re-ask that question again?
R: Definitely, I was seeing that in your description you said that at one point in subsequent depressions what is different about it now is that you can identify, you can really see what it is saying about your life and world. Is that true or how is it true. In what ways?

P2: Well, I think the one I mentioned is adapting is definitely one. In another way it sucks and it is really painful to go through. But there is an essence where it is almost like it is the great opener. Where, sort of, even though it is not healthy, it pries open your soul and forces you to stop for two seconds and say, “What am I doing?” And part of the sadness and part of the depression is looking in there and not really liking what you see. So in that sense the depressive episodes were always, there is somewhat a positive aspect in the long run. But through therapy though, it helps me in the sense, and I mentioned this in the written description too, that I don’t get swallowed by it. You know, before I would fall in that hole, where I would be like, “God, what am I going to do?” And that would be sort of the way the anxiety and depression would communicate. But now I am at a point where I can recognize it for what it is. There’s the bio stuff, the patterns that are contributing to it, the way I’m seeing the world through a transitory period of time. I can look at those for what those are. There’s even a sense of with therapy of just being able to really be able to talk it out and realize there’s an extent where it’s not that bad. Where being so involved and so swallowed up in your hole that it just builds upon each other and gets worse. Then when you just have the chance to express it sort with a person who isn’t as emotionally invested in you per se, you know, it really makes
you say, “It’s really not that huge of deal.” So, definitely a perspective is put on the whole thing.

Of course therapy did many other like leading me to an understanding of certain family struggles.

R: In paragraph fifteen, you were mentioning some other things. I was wondering if you could tell me a bit more about coming to understand family struggles in therapy and what that looked like?

P2: If you would ask me before I went into therapy if my dad had an anxiety disorder I would have said no. After therapy I would say yes. Seeing the way he deals when he’s sick. But seeing the way his thoughts, he gets so internal focused or his heart problems he doesn’t really have that many but if he feels pain wrap around his back a little he goes to the worst case scenario. So, although it doesn’t exhibit itself in symptoms of an anxiety attack per se he always instantly goes to worst case scenario thinking. I think that has an effect and I think therapy sort of helped me to realize that, to see there is a learned behavior there. I mean, it’s snowing outside right now, what in going outside anywhere in the snow the first thing they would say is be careful and always worry. That’s one thing I really notice about my dad is just seeing whoa I got a lot of that in me. So, like understanding origins. When learning about family systems stuff I can go back to my paternal grandmother. But then with my mom and just seeing her worst case scenario thinking but also seeing her always trying to protect dad or always protect me from dad or always trying to protect us from something else or constantly assuming this role of protective bear from us and the world. And just

In therapy, P2 identified his parents’ struggles with experiences of anxiety and worry, as evident in the way his mother attempted to protect him from the dangers of the world and contrasted by his father’s more hypochondriacal and withdrawn manner. Not only did he better understand his parents, the impact his parents had on his development, and family dynamics, he became more aware of himself. P2 found comfort in their shared struggles and a greater sense of acceptance.
trying seeing where that prevented me from having some real life experiences. And seeing the way I try to run back to that comfort when I’m having panic whether, whatever is representing a mom at that point. And so I think those are two big things and seeing how those really went into defining the voice. Just really learning how my anxiety didn’t come out of a vacuum, obviously. But just seeing as a family and you could even throw it as the extended family on how these anxious patterns exist. So it wasn’t to place blame on any family members. But it was to be able to realize there was just and it helps me with acceptance too and to realize where it comes from.

R: So, part of the therapeutic work you were able to then see where the anxiety came from, your father’s anxious, your mother’s anxious and then you were able to see another thing.

P2: Well, they’re both different kinds of anxiousness though, my mom and dad. I would say my mom is protecting and dad is a lot more internal, a lot more withdrawn.

R: Yeah, so you were able to see their different anxieties and how that contributed too.

P2: I noticed that I know more of my patterns. First, I would say it’s all from my mom. But then when I walked out I’d say, “Some of it’s from my mom and a good deal from my dad.” I’m trying to think of another thing about the family that we dealt with well.

R: The one thing was their own anxiety patterns and the second thing was your own tendency to want to come back to mother in light of the safety she provided
when anxious or depressed. And how, I’m hearing how that helped was it helped you to see it for what it was.

P2: Yeah, what it was and it also helped with acceptance. It’s comforting to know it didn’t come out of a vacuum, to know that in some weird way mom and dad experience this not to the same degree. When learning about family systems theory to see that part of my anxiety is just a product of that chronic anxiety that is manifest in my family as a whole really had also really been cool to look at that. And I think that’s part of the same thing just a different way of saying it. Just knowing it doesn’t come out of a vacuum is a great comfort when you feel completely alone too. But then being, it sort of made me aware better aware of those patterns within myself. And so when I start doing things like my dad I can go, “Oh wait a second that is dad and not me.” When I start being my mother or trying to go back to mother, I’m like “Oh yeah.”

R: So, it was understanding these other’s, your mother and father that enabled you to better understand yourself.

P2: Better understand myself and where they are in myself kind of.

thought patterns, and internal dissentions

R: You also were talking about at the end of the written description coming to understand your thought patterns more in therapy. Could you please tell me more about that?

P2: That focused more on the cognitive aspect of my problems. I think we dealt with some of that. One of the things like the exercise of run with that thought I

In therapy, P2 came to identify his thought associations, the way they contributed to his feelings of panic and depressed moods, and the original situation that was of actual concern. He highlighted the themes of helplessness, hopelessness, frustration, and anger that permeated his thoughts and contributed to depressed moods. He learned initially to deal with this process by prereflectively engaging with activities in the world. P2 also came to realize that his parents thought patterns were similar, and to see
would say is understanding those. And knowing that I could think one thought right now and thirty minutes later that thought could be a panic attack but I might not even realize that. It might just be I think one anxious thought and then thirty minutes later I might have a heart palpitation because of that one thought I had. Sort of, I’d say it’s more in the mechanics of just understanding that oh this came from that. And sort of so again that’s the theme you’re going to write a million times in your paper is that seeing it for what it is, and just going, “So that came from that, oh. What am I really worried about here? Oh I’m really worried about going in front of people and talking or something.” Just that’s sort of an example but just understanding where those bad thought trains start and sort of being able to derail them whether that’s through doing something like playing guitar or doing something like making love to my wife. But just doing things like that or just touching a table or just doing that so that’s part of the thought pattern just getting out of yourself. Being able to realize where they are and where they begin and what they start. So, it’s more dealing with symptoms as opposed to dealing with the root of the problem. I’m, and you can say those do deal with the patterns too, but I think those would be a lot harder to articulate.

R: Yeah, and can you think of any one off the top of your head, a thought pattern that contributed to your sense of depression or despair at that time or that you looked at in therapy?

P2: Well, I definitely would say going into myself and getting swallowed in my hole. And in the subsequent episode, one of the things I would do to get out of that would be to watch comedy sitcoms on television
and laugh my head off. But that would get me out of myself. I think one of the things I notice is just this is my inner dialogue: “Oh I’m anxious right now. Aw is this my future? This is it. Aw I don’t want to go through this again. Oh I don’t have the strength to deal with this. God, why are you making me deal with this again? Aw I can’t do this. Oh I don’t want to do this. Oh, oh” (accompanies dialogue with hand gestures and changing intonation to indicate moving and feeling down). And then before you know it I’m crying my eyes out. And here we go again. So, I started being, “Oh I’m depressed right now oh,” and I think it’s good to reflect on that but it’s not good to sit in that cesspool, “Oh let’s watch a comedy” or if I’m not there “Let’s play guitar or let’s maybe think about something good in the future.” Or, do something that takes me out of that cycle. So, I think that’s one of the biggest functional thought pattern things I would notice in depression. I mean they’re so similar to anxiety. I mean they’re such the same monster in my head. They’re separate in a sense, but it’s the same internal dialogue happening just what provokes anxiety while the other provokes depression.

R: Yeah, and the one that provokes depression it sounded like that one was just one that would bring you down.

P2: Yeah and it’s provoked from outside panic circumstances or outside circumstances, but it’s the same, you know what I mean: “Oh my heart just palpitated. Oh I’m going to have a panic attack, oh this panic,” and then before you know it I had a panic attack. “Oh this really sucks right now, oh blah,” and then I get sad. And the cool thing is you can even notice it in everyday non-depressive
circumstance. That’s one of the things connecting me to my parents. Like my dad if something went wrong with the house you would see this thought pattern before you know it like it’s the worst thing that pipe is leaking: “Oh my goodness this pipe is leaking. I’m going to be stressed off and pissed off about this for the rest of the day.” Where I would visit another house and the pipe was leaking: “Oh the pipe’s leaking that’s a project to be accomplished.” And so noticing that stuff in myself in normal days: “Oh I got to do this paper right now. Oh this really sucks I got to do this. This is the rest of the semester.” Or, right now I’m sick: “Oh I’m sick right now this really stinks.” But just noticing those thoughts in my everyday life, almost anxiety and depression is just an exaggerated version of my everyday thinking. So, being able to address those everyday thinking patterns too was a really big thing. Again that works for the parents, that’s a learned behavior. And that was all around both mom and dad had that catastrophic, giganticizing thinking is it, [R: Catastrophizing] yeah thanks, where it’s like something that could just be a mere task to be accomplished is this chore to be done. And I think that there’s, there’s something to say there. And therapy helped me to realize there are other ways to think and that that isn’t necessarily the way everybody thinks.

R: Yeah, yeah, so learning the way you were thinking in the therapy you were also developing different ways of thinking.

P2: Yeah, different ways of being in the world and ways to observe the way other people think. Ways to see the way my wife thinks that’s a lot better than me and ways to see where she thinks that’s a lot worse than me. Or ways to see how other
people think and trying to adopt those and make those your own. I mean it’s really hard to break those huge massive habits and they’ll never be completely broken until the day I die. You know, there’s a sense that that’s always going to be with me. But just the fact that you’re aware of them you can go, “Oh my gosh,” and just laugh at yourself.

R: Also, toward the end of your written description I was wondering if you could tell me about coming to understand internal dissensions in therapy. What did that look like?

P2: What I just described, that’s what I just described. How I would fall into myself and get to the point, like that thought pattern was like, “Oh this, oh this, oh this.” You know, how I would pretty much just put myself there sometimes. I don’t want to say it was always just me. Just how I would take random given challenges and descend into myself. And therapy through whether through recognizing it for what it is, through touching things, just through all those things we’ve discussed already helped me to not do that. And helped me to recognize that for what that was.

R: Is there anything else off the top of your head that you feel we left out today?

P2: No, this is all good!

R: Sounds good, excellent!

; but when I really reflect upon it, these three elements described above are the most helpful.

If not addressed above, please describe any changes experienced: in a bodily way, with other people, in yourself.

His therapist instructed P2 to develop a repertoire of prereflective engagements, rather than focusing on his experience of depression and anxiety as his reflective engagement contributed to a perpetuation of these feelings. P2 became more attentive to his engagements with the
toward your future and past, and in various aspects of your world.

These were mentioned above, but I’ll briefly recap. Therapy helped my being-in-the-world and my being-in-the-world-with-others. My therapist taught me how to do this in concrete ways so not to get caught in the never ending cycles of depression and anxiety. As far as time goes, therapy gave me back my future. As I said before, when the anxiety came my future became hopeless, my present became unbearable, and my past became glorified; thus spiraling me further into anxiety and depression. In giving me back my future, therapy helped to live in the present and put the past where it belonged.

P2: One thing that just came to my mind, this has been really beneficial too in a healing way, now that I, you know, past couple days when I’ve been focusing on this. Because it really helps to see the threads and it helps to actually examine where you came from. I was able to see that there has been a lot of help and a lot of growth during this journey.

R: I’m glad to hear that.

P2: It’s been a positive! R: And I can definitely see that in the care you took to write the description and in the way you were able to articulate what helped, how it helped, and the effects of therapy and also the relationships between these!

P2: One of the good things participating helped me to do is, um, one of the experiences I had was three days after my therapy I’d be like, “What the hell did I just do?” When you have no idea and it is

world and others.

When his experiences of anxiety intensified, P2’s present felt unbearable, his future seemed hopeless, and his past was glorified, which contributed to his depressed moods. The process of therapy helped P2 be more attentive to his life in the present, offered him a perspective on his future, and enabled him to keep past memories as part of his past.

P2 found participation in the research project to be beneficial. His reflection on the entire course of therapy helped him to discern the facets of the process of therapy that were really helpful and to realize that he experienced significant growth since the beginning of therapy.
frustrating and you feel like you’re actually not accomplishing anything. But to really sit and reflect upon the whole, the thing as a whole almost and all these things popped up like to be poetic it was like looking at the night sky on a clear summer night so you look up and see a couple stars but then when you keep on staring these new stars start to pop up. So, that’s sort of the way it happened when I looked up and I thought, “How the heck am I going to write about this?” But then all of a sudden it’s like, “Bloop, bloop, bloop, bloop, bloop (Voice Intonating Stars Appearance). And I remembered all these things and it was really cool to reflect on that.

R: And that showed in the description too.
1. P2 experienced panic attacks and entered psychodynamic therapy. P2 came to feel that his panic attacks were no longer an issue, as these occurrences had decreased, but one year later his experiences of panic and associated anxiety increased in frequency and intensity.

2. Around this time, P2 was entering a transition phase in his life. He was beginning a new romantic relationship with his girlfriend and thinking about employment after college. P2 had experienced a looming anxiety concerning the unknownness of these engagements and sadness over longing for old ones.

3. With the increase in occurrences of panic attacks, P2 did not want to leave the safety of his home and felt sad and weak as the sphere of meaningful engagements in his life shrunk. Moreover, P2 felt frustrated about the reoccurrence of panic attacks and discouraged about the possibility of having to endure them throughout his entire life span. P2 began to feel depressed and felt a sense of emptiness like there was a hole in his heart.

4. When P2 encountered intense feelings of depression and emptiness without an understanding of these feelings, his sense of trust in his own capability was shook. He felt anxious and worried that such dark feelings indicated that he was crazy and would kill himself. P2 then felt more depressed. Feelings of anxiety and depression arose in a cyclical relationship, perpetuated by his thoughts about each.

5. P2’s present felt unbearable because his experience of anxiety was so intense. P2’s future seemed hopeless since he was unable to posit a pathway out of his suffering and anticipate a future without it. He sensed his future held no potential as feelings of anxiety would interfere with significant relationships and a meaningful career and so he felt depressed, as he did not want to engage in such an existence.

6. P2 then took refuge in his past and reminisced over the relationship with his ex-girlfriend to escape from dysphoric feelings in the present and his anticipation of their continuation in the future.

7. P2’s past was glorified, and as the past was no longer, he felt further depressed.

8. In terms of relationships, P2 did not trust others. In particular, he feared that if he were to express his worries to another they would not understand and overreact.

9. P2 isolated himself from significant others. He also felt alone as they appeared to lack an understanding of his struggles and so kept their distance.
10. In particular, P2 fantasized that if he would describe his experience of depression, his girlfriend would reject him. When he did, his description often provoked her worry because she did not understand his experience, and he in turn felt more anxious, especially in her presence. P2 isolated himself from her, which further contributed to the intensity of his feelings of depression.

11. In addition, when P2 would express his feelings in friendships, friends would either acknowledge his experience, but not fully attend to his emptiness, or offer him advice that could not bring emotional relief.

12. One night stood out for P2 as the culmination of his suffering. He was in his room praying for relief, yet even in these efforts, he continued to feel weaker and weaker.

13. P2 sensed that all his engagements provided him no hope to hold onto and he felt helpless. P2 went to an old and empty church to pray. He screamed and questioned God about his suffering, his faith, and God’s sovereignty. P2 felt abandoned even by God and he laid his head in exhaustion on an open Bible only to see a Psalm concerning trusting God and God providing solace. He felt hope and found an engagement with something solid outside himself to hold onto.

14. In therapy, P2 identified the transition he was going through and the way it related to his feelings and psychological life. He moreover highlighted a life-long pattern of feelings of anxiety and sadness, and sometimes depressed moods as well, coming to the fore during transitions.

15. P2 also identified his thought associations that contributed to feelings of panic and depressed moods, and then brought to light the original situations that were of actual concern. In particular, he highlighted the themes of helplessness, hopelessness, frustration, and anger that permeated his thoughts and factored into his depressed moods. P2 also came to realize that his parents’ thought patterns were similar to his, and to see the ways other people thought differently from him.

16. The process of therapy provided P2 with another person with whom he could articulate his feelings of depression, and significantly helped him feel less isolated. When depressed, P2 felt there was no potential for another to understand his experience, which left him alone to deal with his feelings of anxiety and his worry, for instance that the depressed moods would intensify and never cease.

17. For P2, expressing his feelings of anxiety and depression to his therapist was therapeutic insofar as he co-constituted his experience outside himself in the in-between of the therapeutic discourse. By bringing it to light, he came to learn that his experience was not that dark, disturbing, or bad, but just feelings of a transitory nature.
18. After coming to understand the transitory nature of his feelings, P2 began to be able to imagine his future apart from his present experiences and, for instance, realized his call to become a pastor.

19. P2 learned that his depressed moods were just feelings of a transitory nature via his therapist’s stance. When he articulated his thoughts, feelings, fantasies to his therapist, his therapist assumed a stance that showed he understood, normalized P2’s experience, and consequently lifted the burden of suffering alone, and this occurred on three levels. First, his therapist had an attentive and empathic presence. He was also neutral in that he did not react in an anxious manner when P2 expressed his concerns. Second, his therapist’s professional role evoked P2’s confidence that his experience would be understood and that his therapist would see it as commonplace since he probably saw similar cases. Third, his therapist on a few occasions disclosed his own personal experiences in an appropriate and well-modulated fashion that conveyed a sense that P2’s experiences were understood and not out of the ordinary and that further developed his felt sense of relatedness with his therapist.

20. In therapy, his therapist initially highlighted that P2 was not exhibiting psychotic or suicidal behavior, which provided immediate relief, and then encouraged P2 to associate to different imagined worst-case scenarios. For example, P2 worried about fainting after experiencing panic attacks and associated to a fantasy of somebody caring for him after regaining consciousness, which brought to light a theme of not trusting others’ care. P2 also worried about his potential for committing suicide after feeling depressed, which elucidated another theme of not trusting his own care. Moreover, he was thrown back upon his authentic will to live because he could not imagine the possibility of actually considering suicide, and so delineated this as just a thought stemming from his anxiety.

21. When he felt depressed, P2’s thoughts had a ruminative quality and a cyclical relationship between them where he worried about his depressed feelings and then lamented about them, only to finally feel more depressed. This reflective engagement with himself had an abysmal character of spiraling downward for him. To address this problem initially, his therapist suggested he engage in activities such as playing guitar and eating. For instance, playing guitar required he engage with something more automatically while paying attention to that engagement. These activities cultivated his attending to prereflective engagements with the world and others, rather than further attending to the problematic reflective engagement with himself.

22. When P2’s experiences of anxiety intensified, his thoughts contained themes of frustration and hopelessness, and he came to feel depressed. P2 expressed such thoughts during therapy. Based on past therapeutic dialogue, his therapist highlighted the possibility that he may encounter such a period in the future and approximated the potential frequency and duration, while also pointing out the possibility of his acceptance. While processing his therapist’s statement after
session, P2 initially reacted oppositionally as he never wanted to encounter feelings of anxiety and depression again. However, with further processing, P2 concluded that he had the ability to handle another period and ascertained the positive function these feelings provided for him to reconnect with his world. Through these considerations, P2 came to accept his current difficult experiences and to surrender to the course, which brought him a sense of hope and peace.

23. P2 had a series of dreams concerning his ex-girlfriend where he felt perfect, feeling both love and longing, but something prevented him from contacting her. In therapy, he interpreted the image to mean that she was the ideal of something safe and stable from his past. His therapist also confronted him about his embellished memories of his ex-girlfriend. P2 came to see his past in a different light.

24. P2 also identified his parents’ struggles with experiences of anxiety and worry, as evident in the way his mother attempted to protect him from the dangers of the world and contrasted by his father’s more hypochondriacal and withdrawn manner. Not only did he better understand his parents, the impact his parents had on his development, and family dynamics, he became more aware of himself. P2 found comfort in their shared struggles and a greater sense of acceptance.

25. In addition, P2 studied scripture on his own over the course of therapy. He discovered he shared similar experiences with the authors and characters and identified themes in Christianity apparent in his life. In particular, he experienced abandonment by God, but found his faith. P2 also felt redemption like a part of him died when depressed, but through rectifying his faith, he had arisen to truly live. Thus, faith was an overarching theme. P2 was suffering, he did not completely trust himself, others, and the world, and so his existence felt out of his control; however, he maintained a faith in a sovereign God who provided refuge and stability.

26. The atmosphere of P2’s therapy was permeated by an air of comfort from his therapist’s attire to the office itself with its calming pictures and relaxing couch. P2 felt the atmosphere was an invitation to speak freely, and in turn, he felt safe to talk about ever more personal thoughts and fantasies.

27. The intensity of his experiences of panic and anxiety necessitated a basic trust in his therapist as a professional care provider at the beginning of therapy. Nonetheless, when opportunities to express his anxious ruminations about insanity or suicidality were presented in therapy, P2 initially did not trust his therapist would react in a neutral way and fantasized that he might be judged. As he expressed such thoughts, his therapist did not react in the anticipated manner, P2 gained a sense of trust in his therapist.

28. In regards to the relationship, P2 desired at times for his therapist to respond to him like a friend, father, mother, or even pastor. However, his therapist either
avoided responding in such a way or questioned P2 about his desired response. P2 learned that his therapist was not aversely impacted by his desire, or his feelings for that matter, and his therapist kept the relationship professional. In general, P2 felt positive about the relationship and thought it was therapeutic.

29. The process of therapy helped Zack to create a life narrative that provided a way to understand his experience of depression and helped him articulate themes inherent in that experience.

30. Through learning about himself, P2 also became better able to deal with his feelings of depression.

31. The intensity of his depressed moods lessened as P2 came to understand and tolerate his experience of anxiety and panic through the process of therapeutic work.

32. With his understanding of his experience of depression formulated, he did not panic when depressed moods arose during the course of therapy, and so did not need his girlfriend to stay calm to provide support. He was able to confidently express more personal thoughts and feelings to her, and she came to better understand his experience.

33. P2 also did not need his friends to attend to his feelings or to offer appropriate solutions. He felt more confident holding back disquieting thoughts and feelings, and was able to reestablish everyday contact with friends.

34. Through experiencing anxiety and depressed moods, P2 solidified his faith in God and saw it as holding onto something beyond these experiences. After his suffering, P2 acquired a sense of God’s presence in his life, knowledge of the degree of suffering involved in living, and a capability to empathize with others who are suffering.

35. P2 became more attentive to his engagements with the world and others.

36. The process of therapy helped P2 be more attentive to his life in the present, offered him a perspective on his future, and enabled him to keep past memories as part of his past.

37. Most importantly, P2 was able to anticipate a future that was beckoning him and he felt hope.

38. After therapy, P2 encountered for a shorter duration a few periods of more intensified experiences of depressed moods and/or anxious feelings. During the more contemporary period, P2 trusted himself and his capability due to an understanding of such feelings acquired in therapy. He further sensed a more significant development of a different kind in his ability to trust others and God.
39. P2 was going through a transition as he was on his way to graduate from his masters program and he suffered the loss of a beloved other too. He initially experienced panic attacks, and felt depressed about their reoccurrence and resistance toward anticipated sad feelings on the horizon. For a short period, P2 experienced dysphoric feelings accompanied by instances of crying, but his thoughts were not filled with worry. Instead, he identified his feelings, knew they were transitory, and understood their psychological significance for this transition in his life. P2 had previously established a perspective for understanding depressed moods in therapy and had developed specific ways to endure these moods. As he surrendered to this phase with its accompanied moodedness, P2 found he felt better.

40. P2 experienced much less of a sense of and isolation. He felt confident in his wife’s capacity to maintain her composure in the face of him disclosing his feelings. She in turn appeared solid and demonstrated an understanding of his moods.

41. P2 also shared with other important people that he was suffering, and in return, some of these people offered him stories of personal suffering they or their family members endured. From these interactions, P2 gained a sense that he was not alone.

42. In addition, P2 was able to envision his being in the future and imagined caring for children, working at a job, and engaging in leisurely pursuits after graduation.
Appendix 5: Data and Analysis Participant #3

A5.1 Written Description

There was a point during my senior year of college when I lost the ability to smile. I remember most vividly the feeling of leadenness that made the physics of smiling virtually impossible, as well as a sadness that refused to be masked. I wore a Walkman, often with nothing playing, in order to avoid interacting with people, and I slept a lot. I was living away from home, aimless, and in the midst of a bad relationship. This period - which I did not identify as depression- lasted a few weeks and resolved on its own.

I experienced a more protracted bout of depression a year after graduation. Following college I moved to a new town to attend graduate school for a subject I wasn't really interested in. I continued in the bad relationship. At this point there had been three brief episodes of physical violence from him toward me, as well as verbal intimidation. I felt both trapped in the relationship and a tremendous longing for him to love me. I felt despair, lethargy, was at a loss personally- with no goals, and with significant doubt in my ability to find a goal or achieve anything of substance. Instead I attached myself to the relationship, to someone who, unfortunately, was as lost and depressed as me. I was frightened of him but also believed he was better than me. Again, I did not have the information or the perspective to identify any of what I was going through in clinical terms.

However, I did seek counseling for relationship difficulties during this time. Both therapists seemed unhelpful. One, at our first and only meeting, insisted that I confront my boyfriend. When I expressed my fear she directed me to have the confrontation in a
public place so there would be less danger of violence. I was unwilling to do this. A
second counselor was very friendly and smiled a lot, but there was no connection. I
didn't feel that she offered anything beyond cheerfulness and left after several weeks.

I returned to live in my hometown about three years after graduation, continuing
to feel aimless and frustrated by my aimlessness, as well as doubtful about my abilities.
The relationship continued. I grew increasingly self-loathing and entered a vicious
depression lasting several years. My sleep was significantly disturbed, due to the
depression but also due to the medications I took (SSRIs, Tryciclycs and MAOIs as well
as a Drexedrine, Depakote and Lithium at different times, in different combinations and
doses over a 4 year period. None seemed to work.) I spent one year sleeping less that a
couple hours a night and another sleeping at least 18 hours. I ate compulsively at times
and would go weeks without bathing or caring for myself in any way (Although I could
not articulate it then, it strikes me now that part of this self corruption was the only way I
knew how to get out of the bad relationship- to repel him so much that he'd finally let me

At the start of this period I once again sought counseling. Although I remained
with this counselor (a clinical psychologist with a cognitive behavioral orientation in a
medical setting) for nearly a year the experience was not helpful. I recall the counselor
using definitive labels (you are X, this is X) which felt violent and narrow, and his having
a very practical approach (if it hurts to do X, then stop doing X) which did not address
my plaguing questions- Am I anything more than a bag of chemicals and misfiring
neurons? Do I have the right, or the equipment to live a life worth living? Is there such a
thing as life worth living? Being alive was a torment and I could not begin to take
pragmatic steps toward better functioning without first believing that change was deserved or possible.

She was a clinical psychologist with a psychodynamic orientation, in private practice. Early on, upon learning that my parents were coming in for a session, she responded to my distress by noting that they would not meet with her but with another counselor (with whom she would then consult), and that the counselor would ask them to focus on themselves- their thoughts and feelings and issues- rather than on me. This was the first moment of relief I experienced. Her unfolding the concept of the designated patient and exploring family dynamics, rules and expectations with me was tremendously helpful throughout the therapy. She helped me articulate what had initially been only a troubling fog in my relationships with family.

Over the years she helped me to move beyond immobilized fear and longing in the dating relationship by articulating it's poisonousness. She also helped me articulate my parents' limitations and the fury and grief I felt toward those limitations. She helped me- again, over a period of years- to view my feelings- of anger, shame, doubt- as potentially helpful messages rather than proof of my inherent weakness and corruption. I began to read my experiences for what they could tell me. While all of this was going on she provided a constant, open presence. She did not engage me as though I was wrong or crazy. At the same time, she acknowledged my tremendous anger and sadness: Her actions asserted that my being sad, angry, and unsatisfied did not make me sick.

Her constancy and openness- her willingness to go at my pace- were also important. Because my sleep was so disturbed and I was so lethargic (and because of avoidance,) there were periods when I would arrive late to sessions. Once I arrived and
the light in her office was off. As I walked to her door I surprised myself by becoming faint. I felt like I was going to pass out and had to rest against the wall to keep from falling. I thought she had left- that because I was late she had gone home. But, to my great relief she was still there. Although I could not put it into words at the time this event helped to show me that I could rely on her. Knowing that she could handle me, that I could speak my experience without her withdrawing, was crucial. This was one way she told me that my experience, that I, could be seen- and that the sight was not unendurable. Her presence said that I was worth waiting for.

By the end of our work together I was no longer depressed. I was going to school, interacting with people, and had developed a plan for the future. My experiences, including having experienced the curative power of psychotherapy, compelled me to return to school for psychology. Overall, I aimed to treat my thoughts, feelings and reactions with respectful curiosity rather than hostility and contempt, and made concerted efforts to develop and nourish my interests. I felt much more empathy toward my parents, including grief for their fears, frailty, and humanity. I spent about a year after therapy always a few seconds away from crying- for grief at how hard it is for us as humans, for the sadness of the world, and for joy that I had survived to live this difficult and lovely life. And because I was grateful to my counselor for staying with me and doing the difficult work.
A5.2 Interview

R: The first thing that stood out to me was your description of your therapist’s constant and open presence. You mentioned her willingness to go at your pace [P3: Um hmm]. I just wanted you to tell me more about, you know, what you remember concerning your experience of her presence and how that was helpful for you in therapy.

P3: Um hmm, I think, um, probably in contrast to my previous therapist because I had written before about how I saw a few [R: Yeah] and then came to this particular therapist and I felt like it, it worked in a way that none of the other ones did. Um, I think part of it had to do with the fact that she was very, I mean clearly paying attention [R: Um hmm], um, but also kind of reserved, not emotionally reserved in any way [R: Yeah]. But she was kind of, she was sort of in a position of accepting what I would offer [R: Um hmm] as opposed to, ah, kind of inserting her project [R: Yeah] into things. So, and um, ah, I guess that was particularly apparent because the person I had seen prior to her was much more kind of outgoing and vocal and he would show me photographs of his vacation. And, and it felt more social. And, and I just wasn’t in a place where, I was sort of in desperate straights you know [R: Um hmm]. I didn’t want a social relationship. I wanted somebody who was going to help me [R: Yeah]. And that didn’t, that didn’t feel like help to me but her just kind of being there for whatever I brought was really what helped.

R: Yeah, and I remember you writing about her willingness to go at your pace too. There seemed like there was a pace to therapy. A pace, you know, where she was ready to go wherever you wanted to go.

P3: I think, I think part of it was that, um, she was adaptable [R: Um hmm]. Because I think initially she tried some things that maybe she had done in other therapies that just didn’t work with me [R: Yeah]. So there were, initially there were some moments that kind of fell flat where she would make an interpretation, a kind of pretty traditional psychodynamic interpretation [R: Um hmm] and I would respond really badly to it [R: Yeah]. I remember thinking: what the hell, I have no idea. And also I think feeling threatened, um, because I think part of what brought me to that place was not feeling, or sort of feeling, not feeling like I had, um, a personal privacy or a personal identity [R: Um hmm] in that sort of other people were, um, trying to shape me [R: Yeah]. And so I, I think that she was responsive in that she could see that some things weren’t working [R: Um hmm] and was able to modify herself to what I needed.

R: Yeah, yeah, I get a picture of her adaptiveness in that situation.

P3: And, and there was something about I guess what I see as important about that too is that it wasn’t that she knew exactly what she was doing and that she got it right but it was she was trying [R: Um hmm], which mattered a lot.

R: That sounds really important what you just said.
P3: Yeah, yeah, and the, and the constancy that I talked about too. Um, she was there [R: Um hmm]. She was just, she was there. Um, there were, there were periods where I would be late or, um, would sleep through part of the session and she would call and she would. She, She really had a lot of patience [R: Yeah], just personally I think to stick with me.

R: So it seems like those three elements: the, the openness for what, whatever you brought [R: Um hmm], and then the adaptability to go where, you know, you were going [R: Um hmm], and really the constancy she was there for you.

P3: Yeah, yeah, I, I, um, looking back I mean at the time no perspective on it. But looking back after, you know, doing psychotherapy myself I really admire her patience. Um, and I think, I think it was tough. I think it would be tough to do that [R: Um hmm] for her. I, I think I put her through a lot of stress (laughs).

R: I have a question that was coming to my mind when you were describing your experience of her openness, constancy, and patience. Was that something that was going, that you were experiencing during the sessions or during the course of therapy, or was that something that, you know, you’re really seeing now?

P3: That’s a good question. Um, you know, I think that when I started I was so, I’m trying to find the right word. Um, I think that I, that I was non-functional isn’t quite it, but kind of, um, and regressed isn’t quite it, but sub-human is, is really way too many negative connotations. But I was just so, um, I guess fragile and confused and, and sort of I’m not sure. A little bit of all of those things [R: Yeah], but something else that I can’t quite name that I, I don’t think that I had a perspective. But I think that I was just kind of hungry and I didn’t know what for [R: Yeah]. Um, but I knew that it was, it was feeding me somehow. Yeah, so I don’t, yeah, I don’t think I, I knew but I also kind of didn’t know. I just knew I was going to come back. And I think over, um, the time that we worked together I, I’d be able, I was better able to articulate it. And I think, you know, that’s what the therapy was, um, a lot of it was finding words [R: Um hmm], being able to, to name, first notice, um, not reject and name my experiences.

R: Um hmm, I’m getting a sense of the development, you know, over the course of therapy. You were saying, you know, first it seemed more experiential, just you were being fed [P3: Um hmm]. And it seems like, you know, the development of then finding words, if I’m hearing you right.

P3: Right, yes, that’s exactly right, yes. So I think it was kind of this, um, maybe, I mean I guess if we’re going to do psychodynamic, this infantile to a more adult position [R: Um hmm]. Although I like animals so maybe that’s not nice. If I like animals I shouldn’t say that it was kind of like animalistic to human because I think in some ways animals are preferable to humans (laughs) [R: (laughs)]. Um, yeah, but I think you’re right, exactly right. There was a kind of evolutionary process.
R: I was also curious about your description of the, the therapist’s engagement and this really stood out to me. You were describing the way she engaged you, um, and really acknowledged, you know, your feelings. You said she acknowledged your tremendous anger [P3: Um hmm] or sadness, but then did not treat you [P3: Yeah] like you were sick or crazy. So I was just wondering what else should I know about that, that way of acknowledging but then not pathologizing.

P3: (Starts to cry) I can’t, I can’t talk when I cry, which I am right now. [R: We’ll go at whatever pace is good for you]. Yeah, there’s going to be some pauses [R: Um hmm, um hmm] because I just can’t speak when I cry right now [R: Yeah]. Yeah, that was one of the most important (Pauses), I think that that was one of the most important things and that really is, is kind of centered around one of the things that, that brought me there [R: Um hmm] in the first place. Was one of the things that was so broken, um, in myself and in, um, my relationships and my family. And I think, um, I mean, I don’t think there’s anything more to it [R: Um hmm] than just that [R: Yeah]. It’s just the experience hour after hour, week after week, month after month, year after year [R: Um hmm] (Pauses to cry) of someone letting me (Pauses) be who I was. And saying, um, that’s fine. And that was, that was hugely, hugely important, really the most, the most important thing.

R: Yeah, there was nothing more to that experience but it was just that important, it had that grand significance, and that came out [P3: Um hmm] in your description, you know, right now.

P3: And, yeah, um, yeah I don’t, I don’t want to be redundant but I think, um, to not pathologize it but to, I guess, kind of treat it like it is what it is [R: Um hmm]. But also the, the added layer of not only is it fine that you feel what you feel but there may very well be something important here [R: Yeah] that, that you can learn from that can show you something about yourself or what you want or what you’re afraid of or what you don’t want or what’s working or not working. And it becomes not only okay but this place of great importance.

R: Yeah, it was beyond, you know, neutrality or seeing your feelings as something that just are: this is what you’re feeling. It was that and your feelings are something that deserved to be paid attention to.

P3: Yeah, and, and really importantly I think it was, it was also a point where I could realize that part of how I got to a place where I was totally lost and, and, um, sort of had no, nowhere to go internally or sort of no sense of home within myself or anything was because I was, um, rejecting what I was feeling and feeling, um, sort of hating myself for what I was feeling. And then to sort of learn that these feeling are exactly what you need to be exploring [R: Um hmm] to, to find, to find your home [R: Yeah] to find yourself. So it was really, it was a tremendous relief to just be allowed to be [R: Um hmm]. Um, but it was also kind of discovering this map [R: Um hmm] that could really help me. So it was very powerful too.
R: Yeah, there was something similar that came across in your written description. You were describing, um, you know, being away from home [P3: Um hmm]. And I think two times you mention that being away from home and [P3: And not having one] and not having one. And that’s, that was coming out a minute ago. So, it was about coming to therapy, you know, not having a home [P3: Absolutely]. Yeah [P3: Yeah]. I was, I was wondering too, what was coming to my mind when you were talking about learning to have this curiosity about your thoughts, feelings, actions. Um, I was wondering was that related to your therapist’s way of, um, engaging you, you know, acknowledging your feelings, um, but not pathologizing them.

P3: You know, I, I would have to think so. Um, I mean, I can’t, I can’t remember kind of sitting there and, and her saying to me you know: you need to explore this or let’s consider, look at this. I don’t, don’t, I mean she may have very well have, um. But I, and just because I don’t remember doesn’t mean she didn’t. Um, but I, but I think there was, there was a kind of respected curiosity [R: Um hmm] that, even if she never said it, um, she was saying it [R: Um hmm, um hmm]. I think one of the things that I remember about the therapy was I don’t feel like she talked very much. Um, and that was part of going at my pace. Because, I, um, when I, when I came in, I was, I was pretty non-functional. I think even talking was hard [R: Um hmm]. Um, and she was just going to let me, you know, unfold whatever I had to as long as it took [R: Yeah]. So, I don’t, I don’t know if she was very directive at all.

R: Yeah, how was that too? I was wondering about the, you mentioned there was a change in sessions where you did two sessions in a row. I was wondering how did that help. You know basically how did that help you and how did you feel about your therapist’s adjustment?

P3: Um, um, I was grateful. I mean I think that it made it, it made the psychotherapy possible [R: Um hmm]. Because literally, um, it would take me forty plus minutes to begin to speak or to kind of be able to talk about anything of any relevance [R: Yeah]. Um, and, yeah, I’m really grateful that, that she agreed to do that. Um, and I think that is, that’s an example of, of her, her openness and going at my pace [R: Yeah].

R: I’m curious too, how did that, how did the sessions look, um, toward the end of therapy? Um, you mentioned that, that, you know, around forty minutes [P3: Um hmm] you were able to talk during the sessions. Was that something that was, um, similar during the whole course of therapy or did you find at the end of the therapy that you still used that structure?

P3: Yeah, I think that, I think that maybe even having a double session was important in the beginning because I was so, I think that just physiologically from depression I was moving really slow, I was thinking really slow. I remember one of the things that I really noticed when I started getting better was that I regained probably a third of my vocabulary [R: Um hmm], which I had just lost. And I had memory problems, like I couldn’t remember. So, I needed that time [R: Yeah] in the beginning. Um, near the end, I’m not sure if we were still doing double sessions near the very end. But I do know that
near the, near the end of our work together I would actually ask her to say things, um, so I was. And she would [R: Yeah]. I would, I would, you know, sort of look to her more for, for her perspective and, and her thoughts. And just say anything. I would say that to her. And, and I, and I guess that was sort of an example of my becoming less internal. And, you know, depression is just totally narcissistic or self-involved, um, because you hate yourself and, you know, it’s all about, or I did, and it’s all about how you’re the worst possible thing. And so it’s, I think that as I was coming out of it I was noticing other human beings [R: Yeah]. Um, so it was definitely, it was definitely a different exchange [R: Um hmm] from the beginning to the end.

R: Yeah, noticing other human beings and wanting, um, a different sort of involvement with your therapist because she of course was involved all along.

P3: Right, yeah, yeah, and I, and I think that I, I do see the process as a kind of reparenting [R: Um hmm]. And, and I think that, you know, just again how you kind of identified that developmental process, um, maybe changing from this totally dependent to a more interactive relationship.

R: Yeah, you see the process as reparenting.

P3: Yeah, definitely, I think it was. And, and it also changed in that, you know, near the end just as any good parent should she was helping me take over [R: Um hmm] and do it myself.

R: And I was hearing previously that one of the things that were changing while you were changing was, um, a growing vocabulary.

P3: Yeah, it’s true. I learned to walk (laughs) [R: (laughs)]. Yeah, it’s interesting. I actually, I hadn’t, ah, thought about it in those terms but that, it is pretty clear looking at it that way that it was sort of going from this infantile to adult functional position.

R: Yeah, I was thinking about something when you were talking about, um, learning to have more of a curiosity about your feelings [P3: Um hmm], your thoughts, and your reactions, learning to see them as helpful messages rather than something that you feel hostile towards or contempt towards. Is there any, um, examples or instances that stands out in your mind?

P3: I mean I’d have to talk kind of generally [R: Um hmm, yeah]. Um, I think generally there was a period where I absolutely hated my parents. Um, I loved them as much, but, but I definitely hated them. And I think that I, I felt kind of like a bad seed like a hostile, um, bad person [R: Um hmm] for feeling that. And, and, you know, she, she would work with me to kind of unpack that and I don’t, and I think that she wasn’t afraid of, of my, my sort of having this, these murderous feelings [R: Um hmm]. Um, and thankfully because I think that, I’m going to cry right now [R: Um hmm] (starts to cry). I’m very grateful to her. I think thankfully because, um, I think what was behind that anger (pause) was a lot of sadness. I think for me, um, what, um, what my life wasn’t like and
what my relationships with them weren’t like. Um, and also for them [R: Um hmm]. And how woefully human we are and the lack, the lacks that they experienced [R: Yeah] that, that got them to be or to do or to be able to do, um, what they were able to do. And, and so kind of pushing through this anger to this sadness to a kind of I guess bitter-sweet, um, compassion.

R: Yeah, and that was, that was something that was also standing out in your written description. It seems like another development. You were, you know, writing about articulating in therapy your parents’ limitations [P3: Um hmm] and also your feelings of, you know, anger, and what you were saying is that behind the anger there was, was grief [P3: Um hmm] about their limitations. And then at the end of therapy writing about being able to feel more empathy [R: Yeah] toward those limitations.

P3: Yeah, and, and, and I think, I mean I’m grateful to her because I, if I’d, I, I don’t think, I mean I don’t know what would have happened because being that angry just isn’t sustainable [R: Um hmm]. I just, you know, you just can’t maintain that [R: Yeah]. Yeah, but if I hadn’t gotten through that, yeah, so, I’m really grateful that I have got to work with her.

R: Um hmm, and that gratefulness was, you know, coming out within the description. Even the last line you were, you know, saying how grateful you felt. You wrote about your parents’ limitations and just the feelings toward those. And, you know, how the therapy helped you to articulate some of those limitations [P3: Um hmm] and your feelings of anger and grief. What, what was, could you tell me more about that? What was, could you give me example of things that came up in therapy, something that you both worked on?

P3: Ah, um, I think, I mean tell me, tell me if this is sort of not what you’re looking for [R: Okay]. Um, I guess I sort of feel or felt like, um, they just couldn’t see me [R: Um hmm]. And what they, and there was a certain way that I was supposed to be [R: Yeah] and a certain way that I had to look. And the surface was what they saw and there wasn’t sort of a curiosity about who was, who, who was inside. Um, and that, and that really infuriated me [R: Um hmm], broke my heart. There was something else but I lost it. Oh and I think also I was really angry because, um, you know, she talked about goodness of fit in, in families [R: Um hmm, yeah] too and, and I think that also just kind of helped me sort of understand or get some perspective and, um, give them an out because I also wanted to love them [R: Yes, yes]. Um, and I didn’t want it to be, you know, because there was something wrong with me but because they were doing what they knew how to do or were doing their best. Or, um, but I also think that I was probably not the easiest kid to raise like pretty hyper-sensitive. And, um, I think some, some kids are probably a lot heartier and you can just kind of put them out there and they’ll find their way. And I think that I really needed [R: Um hmm]. I mean the world was a huge scary place to me and I needed somebody to tell me what it, what it meant. Um, and they just, they were very hands off [R: Um hmm]. So, I didn’t, I, I was really pretty alone [R: Yeah] and, and was really angry about that, that I was kind of brought to this place and just left to fend for myself.
R: Um hmm, you mentioned goodness of fit. In the written description [P3: Um hmm] you were writing about family dynamics, expectations, rules that you and your therapist articulated [P3: Umm]. So, that was one of the dynamics then.

P3: Yeah, and beyond, um, kind of specific concepts, oh, and she talked about things like, um, let me get out my note card. Um, good enough parenting, mirroring, and that did a couple things. I mean it kind of (sighs) helped me understand what I didn’t have [R: Um hmm], but also maybe what they didn’t have and also what was there. So, it kind of, it both justified my experience [R: Yeah] of, of (sighs) dissatisfaction, um, but it also somehow, I don’t know, it also somehow softened things, um, for me to sort of regain some kind of caring connection with my parents. I’m not sure exactly how. I guess through, you know, their own experiences as kids maybe.

R: Um hmm, and that seems really important like to have both elements [R: Um hmm] there, both of them

P3: Right, that’s right. And I think that that’s, that was also a really important point where I, I had gotten to the point where, um, you know, I was bad because I had these strong feelings. Um, and sort of throughout the course of our work it was also about, um, kind of complexity [R: Um hmm] and things, things can be lots of things at once. You can hate your parents and you love them [R: Yeah]. It’s not either or. Um, you know, just because I have these big feelings, it doesn’t mean I’m bad or broken or ruined or, you know, the designated, um, patient of the family. Um, not, not the bad one [R: Yeah]. Um, so things are more complex and subtle and multifaceted [R: Um hmm] and that was also really important for me to kind of remember that, that it’s not black and white.

R: You gave an example too of, um, about your parents coming in for a session. [P3: It was right in the beginning.] Yeah, and your, you know, your therapist, um, was reassuring you they were seeing, you know, a different therapist [P3: Right] and focusing on themselves. And you wrote that you felt a great deal, sense of relief [P3: Hugely]. Yeah, how, how did your therapist’s way of handling that, um, how did you experience that? How did you, how did that feel?

P3: That was really early on and, and I think it only happened that one time. Um, and I don’t, I don’t really know the details because I was, I mean it, I think I was probably speaking to my family maybe once every few months [R: Um hmm] so I had almost no contact with them. Um, but I was really threatened that, that we were all going to be in the room together. And, and I think not just because, not because I was going to sort of be accused because it was much more subtle than that [R: Yeah]. I think that it was just sort of speaking about this at all. We just didn’t talk. We just don’t talk about this sort of stuff or have emotions in front of each other. Um, that was just way too scary. Um, and I think at that point I was also treated like, frankly probably rightly so because I was pretty off my rocker (laughs). I, I was pretty, ah, distressed, um, that, you know, I was the screwed up one [R: Um hmm]. And, and, and I think the reason why that was a problem was because it was just so invalidating [R: Yeah]. Because it was saying, um, it was sort
of leaping over the possibility that there was a genuine problem. And, and that it wasn’t just me not being able to handle it or me, um, being too sensitive or deluded in some way, um, but that there’s actually something not working here [R: Um hmm] and I’m, I’m responding to that. And so when she said that they were going to be talking about themselves that was just like wow, really so it’s not going to be sort of about how I’m not doing something right or getting something wrong. But they’re sort of scrutinizing their own choices and feelings and actions. Wow, that was an amazing idea.

R: Yeah, and that sounds validating in and of itself.

P3: Yeah, absolutely, taking me serious that was hugely important. Because I, I was barely able to do that myself.

R: You were mentioning earlier in the interview just feeling angry at your family and then, you know, getting to the sadness underneath. Before the therapy was, was the anger apparent before therapy or was that something that, you know, was it, was it feeling primarily the sadness before therapy, you know feeling depressed. Was the anger something that came up in therapy?

P3: I think (sighs), yeah, I’m not sure how I got to the place that I got to [R: Um hmm]. Um, I think mostly I was lost. It started out as just feeling lost [R: Yeah]. And, and I think it’s because I just never learned how to, and I think a lot of it had to do with sort of identifying and expressing emotions [R: Um hmm]. I just didn’t learn how to say I feel this, I believe this, I want this, I hate this. Um, and so I was just sort of aimless and, and I think coupled with that bad relationship, um, started getting on this track of, you know, I’m bad, I’m not good enough, I’m wrong. Um, and then I’m not sure how that transferred to feeling so angry with my parents but I would guess it was probably they just couldn’t handle when I started breaking down and sort of withdrew and were, um, kind of repulsed. And I think that made me really angry with their limitations [R: Yeah].

R: Yeah, with the picture you were painting, I was seeing that prior to the therapy it seemed that you were lost and I could picture there being, you know, there being anger, um, sadness, and just different feelings there. But it seems like in the therapy it was that there was a space to be able to feel and then to name what you’re feeling.

P3: I guess, I, I, I sort of feel I, like I was, again I’m trying to find the right words for what I was pre that really bad episode where I just kind of hit my breaking point. Um, and I, and I think, I think I was pretty foggy. I think I was undifferentiated. I just didn’t, um, I didn’t know how to be a person or a grown up or have an identity [R: Yeah]. Um, so those feelings may have very well been there, um, but I, I think I was so sort of, um, I guess it’s sort of like can you have emotions when you don’t really have an identity [R: Um hmm] or can you articulate them if you don’t really notice them. I’m not exactly sure but there’s, that, there’s that kind of fogginess.

R: Yeah, you’re painting that picture vividly and I can definitely see that. You mentioned mirroring also.
P3: Right, yeah, and I think that’s connected. Because I mean we, you know, get our sense of who we are and kind of what we’re feeling, um, from the people around us from our parents. And, and I think that was, that wasn’t really present.

R: Was that how that concept was taken up in therapy? You mentioned mirroring was something [P3: Um hmm] that you talked about. Was that how that was taken up in therapy?

P3: Yeah, yeah, and, and she talked about sort of, um, and she talked about knowing who you are by seeing yourself reflected in your mother’s eyes. And, and again I think that was an example of putting words to the loss [R: Um hmm] that I felt. But also the, the start of some kind of empathy for them and for myself [R: Yeah].

R: You wrote about your depression, feeling sadness and despair during your previous episodes of depression. And then you wrote that you no longer felt depressed at the end of your psychodynamic therapy. Could you tell me more about the change with your depression?

P3: Yeah, that’s a hard one. I think that, you know, near the end of the psychotherapy I guess it felt like something broke open, um, and, and there was this kind of, sort of air was getting into a place that it, it hadn’t been in years or decades or since I was a kid. And, and so, you know, that’s when I had said there was this long period where like someone could look at me and I would start crying. And it wasn’t sort of this depressed, um, it wasn’t this kind of, um, self-flagellating or, or, ah, negative crying. But kind of this, I’m not sure how to describe it. Um, it was kind of relief but also kind of grief [R: Um hmm] but it wasn’t negative. (Starts to cry) Um, I think, I think it was kind of the, it was kind of a rawness that living, of actually being alive. And that was something that I hadn’t been. Or that exposed and engaged in the world in a realistic way [R: Yeah], um, as opposed to an incredibly defended sort of self internalized way [R: Um hmm]. And that’s just what it looked like to be in the world, which I hadn’t been.

R: Yeah, at the end of therapy, you wrote that for about a year you found yourself crying and that was, that was something about just feeling that realness, you know, being out in the world.

P3: Yeah, and, and I think I was, I mean this might be just sort of a, a part of, you know, how I’m built but, and I think why I’m, you know, prone to depression too, of just really being attuned to, to the sadness of the world. (Starts to cry) But also, um, how sort of sweat and tender and it is too [R: Yeah] that makes me cry too [R: Um hmm]. And I think also, um, a lot compassion for us for, for being, (pauses) for being human for doing this for having to be alive because it’s not easy. So those were the things that I was thinking about and feeling and noticing.

R: It seems like at the end of therapy you were feeling unadulterated, you know, both the sadness of the world and the compassion for the beauty of the world [P3: Um hmm, yeah,
I was grateful to be in it, to have survived. And what really struck me there in describing where you were at, you know, at end of therapy you said, you know, the air was let in to some part of yourself, you know, that part was able to breathe.

P3: And there’s something to about, um, I think that position, I mean if you, we didn’t talk about it then, but certainly I recognize, you know, the movement from the schizoid to the depressive position. Isn’t that right object relations, Melanie Klien? [R: Um hmm] Where, um, boy, I just really get that [R: Um hmm] of, you know, moving from this kind of black and white sterility to understanding that it is awful and wonderful and, and the richness of that [R: Yeah]. And, and the tremendous relief of that because that is, that is, that is a livable life, that it’s complicated and both and ten other things on top of that. That’s, that’s how we work. That’s what it means to experience things. And to have words for that was really important

R: Um hmm, the air was also life giving but just the relief, you know, being able to take a deep breath.

P3: Yeah, yeah, there’s, there was just room that wasn’t there before [R: Um hmm]. And, and I mean, um, before I was working with her there was the therapist that was pretty cognitive-behavioral and that just was not working for me at all (laughs), at all. And, and I think just fundamentally because, and I think this is, you know, a flaw of cognitive-behavioral processes. You have to be, you have to be at a position where, ah, you want to, you want to live or, or you have some motivation to, to do this or past a certain point it just doesn’t, why, why should you, why should you try these things. Um, I just feel like the stuff that I was, the stuff that I needed was, ah, much more fundamental [R: Um hmm] than that. I think that cognitive-behavioral stuff is for people who pretty much have things together already.

R: Yeah, that was, that was coming through in the written description. It was just, you were distinguishing between, um, pragmatic steps [P3: Right] toward a goal and then something else, you know, just about believing that change is possible or even deserved [P3: Right]. And you also talked about goals on the one hand and then, you know, doubting, doubting you could achieve these goals. It seems like [P3: Yeah] you’re articulating two different things.

P3: It was much more fundamental. And plus I think, you know, my, my one of my big issues was, um, feeling, feeling invisible [R: Um hmm] and, and wanting some kind of validation. Or I mean not daring to hope for it and not even sure that I, I should be given it but wanting it anyway [R: Um hmm]. I don’t think cognitive-behavioral stuff even begins to address that.

R: And the way you were describing the cognitive-behavioral therapy does seem, as opposed to when you were describing the psychodynamic therapy as giving you room [P3: Right], it seemed like the cognitive-behavioral therapy for you was, was more delimiting [P3: That’s true]. As you wrote: you’re X, if you want to stop doing Y then do Z.
P3: Right, that’s right, that’s a good point. I think that, um, I mean it’s, it’s tricky and, and, and the process, my own experience in therapy shaped how I do therapy [R: Um], um, in that, you know, I try to do some of the things that I feel worked for me. But I also try to do things that, that didn’t happen or be aware of, of, of stuff that I would have wanted [R: Yeah] when I look back. Um, and I think because I, I grew up kind of on my own like sort of raised by wolves a little bit that I could, that I could have used more fundamental structure and her giving me more sort of concrete [R: Um hmm] stuff. Because I just, I had zero perspective [R: Yeah], just no idea of the most fundamental things about how to be an adult. Um, and I, but I think, you know, part of, part of her reserving or sort of giving me room the other side of that [R: Um hmm] was I don’t know how she could have known it, um, that I could have actually used more guidance sometimes. But I think that she was just trying to give me the space that I also desperately needed to figure out who I was. So it’s a tough balance.

R: Yeah, and, you know, the desire for more guidance was that something that was present at various points in therapy or was that something, you know, that was happening more toward the beginning or more toward the end.

P3: It was actually later. I think when I was able, when I was able to ask for it [R: Um hmm, yeah] and when I was ready to ask for it.

R: Just previously we were talking about just like the difference between, you know, a belief in the possibility of change or your deservedness of change and, um, you know, and actually taking pragmatic steps toward change or formulating those [P3: Um hmm]. What were some changes that happened at the level of belief, um, you know, belief in, belief in the possibility of change or, um, belief in your, your ability? Could you say anything about that?

P3: That’s a tough one, belief in the possibility of change.

R: Or just change on that more fundamental level you were speaking of.

P3: Yeah, I think, I mean I think were talking real fundamental stuff [R: Yeah]. Because I actually remember realizing that, ah, no it wasn’t, it wasn’t even necessarily the question of realizing. Um, I think had to start developing an identity or developing stuff that interested me or stuff that mattered to me, um, kind of building it. I think it was there because I think as a kid as a ten-year-old I had an identity but then sort of entering adulthood I kind of lost it. Um, I’m trying not to get off topic and stick to what you were asking me but I think it is somehow related [R: Yeah, go for it]. Um, but I remember for instance realizing I had to make a conscious effort to sort of gather things, um, or bring things into my life that appealed to me [R: Um hmm]. And, and I think that I had gotten to the point where I was actively pushing everything away or ignoring everything. So like I would, before I would go somewhere and see a book that I’d, something that would speak to me and I would ignore it, um, or, or reject it or, or just, I wouldn’t pursue it [R: Yeah]. And, and making that conscious decision or realizing that, that, you know, part of my project was to gather those things [R: Um hmm] because that was, that was me.
was how I became me. That’s how I kind of, that’s how life would mater [R: Yeah, yeah]. That I had to, I had to build that book by book [R: Um hmm]. Um, and so it was just little tiny movements like instead of, instead of ignoring things, um, I would collect them. I guess it was empowering and concrete enough that, and there was change there because the more you do it the, the bigger you get [R: Yeah]. And then there’s more and bigger. And so the more you engage with the world the more of an identity you have. But how, how I got to the point that I wanted to do that, that, that I, that I was motivated to care about myself to, to take care of myself. I think, I think it, it partly had to do with her caring about me.

R: Um hmm, yeah, so her caring about you and you were brought to a point where you cared.

P3: Yeah, I think so. I’m not sure but I, is this fitting at all? [R: Yes, I’m understanding it] I remember one of the things that really just killed me when I, when I started was, um, this idea that or that kind of saying that nobody’s going to care about you until you care about yourself. And saying how can I care about myself if nobody cares about me. And that, that catch of being in this, in this impossible position, you know, like you can’t get a credit card until you have a credit card [R: (laughs)] Um, and, and I think I was also sort of furious about that too or, and I think that her (starts to cry) making room for me [R: Um hmm], um, helped me, gave me a reason to do that for myself.

R: Yeah, so there’s that fundamental change and then along the way you mentioned the gathering [P3: Um hmm]. And that’s interesting also because gathering is, you know, gathering up but also gathering momentum.

P3: That’s true. And how, I mean just how small it was. Like I remember going into a grocery store and I saw this packet of powdered gravy, chicken gravy. And it looked like it’d probably been there since 1950 because it had this funny little, um, really bad quality photograph of like a chicken on a dinner table or something like that. And it was just so ridiculous and silly looking. It looked, it really looked like, you know, it had fallen behind the shelves and it had been there since 1954. And, um, I bought it [R: Um hmm]. It was a big deal because I thought it was funny [R: Yeah]. And, and just to spend, you know, fifty-nine cents on a chicken, powered chicken gravy packet that no one would ever want to use (laughs) [R: (laughs)]. Um, but I remember sort of making that conscious choice, um, to give that to myself just because I liked it. Yeah, so that’s how it starts.

R: Um hmm, and then it continues. You wrote about developing a plan for the future, um [P3: Um hmm]. Could you tell me more about that, that developing of a future? Because you were writing about the aimlessness before therapy but you wrote about at the end of therapy developing a future.

P3: A future, um, ah, yeah, I mean I’m not, I’m not again I’m not sure how it happened that suddenly the possibility of a future or if it was even sudden. I mean I doubt if it was. It was probably what we were sort of leading up to for the four or five years, you know,
working together. Um, I think part of it, you know, part of it was kind of the newness of learning new things like that I could have feelings (laughs) and be curious about them. Um, that was new. And, and new possibilities that means, um, there were things out there that I couldn’t imagine and expectations that I couldn’t predict [R: Yeah]. And they weren’t necessarily bad expectations or things to come. Um, and ah, and ah being freed again to be curious about the world and other people [R: Um hmm], um, sort of gave me a forward direction. That, that when, you know, depression is just kind of this circle, um, where, yeah, it’s just this closed system and it’s impossible to have a future, um, that way.

R: You mentioned a change in relation to other people. And I was just thinking about the beginning of your written description where you gave an example of putting your Walkman on [P3: Um hmm] to avoid interactions with others but then you wrote at the end of the therapy you were actually interacting with others more [P3: Um hmm]. I was wondering if there was anything that stands out, any instances or examples of that change.

P3: Well, I mean it was kind of a bi-directional thing [R: Um hmm]. I, I reached out more but I think I also felt like people were reaching out to me [R: Yeah]. And I think that was the therapy sort of showing me that, um, that there was goodness out in the world. Um, I mean I remember one experience which I, which I found really profoundly important that, that I kind of see as (sighs) one of the little pieces that got me out of that place was, um, again being in the grocery store because I, you know, I only left the house to (laughs) buy food or something like that. So I wouldn’t meet or have any other experiences any other places. Um, and I was standing in the checkout line. And I think at that point feeling, um, like a non-entity I mean really practically invisible [R: Um hmm]. And, and just saying something to myself out loud. Ah, and the woman behind me or in front of me or something answered back (starts to cry and pauses). And I don’t even remember what she said but it was that she answered back [R: Um hmm, yeah]. And I was astounded (pauses). And I think that, that was one of the things, ah, that made me feel reconnected with the world too. That there were things out there that were good [R: That responded] yeah, that they didn’t hurt and they actually gave something and there was the possibility of a relationship. And I think, and I think that too leads to the possibility of a future.

R: Um hmm, yeah, and the future after therapy you went back to grad school.

P3: Yeah, yeah, and I think, you know, by the time I was, I went back to school for undergrad, ah, and then ultimately grad school and I think by that point (sighs) I was, I was really gung-ho on, on the curative powers of psychotherapy [R: Um hmm]. You know, it was a tool to change the world and right all the ills. And I think since then I’ve gotten a more realistic perspective sadly (laughs). I’ve lost some of the, ah, idealization of it, yeah.

R: I wanted to change it up and go back to the process of the therapy [P3: Yeah]. Another thing you mention that was happening was you and your therapist articulating
the poisonousness of, ah, your past relationship [P3: Um hmm]. I was wondering if you could elaborate on that. What did that work look like?

P3: Again, I mean we’re talking real fundamental [R: Yeah]. Um, in that, I mean I remember her pointing out to me that whenever he would be in town, um, my boyfriend that I would get really withdrawn and I would stop talking, um, and just be incredibly defended. And her just pointing that out. That’s stuff that I didn’t even see, no perspective again, no, no awareness self-awareness. Um and then just unpacking that [R: Yeah]. And I think, you know, when in, there are these little tiny moves where you just kind of, she was respectful and attentive. She took me seriously. And, and what I said mattered and there was something important there to understand. And, and when someone treats you like that it’s, it happens again and again and four-thousand times and then you start thinking: okay, um, I guess, you know, this is, I deserve this or I’m worthy of this. And then it makes, it made me no longer be content with or okay with someone treating me as badly as I treated myself [R: Um hmm]. Um, so, so that’s I mean I think that’s how the therapy worked in terms of that relationship too. It just, it just gave me a, a like a different perspective or it just put that way of relating in, it contrasted with that. And I, and I kind of questioned what I was accepting as okay or as tolerable.

R: Yeah, I was just thinking of micro-processes. It just seems like, you know, many, many experiences [P3: Um hmm] going together over a course of years [P3: Right]. You know, her respect and then that contrasting with the lack of respect with your boyfriend [P3: Um hmm].

P3: And I mean I, I always saw that relationship as, you know, we had some things in common but probably one of the biggest ones was that we both didn’t like me very much or at all. And ah, ah and I think as I, as I started to change by her, I guess my experience of her liking me, um, we had less in common he and I.

R: Yeah, you mentioned that she for instance would point out that you’d be withdrawn when he’d be in town and you’d work through that. What did that look like?

P3: I mean all this is very complex [R: Yeah]. Um, ah, because I think I really, I idealized him [R: Um hmm]. Um, and, you know, as I’m, as I’m studying for the, for the licensure exams and reading about things like secondary psychosis I think it’s called where like one person is psychotic because someone else is psychotic [R: Okay]. I’m thinking was that going on there because I, because I really believed as he did in himself that he was just this brilliant mind that was, um, sort of this, this genius force. I saw him as that and he saw himself as that. Um, and I, and so I wanted, you know, I wanted him to validate me [R: Um hmm]. Um, but on the other hand, I was also scared of him. And, ah, you know there were, there were points where it wasn’t always this way but it got bad. And, and there were points where he was going to hurt somebody or he said he was going to hurt somebody that I cared about, um, if I didn’t do what he wanted me to do. And, and so, you know, I was just, I was just going to hunker down and, and try and survive this [R: Um hmm]. So I was very much in this sort of self-preserving stuck position [R: Yeah]. Um, and, and it really took his losing interest in me, um, for me to
get free because he was scary. And, yeah, and I don’t know how I would have gotten out of that if he hadn’t lost interest. So, so there were a lot of elements at play [R: Um hmm]. So it wasn’t necessarily that she helped me to realize something that helped me to brake free. Because there were, I mean there were, there were physical threats that, that I no amount of insight could have released me from [R: Yeah].

R: I wanted to take a second for us to read one of the paragraphs that were standing out to me. Could you take a second to silently read the third paragraph down on the second page that covers the experience of you being late and your experience of that?

P3: Does it start her constancy? [R: Yes] (Starts to read paragraph) Oh yeah (Continues to read paragraph). Yeah that was, that was a very strange experience [R: Yeah]. I’d never, I’d never had, I guess it was such a physical manifestation of this emotional need [R: Um hmm] that my body actually started to break down when I thought that she wasn’t there. That was, I was shocked that all that was going on inside of me. Um, who knows what I’d of actually done if she wasn’t there (laughs), but I guess, what about that do you want me to describe?

R: I was just wondering what was going on, you know, in the experience, but also what was going on in the therapy or your life at that time?

P3: I know that I was extremely isolated and, and um extremely lonely and kind of deprived, um, as far as sort of care and mattering. I really wanted to mater to somebody and to myself and to not be alone. Um, and she was able to give that to me. In a, in a, in a way, um, you know that starts to sound more like a humanistic or like Rogerian I guess aim of, um, psychotherapy of kind of this unconditional care [R: Um hmm]. Um, but I don’t, I don’t think a kind of humanistic or Rogerian therapy would have been as effective because (sighs) I, I guess because to me that feels, I’m sure the Rogerians are going to disagree with me, but, but that feels kind of naive or overly optimistic about people because there was a lot of big ugly feelings and a lot of anger and hostility. And I think I needed somebody who could help me look at that but also help me talk about how I didn’t want to look at that [R: Yeah] and would deny it and avoid it. And, um, so, so there was a, a realness [R: Um hmmm] to the relationship or a quality of genuineness. Um, yeah, the Rogerians definitely won’t agree with me. But, um, yeah I, I felt like I was actually having a human relationship with her and that, that was, I needed that more than anything [R: Yeah].

R: What is striking me is you said if you didn’t want to look at the material she would help you with that. And just to contrast you wrote about the one therapy where the therapist was very happy and smiley [P3: Right] and there wasn’t that connection and that seems that was what was missing from that previous therapy.

P3: That’s right. And, and again the complexity because I think, you know, I was the designated patient because I was the depressed negative person who would point out the things that weren’t beautiful [R: Hmm]. So I was kind of, of the one who was saying but look at this. This, this, this is a problem [R: Yeah]. Um, but on the other hand, I also,
you know, coming from the place that I was coming from I was also like my denial and repression were going twenty-four-seven. Ah, so there’s also a big part of me that, um, I didn’t want to, I didn’t want to feel this. I knew that I shouldn’t. I didn’t want to have any of those negative feelings. And so somebody who could pay attention to all of that was really important.

R: Um hmm, yeah, the real magnitude of that experience was coming out in that paragraph. The real magnitude of her being there and just [P3: Yeah] what that meant for you.

P3: Yeah, it’s amazing that it seems I mean it’s so small but it’s so big [R: Um hmm]. And I, and I think I love that, that’s sort of the thing that I, I got out of the therapy that is just so fundamentally part of me now which is this kind of it’s this and it’s opposite and ten other things all at once [R: Yeah]. It’s just the realness of that how multifaceted something can be all at the same time. The complexity of it captures a necessary reality for me [R: Um hmm] that when I didn’t have I just couldn’t, I didn’t know how to be in the world.

R: And it’s a part of you now too. You said the therapy’s a part of you.

P3: That, that, that’s what it is, one of the things it gave me [R: Yeah]. Just I mean I live and breathe that. And it allows, I mean it allows, I’m not sure what it allows (pauses). I mean it, I’m not sure, but I know there’s something, there’s something really important about experiences, complexity of experience [R: Um hmm] that you can, that you can feel lots of different even contradictory things all at once. I think, I think that maybe again it sort of goes back to a sense of identity that I felt like it just couldn’t be that complicated [R: Yeah]. That if I sort of had a problem with my parents that I couldn’t be, I don’t know, I couldn’t be my, I’m not sure exactly. Um, but like to have an identity you have to be really clear cut. And just the tremendous kind of validation or sense of relief that, you know, I am who I am and I’m having a whole bunch of different reactions to this or a whole bunch of different feelings toward this person. And, and that’s, that is my identity [R: Um hmm] as opposed to I should be feeling one of these things not this and it’s opposite I guess. Does that make sense?

R: Yes, it definitely makes sense. And my next question is rather self-evident but I want to ask it anyway. You mentioned that really vivid bodily example at the beginning of the written description when you said you lost your ability to smile [P3: Um hmm] and the feeling of leadness in your body. And I was wondering, you know, how’s that different now for you. [P3: Could you say more about that?] Yeah, um, just the embodied experience of losing your smile, not having the ability, and currently how is that bodily experience enacted? You know, how do you experience that?

P3: I think, I mean I guess that example I think that was my first real tangible experience of a depression [R: Um hmm]. Um, and I think that that was before, before it got really bad. Um, because when it got really bad I think I was so detached from myself physically that, ah, I was pretty, I was pretty, um, disembodied and there was kind of this
thing I had to lug around which I absolutely loathed. And, and I think what’s different now is that I mean I feel integrated [R: Um hmm] and that this is me. And it’s not an enemy or a jail [R: Yeah]. Um, and it’s kind of a, yeah, it’s just more integrated. There isn’t a sense of detachment.

R: I’m glad I was able to interview you with your own painting in the background. I mean earlier you were speaking of gathering, you know, and that momentum. And to see that there I’m seeing that as everything you were speaking of as far as like, um, the upsurge of that development, where you are now.

P3: Yeah, that’s actually interesting because I mean one of the, I guess presenting issues when I started the therapy too was that I was unable to, to do any work [R: Um hmm]. I just couldn’t produce anything at all and that lasted for years. And I, and I think there was sort of this, this homelessness [R: Yeah]. You know, I didn’t have anywhere to move from. I didn’t have anywhere to stand in my relationships in myself physically in myself in terms of an identity. So I mean it’s impossible to produce anything if there’s nobody there to produce [R: Yeah]. And that changed.

R: Um hmm, I was wondering if there is anything we left out here today. Is there anything else that is coming to mind?

P3: Let me see. (Pauses) I think, I mean probably another one of the big sort of overarching things that I, that I took out of the experience and that really shaped how I, how I function and also how I work as a, as a psychotherapist is the idea that, I’m just kind of underscoring stuff [R: Um hmm] we already talked about, is that, you know, to look at your experience or what you’re thinking, feeling, or doing with this kind of nonjudgmental curiosity [R: Um hmm] of there’s something important here. Um, that somehow it makes sense. It might not necessarily be, um, a great choice. It could very well be problematic, um, but there’s something important here for us to understand. Um, so to go back into yourself or sort of mine yourself for experiences for what is valuable there [R: Yeah]. And that, that’s just such a better position than kind of this accusation or, or rejection. This kind of trust [R: Um hmm], um, that, that something, there’s something important there [R: Something of value], yeah, yeah.

R: I really appreciate that synopsis. Is there anything else you have on your mind?

P3: No.
There was a point during my senior year of college when I lost the ability to smile. I remember most vividly the feeling of leadenness that made the physics of smiling virtually impossible, as well as a sadness that refused to be masked.

I wore a Walkman, often with nothing playing, in order to avoid interacting with people, and I slept a lot. I was living away from home, aimless, and in the midst of a bad relationship. This period - which I did not identify as depression- lasted a few weeks and resolved on its own.

R: And my next question is rather self-evident but I want to ask it anyway. You mentioned that really vivid bodily example at the beginning of the written description when you said you lost your ability to smile and the feeling of leadness in your body. I was wondering, how's that different now for you. Just the embodied experience of losing your smile, not having the ability, and currently how is that bodily experience enacted? How do you experience that?

P3: I think that was my first real tangible experience of a depression. I think that was before it got really bad. Because when it got really bad I think I was so detached from myself physically that I was pretty disembodied and there was kind of this thing I had to lug around which I absolutely loathed. I think what’s different now is that I feel integrated and that this is me. It’s not an enemy or a jail.

During her senior year, P3 was living away from home and finishing her undergraduate studies. She felt aimless in terms of personal aspirations and stuck in an unsatisfactory relationship. P3 first encountered a period of depression for a few weeks in which she experienced hypersonmia. She bodied forth her sadness where in her body felt heavy and she lost the ability to smile. In an intentional manner, P3 disengaged with others.

P3 now felt more integrated with her body as her body was incorporated in her sense of identity. When severely depressed, P3 had felt detached from her body like her body was an oppressive object that she loathed.
It’s just more integrated. There isn’t a sense of detachment.

I experienced a more protracted bout of depression a year after graduation. Following college I moved to a new town to attend graduate school for a subject I wasn't really interested in. I continued in the bad relationship. At this point there had been three brief episodes of physical violence from him toward me, as well as verbal intimidation. I felt both trapped in the relationship and a tremendous longing for him to love me. I felt despair, lethargy, was at a loss personally— with no goals, and with significant doubt in my ability to find a goal or achieve anything of substance. Instead I attached myself to the relationship, to someone who, unfortunately, was as lost and depressed as me. I was frightened of him but also believed he was better than me. Again, I did not have the information or the perspective to identify any of what I was going through in clinical terms.

However, I did seek counseling for relationship difficulties during this time. Both therapists seemed unhelpful. One, at our first and only meeting, insisted that I confront my boyfriend. When I expressed my fear she directed me to have the confrontation in a public place so there would be less danger of violence. I was unwilling to do this. A second counselor was very friendly and smiled a lot, but there was no connection. I didn't feel that she offered anything beyond cheerfulness and left after several weeks.

I returned to live in my hometown about three years after

---

One year after graduation, P3 lived at a new locale, started graduate school, and was disinterested in her studies. She did not have personal goals, and moreover, doubted her ability to establish or reach any goals. P3 also experienced instances of physical and verbal abuse as her relationship continued. She felt trapped in the relationship because she was frightened of her boyfriend and also because she idealized him and longed for his love. P3 encountered a longer period of depression in which she experienced lethargy and feelings of despair.

During this episode, P3 attended therapy in regards to relationship difficulties. Her first therapist insisted she confront her boyfriend despite P3 voicing concerns. P3 was unwilling to confront him and left therapy after one session. Her second therapist appeared pleasant and cheerful, but P3 felt no sense of connection with her. P3 thought she had nothing to offer and left after several sessions.

Three years after graduation, P3 moved back home. She still felt aimless, doubted
graduation, continuing to feel aimless and frustrated by my aimlessness, as well as doubtful about my abilities. The relationship continued. I grew increasingly self-loathing and entered a vicious depression lasting several years. My sleep was significantly disturbed, due to the depression but also due to the medications I took (SSRIs, Trycicylics and MAOIs as well as a Dexedrine, Depakote and Lithium at different times, in different combinations and doses over a 4 year period. None seemed to work.) I spent one year sleeping less that a couple hours a night and another sleeping at least 18 hours. I ate compulsively at times and would go weeks without bathing or caring for myself in any way (Although I could not articulate it then, it strikes me now that part of this self corruption was the only way I knew how to get out of the bad relationship-to repel him so much that he'd finally let me go.)

At the start of this period I once again sought counseling. Although I remained with this counselor (a clinical psychologist with a cognitive behavioral orientation in a medical setting) for nearly a year the experience was not helpful.

P3: Before I was working with her there was the therapist that was pretty cognitive-behavioral and that just was not working for me at all. I think just fundamentally because I think this is a flaw of cognitive-behavioral processes. You have to be at a position where you want to live or, or you have some motivation to, to do this or past a certain point it just doesn’t, why, why should you, why should you try these things. Um, I just feel like the stuff that I needed her ability, and consequently, was frustrated. P3 continued in the abusive relationship. She encountered a severe depression for a long duration in which she experienced significant sleep disturbances and a sense of self-loathing. P3 did not engage in self-care, like bathing, for weeks at a time and ate compulsively.

At the start of this episode, P3 attended cognitive behavior therapy for a year, but found this therapist unhelpful too. Her therapist used definitive labels on her and her problems, which felt aggressive and confining. He approached her suffering in a pragmatic manner based on the assumption P3 merely had to stop engaging in problematic behaviors by will alone. However, although her life felt tormented, P3 first had to believe change toward a worthy life was deserved and possible and also want to change before taking any practical measures to change. Thus, her therapist did not engage her in a more fundamental way.
was much more fundamental than that. I think that cognitive-behavioral stuff is for people who pretty much have things together already.

R: Yeah, that was coming through in the written description.

I recall the counselor using definitive labels (you are X, this is X) which felt violent and narrow, and his having a very practical approach (if it hurts to do X, then stop doing X) which did not address my plaguing questions- Am I anything more than a bag of chemicals and misfiring neurons? Do I have the right, or the equipment to live a life worth living? Is there such a thing as life worth living? Being alive was a torment and I could not begin to take pragmatic steps toward better functioning without first believing that change was deserved or possible.

R: It was just, you were distinguishing between pragmatic steps toward a goal and then something else, just about believing that change is possible or even deserved. You also talked about goals on the one hand and then, about doubting, doubting you could achieve these goals. It seems like you’re articulating two different things.

P3: It was much more fundamental. And plus I think one of my big issues was feeling invisible and wanting some kind of validation. Or I mean not daring to hope for it and not even sure that I should be given it but wanting it anyway. I don’t think cognitive-behavioral stuff even begins to address that.

R: The way you were describing the cognitive-behavioral therapy does seem, as opposed to when you were describing
the psychodynamic therapy as giving you room, it seemed like the cognitive-behavioral therapy for you was more delimiting. As you wrote: you’re X, if you want to stop doing Y then do Z.

P3: Right, that’s right, that’s a good point. I think it’s tricky and the process, my own experience in therapy shaped how I do therapy in that I try to do some of the things that I feel worked for me. But I also try to do things that, that didn’t happen or be aware of stuff that I would have wanted when I look back. I think because I grew up kind of on my own, sort of raised by wolves a little bit, that I could have used more fundamental structure and her giving me more sort of concrete stuff. Because I had zero perspective, just no idea of the most fundamental things about how to be an adult. Part of it was her reserving or sort of giving me room the other side of that was I don’t know how she could have known it, that I could have actually used more guidance sometimes. But I think that she was just trying to give me the space that I also desperately needed to figure out who I was. So it’s a tough balance.

R: The desire for more guidance was that something that was present at various points in therapy or was that something that was happening more toward the beginning or more toward the end.

P3: It was actually later. I think when I was able to ask for it and when I was ready to ask for it.

R: Just previously we were talking about the difference between a belief in the possibility of change or your deservedness of change and, actually taking pragmatic steps toward change or formulating those. What were some changes that happened at

Later in therapy when she was better able to articulate her wants, P3 wanted more concrete structure and interventions as she had not received much guidance from her parents and had little perspective on adulthood. However, her therapist’s analytic stance instead provided her space to work out her sense of identity.
the level of belief, belief in the possibility of change or, belief in your ability? Could you say anything about that?

P3: That’s a tough one, belief in the possibility of change.

R: Or just change on that more fundamental level you were speaking of.

P3: I think were talking real fundamental stuff. Because I actually remember realizing that it wasn’t even necessarily the question of realizing. I think had to start developing an identity or developing stuff that interested me or stuff that mattered to me and kind of building it. I think it was there because I think as a kid as a ten-year-old I had an identity but then sort of entering adulthood I kind of lost it. I’m trying not to get off topic and stick to what you were asking me but I think it is somehow related. I remember for instance realizing I had to make a conscious effort to sort of gather things or bring things into my life that appealed to me. I think that I had gotten to the point where I was actively pushing everything away or ignoring everything. So before I would go somewhere and see a book or something that would speak to me and I would ignore it, or reject it, or I wouldn’t pursue it. Making that conscious decision or realizing that part of my project was to gather those things because that was me. That was how I became me. That’s how life would matter. I had to build that book by book. And so it was just little tiny movements like instead of ignoring things I would collect them. I guess it was empowering and concrete enough that, and there was change there because the more you do it the, the bigger you get. And then there’s more and bigger. And so the more you engage with the world the more of an identity you have. But how I

P3 attained a more developed sense of identity. She found that her identity was reflected in her engagements with the things of her world, and so rather than ignoring or rejecting these, she let herself intentionally engage with more and more things she found meaningful. Since her therapist cared enough to provide a therapeutic space for her to be in her fullness of being, P3 felt motivated to care about herself and gave herself room to develop.
got to the point that I wanted to do that, or that I was motivated to care about myself to take care of myself. I think it partly had to do with her caring about me.

R: So her caring about you and you were brought to a point where you cared.

P3: Yeah, I think so. I’m not sure, but is this fitting at all? I remember one of the things that really just killed me when I started was this idea that or that kind of saying that nobody’s going to care about you until you care about yourself. And saying how can I care about myself if nobody cares about me. And that, that catch of being in this, in this impossible position, like you can’t get a credit card until you have a credit card. I think I was also sort of furious about that too or, and I think that her making room for me helped me, gave me a reason to do that for myself.

R: Yeah, so there’s that fundamental change and then along the way you mentioned the gathering. And that’s interesting also because gathering is gathering up but also gathering momentum.

P3: That’s true. And how small it was. Like I remember going into a grocery store and I saw this packet of powdered gravy, chicken gravy. And it looked like it’d probably been there since 1950 because it had this funny little really bad quality photograph of like a chicken on a dinner table or something like that. And it was just so ridiculous and silly looking. It really looked like it had fallen behind the shelves and it had been there since 1954. And I bought it. It was a big deal because I thought it was funny. Just to spend fifty-nine cents on a chicken, powered chicken gravy packet that no one would ever want
to use. But I remember sort of making that conscious choice to give that to myself just because I liked it. Yeah, so that’s how it starts."

R: I’m glad I was able to interview you with your own painting in the background. I mean earlier you were speaking of gathering that momentum. And to see that there I’m seeing that as everything you were speaking of as far as the upsurge of that development, where you are now.

P3: Yeah, that’s actually interesting because I mean one of the presenting issues when I started the therapy too was that I was unable to do any work. I just couldn’t produce anything at all and that lasted for years. And I think there was sort of this homelessness. I didn’t have anywhere to move from. I didn’t have anywhere to stand in my relationships in myself physically in myself in terms of an identity. So I mean it’s impossible to produce anything if there’s nobody there to produce. And that changed.

At the beginning of therapy, P3 was unable to produce anything creative since she was not grounded in a sense of identify and embodiment, nor in terms of relationships with others. As P3 established such a ground from which to create, she once again engaged in painting.

She was a clinical psychologist with a psychodynamic orientation, in private practice. Early on, upon learning that my parents were coming in for a session, she responded to my distress by noting that they would not meet with her but with another counselor (with whom she would then consult), and that the counselor would ask them to focus on themselves- their thoughts and feelings and issues- rather than on me. This was the first moment of relief I experienced.
R: You gave an example too about your parents coming in for a session. Your therapist was reassuring you that they would be seeing a different therapist and focusing on themselves. And you wrote that you felt a great deal, a sense of relief. How did your therapist’s way of handling that situation, how did you experience that? How did that feel?

P3: That was really early on and I think it only happened that one time. I don’t really know the details because I think I was probably speaking to my family maybe once every few months so I had almost no contact with them. But I was really threatened that, that we were all going to be in the room together. I think not just because I was going to sort of be accused because it was much more subtle than that. I think that it was just sort of speaking about this at all. We just didn’t talk. We just don’t talk about this sort of stuff or have emotions in front of each other. That was just way too scary. I think at that point I was also treated like, frankly probably rightly so because I was pretty off my rocker. I was pretty distressed. I was the screwed up one. I think the reason why that was a problem was because it was just so invalidating. Because it was saying, it was sort of leaping over the possibility that there was a genuine problem. And that it wasn’t just me not being able to handle it or me being too sensitive or deluded in some way, but that there’s actually something not working here and I’m responding to that. And so when she said that they were going to be talking about themselves that was just like wow, really so it’s not going to be sort of about how I’m not doing something right or getting something wrong. But they’re sort of scrutinizing their own choices and feelings and
actions. Wow, that was an amazing idea.

R: Yeah, and that sounds validating in and of itself.

P3: Yeah, absolutely, taking me serious that was hugely important. Because I was barely able to do that myself.

Her unfolding the concept of the designated patient and exploring family dynamics, rules and expectations with me was tremendously helpful throughout the therapy. She helped me articulate what had initially been only a troubling fog in my relationships with family.

R: You mentioned goodness of fit. In the written description you were writing about family dynamics, expectations, rules that you and your therapist articulated. So, that was one of the dynamics then.

P3: Yeah, and beyond, kind of specific concepts, and she talked about things like, um, let me get out my note card. Good enough parenting, mirroring, and that did a couple things. I mean it kind of helped me understand what I didn’t have, but also maybe what they didn’t have and also what was there. So, it both justified my experience dissatisfaction, but it also somehow softened things for me to sort of regain some kind of caring connection with my parents. I’m not sure exactly how. I guess through their own experiences as kids, maybe.

R: That seems really important to have both elements there.

P3: Right, that’s right. I think that was also a really important point where I had gotten to the point where I was bad because I had these strong feelings.

Her therapist explored family dynamics and helped P3 discern problems that were previously unclear and unarticulated. Her therapist discussed specific concepts such as mirroring, which helped P3 to better understand her development. By way of these concepts, P3 comprehended care that was not received and her feelings of frustration were validated. She also appreciated such care her parents had presumably not received and felt more empathy for them.
Throughout the course of our work it was also about, kind of complexity and things, things can be lots of things at once. You can hate your parents and you love them. It’s not either or. Just because I have these big feelings, it doesn’t mean I’m bad or broken or ruined or the designated patient of the family. I’m not the bad one. So things are more complex and subtle and multifaceted and that was also really important for me to kind of remember that, that it’s not black and white. 

Over the years she helped me to move beyond immobilized fear and longing in the dating relationship by articulating its poisonousness.

R: I wanted to change it up and go back to the process of the therapy. Another thing you mention that was happening was you and your therapist articulating the poisonousness of your past relationship. I was wondering if you could elaborate on that. What did that work look like?

P3: Again, I mean we’re talking real fundamental. I mean I remember her pointing out to me that whenever he would be in town, my boyfriend, I would get really withdrawn and I would stop talking, and just be incredibly defended. And her just pointing that out. That’s stuff that I didn’t even see, no perspective again, no, no awareness self-awareness. And then just unpacking that. And I think there are these little tiny moves where you just kind of, she was respectful and attentive. She took me seriously. What I said mattered and there was something important there to understand. And when someone treats you like that it’s, it happens again and again and four-thousand times and then you start thinking: okay, I guess I deserve this or I’m worthy of this. And then it makes, it

and that she can feel many different ways toward the same person. She came to see that she can both love and hate her parents and that experiencing a strong emotion such as anger did not indicate her own badness.

Before therapy, P3 felt a sense of stuckness as she was unable to end her dating relationship in two regards. First, P3 feared her boyfriend in the face of his threats to obey his commands, and consequently, she entered into a survival mode of existence. Second, she longed for her boyfriend as P3 idealized him and so wanted to obtain his validation. During therapy, her therapist helped her articulate the unhealthy effects of the relationship and P3 began to feel more of a sense of movement. P3 gained knowledge about and perspective on the relationship and herself. In addition, she continued to experience her therapist’s constant attentiveness, respect, and interest. P3 started to believe that she was worthy of such treatment, and so felt the way she treated herself and the way she was treated by her boyfriend were both unacceptable.
made me no longer be content with or okay with someone treating me as badly as I treated myself. So I think that’s how the therapy worked in terms of that relationship too. It just gave me a different perspective or it just put that way of relating in, it contrasted with that. And I kind of questioned what I was accepting as okay or as tolerable.

R: Yeah, I was just thinking of micro-processes. It just seems like many, many experiences going together over a course of years. Her respect and then that contrasting with the lack of respect with your boyfriend.

P3: I always saw that relationship as, you know, we had some things in common but probably one of the biggest ones was that we both didn’t like me very much or at all. And I think as I started to change by her, I guess my experience of her liking me, he and I had less in common.

R: Yeah, you mentioned that she for instance would point out that you’d be withdrawn when he’d be in town and you’d work through that. What did that look like?

P3: I mean all this is very complex because I idealized him. As I’m studying for the licensure exams and reading about things like secondary psychosis, where one person is psychotic because someone else is psychotic. I’m thinking was that going on there because I really believed as he did in himself that he was just this brilliant mind that was this genius force. I saw him as that and he saw himself as that. And so I wanted him to validate me. But on the other hand, I was also scared of him. There were points where it wasn’t always this way, but it got bad. And there were points where he was going to hurt
somebody or he said he was going to hurt somebody that I cared about if I didn’t do what he wanted me to do. And so, I was just going to hunker down and try and survive this. So I was very much in this sort of self-preserving stuck position. It really took his losing interest in me for me to get free because he was scary. I don’t know how I would have gotten out of that if he hadn’t lost interest. So, there were a lot of elements at play. So it wasn’t necessarily that she helped me to realize something that helped me to brake free. Because there were physical threats that no amount of insight could have released me from [R: Yeah].

She also helped me articulate my parents’ limitations and the fury and grief I felt toward those limitations.

R: That was something that was also standing out in your written description. It seems like another development. You were writing about articulating in therapy your parents’ limitations and also your feelings of anger, and what you were saying is that behind the anger there was grief about their limitations. And then at the end of therapy writing about being able to feel more empathy toward those limitations.

P3: I’m grateful to her because I don’t know what would have happened because being that angry just isn’t sustainable. I just, you just can’t maintain that. Yeah, but if I hadn’t gotten through that, I’m really grateful that I got to work with her.

R: That gratefulness was coming out within the description. Even the last line you were saying how grateful you felt. You wrote about your parents’ limitations and just the feelings toward those. You mentioned how the therapy helped you to

Her therapist helped P3 to articulate the limitations of her parents’ care and her feelings of rage and grief toward such limitations. P3 came to understand that rather than seeing and validating her more personal qualities and potentials, her parents recognized and valued her only in terms of her appearing in line with their expectations.
articulate some of those limitations and your feelings of anger and grief. Could you tell me more about that? Could you give me example of things that came up in therapy, something that you both worked on?

P3: Tell me if this is sort of not what you’re looking for. I guess I sort of felt like they just couldn’t see me, and there was a certain way that I was supposed to be, and a certain way that I had to look. And the surface was what they saw and there wasn’t sort of a curiosity about who was inside. That really infuriated me, broke my heart. There was something else but I lost it. Oh and I think also I was really angry because she talked about goodness of fit in families too and I think that also just kind of helped me sort of understand or get some perspective and give them an out because I also wanted to love them. I didn’t want it to be because there was something wrong with me, but because they were doing what they knew how to do or were doing their best. I also think that I was probably not the easiest kid to raise like pretty hyper-sensitive. And, um, I think some, some kids are probably a lot heartier and you can just kind of put them out there and they’ll find their way. And I think that I really needed guidance [R: Um hmm]. I mean the world was a huge scary place to me and I needed somebody to tell me what it, what it meant. Um, and they just, they were very hands off [R: Um hmm]. So, I didn’t, I, I was really pretty alone [R: Yeah] and, and was really angry about that, that I was kind of brought to this place and just left to fend for myself."

She helped me—again, over a period of years—to view my feelings—of anger, shame, doubt—as potentially helpful messages rather than proof of my

Her therapist explaining the significance of goodness of fit between parents and child and P3 acquired some perspective on their parenting that enabled her to be more sympathetic. P3 came to understand that her parents were providing the only kind of care they were able to offer and that she simply needed additional guidance from them in light of her more sensitive constitution.

Before therapy, P3 assumed that objectionable feelings such as anger and shame signified a personal deficit, and for example, she took her hatred of her
inherent weakness and corruption. I began to read my experiences for what they could tell me.

R: Yeah, I was thinking about something when you were talking about learning to have more of a curiosity about your feelings, your thoughts, and your reactions, learning to see them as helpful messages rather than something that you feel hostile towards or contempt towards. Is there any examples or instances that stands out in your mind?

P3: I’d have to talk kind of generally. I think generally there was a period where I absolutely hated my parents. I loved them as much, but I definitely hated them. I think that I felt kind of like a bad seed like a hostile bad person for feeling that. She would work with me to kind of unpack that and I don’t think that she wasn’t afraid of my sort of having these murderous feelings. Thankfully because I think that, I’m going to cry right now. I’m very grateful to her. I think thankfully because I think what was behind that anger was a lot of sadness. I think for me, what my life wasn’t like and what my relationships with them weren’t like, and also for them. How woefully human we are and the lack, the lacks that they experienced that, that got them to be or to do or to be able to do what they were able to do. And so kind of pushing through this anger to this sadness to a kind of I guess bitter-sweet compassion."

parents to mean that she was a bad person. Her therapist helped her work through such hatred, and P3 found that beyond her experiences of anger that feelings of grief and sadness emerged on the horizon. She felt grief concerning lacks in the quality of care that she received throughout her development and current existence. P3 further felt sad for her parents who presumably encountered similar lacks in care that contributed to their deficient quality of care. She ultimately felt a sense of compassion for them. Through the process of therapy, her therapist thus helped her to understand that her feelings were meaningful for and valuable to her life.

R: You were mentioning earlier in the interview just feeling angry at your family and then getting to the sadness underneath. Was the anger apparent before therapy or was that something that, you know, was it feeling primarily the sadness before therapy, feeling
depressed. Was the anger something that came up in therapy?

P3: I think I’m not sure how I got to the place that I got to. I think mostly I was lost. It started out as just feeling lost. I think it’s because I just never learned how to, and I think a lot of it had to do with sort of identifying and expressing emotions. I just didn’t learn how to say I feel this, I believe this, I want this, I hate this. So I was just sort of aimless and I think coupled with that bad relationship, I started getting on this track of I’m bad, I’m not good enough, I’m wrong. Then I’m not sure how that transferred to feeling so angry with my parents but I would guess it was probably they just couldn’t handle when I started breaking down and sort of withdrew and were kind of repulsed. And I think that made me really angry with their limitations.

R: With the picture you were painting, I was seeing that prior to the therapy it seemed that you were lost and I could picture there being anger, sadness, and just different feelings there. But it seems like in the therapy it was that there was a space to be able to feel and then to name what you’re feeling.

P3: I’m trying to find the right words for what I was pre that really bad episode where I just kind of hit my breaking point. I think I was pretty foggy. I think I was undifferentiated. I didn’t

Before therapy, P3 had a less developed sense of identity. P3 felt aimless in her projects and relationships and she experienced a less differentiated sense of self and others. In regards to herself, when she attended to her prereflective experience, P3 could not clearly recognize, identify, and express emotions, such as anger, and so could not articulate her feelings, wants, and beliefs. In regards to others, when she encountered an unsatisfactory relationship, P3 assumed that another’s ill-treatment, such as her boyfriend’s, indicated that she was a bad person. In therapy, her therapist highlighted the importance of a parent mirroring the child for identity formation, which helped her to articulate a sense of loss stemming from her parents’ limited care as well as to develop empathy for herself and her parents who presumably received similar care.
know how to be a person or a grown up or have an identity. So those feelings may have very well been there, but I guess it’s sort of like can you have emotions when you don’t really have an identity or can you articulate them if you don’t really notice them. I’m not exactly sure but there’s that kind of fogginess.

R: You’re painting that picture vividly and I can definitely see that. You mentioned mirroring also.

P3: Right, and I think that’s connected. Because I mean we get our sense of who we are and kind of what we’re feeling from the people around us from our parents. I think that wasn’t really present.

R: Was that how that concept was taken up in therapy? You mentioned mirroring was something that you talked about. Was that how that was taken up in therapy?

P3: Yeah, she talked about knowing who you are by seeing yourself reflected in your mother’s eyes. And again I think that was an example of putting words to the loss that I felt. But also the start of some kind of empathy for them and for myself [R: Yeah].

While all of this was going on she provided a constant, open presence. She did not engage me as though I was wrong or crazy. At the same time, she acknowledged my tremendous anger and sadness: Her actions asserted that my being sad, angry, and unsatisfied

The most significant facet of therapy was the therapist’s analytic stance and it ameliorated the core issue for which P3 sought therapy. Rather than pathologizing P3, her therapist acknowledged her feelings, such as anger and sadness, and thereby let her be in the fullness of her
R: I was also curious about your description of the therapist’s engagement and this really stood out to me. You were describing the way she engaged you and really acknowledged your feelings. You said she acknowledged your tremendous anger or sadness, but then did not treat you like you were sick or crazy. So I was just wondering what else should I know about that, that way of acknowledging but then not pathologizing.

P3: I can’t talk when I cry, which I am right now. There’s going to be some pauses because I just can’t speak when I cry right now. Yeah, that was one of the most important things and that really is, is kind of centered around one of the things that brought me there in the first place. Was one of the things that was so broken in myself and in my relationships and my family. I don’t think there’s anything more to it than just that. It’s just the experience hour after hour, week after week, month after month, year after year of someone letting me be who I was. And saying that’s fine. And that was hugely important, really the most important thing.

R: Yeah, there was nothing more to that experience but it was just that important, it had that grand significance, and that came out in your description and right now.

P3: I don’t want to be redundant but I think, to not pathologize it but to treat it like it as what it is. But also the added layer of not only is it fine that you feel what you feel but there may very well be something important here that you can learn from that can show you something about yourself or what you want or what you’re afraid of or what you don’t want or what’s working or not working. And it being who she was. Her therapist moreover approached her with respectful curiosity and questioned P3 about her feelings to help her learn more about herself; e.g., her wants and her fears. P3 came to understand that, in addition to her parents and boyfriend invalidating her, she too was rejecting her feelings and she realized that such a manner of attending to her experience contributed to her feeling lost with little sense of identity.
becomes not only okay but this place of great importance.

R: It was beyond neutrality or seeing your feelings as something that just are: this is what you’re feeling. It was that and your feelings are something that deserved to be paid attention to.

P3: Yeah and really importantly I think it was, it was also a point where I could realize that part of how I got to a place where I was totally lost and had nowhere to go internally or sort of no sense of home within myself or anything was because I was rejecting what I was feeling and hating myself for what I was feeling. And then to sort of learn that these feeling are exactly what you need to be exploring to find your home, to find yourself. So it was really, it was a tremendous relief to just be allowed to be. It was also kind of discovering this map that could really help me. So it was very powerful too.

R: There was something similar that came across in your written description. You were describing being away from home. I think two times you mention that being away from home and not having one. That was coming out a minute ago as well. So, it was about coming to therapy and not having a home. I was wondering too, what was coming to my mind when you were talking about learning to have this curiosity about your thoughts, feelings, actions. I was wondering was that related to your therapist’s way of engaging you, of acknowledging your feelings but not pathologizing them.

P3: I would have to think so. I can’t remember kind of sitting there and her saying to me you know: you need to explore this or let’s consider, look at this. I mean she may have very well have done
that. But I don’t remember, but that
doesn’t mean she didn’t. I think there was
a kind of respected curiosity that, even if
she never said it she was saying it. I
think one of the things that I remember
about the therapy was I don’t feel like she
talked very much. That was part of going
at my pace. Because when I came in, I
was pretty non-functional. I think even
talking was hard. She was just going to
let me unfold whatever I had to as long as
it took. So, I don’t know if she was very
directive at all.

Her constancy and openness—
her willingness to go at my pace—were
also important.

R: The first thing that stood out to me was
your description of your therapist’s
constant and open presence. You
mentioned her willingness to go at your
pace. I just wanted you to tell me more
about what you remember concerning
your experience of her presence and how
that was helpful for you in therapy.

P3: I think probably in contrast to my
previous therapist because I had written
before about how I saw a few and then
came to this particular therapist and I felt
like it worked in a way that none of the
other ones did. I think part of it had to do
with the fact that she was very, I mean
clearly paying attention, but also kind of
reserved, not emotionally reserved in any
way. But she was sort of in a position of
accepting what I would offer as opposed
to kind of inserting her project into things.
So, I guess that was particularly apparent
because the person I had seen prior to her
was much more kind of outgoing and
vocal and he would show me photographs
of his vacation. It felt more social. And I
just wasn’t in a place where, I was sort of
in desperate straights you know. I didn’t

An important aspect of therapy was her
therapist’s receptive presence. First, her
therapist provided constancy as P3 weekly
encountered a consistent presence for
several years. Second, her therapist
exuded openness insofar as her therapist
was attentive to her and accepting of her,
yet reserved and nondirective. Third, her
therapist was responsive, and patiently
engaged with her at the pace P3 set.
When P3 felt threatened and responded as
such to interpretations due to her lack of
identity formation and past experiences of
manipulation by others, her therapist was
adaptable and modified the treatment. In
general, P3 sensed that her therapist was
trying to help and such a helpful presence
was more significant to the process than
the correctness of the content of treatment.
want a social relationship. I wanted somebody who was going to help me. That didn’t feel like help to me but her just kind of being there for whatever I brought was really what helped.

R: Yeah, and I remember you writing about her willingness to go at your pace too. There seemed like there was a pace to therapy. A pace where she was ready to go wherever you wanted to go.

P3: I think part of it was that she was adaptable. Because I think initially she tried some things that maybe she had done in other therapies that just didn’t work with me. So, initially there were some moments that kind of fell flat where she would make an interpretation, a kind of pretty traditional psychodynamic interpretation and I would respond really badly to it. I remember thinking: what the hell, I have no idea. And also I think feeling threatened, because I think part of what brought me to that place was not feeling, or sort of feeling, not feeling like I had a personal privacy or a personal identity in that sort of other people were trying to shape me. I think that she was responsive in that she could see that some things weren’t working and was able to modify herself to what I needed.

R: I get a picture of her adaptiveness in that situation.

P3: There was something about I guess what I see as important about that too is that it wasn’t that she knew exactly what she was doing and that she got it right but it was she was trying, which mattered a lot.

R: That sounds really important what you just said.
P3: Yeah, the constancy that I talked about too. She was there. She was just, she was there. There were periods where I would be late or would sleep through part of the session and she would call. She really had a lot of patience, just personally I think to stick with me.

R: So it seems like those three elements: the, the openness for whatever you brought, and then the adaptability to go where you were going, and really the constancy she was there for you.

P3: Yeah, looking back I mean at the time no perspective on it. But looking back after, you know, doing psychotherapy myself I really admire her patience. I think it was tough. I think it would be tough to do that for her. I think I put her through a lot of stress.

R: I have a question that was coming to my mind when you were describing your experience of her openness, constancy, and patience. Was that something that was going, that you were experiencing during the sessions or during the course of therapy, or was that something that you’re really seeing now?

P3: That’s a good question. I think that when I started I was so, I’m trying to find the right word. I think that I was non-functional isn’t quite it, but regressed isn’t quite it, but sub-human is, is really way too many negative connotations. But I guess I was fragile and confused and I’m not sure. A little bit of all of those things, but something else that I can’t quite name that I don’t think that I had a perspective. But I think that I was just kind of hungry and I didn’t know what for. I knew that it was feeding me somehow. So I don’t think I knew but I also kind of didn’t know. I just knew I was going to come

Without a developed sense of identity, P3 felt fragile and confused at the beginning of therapy. She had few purposeful engagements and existed more like a child than an adult. P3 had a prethematic sense that she was wanting and her therapist was providing, as if the process was feeding some unarticulated hunger. Over the course, she came to articulate this experience and others. P3 discovered and acquired the words necessary to recognize and identify themes in her prereflective experience, and she developed a more adult sense of identity.
back. And I think over the time that we worked together I was better able to articulate it. And I think that’s what the therapy was, a lot of it was finding words, being able to name, first notice, not reject and name my experiences.

R: I’m getting a sense of the development, you know, over the course of therapy. You were saying, first it seemed more experiential, just you were being fed. And it seems like the development of then finding words, if I’m hearing you right.

P3: Right, yes, that’s exactly right, yes. So I think it was this, maybe, I mean I guess if we’re going to do psychodynamic, this infantile to a more adult position. Although I like animals so maybe that’s not nice. If I like animals I shouldn’t say that it was kind of like animalistic to human because I think in some ways animals are preferable to humans. But I think you’re right, exactly right. There was a kind of evolutionary process.

Because my sleep was so disturbed and I was so lethargic

R: Yeah, how was that too? You mentioned there was a change in sessions where you did two sessions in a row. I was wondering how did that help. How did that help you and how did you feel about your therapist’s adjustment?

P3: I was grateful. I mean I think that it made the psychotherapy possible. Because literally, it would take me forty plus minutes to begin to speak or to kind of be able to talk about anything of any relevance. I’m really grateful that she agreed to do that. I think that is an

When depressed, P3 had significant sleep disturbances. Her existence had slowed as she was both moving and thinking slowly. Her existence had also become more limited in scope since her vocabulary had shrunk and she had difficulty remembering. As such, P3 found she was only able to speak about something important, or even speak at all, after a significant portion of the session had elapsed. Therefore, at the beginning of the course of therapy, her therapist scheduled two sessions for her in a row to enable P3 to participate.
example of her openness and going at my pace.

R: I’m curious too, how did the sessions look toward the end of therapy? You mentioned that around forty minutes you were able to talk during the sessions. Was that something that was similar during the whole course of therapy or did you find at the end of the therapy that you still used that structure?

P3: I think that maybe even having a double session was important in the beginning because I think that just physiologically from depression I was moving really slow, I was thinking really slow. I remember one of the things that I really noticed when I started getting better was that I regained probably a third of my vocabulary, which I had just lost. And I had memory problems, like I couldn’t remember. So, I needed that time in the beginning. Near the end, I’m not sure if we were still doing double sessions near the very end. But I do know that near the end of our work together I would actually ask her to say things. I would look to her more for her perspective and her thoughts. And just say anything. I would say that to her. I guess that was sort of an example of my becoming less internal. And depression is just totally narcissistic or self-involved because you hate yourself and it’s all about how you’re the worst possible thing. And so it’s, I think that as I was coming out of it I was noticing other human beings. It was definitely a different exchange from the beginning to the end.

R: Noticing other human beings and wanting a different sort of involvement with your therapist because she of course was involved all along.

At the start of therapy, P3 mostly attended to her negative attributes and primarily engaged in self-loathing. Toward the end, P3 became more interested in and engaged with others. P3 started to request her therapist’s verbal participation and to ask for her point of view. In turn, as the relationship had developed, her therapist helped to foster P3’s autonomy.
P3: Right and I think that I do see the process as a kind of reparenting. I think that just again how you kind of identified that developmental process, maybe changing from this totally dependent to a more interactive relationship.

R: Yeah, you see the process as reparenting.

P3: Yeah, definitely, I think it was. And it also changed in that near the end just as any good parent should she was helping me take over and do it myself.

R: I was hearing previously that one of the things that were changing while you were changing was a growing vocabulary.

P3: Yeah, it’s true. I learned to walk. Yeah, it’s interesting. I actually, I hadn’t thought about it in those terms but that, it is pretty clear looking at it that way that it was sort of going from this infantile to adult functional position.]

[Because my sleep was so disturbed and I was so lethargic] (and because of avoidance,) there were periods when I would arrive late to sessions. Once I arrived and the light in her office was off. As I walked to her door I surprised myself by becoming faint. I felt like I was going to pass out and had to rest against the wall to keep from falling. I thought she had left- that because I was late she had gone home. But, to my great relief she was still there. Although I could not put it into words at the time this event helped to show me that I could rely on her. Knowing that she could handle me, that I could speak my experience without her withdrawing, was crucial. This was one way she told me that my experience, that I, could be seen- and that the sight

P3 was isolated and deprived of feeling of value to another, but P3 wanted to feel worthy and her therapist’s treatment of her offered such a potential. P3 had arrived late to session, as she had for other sessions, and upon seeing that the office light was off, P3 became faint. Her body broke down when she encountered a disruption in the therapeutic relationship and her reaction bodied forth the unmet relational need. However, her therapist was still in the office and she experienced a great sense of relief. Her therapist’s presence indicated that her therapist was reliable, that she could handle such disruptive behaviors, and that P3 was worth waiting for.
was not unendurable. Her presence said that I was worth waiting for.

R: I wanted to take a second for us to read one of the paragraphs that were standing out to me. Could you take a second to silently read the third paragraph down on the second page that covers the experience of you being late and your experience of that?

P3: Does it start her constancy? Yeah that was a very strange experience. I’d never had, I guess it was such a physical manifestation of this emotional need that my body actually started to break down when I thought that she wasn’t there. I was shocked that all that was going on inside of me. Who knows what I’d of actually done if she wasn’t there, but I guess, what about that do you want me to describe?

R: I was just wondering what was going on in the experience, but also what was going on in the therapy or your life at that time?

P3: I know that I was extremely isolated and extremely lonely and kind of deprived, as far as sort of care and mattering. I really wanted to mater to somebody and to myself and to not be alone. She was able to give that to me. In a way, that starts to sound more like a humanistic or like Rogerian I guess aim of psychotherapy of kind of this unconditional care. I don’t think a kind of humanistic or Rogerian therapy would have been as effective because to me that feels, I’m sure the Rogerians are going to disagree with me, but that feels kind of naive or overly optimistic about people because there was a lot of big ugly feelings and a lot of anger and hostility. And I think I needed somebody who could

P3’s participation in the therapeutic relationship was significant for the treatment. In this relationship, her therapist cared unconditionally and genuinely responded to P3 disclosing a multitude of her feelings. Although she seemed like a humanistic therapist offering such care, her psychodynamic therapist further helped P3 to explore the importance of particularly unpleasant feelings, such as anger, and to address the ways she resisted such exploration.
help me look at that but also help me talk about how I didn’t want to look at that and would deny it and avoid it. So there was a realness to the relationship or a quality of genuineness. The Rogerians definitely won’t agree with me. But I felt like I was actually having a human relationship with her and that was what I needed more than anything.

R: What is striking me is you said if you didn’t want to look at the material she would help you with that. And just to contrast you wrote about the one therapy where the therapist was very happy and smiley and there wasn’t that connection and that seems that was what was missing from that previous therapy.

P3: That’s right. And again the complexity because I think I was the designated patient because I was the depressed negative person who would point out the things that weren’t beautiful. So I was kind of the one who was saying but look at this. This is a problem, but on the other hand, I also, coming from the place that I was coming from my denial and repression were going twenty-four-seven. Ah, so there’s also a big part of me that didn’t want to, I didn’t want to feel this. I knew that I shouldn’t. I didn’t want to have any of those negative feelings. And so somebody who could pay attention to all of that was really important.

R: The real magnitude of that experience was coming out in that paragraph. The real magnitude of her being there and just what that meant for you.

P3: Yeah, it’s amazing that it seems I mean it’s so small but it’s so big. I think I love that, that’s sort of the thing that I got out of the therapy that is just so

Through therapy, P3 acquired and integrated a lived sense of the complexity of experience. P3 came to understand that
fundamentally part of me now which is this kind of it’s this and it’s opposite and ten other things all at once. It’s just the realness of that how multifaceted something can be all at the same time. The complexity of it captures a necessary reality for me that when I didn’t have I just couldn’t, I didn’t know how to be in the world.

R: And it’s a part of you now too. You said the therapy’s a part of you.

P3: That’s one of the things it gave me. Just I mean I live and breathe that. And it allows, I mean it allows, I’m not sure what it allows. I know there’s something really important about experiences, complexity of experience that you can feel lots of different even contradictory things all at once. I think that maybe again it sort of goes back to a sense of identity that I felt like it just couldn’t be that complicated. That if I sort of had a problem with my parents that I couldn’t be, I’m not sure exactly, but to have an identity you have to be really clear cut. And just the tremendous kind of validation or sense of relief that, I am who I am and I’m having a whole bunch of different reactions to this or a whole bunch of different feelings toward this person. And that is my identity as opposed to I should be feeling one of these things not this and its opposite I guess. Does that make sense?

R: Yes, it definitely makes sense.

By the end of our work together I was no longer depressed.

R: You wrote about your depression, feeling sadness and despair during your previous episodes of depression. And then you wrote that you no longer felt depressed at the end of your

in a shared world issues are multifaceted and that she can feel a multitude of contradictory emotions toward the same person. P3 moreover learned that her identity consisted of her differing feelings yet persisted throughout these.

After therapy, P3 did not feel depressed. She felt as if something had broken open allowing in air and she experienced a certain rawness of being. As opposed to her previous solipsistic focus on herself, P3 more fully engaged herself in a less defended manner with the world and others and she felt truly alive.
psychodynamic therapy. Could you tell me more about the change with your depression?

P3: Yeah, that’s a hard one. I think that near the end of the psychotherapy I guess it felt like something broke open, and there was this kind of, sort of air was getting into a place that it hadn’t been in years or decades or since I was a kid. And that’s when I had said there was this long period where someone could look at me and I would start crying. And it wasn’t this depressed, it wasn’t this kind of self-flagellating or negative crying. But kind of this, I’m not sure how to describe it. It was kind of relief but also kind of grief, but it wasn’t negative. I think it was kind of a rawness that living, of actually being alive. And that was something that I hadn’t been. Or that exposed and engaged in the world in a realistic way as opposed to an incredibly defended sort of self internalized way. And that’s just what it looked like to be in the world, which I hadn’t been.

I was going to school, interacting with people,

R: You mentioned a change in relation to other people. And I was just thinking about the beginning of your written description where you gave an example of putting your Walkman on to avoid interactions with others but then you wrote at the end of the therapy you were actually interacting with others more. I was wondering if there was anything that stands out, any instances or examples of that change.

P3: Well, I mean it was kind of a bidirectional thing. I reached out more but I think I also felt like people were reaching out to me. And I think that was the

P3 was relating better with people. She had initiated interactions with others and they reciprocated by doing the same. Before therapy, P3’s world had dwindled with her only engagement consisting of buying groceries and she felt as if she did not exist with others. Nonetheless, P3 had a significant encounter at the grocery store during therapy. She expressed a thought that was directed toward herself aloud, another person in the store responded, and P3 felt reconnected with others and the world. The process of therapy, along with this experience, elucidated the possibility of relatedness with others and the potential for relationships to be benevolent and reciprocal.
therapy sort of showing me that there was goodness out in the world. I mean I remember one experience which I found really profoundly important that I kind of see as one of the little pieces that got me out of that place was again being in the grocery store because I only left the house to buy food or something like that. So I wouldn’t meet or have any other experiences any other places. I was standing in the checkout line. And I think at that point feeling like a non-entity I mean really practically invisible. And I was just saying something to myself out loud. And the woman behind me or in front of me or something answered back. I don’t even remember what she said but it was that she answered back. I was astounded. I think that was one of the things that made me feel reconnected with the world too. That there were things out there that were good, that they didn’t hurt and they actually gave something and there was the possibility of a relationship. I think that too leads to the possibility of a future. 

and had developed a plan for the future.

R: Then it continues. You wrote about developing a plan for the future. Could you tell me more about that, that developing of a future? Because you were writing about the aimlessness before therapy but you wrote about at the end of therapy developing a future.

P3: A future, again I’m not sure how it happened that suddenly the possibility of a future or if it was even sudden. I mean I doubt if it was. It was probably what we were sort of leading up to for the four or five years, you know, working together. I think part of it was kind of the newness of learning new things like that I could have

P3 was engaging in academic course work and formulated personal goals for her future. In light of her experiences including the therapeutic effects of treatment, P3 felt impelled to pursue studies in psychology, and ultimately completed graduate school. The process of therapy enabled the envisioning of such new potentials in her future. Through therapy, P3 learned to foster curiosity, rather than animosity, toward her feelings, others, and the world, which opened up new possibilities of engagement. She also learned to be receptive toward novel possibilities, rather than anticipating only negative ones.
feelings and be curious about them. That was new. And new possibilities that means, there were things out there that I couldn’t imagine and expectations that I couldn’t predict. And they weren’t necessarily bad expectations or things to come. Being freed again to be curious about the world and other people sort of gave me a forward direction. That depression is just kind of this circle where it’s just this closed system and it’s impossible to have a future that way.

My experiences, including having experienced the curative power of psychotherapy, compelled me to return to school for psychology.

R: Yeah, and the future after therapy you went back to grad school.

P3: Yeah, by the time I went back to school for undergrad and then ultimately grad school and I think by that point I was really gung-ho on the curative powers of psychotherapy. It was a tool to change the world and right all the ills. And I think since then I’ve gotten a more realistic perspective sadly. I’ve lost some of the idealization of it, yeah.

Overall, I aimed to treat my thoughts, feelings and reactions with respectful curiosity rather than hostility and contempt,

R: I was wondering if there is anything we left out here today. Is there anything else that is coming to mind?

P3: Let me see. I think another one of the big sort of over-arching things that I took out of the experience and that really shaped how I function and also how I work as a psychotherapist is the idea that, I’m just kind of underscoring stuff we

Through therapy, P3 assumed a stance of respectful curiosity toward her experiences. Rather than rejecting her experiences and getting angry with herself, P3 believed that her thoughts, feelings, and reactions were valuable to her sense of identity and meaningful for her understanding of the world.
already talked about, is that to look at your experience or what you’re thinking, feeling, or doing with this kind of nonjudgmental curiosity of there’s something important here. That somehow it makes sense. It might not necessarily be a great choice. It could very well be problematic, but there’s something important here for us to understand. So to go back into yourself or sort of mine yourself for experiences for what is valuable there. And that’s just such a better position than kind of this accusation or rejection. This kind of trust that there’s something important there.

and [I] made concerted efforts to develop and nourish my interests. I felt much more empathy toward my parents, including grief for their fears, frailty, and humanity. I spent about a year after therapy always a few seconds away from crying— for grief at how hard it is for us as humans, for the sadness of the world, and for joy that I had survived to live this difficult and lovely life. And because I was grateful to my counselor for staying with me and doing the difficult work.

R: At the end of therapy, you wrote that for about a year you found yourself crying and that was something about just feeling that realness, just being out in the world.

P3: Yeah, and I think why I’m prone to depression too, of just really being attuned to, to the sadness of the world. But also, how sort of sweat and tender and it is too, that makes me cry too. And I think also, a lot compassion for us for being human for doing this for having to be alive because it’s not easy. So those were the things that I was thinking about and feeling and noticing.

P3 intentionally cultivated her interests. P3 developed a greater sense of empathy for her parents including sadness for their vulnerabilities that make them human.

For one year after therapy, crying was a potential way of being on the horizon, which she frequently actualized. P3 felt sad for the difficulties inherent in living as she acquired a shared sense of humanity. In addition, P3 felt grateful that she endured her own difficulties during therapy to participate more fully in life since life was also beautiful, and felt particularly grateful for her therapist’s constant presence throughout such demanding therapeutic work. Her tears in response to such incongruous emotions as sadness and gratitude were evidence of her development from perceiving the world in a rigid, dichotomous manner to seeing the world in its complexity and richness. Such a description was more accurate and such a world more inhabitable.
R: It seems like at the end of therapy you were feeling unadulterated, both the sadness of the world and the compassion for the beauty of the world. And what really struck me there in describing where you were at end of therapy you said, the air was let in to some part of yourself, that part was able to breathe.

P3: And there’s something too about, I think that position, I mean if we didn’t talk about it then, but certainly I recognize, the movement from the schizoid to the depressive position. Isn’t that right object relations, Melanie Klien? Where, boy, I just really get that of moving from this kind of black and white sterility to understanding that it is awful and wonderful and the richness of that. And the tremendous relief of that because that is a livable life, that it’s complicated and both and ten other things on top of that. That’s how we work. That’s what it means to experience things. And to have words for that was really important

R: The air was also life giving but just the relief, being able to take a deep breath.

P3: Yeah, there was just room that wasn’t there before.
A5.4 Integration of Central Themes

1. During her senior year in college, P3 first encountered a period of depression for a few weeks in which she experienced hypersomnia. She bodied forth her sadness, where in her body felt heavy and she lost the ability to smile. In an intentional manner, P3 disengaged with others. One year later, P3 started graduate school and encountered a longer period of depression in which she experienced lethargy and feelings of despair. Around this time, P3 felt aimless since she did not have personal goals and doubted her ability to establish or reach any goals. P3 also felt stuck in a relationship wherein she experienced instances of physical and verbal abuse.

2. During the latter episode, P3 attended therapy in regards to relationship difficulties. Her first therapist insisted she confront her boyfriend despite P3 voicing concerns. P3 was unwilling to confront him and left therapy after one session. Her second therapist appeared pleasant and cheerful, but P3 felt no sense of connection with her. P3 thought she had nothing to offer and left after several sessions.

3. Two years later, P3 moved back home. She encountered a severe depression for a long duration in which she experienced significant sleep disturbances and a sense of self-loathing. P3 did not engage in self-care, like bathing, for periods and ate compulsively. She still felt aimless, and consequently, was frustrated. P3 continued in the abusive relationship.

4. At the start of this episode, P3 attended cognitive behavioral therapy for a year, but found this therapist unhelpful too. Her therapist used definitive labels on her and her problems, which felt invalidating and confining. He approached her suffering in a pragmatic manner based on the assumption P3 merely had to stop engaging in problematic behaviors by will alone. However, P3 first had to believe that change toward a worthy life was deserved and possible, and want to change before taking any practical measures to change. Thus, her therapist did not did not engage her in a more fundamental way.

5. P3 had a less developed sense of identity, which contributed to her feeling aimlessness in projects and relationships. She experienced a less differentiated sense of self and others. In regards to herself, when she attended to her prereflective experience, P3 could not clearly recognize, identify, and express emotions, such as anger, and so could not articulate her wants and beliefs. In regards to others, when she encountered an unsatisfactory relationship, P3 assumed that another’s ill-treatment, such as her boyfriend’s, indicated that she was a bad person.

6. Without a developed sense of identity, P3 felt fragile and confused at the beginning of therapy. P3 had a pre thematic sense that she was wanting and her therapist was providing, as if the process was feeding some unarticulated hunger.
Over the course, she came to articulate this experience and others. P3 discovered and acquired the words necessary to recognize and identify themes in her prereflective experience, and she developed a more adult sense of identity.

7. The most significant facet of therapy was the therapist’s analytic stance and it ameliorated the core issue for which P3 sought therapy. Rather than pathologizing P3, her therapist acknowledged her feelings, such as anger, and thereby let her be in the fullness of her being who she was. Her therapist moreover approached her with respectful curiosity and questioned P3 about her feelings to help her learn more about herself; e.g., her wants. P3 came to understand that, in addition to her parents and boyfriend invalidating her, she too was rejecting her feelings. She realized that such a manner of attending to her experience contributed to her feeling lost with little sense of identity.

8. An important aspect of therapy was her therapist’s receptive presence. First, her therapist provided constancy as P3 weekly encountered a consistent presence for several years. Second, her therapist exuded openness insofar as her therapist was attentive to her and accepting of her, yet reserved and nondirective. Third, her therapist was responsive, and patiently engaged with her at the pace P3 set. When P3 felt threatened and responded as such to interpretations due to her lack of identity formation and experiences of manipulation by others, her therapist was adaptable and modified the treatment. In general, P3 sensed that her therapist was trying to help and such a helpful presence was more significant to the process than the correctness of the content of treatment.

9. P3 was isolated and deprived of feeling of value to another, but P3 wanted to feel worthy and her therapist’s treatment of her offered such a potential. P3 had arrived late to session, as she had for other sessions, and upon seeing that the office light was off, P3 became faint. Her body broke down when she encountered a disruption in the therapeutic relationship and her reaction bodied forth the unmet relational need. However, her therapist was still in the office and P3 experienced a great sense of relief. Her therapist’s presence indicated that her therapist was reliable, that she could handle such disruptive behaviors, and that P3 was worth waiting for.

10. When depressed, P3 had significant sleep disturbances. Her existence had slowed as she was both moving and thinking slowly. Her existence had also become more limited in scope since her vocabulary had shrunk and she had difficulty remembering. As such, P3 found she was only able to speak about something important, or even speak at all, after a significant portion of the session had elapsed. Therefore, at the beginning of the course of therapy, her therapist scheduled two sessions in a row to enable P3’s participation.

11. Before therapy, P3 felt a sense of stuckness as she was unable to end her dating relationship in two regards. First, P3 feared her boyfriend because of his threats and abuse, and consequently, she entered into a survival mode of existence.
Second, she longed for her boyfriend as P3 idealized him and so wanted to obtain his validation. During therapy, her therapist helped her articulate the unhealthy effects of the relationship and P3 began to feel more of a sense of movement. P3 gained knowledge about and perspective on the relationship and herself. In addition, she continued to experience her therapist’s constant attentiveness, respect, and interest. P3 started to believe that she was worthy of such treatment, and so felt the way she treated herself and the way she was treated by her boyfriend were both unacceptable.

12. Her therapist explored family dynamics and helped P3 discern problems that were previously unclear and unarticulated. Her therapist discussed specific concepts such as mirroring, which helped P3 to better understand her development.

13. Her therapist helped P3 to articulate the limitations of her parents’ care. P3 came to understand that rather than seeing and validating her more personal qualities and potentials, her parents recognized and valued her only in terms of her appearing in line with their expectations.

14. P3 assumed that objectionable feelings such as shame signified a personal deficit, and for example, she took her hatred of her parents to mean that she was a bad person. Her therapist helped her work through such hatred, and P3 found that beyond her experiences of anger feelings of grief and sadness emerged on the horizon. She felt grief concerning lacks in the quality of care that she received throughout her development and current existence. P3 further felt sad for her parents who presumably encountered similar lacks in care that contributed to their deficient quality of care. She ultimately felt a sense of empathy for them.

15. Her therapist also explained the significance of goodness of fit between parents and child and P3 acquired some perspective on their parenting that enabled her to be more sympathetic. P3 came to understand that her parents were providing the only kind of care they were able to offer and that she simply needed additional guidance from them in light of her more sensitive constitution.

16. When such family issues were addressed, the therapist usually focused on the complexity of P3’s experience, highlighting that issues are multiperspectival not black and white and that she can feel many different ways toward the same person. She came to see that she can both love and hate her parents and that experiencing a strong emotion such as anger did not indicate her own badness.

17. For one year after therapy, crying was a potential way of being on the horizon, which she frequently actualized. P3 felt sad for the difficulties inherent in living as she acquired a shared sense of humanity. In addition, P3 felt grateful that she endured her own difficulties during therapy to participate more fully in life since life was also beautiful, and she felt particularly grateful for her therapist’s constant presence throughout such demanding therapeutic work. Her tears in response to such incongruous emotions as sadness and gratitude were evidence of
her development from perceiving the world in a rigid, dichotomous manner to seeing the world in its complexity and richness. Such a description was more accurate and such a world more inhabitable.

18. P3 acquired and integrated a lived sense of the complexity of experience. P3 came to understand that in a shared world issues are multifaceted and that she can feel a multitude of contradictory emotions toward the same person. Moreover, P3 learned that her identity consisted of her differing feelings yet persisted throughout these.

19. P3 assumed a stance of respectful curiosity toward her experiences. Rather than rejecting her experiences and getting angry with herself for them, P3 believed that her thoughts, feelings, and reactions were valuable to her sense of identity and meaningful for her understanding of the world.

20. P3 attained a more developed sense of identity and continued to cultivate her interests. She had found that her identity was reflected in her engagements with the things of her world, and so rather than ignoring or rejecting these, she had let herself intentionally engage with more and more things she found meaningful during therapy. Since her therapist cared enough to provide a therapeutic space for her to be in her fullness of being, P3 felt motivated to care about herself and gave herself room to develop.

21. P3 felt more integrated with her body as her body was incorporated in her sense of identity. When severely depressed, she had felt detached from her body as if her body was an oppressive object that she loathed.

22. When depressed, P3 was unable to produce anything creative since she was not grounded in a sense of identity and embodiment, nor in terms of relationships with others. As P3 established such a ground from which to create, she once again engaged in painting.

23. After therapy, P3 did not feel depressed. She felt as if something had broken open allowing in air and she experienced a certain rawness of being. As opposed to her previous solipsistic focus on herself, P3 more fully engaged herself in a less defended manner with the world and others and she felt truly alive.

24. P3 developed a greater sense of empathy for her parents.

25. In addition, P3 was relating better with people. She had initiated interactions with others and they reciprocated by doing the same. Beforehand, P3’s world had dwindled with her only engagement consisting of buying groceries and she felt as if she did not exist with others. Nonetheless, P3 had a significant encounter at the grocery store during therapy. She expressed a thought that was directed toward herself aloud, another person in the store responded, and P3 felt reconnected with others and the world. The process of therapy, along with this experience,
elucidated the possibility of relatedness with others and the potential for relationships to be benevolent and reciprocal.

26. P3 was engaging in academic course work and formulated personal goals for her future. In light of her experiences including the therapeutic effects of treatment, P3 felt impelled to pursue studies in psychology, and ultimately completed graduate school. The process of therapy enabled the envisioning of such new potentials in her future. Through therapy, P3 learned to foster curiosity, rather than animosity, toward her feelings, others, and the world, which opened up new possibilities of engagement. She also learned to be receptive toward novel possibilities, rather than anticipating only negative ones.
Appendix 6: Data and Analysis Participant #4

A6.1 Written Description

I was very tired, had low energy would sit at my desk at work, unable to function. I was very anxious, had stomach acid problems, was taking a lot of Tums and would wake up each night at 2-3 a.m. worried and not able to get back to sleep. I was constantly worrying about my job, what I had to do and I was also exhausted since I had a two year old to care for. I had had little time for myself or fun, and felt that I had to leave my child at day care, work all day, was very busy at work running a program, and then would come home, have to cook dinner, clean up. I had no time to spend with my husband and we were both tired, stressed, and argued a lot. I worried that I did not have enough energy to enjoy my son. I would sit and watch videos with him. I felt very negative and detached from life.

I had so much trouble sleeping and felt so exhausted and anxious that I had to quit my job and go on medical leave. I started to work part-time. I sat on the couch and slept while my son was at daycare. I finally asked my Dr. for help. I wondered if I was entering early menopause (I was at 38) and she said no but gave me Trazedone 50 mg. for sleep. This helped a lot. I finally could sleep again and started to feel more positive. Later I went to see a psychiatrist who diagnosed me with Depressive Disorder but I continued to take Trazedone for about six to nine months through my M.D.

I went back to a therapist I had seen before who had Jungian framework. (I also went to the EAP therapist who had a CBT framework). It was interesting since she said I was presenting with the same issues I had had previously. She diagnosed me with GAD (anxiety more based on dreams I had had). It was a bit harder, since I was more
depressed and anxious than I had been before. It was positive to work with her due to
dream focus and choice of a totem (a figure) to pick as a symbol. I picked a dragonfly for
mine since it seemed to be a symbol of my need for change. I have tended to be someone
who takes on too much and then gets anxious—I think that I didn’t realize that I could
not be “superwoman,” a parent, and work all day. I had waited too long to get help.

I read Descent to the Goddess again, and some other Jungian themed books. I
began to realize that I couldn’t “run” things at work, be a parent and still have a fun life
without getting over-stressed. I had to realize that my life of full-time work was over to
some extent. I began to work part-time, focus on my private practice more, have a
flexible schedule that worked with time for my son, for my work, and for my husband. I
looked at my guilt about my life overall, and came to see the difference—anxiety and
depression as a reminder to take care of myself. (I can use this now: going with the
feeling and letting emotions more through you, instead of overanalyzing help). It took
about a year to start to feel like “myself” again—more energized, positive, and hopeful
about the future. My therapist was open about her own life and had a less “medical
model” style, less psychiatric approach to therapy that was very different from the
approach common now. Looking at dreams and images was very helpful, writing them
down helped. Write some poetry to increase my love of music again. Previously, I had
used dream images to write songs when I was in a band.

Now I feel very positive about my life, my work, and parenthood. I am more
open to life’s changes and see my past depression as a learning experience, which has
helped me in my own work with patients. I started to feel happy again, but was careful
not to overdo and overstress myself. My husband started to work more and get health
insurance so I didn’t have to work full-time. I have had time to spend with my son, his
school, and have fun. I try to listen to my deep emotions. I am more aware of my need
for quiet and time to de-stress with meditation and let my brain “relax” each day. I try to
see life in a more positive way. I started to do tai chi and yoga again for relaxation. This
made me more aware of my body/emotional stress. I also started to swim again, play
music, and to “reclaim” parts of my life that gave me joy.
A6.2 Interview

R: One of the things that was coming across to me when I was reading your description was your writing about the dragonfly as a symbol for your need for change. I was wondering how that work with the dragonfly helped you.

P4: Well, eh, partially I think the women that I was seeing, um, had a Jungian framework, not an analyst. But she had been doing Jungian oriented therapy for a really long time and I think still does [R: Um hmm]. And it was interesting because in her office she had several, eh, what were they, like shells and sort of organic type things. And I think, it’s hard to, it’s interesting because I can sort of talk about from the standpoint of how I reacted to it, but then it’s hard kind of not to like step back because I read a lot of Jungian stuff too. There’s, I think, there’s like an idea of focusing on some kind of totem as a symbol of transition [R: Um hmm] and I’m sure that’s partially why she has those there, had those there sitting in her office. But, um, I think she had like, you know, a crab shell and things like that that seemed very, um, I forget the name of the book. But like I think sometimes in the dream symbology [R: Um hmm] there’s often one image or one totem or one animal or whatever it might be that sort of symbolizes the self perhaps. So, I tended to think of the dragonfly and I didn’t think of it initially because I think I wasn’t able to step back from it because I was in the process but the dragonfly is a really cool animal because of all the changes that it makes. And I think I was just, I’ve always liked dragonflies [R: Yeah] but I think that when I was in therapy that was the thing I sort of focused on when I was going through the process and as time went by I was kind of able to see that the dragonfly represented all of these changes, right, because it has so many life transitions. I think it starts in the water and then moves into the air and it sheds these various carapaces and things like that [R: Um hmm]. So, um, I kind of came to see it as a symbol of what I was going through because at the time when I was doing this particular therapy that was like, god I think I had seen her in the, I had seen her when I was around thirty because I was sort of going through a similar thing but more like related to work, and then after I had my son about two years later I was sort of going through a I think kind of a post-partum kind of depression. But, I think, probably because of, you know, hormonal stuff. But I think I am also a little more susceptible to it to depression because it runs in my family. But the interesting thing was that I was sort of going through a change as a parent [R: Yeah] and that was a first. I mean sort of having to take care of somebody else because I had had waited a long time to have a child until my like late thirties [R: Um hmm]. My husband and I were like punks and we were kind of like, “Oh my god.” There’s a t-shirt that says, “Oh my god I forgot to have children,” [R: Laughs] so that was kind of us, right. You know, we’d a, I was in a band and then we, I was in graduate school and then, you know, we bought a house and then it was like, “Oh, we’re going to have a kid now, oh, okay.” So I really hadn’t prepared myself emotionally for all those changes [R: Um hmm]. So, I sort of saw the dragonfly sort of as fitting my changes, um, like from you know an independent person, a person who saw herself mostly in terms of work and in terms of fun stuff and sort of changing to a parent. And I think that that’s what was difficult for me as a transition [R: Yeah] was going from somebody who only had to take care of myself to someone who had to take care of a child and then do all these other things like, you know, a lot of professional woman do
[R: Um hmm] and trying to balance out those things. So, that’s sort of how I came to see the dragonfly as it being okay to change [R: Um hmm] as the fact that all these changes were very natural and that as a point of acceptance of that change, right.

R: Yeah, it sounds like the dragonfly had this organizing power for [P4: Yeah, um hmm] what you were going through.

P4: And at the time I think I was just looking on something to feel more positive about because I didn’t feel very positive at all and it was like an incredible crisis point and I was like, really, it was, it was pretty bad [R: Um hmm]. It was like I think one of the worst, was it the worst, yeah it was pretty bad. I, I was like at the point where I had to leave my job. For a period of time I had to go on medical leave and stuff like that. And I was just like (makes a sound like a building collapsed), I was like, I was like flat [R: Yeah] I was just like (makes a sound like a building collapsed). It, it was serious, right. Um, so I think it was sort of a symbol for hope [R: Um hmm] in some ways too, right. And, and, and actually it’s interesting because I sort of carried that image of the dragonfly since then [R: Um hmm]. I have dragonfly earrings. I have some in my bathroom. I have like, it, it’s just a symbol that I sort of carried as a reminder of the need to kind of allow those transitions [R: Um hmm]. And be gentle to myself about it, right [R: Um hmm]. So, it ended up being a very powerful symbol [R: Yeah] and I’m thinking that there’s a, um, I forget the name of the book. There’s a book, a Jungian analysis book. I forget the name of the guy, a pretty, pretty well-known analyst from the forties and he has, um, it’s about, it’s about a lot of different things. But there’s an image, eh, of something, eh, someone, a guy who’s using the dream image of a rabbit. Are you familiar [R: I’m not familiar with that] Jungian study? But I think there’s like always one powerful image, symbol, whatever you might want to call it that kind of carries people, you know [R: Um hmm] transition object. I don’t know, whatever you might want to call it. But I think that that. And so I sort of tended to see the dragonfly that way.

R: Yeah [P4: Right] and I’m seeing that it was organizing and it captured something for you also [P4: Um hmm] like a change orientation [P4: Um hmm], there’s something positive about it too.

P4: Right, and I think that sometimes people they can sort of know, um, cognitively what they’re going through. Because I had sort of been through, eh, like I think went before I went to see this women. I waited too long because I was crazy busy with all the different things I was doing and I’m like superwoman and I can do all these things. And I waited to long to sort of see that I couldn’t do all these things at once: be a parent, and work full time, and do all these things, and without some damage to myself [R: Um hmm]. So, eh, I had been to like a cognitive-behavioral therapist for like at work for like two sessions. I was too, I was too far gone for that [R: okay]. Like if, if I had gone earlier it probably would have made a difference. But it I think the thing with the, um. And that tends to be very symptom oriented. Eh, but I think seeing somebody who, who has like a Jungian orientation or a psychodynamic orientation or whatever you want to call depth-psychology orientation probably makes more sense in the long run for like not repeating
patterns that tend to be a problem [R: Um hmm]. I mean for me, I had sort of had a, it was very interesting because when I went to see this woman. Am I sort of telling you more than you want to know? [R: Not at all] Okay, um, when I had gone to see this woman, I had seen this woman before. And when I went to see her again she had pulled out my files from when I had seen her like ten years previously (laughs). And she said: gee this is the same stuff you said before [R: Um hmm]. Which is very of funny because I like hadn’t learned my lesson from the last time (laughs). And I had sort of developed a pattern of like superwoman, you know, and not being able to be superwoman [R: Yeah], right. Eh, thinking that you can kind of expend all this energy without sort of having some self-nurturing [R: Um hmm], right. Um, so, eh, so that was interesting from that standpoint of saying that well, cognitive-behavioral therapy would have helped from, if I had done it earlier. And it probably would still have helped if, if, if she had had a little more of that. Because I think you need, sometimes you need both. I don’t think depth psychology is always enough depending upon the severity of the symptomology, right. But I think that depth psychology looks at a deeper (sighs) a deeper level [R: Um hmm]. One of the books that she had used was, eh, Descent to the Goddess. Are you familiar with that? [R: I’m familiar with it, although I have not read it] Okay, I think for woman it’s very useful, and probably for men too. But the idea of the depth, of the Descent to the Goddess is like you have to kind of really go down there and look at the crap (laughs) [R: Um hmm], look at your old stuff, look at the sort of history, look at unpleasant things, things you don’t want to think about. And I think that the therapy from that standpoint with this particular individual was really helpful in kind of like looking at the past, looking at a lot of things I really hadn’t looked at before [R: Um hmm] at a depth level, which sort of I think tends to ensure that you learn not to do it again [R: Um hmm], right. You learn, it helps you to grow but at the same time you learn not to go through that same process again or you learn not to put yourself in the position that got you there in the first place, which I think is something that I think a lot clients or folks in, you know, therapy don’t, they reduce their symptoms and then they just go and do the same thing again (laughs). And I think sometimes, not always, but I think sometimes like psychoanalytic-oriented or depth-oriented psychology helps you better to kind of look deeply into yourself [R: Um hmm], which I don’t think other forms of therapy do to the same extent.

R: And it sounds like your differentiating something that this therapy had for you like more of a depth-orientation [P4: Yeah, yeah] than something more cognitively-oriented

P4: Right and that’s what I think individuation is. I mean and I think a lot of therapy doesn’t really produce individuation in the same sense. I mean it can produce aspects of it. I don’t see adults in, in my work very much but when I do I can sort of, it’s interesting how I can sort of like see from my own experience with this therapy and just, you know, growing in general that like I can sort of see the path they’re on (laughs) because I’ve already been down it [R: Yeah] especially woman particularly. Where you kind of go, eh, there’s an aspect, um, for women like a very caretaking model, a very self-sacrificing model [R: Um hmm], a very, um, denying of certain aspects of self, which I think that for me the depth-psychology really looks at all those parts, right, and sort of honors those parts in a way that sometimes a more surface cognitive level doesn’t, right. Um, so, I think that’s another aspect of benefit of it at least for me [R: Yeah]. Um, I can’t really
speak to other people. Because actually it’s funny because like sometimes therapy, and I don’t know if you find this in your studies, but sometimes therapists and psychologists really should go to therapy. When I see, deal with younger folks sort of, um, who are talking to me about, um, there, um, work like when they’re therapists and they don’t do any personal work they get themselves in trouble [R: Yeah]. And they, I think they really need to do that personal work even if they think they don’t have any issues, right. They will have issues that are brought up by working with clients and if they don’t deal with that I don’t think that, I don’t think they develop their practice well enough or sort of their self, interactive self in the process if they don’t sort of like go through that process.

R: You mentioned Descent to the Goddess and other books. How did those help? How were those taken up in your therapy?

P4: Eh, well once I felt. It’s funny because I had a very low point of energy at first where I just felt like crap all the time and I was tired. And it took me a good long time to sort of move out of that phase, um. And once I started to move out a little bit, a little bit, eh, the interesting, well, the interesting thing about Descent to the Goddess is it says, it sort of values depression as a way of looking at self-issues. I mean it’s not like it, it doesn’t just want to eradicate it. Some of that particular style of depth psychology seems to sort of honor the fact that you have to go down into the pit [R: Um hmm]. I mean you have to go down really far into yourself and see, feel crappy and sort of like deal with that aspect of, of, um, your psyche, um, to kind of grow, okay, which I don’t think you would hear that in a lot of other systems because like most people think, “Oh, depression is bad. This is horrible. You should take a pill and then you’ll feel better.” And some, you need some, I had, I think I did end up taking an anti-depressant at that point because I couldn’t sleep [R: Um hmm] that was bad. I mean I had a kid. I had to go to work, you know. I had to do that. Um, but I think that the Descent to the Goddess, eh, I think there’s other books that had a similar style, is that it’s sort of like there’s kind of a, not madwoman in the attic aspect but that like, eh. It’s very Greek tragedy oriented. You find figures where women kind of have to go raging in the woods lost like a point, almost like an insanity is some benefit to find yourself. Does that make sense? [R: I understand you] And that’s kind of, although I don’t totally agree with it I think there’s some value in it that I think people have to go through stages of dealing with grief or sadness or anger or depression to kind of find themselves to some extent or, and to grow and develop, to individuate, to find the wholest or most full of yourself [R: Yeah]. Um, and I think for me that makes a lot of sense because that’s something I still think about [R: Um hmm] even though it’s been, boy how long has that been, seven or eight years. Um, and it’s something I also use in my work. Because it’s sort of a path that I went down and, and it makes it easier to guide other adult females through it to some extent [R: Um hmm] or like a frame, a template to use to see people going down that path. Another aspect of it was that the idea of sitting with the feeling because I think a lot of people tend to be very afraid of feelings especially intense sad feelings. Um, and for me I think people tend to push those things away or do whatever of the Freudian (laughs), you know, defense mechanisms because they don’t want to feel pain [R: Yeah], right, especially emotional pain. So, one of the useful things from that therapy for me was the idea that you would sit with it and sort of feel it and experience that feeling and see what information it gave
you. I think one of the phrases that the woman I saw used was, um, what does it teach you [R: Um hmm] or what, let the information come to you like from sort of a feeling, a body-feeling sense [R: Yeah], right, that can kind of either tells you kind of where, what the origins of some of those emotions are, um, or how it feels to kind of allow them to move through you [R: Um hmm]. That’s the feeling, in fact that’s actually, like that’s kind of a phrase sometimes I use in my own work to say, “You got to sit with it and you have to kind of allow that feeling to move through you and not be afraid of it. And if you have to sit there and feel really crappy that’s okay because you’re going to learn something from that.” [R: Yeah] It’s going to take you somewhere emotionally that you might not have been willing to go before, right. And I think there’s a very healing quality, quality to that, right. Whereas I think what I’ve seen here in my office sometimes and probably in my own experience sometimes when I think people are very sad and crying and they’re sort of at that like real low point, ah, often people are very embarrassed by that, they’re very uncomfortable with exposing that or feeling that way. But I think that once they go through that, it’s very healing [R: Yeah]. So, what I would do once I kind of got used to that idea, and I think that’s something I hadn’t seen when I had seen her previously I think that was kind of new at least for me my experience of it. Um, so I would take, what I would do for a good time after and I still do this sometimes I would go sit somewhere like in a park or something and just sort of allow that time to occur, sort of like go down within my emotional self to kind of see what was there. It has almost like a cleansing [R: Yeah] aspect. Um, I don’t know, if you’ve ever seen Broadcast News where Holly Hunter sits and cries, she like had a crying jag (laughs). It’s sort of like that but I think it’s like more, more, less shallow, right. It’s just time for self [R: Um hmm], time for analyzing kind of what self brings you, right. So, so that was one aspect. I, I still do that a lot and I found it very useful in my own life, um, in kind of listening to myself because I think sometimes in our culture we don’t allow time to listen to ourselves, we don’t allow time to experience emotions fully, um, we’re afraid of sadness, like we’re supposed to be all: (makes playful noise) he, he, he (laughs), you know. And, and, and we don’t allow some things to, one of the terms she used was move [R: Um hmm]. You have to let something move. And that sort of fits with something I was saying before [R: Yeah] that you have to let that emotional state move through you or if some event occurs in your life you have to allow that state to have an effect, you know, be it someone you ran into or an old friend or some fight you had with your partner or whatever it is. Moves the psyche, like, almost like the psyche is malleable, sort of in the transference sense [R: Um hmm], right. Are you guys big into transference? [R: In a way] because most people aren’t big into it (laughs) [R: laughs]. Most people like are, are they probably think it’s crap. They don’t, they just think that’s some weird. I don’t know, I don’t know what they think it is. I think they think, they just think it’s bullshit, right. But that transference aspect sort of fits in with the movement I think, that there’s almost like a psychic communion or communication between therapist and patient or just like the patient or that any individual might have when they deal with people in their life or elsewhere. And I think you get sensitized to that transference. And that’s also a point of information [R: yeah] not just in therapy but when you deal with anyone else. I mean that’s a, that would probably be another aspect and it sort of fits with the moving aspect and the emotional awareness aspect: transference and what it can teach you, right, not just about a client that you are working with but about yourself [R: yes],
right. And, eh, I, I think that’s, I’ve always found transference fascinating. Um, but she, this woman I saw she was the first, I think when I saw her the first time it was the first time she, that someone had ever said to me, “That’s the transference.” Like if you had a reaction to somebody if you’re mad at somebody or discussing the fee, right, or whatever it is in your work, in your therapeutic work. You, I still remember her saying to me, “That’s the transference.” Because it sort of feels like, um, eh, like butterflies, right, or whatever anger. I mean and it’s fascinating, but no one, no one analyzes it (laughs). I’m sure there are plenty of books where people analyze it, but my work even with the kind of experiential, um, counseling program I went to transference wasn’t discussed I don’t think. So I think that’s another aspect of like depth-psychology where you kind of have to pay attention to what that information tells you [R: Yeah] as an individual in therapy or as someone who does therapy. And I think that that’s, that’s been real useful. I mean because sometimes I can remember one time when I was doing therapy way before this because I’ve like done family therapy for, well, like for twenty years. And, eh, I remember, I could sit sometimes with people say a parent and child who were like very contentious and I still remember one time when I knew like the mom was going to flip out and leave the room and she did (laughs). Like you know, again that brings you information in, in, in your therapeutic work as a practitioner and also in your own therapeutic work as a patient [R: Yeah], right. I still remember I’m like, “She’s going to get up and she threw her hand down on the table and leave.” Yeah that’s just what she did. I’ll be damned. Or if you’re like dealing with someone who’s like a borderline, which I don’t other than the parents (laughs), I don’t, oh, I don’t treat borderlines. But like I’ve treated borderlines in the context of treating their children and you can tell when they’re going to blow. You can feel it, like, so there’s that sort of again self-awareness in dealing with again your own issues and sort of, eh, in an interactive sense your body will tell you what somebody’s going to do [R: Um hmm]. And I think that depth psychology is much more useful in supporting the use of that or teaching the use of that than sort of what’s in vogue now.

R: Yeah, and what was coming across to me in your reading of the books was you were mentioning that they taught you to honor what you were going through [P4: Right], to honor your suffering [P4: Right], and then your therapist taught you to sit with it [P4: Right] and let it move through you [P4: Right]. And you even said concretely that that would come about during the course of therapy when you gave yourself time to maybe go somewhere [P4: Right] and sit with what you were feeling.

P4: Right, like not always afterwards, but well sometimes. Like more after I was done with therapy or like in the course of like when I was finished as a way of kind of maintaining health or kind of paying attention to myself [R: Yeah]. Um, because I always found myself as pretty insightful and pretty emotionally aware, but I think there’s always more levels you can move to. And I think that in terms of the way our culture is now people have to take that time. It’s like people don’t take meditation time. They don’t take quiet time. They don’t do any of those things they need to do because they just rush like, like mad people [R: Um hmm] from thing to thing, right. And I think there’s real value in that sort of meditative aspect or sitting quietly with yourself and kind of of seeing what is there emotionally [R: Yeah] aspect.
R: And it seems like that was helpful for you [P4: Um hmm] to sit with your emotions. It seemed like the books provided an ideal of sorts, some guiding.

P4: I just think it’s paying attention to what’s inside you. If you don’t pay attention to what’s inside you emotionally it will come and bite you on the ass [R: Um hmm], right. I mean that’s, that’s more for me like if I didn’t pay attention to that I’d end up like being in therapy again. Or, or going through, like making some of the same mistakes that I had made before [R: yeah, and] or not growing even. I mean I think that really helps people to grow emotionally to take that time to kind of listen to yourself [R: Um hmm], right.

R: And what you said reminded me of something in your written description. You wrote that you came to see anxiety and depression as a reminder to take care of yourself [P4: Um hmm] and I was wondering what therapeutic work preceded that realization?

P4: Eh, well, I was an anxious kid. I’ve always been an anxious kid. Um, and I don’t really, I, I think there’s some work, some work I had to do sort of thinking about why that was. I mean some of it’s genetic. I think my, it sort of runs, like there’s a history of depression on my mom’s side of the family. Um, so, I kind of like gotten used to that because sometimes I like think anxiety can have, um, I don’t know how to say it, can have a very protective or useful quality in say like for somebody’s academics or. I mean there’s some use for anxiety for kind of paying attention to what’s around you and keeping yourself safe [R: yes] and like not doing the thing that maybe everyone else is doing. Just like, sort of just a sense of awareness [R: yeah] or like awareness of like what’s good to do and what’s not good to do. So I think anxiety like has that kind of function. And, eh, let’s see, I think for me, because I still remember when I initially went to see this women for the second time, this time that I’m speaking about, this time that probably had more effect on me was that I told her about one of those, um, anxiety, one of those dreams where you like can’t find the classroom. You know, you’re naked and you have to go take a test and you’re wondering around in the class, in the school hallway and can’t find the room and stuff [R: Um hmm]. And, and it was interesting because she said to me: sounds like an anxiety dream [R: Um hmm] from that framework’s perspective. And then she said, “oh, you probably have GAD, right” (laughs). I thought it was fascinating that that like her supervisor would say to her, “Well, if you’re having an anxiety dream that probably means you have GAD.” I mean which ended up being accurate only to some extent. But like most, most practitioners wouldn’t approach it from that (laughs) [(laughs)]. They’d give you a scale and they’d ask you some questions [R: Yeah]. They wouldn’t be like, “Well, this dream says this and you’re probably anxious, right.” So, I still, it’s funny I haven’t thought about that for a long time and I remember thinking that was really funny because at the time I was like moving heavily into short-term therapy, cognitive therapy. I think I had, I had just got my psychologist license a couple years before [R: Um hmm]. So, I was like loaded with research data: eight sessions is effective, you know. Just like totally boom, focused on that kind of model, right. And I remember going, “Oh, this would be good.” That would be really fun if you had to explain that to insurance companies, right, “Well, it was this dream that kind of told us she had GAD, right.” So, it was interesting because like on one level I
was like, um, I think she could have used a little bit more CBT. I remember thinking that at the time. And again being like a practitioner in therapy you kind of go, “Well, well, you really should be doing this” (laughs). Um, because I think that there really could have been some of those symptomatic reduction things used in the, in the process [R: Um hmm], but as time went by it ended up being effective anyway. But I remember thinking at the time with my sort of like very, you know, research oriented like quoting statistics mind it was like, “Oh, no, well if it were me doing this this is what I would do” [R: Yeah], right, as a practitioner, right. So, um, so to the anxiety part, eh, ask me again.

R: Yeah, I was wondering about you seeing depression and anxiety as a reminder to take care of yourself [R: Um] and

P4: Depression yes, anxiety no, I think for me the sort of cognitive model works better for anxiety. I mean I think you can look at what the reasons might be that you are anxious but I don’t think they’re all based in childhood, right. Um, I think some of them are just genetic and, and neurochemical, right. Um, so I think for me and, and, and, um, rational. I think there’s like cognitive model type strategies you can use to reduce that. So, I’ve found that sort of, um, using what’s the worst thing that could happen, you know, sort of the standard treat, [R: Um hmm], like, eh, Beck type model works much better for me for anxiety. And also although I do have to say that like I think if you’re individuated and if you’ve kind of like come to accept yourself and like yourself and all your aspects that there’s less, much less reason to be anxious [R: Yeah] because you’re not going to be. I, I think there’s like a very childlike quality sometimes to some anxiety that like it’s sort of like: I’m going to be found out and punished kind of thing [R: Yeah]. I was raised Catholic so I think, like depending upon whether you’re raised Catholic or Jewish I think there’s a very guilt oriented model that operates (laughs) from when people are raised to some extent and that’s something they sometimes have to conquer. Um, and I, eh, so I suppose there’s some aspect of that just sort of like self-acceptance is a way of reducing anxiety [R: Yeah], right, of sort of like accepting your whole self or your fuller self in all its aspects that like you’re fine, you’re going to do well, you’re not going to be exposed as like someone who doesn’t know what they’re doing, you know, whatever it might be [R: Um hmm]. But I think in terms of like actually reducing aspects of anxiety I found the sort of like cognitive strategies more helpful in the long run I think then the psychodynamic.

R: I was curious too, what did that realization about depression look like in the therapy? You wrote about something that seemed like a big realization for you about depression as a reminder to take care of yourself. How did that come about in the process of therapy?

P4: Well, I think that that’s true in general. Um, because I think sometimes there’s a, you know, if you look at it from a multifactorial standpoint there’s a lot of reasons that people sometimes get depressed. I mean it’s biological, physiological, there’s stressors, there’s you know, people not getting enough help, people thinking that they, you know, I think it’s much more common for women who I think tend to kind of allow themselves to get into that position more [R: Yeah]. Eh, from the therapy standpoint, I think it was more of the aspect of like if you look at your full self or if you look at depression as a, as a
reminder [R: Um hmm]. Because I, I, I think in some aspects, one of the aspects that I 
would think about with the Descent to the Goddess was that you’re not paying attention 
to shadow. You’re not paying attention to sort of the dark side. You’re not paying 
attention to stuff that you don’t like about yourself or whatever. So, I, I think that 
sometimes like people, I mean absent all the other factors, you get kind of dragged down 
there because you need to be dragged down there [R: Um hmm]. I don’t think that’s a 
common viewpoint (laughs). Among other people, people other than like people who 
have like that sort of orientation that you’re going to end up down there because you 
haven’t been down there [Um hmm]. Because you’re like up here on top in the non-
shadow part, right. And that there’s this whole other part of you that you’re not paying 
any attention to [R: Um hmm].

R: Yeah, and what, what part of yourself was coming to view in therapy? What part were 
you not paying attention to?

P4: (laughs) I think one time I had a dream about, you know, like that I was like Ilsa of 
the SS or something in one of those Nazi dreams [R: Um hmm], right. Um, I think that 
was one aspect. For me, it was like not paying attention to the like bitch sort of part of 
myself. Because I’m sort of like one of these people-pleasing, pleasant, um, 
accommodating, you know, oldest child kind of things [R: Um hmm]. Um, so I kind of 
had to allow my bitch self to come through or my like stronger self [R: Yeah] like what I 
would refer to as like my stubborn Irish woman self, right. Um, eh, let’s see, there also 
was. I remember one of the dreams I had that I sort of saw as a Descent to the Goddess 
dream was, um, sort of going down in a swamp, like in a basement. It’s like very, it’s 
very, it’s funny in a way because it’s so obvious at some level. In a basement sort of 
finding, archeological dig in a swamp in a basement where you’re finding all this yucky 
stuff that you don’t really want to see [R: Yeah] going, “Oh my God, right.” Like being 
down at the bottom of the ocean and discovering all those creatures like creature that live 
down there. And I usually saw the house and I think it’s common as a dream structure 
that the house is yourself. So, I was down in the basement going, “Oh my God,” right [R: 
Um hmm]. And to me that sort of related to some aspect of, of the depression in the 
sense of like having to look at crap you don’t want to look at, at shadow, at stuff that’s 
buried, at stuff that you need to pay attention to be fully whole, right. So that’s one 
dream that comes, that’s like a not quiet a shadow dream but has aspects of like needing 
to dig down and, and discover yourself more.

R: Yeah, yeah, so it sounds like some of the shadow aspects, like you were speaking of 
one that would be your more you were using the word bitch self [P4: Yeah], sort of your 
more assertive [P4: Assertive] and

P4: Maybe female power in the sense of like female power doesn’t have to come from 
being accommodating all the time [R: Um hmm], right. It’s interesting because I was 
having this conversation with my husband the other day. We’re both, I’m going to be, I 
just turned 49 and he’s 48. And, eh, we’re like, “Oh, we don’t put up with shit anymore.” 
You know, we were discussing like old friends and friends we don’t see anymore and 
how we are just unwilling to put up with crap anymore. So, for me some aspects of the
therapy are like, eh, sort of a more of a point of competence, of strength, of like, you
know, I don’t have to, I don’t have to be nice to people I don’t like. You know, being
assertive and saying, “No, I’m not doing that.” I mean, in a work life, in a, in a parent
life, it’s like I can’t do everything, I can’t take care of everything and I think that that is
sort of what kind of persona I had functioned with prior to this period where it was just
like, “Oh, okay, I’ll do that or I can take care of this.” I can do everything without paying
attention to my inner needs or to my health to some extent [R: Um hmm]. Um, so, eh, so,
I use the word bitch but that’s probably a little bit strong, in the sense of like self-care [R:
Yeah], um, assertiveness, um, maybe that it’s okay to say no more, that I can’t do
everything, that I’m not superwoman. I think a lot of woman have like this dichotomy of
like, you know, where, I, I mean, I know friends who would say like nun/whore, kind of
just like a dichotomy where like woman are just either this or this or they’re a slut or
they’re a, you know, princess, you know what I mean [R: Yes], all those terrible
dichotomies that woman are taught as there, you know, as there growing up. And just to
kind of find a more personal and emotional complexity [R: Yeah], right. Um, so that for
me, like a point of strength I guess. There’s a strength in sort of taking myself worts and
all, which is I think that is what people have to do to survive and to kind of grow. So,
when I think about sort of, you know, whether it be like, you know, Nazi imagery or, you
know, something that you associate with a very negative aspect of life in general or, um,
a swamp or just muck or ick, you know, something that people would think of as
negative. Like bringing that negative stuff into the self [R: Um hmm]. And I think
sometimes without, I don’t know if I would think this in my work totally but like you
have to kind of, sometimes you have to, the depression forces people to go down in there
and that’s sort of the idea of the Descent to the Goddess is that you kind of have to go
down there to grow [R: Um hmm]. And it’s interesting because if you look at myth
because we’ve actually read some of these books to my son like sort of mythology books
and there’s a lot of, if you read Joseph Campbell or whatever, there’s a lot of
mythological aspects where women or men have to go through these trials and
tribulations or, or female, I forget the name of the goddess, well, Innana is like a
Babylonian goddess, where they have to go, they’re living up in, in the great like
beautiful sun and then they have to, or Persephone, you know whatever it may be, and
they have to go down to the underworld where everything else has survived. So, I guess
you could in some, in some ways see depression as some aspects of having to go down
into your personal underworld [R: Yeah] so that things can continue to function.

R: I’m getting a sense that for you therapy on the whole was helping you to go down into
the depths and one of the things you were finding was, you know, this part of yourself
that was yearning to be empowered or assertive [P4: Right], yeah.

P4: And I don’t know if I would have seen that without the depression. It forces people
to take stock. I mean sort of like anyone who, when, if I have adults come into this
office, um, they come down, they come in here, or they come to therapy because they’re
hurting and they can’t stand it and they feel awful. And sometimes that’s the only thing
for some people that’s going to make them go, “This isn’t going to work. I can’t live like
this.” And I think it’s often those transition points in life where there’s like a big change,
job change, partner change, parenthood, um, you know, whatever it might be that sort of
forces people, the stress of it forces people or just like, I mean there’s obviously a lot of factors because not everybody goes through that. But I think that sometimes people have to, there’s like something that has to force them like a crisis or whatever like Joseph Campbell would say, you know, a, a challenge, a life crisis or whatever that makes people kind of have to stop and look at those kinds of things [R: Yeah]. So, that’s kind of how I come to view it. Not just like, “Oh, I have depression and it’s this pathology and blah, blah, blah.” I don’t try to think of it like that [R: Yeah], um [R: Um hmm, so]. When I see people in here I, I try to think of it as more of a positive thing, you know. I just don’t think of it as like, “Oh, someone has this disorder,” right. I think that’s like a really limited way of looking at someone’s problem. That there’s probably more to that and if there weren’t other certain sort of, um, social factors, environmental factors, stress factors, they might not have been put into that position, right.

R: So, it seems like your work with books or your work with, you know, dreams during therapy, it seems like it was a way to come to see things about yourself. I get the impression for you it was a coming to see things and

P4: Yeah, well, I think you talk about it in therapy and then I would go out and find books or she would recommend books or whatever like the book about, I forget the name of it now, but like the book with the rabbit image. Reading some of those books open you up to a new way of looking at your psyche and at yourself, you know [R: Yeah] that I might not have done before. I might have because I mean my husband and I are kind of like, eh, we’re pretty alternative oriented. So, my husband’s always, he does tarot, he does astrology. He’s kind of like, some people call him a woo-woo (laughs), right. He’d always had books like that and we read mythology. Also, we thought of ourselves as fairly insightful. But I think when it’s applied to your own personal work it’s a little different [R: Um hmm]. I mean I read books like that before in school. I’ve taken some classes and things like that. But I think when it’s your own, when it’s yourself, when you’re the study, when yourself is the study, it’s a little different [R: Yeah], right.

R: You mentioned dreams. Were there any dreams that stood out to you in the therapy?

P4: Oh that basement dream that’s the main one I can remember at this point [R: Yeah]. Um, oh, I think this is more later in the therapy but there’s sort of aspects of like, um, eh, aspects of archetypes like the puer, the puer eternis. Are you familiar with that? [R: No I’m not] I think that’s what it is called. Like there are different archetypal aspects of, um, self like the croan like, you know sort of the stereotypical ones, the croan, the young girl, um, the eternal boy. I think again being female if you look at it from the standpoint of the dichotomy. I think for me I didn’t really pay attention to sort of my rough and tumble boy self [R: Um hmm]. That’s how I thought of it. And sometimes I’d have dreams about, like merging dreams, where you’re sort of like involved in some personal contact or, or some sexual contact with a character that’s not female [R: Um hmm], right. That’s like a different aspect of self or maybe even like, eh, how can I describe it? I’d say probably like a merging dream where you kind of have to merge how you see yourself with some other aspect of yourself that you’ve ignored be it a shadow be it, um, more masculine aspect. I think I remember having some dreams of like merging so to
speak like that. But they weren’t like sexual but sometimes you’d wake up and be like it sort had like that quality, um, or that feeling of like happiness or merging or sort of like a bonding [R: Yeah] kind of feeling. So, I’ve had, that’s another one that comes to mind, but not a lot specifics on that one [R: Yeah]. The basement dreams is probably the most powerful one of like, “Oh, look at all this stuff that’s down here that I haven’t paid attention to.”

R: And both of those dreams sound very interesting. The basement dream, um, when you brought that into the therapy. How was that dream worked with? How did you and her work with it?

P4: Eh, you know, I don’t remember [R: Um hmm]. Eh, eh, I don’t, she didn’t really over-analyze them a lot [R: Yeah]. I think it, that’s one of some nice aspects I mean like maybe a Freudian would, I don’t know. Um, I think she wasn’t really into over-analyzing dreams like I’d write them down [R: Yeah], I’d write down a lot of dreams. I don’t know, but it’s funny I don’t know where those are (laughs). I remember writing down a number of them in like a dream journal. My husband keeps a dream journal and records it in the morning and stuff. He’s into like Robert Moss. Do you know who that is? [R: I don’t know who Robert Moss is]. He’s a hardcore dream analyst guy very different perspective on things sort of a Native American style, fascinating guy, a little out there but interesting. But some people think that within the dream you can kind of go into the dream and have, do therapeutic self-work in the dream [R: Um hmm] itself or sort of like a lucid dreaming or shamanic type of thing. Anyway, eh, I remember I had to write them down, but I don’t remember, and I’m sure there were some discussions of them. But not discussion, not discussion in the over-analytic way, more discussion about how did I feel about particular aspects of the dream or like the main figure [R: Yeah] or something.

R: The impression you’re giving me is that the work with the dream is less of an analytic-meticulous looking at it and more of a, you know, how you felt toward the different aspects of this dream.

P4: I think that’s why I got really interested in like I think that’s why I went to get some of those books [R: Um hmm] and again I wish I could remember the tile of that book.

R: And with the basement dream it seems like the impression you got there was, you know, there were certain things that you needed to get in touch with [R: Um hmm], you know, certain parts of yourself [P4: Um hmm] and

P4: Yeah, right, well, I think if you read books about individuation from the standpoint I think that they usually think that there’s a part of yourself you’re not, I mean the shadow is probably one of the bigger concepts, although I think that’s unfair. I think they have more complex concepts than that. Um, but that you can’t just function in one limited box. But there’s other parts of you that may have been sort of walled off or you know, from the, what’s the word I want, like if you look for the aspect of complex there’s something, is there something like, that’s what shadow is. Shadow is the main thing you
can’t see because it’s to frightening for you to see it [R: Um hmm]. It’s just like, “Oh, I’m not like that, now why am I having a dream about a Nazi,” right. Do you know what I mean? [R: Yes] That aspect of like sort of walling yourself off from it and I think too as you sort of discuss these things in treatment and then you go home and you kind of carry that feeling with you outside of the session that sort of sense of movement. Because sometimes I’d have a session and then like a day later or even a couple hours later I’d have this big crying jag and I sort of realized something that I hadn’t really paid attention to. And that is what I’d describe as something, I’d go back in and she’d say something moved [R: Um hmm], something moved, right. Um, oh, interesting like something again internal [R: Yeah] something psyche something, eh, some emotional state that, eh, maybe was kind of ignored for a period of time.

R: Was there anything particular that was coming to mind when you were thinking about, you know, having a crying jag or having something move through you?

P4: Eh, um, oh gee, probably childlike-like kind of stuff like, um, you know, the nobody cares about me kind of thing or, eh, you know, self-pity. Um, I think sometimes it’d have a really negative quality at first, eh, sort of like getting those feelings out [R: Um hmm], although I couldn’t always say exactly what they were. It’s like a sadness or whatever and kind of at the end kind of like coming to some sort of resolution after it was over, um, like a healing a salving [R: Yeah]. I don’t know? That’s a good question.

R: Yeah, I mean, the picture you’re painting of the therapy seems like you might initially see something in a dream, it might have a frightening aspect [P4: Um hmm], but then the emotion begins to move. And when it begins to move through you, you might experience some sort of sadness initially and then you engage in a healing process.

P4: I think the dream aspect kind of like comes. I think there’s a sort of an emotional quality that people have when they wake up. Because often times I wouldn’t feel sad when I’d wake up. I think the sadness was more like an internal state that maybe was set off by the dream to some extent [R: Um hmm]. But I don’t know if I really connected those two. I suppose that you’d kind of like allow yourself to be open. Those dreams would sort of open up your psyche to some extent so that you could have those experiences, although I don’t know if I associated them as strongly at the time, right. I mean I don’t know if I saw them as one thing. I think I tended to kind of compartmentalize them a little bit more [R: Yeah]. Um, that’s interesting, that’s an interesting question.

R: I was also wondering about something else. What was striking me in the description was you writing about feeling exhausted and tired before you entered therapy but after the course of therapy feeling energized again. And I was wondering if there were any instances concerning this change, this more bodily change.

P4: Um, well, I think some of it had to do with like, partially with medication and getting more sleep (laughs). Um, eh, it took a while. I mean I think I saw her for like a year [R: Um hmm]. It took a couple of months I think before I started to feel like. Because I
think I was a little resistant to it. I was like, “Oh god, do I have to do this again.” Um, because I sort of didn’t want to go through it, understandably a lot of people don’t want to go through that process. Eh, eh, I think it was sort of a feeling of feeling that it was okay to feel like this and that it wasn’t the end of the world and that I could make the changes I need to make. Because I had to leave, you know, I had to kind of quit my job, which was good in a way. I started working part time and actually I still do that. I still do consulting and work part time. So, that turned out to be a really good thing at, at the beginning it was like, “Oh my god. I can’t do this. This is what I’ve always done.” Sort of just like not, sort of clinging to sort of my old way [R: Yeah] and not really wanting to let go of that. Eh, so I think it was kind of when I started to see (sighs) that it was okay, that it was like (sighs), that I would feel good again [R: Um hmm]. I mean I think one of the difficulties is sometimes with that kind of therapy is like when you go down into those like low places you’re thinking you’re not coming out and you kind of have to allow yourself to know that you will come out [R: Yeah]. And I think that took a little while. Because sometimes I’d leave there in the beginning sort of feeling like just crap and I would be like, “Oh my god.” Eh, and then, well, I think too it was spring. I’m thinking to think if it was spring or something like or summer and I think that that kind of. I mean I think there was a, you know, I think the seasons changed, I was feeling better, I was getting more sleep, I wasn’t working, I wasn’t like depleted [R: Yeah] to the same extent. Um, but I can’t exactly say when that occurred [R: Yeah] or what the, I don’t know if there was a defining moment per se. It was more gradual. It took a while.

R: It sounds like a gradual change [P4: Yeah] at which point you were feeling more energized.

P4: Right, it took a while though. I was pretty far down there. It was like a moderate depression. I still remember like when I decided I couldn’t work anymore. I would just sit there like, like people, you know, it’s like the classic, it’s just like, like you just couldn’t move, you couldn’t do anything. It was bad [R: Yeah], um.

R: From what you were saying before, it sounded like there were different phases of therapy. The first phase where you were more exhausted and less energized [P4: Yeah]. And then another phase

P4: I think I was ready to talk though. Because I think I was ready for her to hear me [R: Yeah]. Um, hmm, I can’t remember, eh, I, well, I think even though the first or second session is when she said to me this is similar to what you said before in your previous therapy [R: Um hmm] {laughs}. And it was worse, right. So, I, I remember laughing. I mean it must have, I mean I think there was an insight aspect where I was kind of like, “Oh my god did I do this again?” Because she had like read me a description of something I had said or maybe a form I had filled out the first time and it was the same stuff [R: Yeah]. I was like, “Oh my god, right.” I did this to myself again and, and I made it worse. It’s, it’s worse than it was, right, so, um, yeah.

R: So, for you, it seems like a realization of the continuity between [P4: Yeah] this course of therapy and [P4: Right] your previous course of therapy [P4: Right].
P4: Right or a pattern of behavior that like changed to some extent but, but hadn’t [R: Yeah]. Um, well it had but it, it, I mean it’s like not taking stalk of like all the stressors and like the fact that I couldn’t do everything.

R: Yeah, so that’s what it was then the coming to see that you couldn’t be superwoman [P4: Right] you were trying to be superwoman again [P4: Right].

P4: I still remember I went to see, I had to go and see a psychiatrist. Well, I went to my family doctor and said, “I can’t sleep. I can’t function like this.” And I ended up taking Trazodone, which like knocks you. It’s like an old style, old line antidepressant that knocks you out. And eh, it was like, “Oh, I’ll be able to sleep again.” Because I was having that 3:00 a.m. waking panic like, “Oh, the world is terrible, this is awful, everything’s horrible, kind of thing” [R: Yeah]. Um, and eh, I remember the, the psychiatrist said, “You waited too long.” And I’d say, “I tried to be superwoman.” And he was like shaking his head (laughs). He’d seen it probably like hundred of times before (laughs), so. Which is funny now, but I still remember leaving his office and going, I said to him, “I must be feeling better because I was singing in the car again” [R: Um hmm], right, so, um.

R: And you wrote about in your therapy too coming to realize you were trying to be superwoman again.

P4: Yeah, it’s interesting because I’ve sometimes thought there’s was some kind of bipolar quality that got triggered by hormones, by, um, eh, pregnancy hormones or something because I felt like I was like superwoman through most of my pregnancy because I had just started a new job, which was really stupid. Looking back on it I would have never have done that [R: Um hmm] if I had known what was, what was going to happen. I was like running this like, you know, program I developed [R: Yeah] and I was like running all over the place. I, I was working part-time too. I, I just liked to do everything so I used up all my pregnancy energy running all over the place. And then after my kid was born it was like (makes a sound like a building collapsed) [R: Um hmm], right. But it took me like a year of, of trying to do everything before I went, “Oh my god. I can’t do this. This is really bad.” So, um, there’s a post-partum quality to it. There’s like a depleting self aspect and kind of like realizing that you can’t do everything [R: Yeah]. Like I think for me it’s interesting because of one of the things I learned about being a parent was that I can’t, I can’t do everything. I can’t go home and do X, Y, and Z and take care of the kid and have worked all day and then like I can’t sleep. You know what I mean. You can’t do all those things. Um, so I kind of learned to like to sort of share it out a little more. I decided there’s like a three prong thing with kids like you spend some time with your kid, you send your kid to daycare sometimes, and you have other people to help you. Which is sort of like, it is like something I think people have to learn about parenthood, about motherhood, about what, um, like not overdoing it, not thinking you can do everything without help. And also sort of like a change of life, your, your sense of self changes so much as a mother or a father that you kind of have to incorporate that aspect to [R: Um hmm], right. And it was sort of realizing that you
can’t, you can’t, if you don’t take care of yourself you can’t take care of your child. You can’t like, the only way to have a healthy life is not to be able to, not to do everything that like you’ve done before, you have to, like some things have to go

R: I got a sense of that in your description where you were writing that there wasn’t enough time for your son, there wasn’t enough time for your husband, you weren’t having as much fun [P4: Yeah] as you could of with them [P4: No, no]. Are there any, like, examples of that change, you know, where you were having more fun with these significant others?

P4: Um, well, I quit working full-time [R: Um hmm]. I mean I think that was the main thing. I think my son went to, he was in day care to some extent. So like I, I, I even though I felt kind of bad about it, I’d just stay home and sleep [R: Um hmm]. I would just like, I would go and put on music and I would sleep for a couple hours until I had to pick him up. And I felt bad about it. But it was just like if I don’t do this I won’t be able to take care of him. Well, it wasn’t like I couldn’t take care of him, but, but I didn’t need to be anymore depleted. So, I would just like sleep. I went through a period where I was just like, um, cocooning [R: Um hmm], right. It reminded me of something a professor of mine had said in graduate school where he said he went through a year in his back yard where he just like sat there [R: Um hmm], digging things or going into this almost vegetative state. So, that’s sort of, that’s what I felt I did, um, where I just played. You know, I just sort of started to like not have to do everything all the time, not looking at my watch all the time [R: Yeah], that kind of thing. Just time to vegetate, just time to sit, time to like listen to music and just like read or lay on the couch. Because sometimes when you have a small child you go from having all the time in the world to not having hardly any at all [R: Um hmm], especially with a young child. So, um, like, just like having time to myself which I hadn’t had really done because I was always working or I was always picking up my son or I was like cooking dinner or I was just like doing everything. So there was no time for me. I had to build that in. I had to kind of realize that this has to be a priority and I have to build that in or I, I won’t be standing.

R: Yeah, what was striking me was an interrelationship there. So, you were developing a time for yourself, a time where you’d be able to read, a time where you’d be able to play [P4: Or just sit], a time for self and

P4: Because I used to be in a band and I didn’t have time to do music anymore. I, I got sick of rock and roll, which is funny because I thought that was something I’d never get sick of. So, um, I played drums and stuff like that. I’d been in a punk band for a long time. So, eh, I started to have time for that to pay attention to those things again [R: Yeah], right, so.

R: Through the process of therapy, you were developing time for yourself and you got into music again as well.

P4: Well, I was in a band for a long time. It’s interesting because when I was first in the band the first time I went to see her we had made an album, right. And, um, we made a
couple of albums like sort of indie-type albums and one of them. Um, I used to write songs, and I, kind of like more like poetry, you know, inner girl poetry (laughs) kind of thing or political kind of thing. And I had a song called *Faces of Eyes*, right. And it ended up on one of our records. And the, this was something an image I had used in therapy before where I was like, it’s like a face but only it has a whole bunch of eyes [R: Um hmm]. Its like a common, um, sort of mythological symbol. And I had seen that symbol as like awareness to some extent or that’s sort of like what I came to think. I remember like the woman thinking this was so cool, right. Oh, this is really cool, right. Like, I had sort of made a drawing of it one time. And like I think it was a dream image actually because I used to use dream images to write songs all the time. I didn’t write a lot of songs but the ones I did sort of had that quality, um, you know, about goddesses and muses. I’m a feminist, so, like had very much that quality. And I think later on I started to kind of like pay attention to that side of myself again [R: Um hmm]. Because I kind of like had to shelf it. I had to retire. My girlfriend and I both got pregnant about the same time. She was also in the band and like we just had to retire from, from, from being punk rockers and from being, from being women musicians. We kind of had to quit doing that. We’d done it for like ten years [R: Yeah] so that was like a big change and, ah, I guess I started just to allow myself to kind of have time to write. Like I had had these dreams and I’d like get up and write, write them down in the morning and sometimes I’d try to make songs out of them [R: Um hmm]. Just to kind of like revisit, regain that part of myself. Because I sort of like had to put these parts of myself aside [R: Um hmm] or at least I thought I did [R: Um]. I thought I don’t have time for this anymore. I think it was my image of what I thought parenthood should be. Probably similar to maybe self-sacrificing parent, you know, mothers of the fifties and sixties. Because my mom didn’t work outside the house, never went to college. But very bright, read all the time and wanted us to go to college and stuff. And I think when I became a parent I think I sort of like adopted some of that aspect of like, “Well, I have to put myself aside.” It’s like, “No, you can’t put yourself aside.” It’s really dangerous to put yourself aside or to put things that you love or aspects of life that are important to you aside, like music, for me like music, you know, like spending more time with friends, you know, whatever it is. Like you don’t necessarily have to give up, when you become a parent you don’t have to give up everything that you already, already had before. Maybe you do for the first couple months [R: Um hmm] or something because you’re just like, you know, pie-eyed. But, um, for me, it was like I had to kind of regain. So, I was sort of like reintegrating and regaining parts of myself that I had kind of shelved [R: Yeah]. And I thought, “Oh I can’t do that anymore. I’m too old. I’m a parent now.” Which is absurd because I don’t think I would have thought that before [R: Yeah]. Right, because part of me is like I can do all of this. And then it’s like no I can’t do any of this because I’m like either too tired or I don’t have time or whatever [R: Um hmm], right, so, reintegrating.

R: Yes, your renewed interest in music was part of this broader reintegrating [P4: Yeah] of parts of yourself.

P4: I remember thinking that I’d hear what I’d call whiny boy rock, love rock on the radio and going, “Oh god those people are so stupid. I can’t believe it.” Like that’s sort
of been a big part of my life, but that I’ve always liked that kind of thing. And then as a parent I was just sick of it. I was just like, I’d listen to a lot of things, but I was just sick of it. You know, probably because I just felt bad, but partially it’s just like, “Oh for god’s sake,” you know. Thinking that suddenly I’m like super grown up right now because I have a parent, because I’m a parent, right, so (laughs). Thinking that I had to shelve and get rid of all those parts of myself that always kept me healthy even though for years I’d been like, like I worked for X for a couple of years. I’d always been a therapist with kids and seen a lot of really problematic stuff and I think music for me was always my way of staying sane [R: Yeah]. It like balanced everything out. So, and then when that was gone I was like ah oh what am I going to do now, you know, I don’t have time for these things that nurture me, right. So, I guess there’s a kind of self-nurturing kind of quality too that I had to kind of re-find [R: Yeah]. It sort of fits with what I was talking about before [R: Yeah].

R: It sounded like the writing down of a dream or poetry [P4: Um hmm], it sounded like the writing down was helpful to the process of therapy too.

P4: Yeah, it was. Because before I hadn’t really felt like that or I didn’t really have time for that [R: Um hmm]. Because I’ve always sort of been like a bit of a diarist, because I like, like to write things down stuff like that or write down little snatches of poetry or song or whatever. And, um, I think, I, I, again I don’t know exactly when I started doing that again. Probably it had something to do with, you know, writing down the dreams where you sort of start to say oh there’s still things to learn [R: Yeah]. Because I think to some extent I probably might have felt like oh my life is over, my life as I knew it is over, which was true to some extent but it wasn’t true in the way that I thought it was when I was depressed. Um, because I thought like oh I can’t do this anymore, oh I can’t play music anymore, I can’t. It was very sort of very limited view of what parenthood was and I don’t exactly know where that came from [R: Um hmm]. Um, be, because I’m nothing, I wasn’t really anything like my mom in the same sense. Like I mean I worked all the time, you know, I was working. I was doing all these different things. Um, so, eh, I don’t know if I talked to her, I’m trying to think if I talked to her about that or not. Probably like, it probably like had some nurturing aspect too because I think, um, when you suddenly have to give all your nurturing to a child you forget, sometimes its easy, at least for me I sort of forgot to nurture myself [R: Um hmm]. Eh, and I think that’s an issue for a lot of people, but I think for me I needed a wake up call, you know, before I, to just see kind of see this well you can’t you can’t nurture anyone else unless you nurture yourself, right. And that’s sort of part of that going to the well. Ah, here’s an interesting thing. When I was first in therapy, she, I remember the therapist saying to me: your well has run dry [R: Um hmm]. Um, and that sort of fit with the whole Descent to the Goddess thing that you have to go down into the muck and deep and stuff to start re-enriching yourself [R: Yeah], rebuilding your psyche, um, reintegrating whatever it is. I think that’s a really good image too [R: Yeah] that there has to be self-nurturing and self, eh, like nourishing, right [R: Um hmm]. So, I think that’s a good image too. I had forgotten about that.
R: Yeah, it sounds like that incident was really representative of what was working for you in that therapy? [P4: Right] You know, her pointing out that the well ran dry had a huge power to it for you.

P4: Right, yeah, and I think too maybe it made it a little easier to kind of start nourishing. I think that’s the reason why I went back to this particular person because she and I had always had a bond [R: Um hmm].

R: That’s what I was wondering about too. What was your experience of your therapist’s presence and the therapeutic relationship like?

P4: Eh, well, she’s kind of a wild character. Um, she’s very open like. Eh, especially toward the end of my therapy because she knew that I was a psychologist, right, she would tell me stuff about her own personal work [R: Yeah], which usually you don’t see therapists doing that. And I, not always, not in the beginning, but like we’d been friends, not friends, but we liked seeing each other off and on. I’d see her at like art shows. She’s kind of like a very alternative character in some ways. Um, and she’d even tell me about when she was having a rough time, like not a lot. But that’s very rare for therapists to do that. And I think that’s something that maybe Jungian therapists or they don’t have sort of that sort of blank wall, kind of what I joke about in here as kind of like that, “Tell me about your feelings.” I, I really despise the sort of blank slate form of therapy. I mean I suppose for maybe for borderlines it might work. But I don’t think its really an honest way of communicating with someone. Especially because they’re in here spilling there guts to you, right, and you offer them nothing in return (laughs). It doesn’t seem right to me, so, so. But I, I think she was, um, (sighs). I don’t know. We had a nice bond.

R: Yeah, so there was a bond there.

P4: Yeah, and I think I learned a lot the first time and so the second time it made sense to go back to her, right. And I think a lot of people do that. I mean I’ve had people here that have come back a couple of times for what I call a tune up. I call it a tune up. Um, and, and I think because you already have that relationship established. And I think it was interesting and I think there’s a very nurturing quality to it [R: Yeah]. Um, one of the interesting things about her was I think she, I remembered her mother had died. I remember her telling me about her mother dying, which was very interesting. And I don’t remember what the context of it was. I think she was kind of having a rough time in terms of that or her mother had died when she was young or something, which is something like therapists don’t usually tell you [R: Um hmm]. Um, and that it wasn’t like my mother had died or anything like that but I really don’t know what the content. Probably like a lot of nurturing discussions and discussions about parenthood. She always found it interesting that I treated kids, um, because that’s mostly what I have done in my career. Um, she found that really positive [R: Yeah], which was good because like at the time I didn’t always think of it as positive I’d think of it as, “Oh my god, could you imagine.” Sometimes I would go to my husband and I wouldn’t tell him details, “Oh my
god you won’t believe what I heard today,” right. Because sometimes like you just hear this horrible stuff [R: Um], right, so.

R: When she was sharing stuff with you, you know, her own personal experiences, what was that experience like for you?

P4: Oh, it was a little odd at first because of, of my orientation. Because I don’t share, I share some personal stuff, but I’m not like, I don’t go real deep in it. Because that’s not how, even though I went to sort of like a hippie group process experiential program (laughs), you don’t really do that. I mean you kind of have to watch that. But I think we’d known each other long enough and we’d see each other occasionally out in the community because she doesn’t live, she sort lives in Y where I live. So, I’d see her out and we’d chat and stuff like that. Um, so, not like we were friends, but we were acquaintances almost outside of that. So, I think it was easier to accept that from her. Also, oh, here’s an interesting thing. I think she’s probably the first therapist I ever met who said, and I think this is sort of more of a Jungian, psychodynamic, they feel that like drinking kind of takes people into that like same dark space that people need to go to (laughs) [R: Um hmm]. It opens up a lot of emotional stuff, which I don’t think you’ll hear too many therapists say that. I thought that was interesting because like it’s a very different orientation then sort of the blank slate, um, I know best kind of, you know, limited dialogue [R: Yeah] kind of. Eh, I always thought that was kind of interesting. Because like I think there’s some truth to it that sometimes they drink, they probably drink to medicate [R: Um hmm] and therefore they kind of go into this space where, you know, boundaries are relaxed and stuff, inhibitions are loosened. So, so for some people probably for them drinking is a way for them to get to that point [R: Yeah] where, as they wouldn’t be able to otherwise, so.

R: So, it does seem like there was a bond there.

P4: Yeah, yeah, she’s an odd woman in some ways, which is funny because I’m very open minded and kind of a left-wing, arty type, punk, you know, eh. I mean I know lots of alternative people like she was really into a lot of alternative, a lot of interesting alternative stuff. Eh, let’s see, yeah, she, I mean I can’t say, I don’t know if I had warm feelings toward her. Because sometimes like, you know, with transference sometimes it was a little bit prickly [R: Um hmm]. So, I, I, I don’t know. Yeah, I mean it was very useful. I still have a lot of affection for her. But I can’t say it was like, you know, how some people get like get so caught up in the transference that they can’t see anything else I, I, I wouldn’t say that that was true for me [R: Um hmm]. Eh, she, she was a very interesting woman.

R: Yeah and there was work with the transference in therapy like you remember instances of transference work.

P4: Sometimes, yeah, well, it’d usually be about money for some weird reason. Like I remember one time she said to me, “You didn’t give me the check.” And I was like, “Oh.” And for some reason I got mad at her and I’m like, “Well, I always give you
money, what’s the issue.” Because sometimes like transference comes out in really weird ways [R: Yeah]. Eh, yeah, I think being heard, you know, I think especially since I’d been so besieged by these other things. And my husband, him and I were doing a certain amount of arguing at that point because I think we were both stressed like being first time parents and all these changes. And my husband was like working in Z and he hates driving. And he was like, “Oh god, I hate Z.” So we were both kind of miserable for a while. Um, what was my point? I had a point there. Eh, because you were asking about her right? [R: Um hmm] I forgot what I was going to say, something about stressors, sorry [R: That’s okay]. It’s gone. Eh, I’m trying to think of anything else about her per se. Yeah, I think she was like really good at, oh, oh, transference, um, I think too in the sense of like nurturing like somebody guiding me [R: Um hmm] because we had had this relationship before. Um, I think the thing with the dragonfly like I think that was a point of like where I allowed myself to get focused on dragonfly aspect of it of like. Instead of her staying to me, “You need to change.” It was easier to sort of look at this image of change [R: Um hmm], this dragonfly. And I think I remember that when, I don’t know if she specifically told me to pick out one of these images or something but. I just think she had them out there and I remember focusing on one. And for some reason I think after that there was a little shift for me that like I could start to see the light at the end of the tunnel [R: Yeah] a little bit. I mean it wasn’t real overt and it wasn’t real cognitive or anything. It was very like symbolic [R: Um hmm]. So, I, I think that aspect of the therapy had a very symbolic quality. And, and that’s what I meant before in that I’d write down these dreams but I think like the point wasn’t real cerebral. I mean the therapeutic aspect of it wasn’t. There was discussion. I mean we discussed a lot of things. But like there was this cerebral, there was this underlying symbolic organic aspect that really kind had a really kind of had a nice positive effect [R: Yeah] that you couldn’t always put your finger on.

R: Yes, that’s the impression I’m getting. There seemed to be, you know, whether it be the therapist or the books, um, or your own work, it seemed like it was providing a guide almost like a light [R: Um hmm, um hmm]. But the work itself seemed like it occurred on this other level.

P4: Well, I think too there’s the talk level and there’s the meeting level and there’s just sort of like the interaction level. But like I think a lot of work takes place outside. A lot of work is on this sort of maybe psyche level or, or maybe even an ultra-symbolic level that like you can’t really put your finger on, which is really cool. I mean sometimes I think sometimes people just leave the session and they feel, they feel like they’re heard, they feel nurtured, whatever it might be. Eh, I think too the aspect of like somebody really paying attention to either, you know, hearing someone’s pain or just wanting them to get better or whatever it might be. I think that there’s, I mean you think that there’s, in some ways that’s inherent. But I think that kind of people don’t always think about that aspect [R: Yeah]. Eh, it’s interesting because I used to go see her and I’d leave there and then come here. I’d be sometimes seeing people myself. So, it’s really interesting to be kind of be doing your own work and then kind of be going into the situation where you’re, you’re like on the other side of the chair [R: Yeah] or on the other side of the table. So, that was interesting too.
R: I was curious too about, um, what was the depression like after therapy? What was the anxiety like?

P4: Eh, that’s a good question. It took a while. It took a good year or two for me to really get back to like feeling like I was before. It took a pretty long time. Eh, because I was tired. And then I felt weird because I wasn’t working full time anymore. And like I felt like a part of me had just like given up on sort of what had been like the defining characteristic of myself of work life [R: Yeah]. Eh, I think, well, the anxiety wasn’t as bad. I mean because like I’d actually dealt with it. And I was sleeping more and that kind of. I think in my work I’d gotten to that like ultra-stressed, sort of almost slightly paranoid, almost, “Oh no, what’s going to happen when the phone rings next time.” Because I was running a certain program that was horrifying to run. I will never do anything like that again. Um, so, I think there was this work quality that kind of, um, went away. So, I didn’t have to deal with that. But like I had to deal with adjusting to the idea that I was going to run my own show, which I’ve pretty much been doing since then. So, in a sense, the whole thing ended up being a good thing because it forced me to say, “I’m going to a, I’m going to run my own show. I’m going to do it. I’m not going to work for an agency anymore. I won’t have to sit in all these meetings. I’ll, I’ll work when I want to work.” You know, um, so I think that was positive in the sense of sort of having that, eh, inner locus of control aspect [R: Yeah]. Eh, just feeling better, not feeling so stressed, not feeling so angry, less argumentative with my husband, um, more energy like for him, eh, more able to enjoy things. Um, yeah, because that same level of anxiety had decreased quite a bit, although I’ve always had it. Like I said the cognitive behavioral stuff seemed to work better like in the past couple of years I haven’t really had that nearly to the same extent. I don’t go, “Oh my god, what’s going to” (laughs). I don’t seem to do that nearly as much. Um, let’s see, um, what I, I think sometimes with if I start feeling like too stressed or too tired or whatever I take a nap, I, I, I do a little meditation, I make sure I have time to do something fun. And, and that’s like protective. So, I’ve been sort of like trying to hold to that. I mean for, for like probably a couple of years when I wasn’t like at work or something if I was home before I had to pick up my son from school or something I would take a fifteen minute meditation [R: Um hmm], pretty much everyday. I like insisted. And I would like have the dragonfly there as a reminder. And I also like kept this bottle of Trazodone, the bottle, and I, I, I’d leave that in my cupboard as a reminder [R: Yeah] of this is what I do not want to do. I do not want to go there again, right, um, so.

R: It sounds like after therapy you really set up your world in a certain way that really
started working full time. And he got health insurance so I had a little more flexibility like to go and do things at my son’s school and stuff like that. It ended up turning out to be a good thing. It just took a while for me to start to see it as a good thing [R: Yeah]. So, in some way, the whole thing was a really good but a painful wake up call that kind of like made me go, “Oh my life can be different.” I mean I, I, I sort of took the, the, the difficult way down there and through it but it turned out well on the other side [R: Yeah]. Like there’s a light at the end of the tunnel kind of thing. Um, so it was. And, and since that time I’m real careful. I, I, I just don’t. And I think that’s learning to be older, learning sort of like to come into this different phase in my life as a parent, as a professional women and stuff like that, um, that I couldn’t do things the same way and that was okay [R: Um hmm]. That I learned lesson, I learned a valuable lesson and I’m very careful to kind of a, um, take care of myself and make sure that I have time for myself. And actually have more control over what is going on with me, eh, overall so that I don’t have to go through that again, knock on wood (laughs). I mean I’m not the same person [R: Yeah], I’m not the same person as I was then, which I mean I think is like a cliché. But I think that, um, I think we’re always changing, right, and growing. And it’s just sometimes, it would be nice if it wouldn’t have, if it wouldn’t have had to behave as such a storm and draught kind of thing, but you know, that’s life, right, so.

R: I do see that time is running down here, um, I was wondering if you feel there was anything that we left out today.

P4: Not for me!
A6.3 Master Psychological Text with Meaning Units and Central Themes

Written Description: Bold Font  
Interview: Regular Font  
Demarcation of Meaning Units: ||

| Demarcation of Meaning Units: || | Central Themes: Right Column |
| --- | --- |
| I was very tired, had low energy would sit at my desk at work, unable to function. I was very anxious, had stomach acid problems, was taking a lot of Tums and would wake up each night at 2-3 a.m. worried and not able to get back to sleep. I was constantly worrying about my job, what I had to do and I was also exhausted since I had a two year old to care for. I had had little time for myself or fun, and felt that I had to leave my child at day care, work all day, was very busy at work running a program, and then would come home, have to cook dinner, clean up. I had no time to spend with my husband and we were both tired, stressed, and argued a lot. I worried that I did not have enough energy to enjoy my son. I would sit and watch videos with him. I felt very negative and detached from life. ||
| P4 felt anxious and bodied forth such anxiety in her acid reflux difficulties. She worried about her job and experienced early morning waking at 3 a.m. P4 also felt exhausted and was unable to engage with work. |

| P4 was busy directing a program at work. She was also busy performing household tasks and caring for a child at home. P4 had little quality time for herself, for her husband, or for her two-year-old son, and consequently, she and her husband were frequently arguing. P4 felt negative toward and detached from her life. |

| I had so much trouble sleeping and felt so exhausted and anxious that I had to quit my job and go on medical leave. I started to work part-time. I sat on the couch and slept while my son was at daycare. I finally asked my Dr. for help. I wondered if I was entering early menopause (I was at 38) and she said no but gave me Trazedone 50 mg. for sleep. This helped a lot. I finally could sleep again and started to feel more positive. Later I went to see a psychiatrist who diagnosed me with Depressive Disorder but I continued to take Trazedone for about six to nine months through my M.D. ||
| Due to anxiety and exhaustion, P4 took a medical leave of absence from her job, and subsequently, engaged in part-time work. She continued to take her son to childcare to allow her to sleep when not at work. |

| P4 went to her primary care physician for assistance, since she assumed her symptoms could be explained medically. Her physician prescribed a tricyclic antidepressant to treat her insomnia, which she took for around six months. P4 also went to a psychiatrist who diagnosed her with major depressive disorder. |
I went back to a therapist I had seen before who had Jungian framework. (I also went to the EAP therapist who had a CBT framework). It was interesting since she said I was presenting with the same issues I had had previously.

P4: I had been to a cognitive-behavioral therapist at work for two sessions. I was too far gone for that. Cognitive-behavioral therapy tends to be very symptom oriented. I think seeing somebody who has like a Jungian orientation or a psychodynamic orientation probably makes more sense in the long run for not repeating patterns that tend to be a problem. I mean for me, it was very interesting because when I went to see this women. Am I sort of telling you more than you want to know? Okay, when I had gone to see this woman, I had seen this woman before. And when I went to see her again she had pulled out my files from when I had seen her ten years previously. And she said: This is the same stuff you said before. Which is very funny because I apparently hadn’t learned my lesson from the last time. And I had developed a pattern of superwoman and not being able to be superwoman, right. Thinking that you can expend all this energy without having some self-nurturing, right. So that was interesting from that standpoint of saying that well, cognitive-behavioral therapy would have helped, if I had done it earlier. And it probably would still have helped if she had had a little more of that. Because I think you need, sometimes you need both. I don’t think depth psychology is always enough depending upon the severity of the symptomology, right. But I think that depth psychology looks at a deeper level. One of the books that I read was, Descent...
to the Goddess. Are you familiar with that? Okay, I think for women it’s very useful, and probably for men too. But the idea of the depth, of the Descent to the Goddess is that you have to really go down there and look at the crap, look at your old stuff, look at the history, look at unpleasant things, things you don’t want to think about. And I think that the therapy from that standpoint with this particular individual was really helpful in kind of looking at the past, looking at a lot of things I really hadn’t looked at before at a depth level, which I think tends to ensure that you learn not to do it again, right. You learn, it helps you to grow but at the same time you learn not to go through that same process again or you learn not to put yourself in the position that got you there in the first place, which I think is something that I think a lot clients in therapy don’t do. They reduce their symptoms and then they just go and do the same thing again. I think sometimes, not always, but I think sometimes like psychoanalytic-oriented psychology helps you better to look deeply into yourself, which I don’t think other forms of therapy do to the same extent.

R: It sounds like your differentiating something that this therapy had for you like more of a depth-orientation than something more cognitively-oriented.

P4: Right and that’s what I think individuation is. I think a lot of therapy doesn’t really produce individuation in the same sense. I mean it can produce aspects of it. I don’t see adults in my work very much but when I do, it’s interesting how I can see from my own experience with this therapy and growing in general that I can see the path they’re on because I’ve already been down it especially woman
particularly. Where you kind of go, there’s an aspect, for women like a very caretaking model, a very self-sacrificing model, a very denying of certain aspects of yourself, which I think that for me the depth-psychology really looks at all those parts, right, and sort of honors those parts in a way that more surface cognitive level doesn’t, right. I think that’s another aspect of benefit of it at least for me. I can’t really speak for other people. I don’t know if you find this in your studies, but sometimes therapists and psychologists really should go to therapy. When I deal with younger folks who are talking to me about their work like when they’re therapists and they don’t do any personal work they get themselves in trouble. I think they really need to do that personal work even if they think they don’t have any issues, right. They will have issues that are brought up by working with clients and if they don’t deal with that I don’t think that they develop their practice well enough or their self, interactive self in the process if they don’t go through that process.

She diagnosed me with GAD (anxiety more based on dreams I had had).

R: What you said reminded me of something in your written description. You wrote that you came to see anxiety and depression as a reminder to take care of yourself and I was wondering what therapeutic work preceded that realization?

P4: Well, I was an anxious kid. I’ve always been an anxious kid. I don’t really, I think there’s some work I had to do sort of thinking about why that was. I mean some of it’s genetic. There’s a history of depression on my mom’s side of the family. I had gotten used to that

Her therapist assessed the prevalence of anxiety in P4’s life based off her interpretation of P4’s dreams that had an anxious quality. Experiences of anxiety were common throughout P4’s entire life and she came to appreciate the usefulness such feelings had for her awareness of her world.
because sometimes I think anxiety can have a very protective or useful quality for somebody’s academics. I mean there’s some use for anxiety for kind of paying attention to what’s around you and keeping yourself safe and not doing the thing that maybe everyone else is doing. Having a sense of awareness or awareness of what’s good to do and what’s not good to do. So I think anxiety has that kind of function. I think for me, because I still remember when I initially went to see this women for the second time, this time that I’m speaking about, this time that probably had more effect on me was that I told her about one of those dreams where you can’t find the classroom. You’re naked and you have to go take a test and you’re wondering around in the class, in the school hallway and can’t find the room and stuff. It was interesting because she said to me: sounds like an anxiety dream from that framework’s perspective. Then she said, “oh, you probably have GAD, right”. I thought it was fascinating that her supervisor would say to her, “Well, if you’re having an anxiety dream that probably means you have GAD.” I mean which ended up being accurate only to some extent. But most practitioners wouldn’t approach it from that. They’d give you a scale and they’d ask you some questions. They wouldn’t say, “Well, this dream says this and you’re probably anxious, right.” So, I still think it’s funny. I haven’t thought about that for a long time and I remember thinking that was really funny because at the time I was moving heavily into short-term therapy, cognitive therapy. I think I had just got my psychologist license a couple years before. So, I was loaded with research data: eight sessions is effective, you know. Just totally boom, focused on that kind of model, right. And I remember going, “Oh, this would be good.” That would be
really fun if you had to explain that to insurance companies, “Well, it was this dream that kind of told us she had GAD, right.” So, it was interesting because on one level I think she could have used a little bit more CBT. I remember thinking that at the time. And again being a practitioner in therapy you kind of go, “Well, well, you really should be doing this,” because I think that there really could have been some of those symptomatic reduction things used in the process, but as time went by it ended up being effective anyway. I remember thinking at the time with my very research oriented like quoting statistics mind, “Oh, no, well if it were me doing this, this is what I would do” as a practitioner. So to the anxiety part ask me again. ||

It was a bit harder, since I was more depressed and anxious than I had been before. || It was positive to work with her due to dream focus

R: What part of yourself was coming to view in therapy? What part were you not paying attention to?

P4: I think one time I had a dream that I was like Ilza of the SS or something in one of those Nazi dreams. I think that was one aspect. For me, I was not paying attention to the bitch part of myself. Because I’m one of these people-pleasing, pleasant, accommodating, oldest child kind of people. So I had to allow my bitch self to come through or my stronger self. It is what I would refer to as my stubborn Irish woman self. Let’s see, there also was a dream I had of going down in a swamp, like in a basement. It’s funny in a way because it’s so obvious at some level. In a basement sort of finding, archeological dig in a swamp in a basement where you’re finding all this yucky stuff that you

P4 found engaging in the therapeutic work more difficult during this course of therapy since she felt significantly depressed and anxious.

P4 appreciated the focus on dreams throughout the therapeutic work, which helped her develop a sense of personal and emotional complexity. P4 analyzed a dream in which she descended into a swamp-like basement and felt disgusted, as she did not want to look at the repulsive sites. P4 interpreted the dream to mean that she did not desire to acknowledge unpleasant feelings, and such a dream, like the depression, made her more aware of these. P4 analyzed another dream wherein she was a prominent Nazi figure. Such a female figure was powerful yet undesirable, and P4 interpreted the image to mean that she was denying the more assertive facets of
don’t really want to see and you’re saying, “Oh my God.” Being down at the bottom of the ocean and discovering all those creatures that live down there. I usually saw the house and I think it’s common as a dream structure that the house is yourself. So, I was down in the basement going, “Oh my God,” right. To me, that related to some aspect of the depression in the sense of having to look at crap you don’t want to look at, at stuff that’s buried, at stuff that you need to pay attention to be fully whole. So that’s one dream that comes to mind. It’s not quite a shadow dream but has aspects of needing to dig down and discover yourself more.

R: So, it sounds like some of the shadow aspects, like you were speaking of one that would be your more you were using the word bitch self, your more assertive self.

P4: Maybe female power in the sense that female power doesn’t have to come from being accommodating all the time. It’s interesting because I was having this conversation with my husband the other day. I just turned 48 and he’s 54. We’re saying, “Oh, we don’t put up with shit anymore.” We were discussing old friends and friends we don’t see anymore and how we are just unwilling to put up with crap anymore. So, for me some aspects of the therapy are more of a point of competence, of strength, of I don’t have to be nice to people I don’t like. Being assertive and saying, “No, I’m not doing that.” In a work life and in a parent life, it’s like I can’t do everything, I can’t take care of everything and I think that is sort of what kind of personality I had functioned with prior to this period where it was just like, “Oh, okay, I’ll do that or I can take care of this.” I can do everything without paying attention to my inner herself. As opposed to her previously accommodating style, P4 realized that she had the strength to say no and not engage in an unrealistic amount of work while also taking care of herself.
needs or to my health to some extent. I use the word bitch but that’s probably a little bit strong, in the sense of self-care, assertiveness, maybe that it’s okay to say no more, that I can’t do everything, that I’m not superwoman. I think a lot of woman have like this dichotomy way of thinking. I know friends who would say nun/whore, just a dichotomy where woman are either this or that. They’re a slut or they’re a princess. You know what I mean? There are all those terrible dichotomies that woman are taught as they’re growing up. And just to find a more personal and emotional complexity. There’s a strength in taking myself worts and all, which is what I think people have to do to survive and to grow. So, when I think about whether to be like, Nazi imagery or something that you associate with a very negative aspect of life in general or a swamp or just muck or ick, something that people would think of as negative. Like bringing that negative stuff into the awareness. I think sometimes without, I don’t know if I would think this in my work totally but sometimes you have to, the depression forces people to go down in there and that’s sort of the idea of the Descent to the Goddess is that you have to go down there to grow. And it’s interesting because if you look at myth because we’ve actually read some of these books to my son like sort of mythology books and there’s a lot of, if you read Joseph Campbell or whatever, there’s a lot of mythological aspects where women or men have to go through these trials and tribulations or female, I forget the name of the goddess, Innana is a Babylonian goddess and they’re living it up in the great beautiful sun and then they have to, or Persephone, and they have to go down to the underworld where everything else has survived. So, I guess you could in some ways see depression as some aspects

P4 thought that life transitions, like parenthood, and challenging experiences, like depression, call forth a personal, emotional examination and a descent into that which is undesirable in order to become better aware and grow.
of having to go down into your personal underworld so that things can continue to function.

R: I’m getting a sense that for you therapy on the whole was helping you to go down into the depths and one of the things you were finding was this part of yourself that was yearning to be empowered or assertive.

P4: Yes, I don’t know if I would have seen that without the depression. It forces people to take stock. If I have adults come into this office, they come down, they come in here, or they come to therapy because they’re hurting and they can’t stand it and they feel awful. And sometimes that’s the only thing for some people that’s going to make them go, “This isn’t going to work. I can’t live like this.” And I think it’s often those transition points in life where there’s a big change, job change, partner change, parenthood, whatever it might be that forces people, the stress of it forces people, I mean there’s obviously a lot of factors because not everybody goes through that. But I think that sometimes people have to, there’s like something that has to force them like a crisis or whatever like Joseph Campbell would say a challenge, a life crisis or whatever that makes people kind of have to stop and look at those kinds of things. So, that’s kind of how I come to view it. Not just “Oh, I have depression and it’s this pathology and blah, blah, blah.” I don’t try to think of it like that. When I see people in here I try to think of it as more of a positive thing. I just don’t think of it as, “Oh, someone has this disorder,” right. I think that’s a really limited way of looking at someone’s problem. That there’s probably more to that and if there weren’t other certain social factors,
environmental factors, stress factors, they might not have been put into that position.

R: So, it seems like your work with books or your work with dreams during therapy was a way to come to see things about yourself. I get the impression for you it was a coming to see things and

P4: Yeah, I think you talk about it in therapy and then I would go out and find books. For example, I forget the name of it now, but the book with the rabbit image. Reading some of those books open you up to a new way of looking at yourself that I might not have done before. I might have because my husband and I are pretty alternative oriented. My husband does tarot, he does astrology. He’s kind of some people call him a woo-woo. He’d always had books like that and we read mythology. Also, we thought of ourselves as fairly insightful. But I think when it’s applied to your own personal work it’s a little different. I mean I read books like that before in school. I’ve taken some classes and things like that. But I think when it’s your own, when it’s yourself, when you’re the study, when yourself is the study, it’s a little different.

R: You mentioned dreams. Were there any other dreams that stood out to you in the therapy?

P4: Oh that basement dream is the main one I can remember at this point. I think this is later in the therapy but there are different archetypal aspects of self like the croan, you know sort of the stereotypical ones, the croan, the young girl, the eternal boy. I think again being female if you look at it from the standpoint of the dichotomy. I think for me I didn’t really pay attention to my rough and tumble boy

When P4 presented dreams that she wrote down between sessions, her therapist did not over-analyze them, but questioned P4 about her feelings concerning particular aspects of or figures in the dream. These discussions stimulated P4’s interest and she searched for books to supplement the therapeutic work. The dreams as well as the books provided her with a novel perspective from which to understand herself.
self. That’s how I thought of it. And sometimes I’d have dreams about, like merging dreams, where you’re involved in some personal contact or some sexual contact with a character that’s not female. That’s like a different aspect of yourself or maybe even like, how can I describe it? I’d say probably like a merging dream where you kind of have to merge how you see yourself with some other aspect of yourself that you’ve ignored be it a more masculine aspect. I think I remember having some dreams of merging so to speak like that. But they weren’t sexual but sometimes you’d wake up and feel like it had that quality or that feeling of happiness or merging or a bonding kind of feeling. So, I’ve had, that’s another one that comes to mind, but not a lot of specifics on that one. The basement dreams is probably the most powerful one of, “Oh, look at all this stuff that’s down here that I haven’t paid attention to.”

R: And both of those dreams sound very interesting. The basement dream, when you brought that into the therapy, how was that dream worked with? How did you and her work with it?

P4: I don’t remember. She didn’t really over-analyze them a lot. I think that’s one of the nice aspects. I think she wasn’t really into over-analyzing dreams. I’d write down a lot of dreams. I don’t know where those are. I remember writing down a number of them in a dream journal. My husband keeps a dream journal and records it in the morning and stuff. He’s into like Robert Moss. Do you know who that is? He’s a hardcore dream analyst guy very different perspective on things. He has a Native American style, fascinating guy, a little out there but interesting. But some people think that within the dream you can go into the
dream and do therapeutic self-work in the dream itself or sort of like a lucid dreaming or shamanic type of thing. Anyway, I remember I had to write them down, but I don’t remember, and I’m sure there were some discussions of them. But not discussion in the over-analytic way, more discussion about how did I feel about particular aspects of the dream or like the main figure or something like that.

R: The impression you’re giving me is that the work with the dream is less of an analytic-meticulous looking at it and more of a how you felt toward the different aspects of this dream.

P4: I think that’s why I got really interested in some of those books, and again I wish I could remember the title of that book.

R: And with the basement dream it seems like the impression you got there was there were certain things that you needed to get in touch with, certain parts of yourself and

P4: I think if you read books about individuation from the standpoint I think that they usually think that there’s a part of yourself you’re not, I mean the shadow is probably one of the bigger concepts, although I think that’s unfair. I think they have more complex concepts than that.

You can’t just function in one limited box. But there’s other parts of you that may have been walled off or what’s the word I want, like if you look for the aspect of complex there’s something, is there something like, that’s what shadow is. Shadow is the main thing you can’t see because it’s too frightening for you to see it. It’s like, “Oh, I’m not like that, now why am I having a dream about a Nazi,” right. Do you know what I mean? That

When exploring dreams, P4 would initially catch sight of a facet of herself that frightened her or a feeling about herself and others that made her feel vulnerable. After session, this prethematic sense remained on her horizon. P4 would then experience an initially unpleasant feeling, cry, and at times, further articulate her thoughts and feelings. For instance, she would realize she felt sad and thought that others did not care about her. P4 would lastly feel a sense of resolution and comfort, and would feel a greater sense of movement throughout this therapeutic process.
aspect of walling yourself off from it and I think as you discuss these things in treatment and then you go home and you kind of carry that feeling with you outside of the session that sort of sense of movement. Because sometimes I’d have a session and then a day later or even a couple hours later I’d have this big crying jag and I sort of realized something that I hadn’t really paid attention to. That is what I’d describe as something. I’d go back in and she’d say something moved, right. It was interesting like something again internal, some emotional state that was kind of ignored for a period of time.

R: Was there anything particular that was coming to mind when you were thinking about, having a crying jag or having something move through you?

P4: Probably childlike-like kind of stuff like, the nobody cares about me kind of thing or self-pity. I think sometimes it’d have a really negative quality at first, getting those feelings out, although I couldn’t always say exactly what they were. It’s like a sadness and at the end coming to some sort of resolution after it was over, like a healing a saving. I don’t know? That’s a good question.

R: The picture you’re painting of the therapy seems like you might initially see something in a dream, it might have a frightening aspect, but then the emotion begins to move. And when it begins to move through you, you might experience some sort of sadness initially and then you engage in a healing process.

P4: I think the dream aspect kind of like comes. I think there’s a sort of an emotional quality that people have when they wake up. Because often times I wouldn’t feel sad when I’d wake up. I
think the sadness was more like an internal state that maybe was set off by the dream to some extent. But I don’t know if I really connected those two. I suppose that you’d kind of like allow yourself to be open. Those dreams would sort of open up your psyche to some extent so that you could have those experiences, although I don’t know if I associated them as strongly at the time, right. I mean I don’t know if I saw them as one thing. I think I tended to kind of compartmentalize them a little bit more. That’s an interesting question.

and [it was positive to work with her due to] our focus on a figure. I picked a dragonfly since it seemed to be a symbol of my need for change.

R: One of the things that was coming across to me when I was reading your description was your writing about the dragonfly as a symbol for your need for change. I was wondering how that work with the dragonfly helped you.

P4: I think the woman that I was seeing had a Jungian framework, not an analyst. But she had been doing therapy for a really long time and I think still does. It was interesting because in her office she had several shells and sort of organic type things. It’s interesting because I can sort of talk about it from the standpoint of how I reacted to it, but then it’s hard not to step back because I read a lot of Jungian stuff too. There’s an idea of focusing on some kind of totem as a symbol of transition. I think she had a crab shell and things like that that seemed very, I forget the name of the book. But I think sometimes in the dream symbology there’s often one image or one totem or one animal or whatever it might be that sort of symbolizes the self perhaps. So, I tended to think of the

P4 appreciated the therapeutic focus on a particular symbol. Her therapist had organic type items throughout her office and P4 found herself prereflectively focusing on a specific figure. Later in therapy, P4 articulated the way it had represented her need to change and to accept change. In particular, P4 felt emotionally unprepared for the difficult transition from engaging mostly with work and leisurely projects to also caring for a child. The figure was also a symbol of hope when she felt significantly depressed. After therapy, P4 adorned herself and her home with the figure to remind herself to allow change.
dragonfly and I didn’t think of it initially because I think I wasn’t able to step back from it because I was in the process but the dragonfly is a really cool animal because of all the changes that it makes. I’ve always liked dragonflies, but I think that when I was in therapy that was the thing I focused on when I was going through the process and as time went by I was able to see that the dragonfly represented all of these changes, because it has so many life transitions. I think it starts in the water and then moves into the air and it sheds these various carapaces and things like that. So, I came to see it as a symbol of what I was going through because at the time when I was doing this particular therapy that was like, god I think I had seen her in the, I had seen her when I was around thirty because I was going through a similar thing but more like related to work, and then after I had my son about two years later I was sort of going through I think sort of a post-partum kind of depression. But, I think, probably because of hormonal stuff. But I think I am also a little more susceptible to depression because it runs in my family. But the interesting thing was that I was going through a change as a parent and that was a first. Having to take care of somebody else because I had waited a long time to have a child until my late thirties. My husband and I were like punks and we were kind of like, “Oh my god.” There’s a t-shirt that says, “Oh my god I forgot to have children,” So that was us. I was in a band and then I was in graduate school and then we bought a house and then it was like, “Oh, we’re going to have a kid now, oh, okay.” So I really hadn’t prepared myself emotionally for all those changes. So, I saw the dragonfly as fitting my changes from an independent person, a person who saw herself mostly in terms of work and in
terms of fun stuff and sort of changing to a parent. And I think that’s what was difficult for me as a transition was going from somebody who only had to take care of myself to someone who had to take care of a child and then do all these other things a lot of professional woman do and trying to balance out those things. So, that’s sort of how I came to see the dragonfly as it being okay to change as the fact that all these changes were very natural and that as a point of acceptance of that change.

R: Yeah, it sounds like the dragonfly had this organizing power for what you were going through.

P4: And at the time I think I was just looking on something to feel more positive about because I didn’t feel very positive at all and it was like an incredible crisis point and it was pretty bad. I think it was one of the worst, was it the worst, yeah it was pretty bad. I was at the point where I had to leave my job. For a period of time I had to go on medical leave and stuff like that. And I was like flat. It was serious, right. I think it was sort of a symbol for hope in some ways too. Actually it’s interesting because I carried that image of the dragonfly since then. I have dragonfly earrings. I have some in my bathroom. It’s a symbol that I carried as a reminder of the need to allow those transitions, and be gentle to myself about it. So, it ended up being a very powerful symbol and I’m thinking that there’s a, I forget the name of the book. There’s a book, a Jungian analysis book. I forget the name of the guy, a pretty well-known analyst from the forties and it’s about a lot of different things. But there’s an image of a guy who’s using the dream image of a rabbit. Are you familiar with that Jungian study? But I think there’s always one
powerful image, symbol, whatever you might want to call it that kind of carries people, like a transition object. I don’t know, whatever you might want to call it. So I sort of tended to see the dragonfly that way.

R: Yeah, I’m seeing that it was organizing and it captured something for you also like a change orientation, there’s something positive about it too.

P4: Right, and I think that sometimes people can know cognitively what they’re going through. Because I had been through, eh, like I think went before I went to see this women. I waited too long because I was crazy busy with all the different things I was doing and I’m superwoman and I can do all these things. And I waited too long to see that I couldn’t do all these things at once: be a parent, and work full time, and do all these things, and without some damage to myself.

I have tended to be someone who takes on too much and then gets anxious—I think that I didn’t realize that I could not be “superwoman,” a parent, and work all day. I had waited too long to get help.

R: Yeah, so that’s what it was then, the coming to see that you couldn’t be superwoman and you were trying to be superwoman again.

P4: I still remember I had to go and see a psychiatrist. Well, I went to my family doctor and said, “I can’t sleep. I can’t function like this.” And I ended up taking Trazodone, which knocks you. It’s like an old style, old line antidepressant that knocks you out. And it was like, “Oh, I’ll be able to sleep again.” Because I was

P4 started a new job when pregnant. She was directing a program that necessitated a lot of local travel and working another part-time job as well as performing household tasks. When her child was born, P4 was also caring for her son, and she felt anxious due to the amount of commitments. Years later, P4 realized the extent of her dysphoric feelings and that she could not fulfill all her engagements.
having that 3:00 a.m. waking panic like, “Oh, the world is terrible, this is awful, everything’s horrible, kind of thing.” I remember the psychiatrist said, “You waited too long.” And I’d say, “I tried to be superwoman.” And he was shaking his head. He’d seen it probably a hundred of times before. Which is funny now, but I still remember leaving his office and going, I said to him, “I must be feeling better because I was singing in the car again.”

R: And you wrote about in your therapy too coming to realize you were trying to be superwoman again.

P4: Yeah, it’s interesting because I’ve sometimes thought there’s was some kind of bipolar quality that got triggered by hormones, pregnancy hormones or something because I felt like I was superwoman through most of my pregnancy because I had just started a new job, which was really stupid. Looking back on it I would have never have done that if I had known what was going to happen. I was running this program I developed and I was like running all over the place. I was working part-time too. I just liked to do everything so I used up all my pregnancy energy running all over the place. Then after my kid was born it was like (makes a sound like a building collapsed). But it took me a year of trying to do everything before I went, “Oh my god. I can’t do this. This is really bad.” So there’s a post-partum quality to it. There’s a depleting self aspect and realizing that you can’t do everything. I think for me it’s interesting because of one of the things I learned about being a parent was that I can’t do everything. I can’t go home and do X, Y, and Z and take care of the kid and have worked all day and then I can’t sleep. You know

As she integrated her perception of parenthood into her sense of identity, P4 came to realize that child-care required self-care, and so she learned to end certain engagements and to share responsibilities with others.
what I mean. You can’t do all those things. So I learned to share it out a little more. I decided there’s a three prong thing with kids. You spend some time with your kid, you send your kid to daycare sometimes, and you have other people to help you. I think people have to learn that about parenthood, about motherhood, about not overdoing it, not thinking you can do everything without help. And also a change of life, your sense of self changes so much as a mother or a father that you have to incorporate that aspect too. And it was sort of realizing that if you don’t take care of yourself you can’t take care of your child. The only way to have a healthy life is not to do everything you’ve done before, some things have to go

I read Descent to the Goddess again, and some other books as well.

R: You mentioned Descent to the Goddess and other books. How did those help? How were those taken up in your therapy?

P4: It’s funny because I had a very low point of energy at first where I just felt like crap all the time and I was tired. And it took me a good long time to move out of that phase. Once I started to move out a little bit, well, the interesting thing about Descent to the Goddess is, it says that it values depression as a way of looking at self-issues. It doesn’t just want to eradicate it. Some of that particular style of depth psychology seems to honor the fact that you have to go down into the pit. I mean you have to go down really far into yourself and see or feel crappy and deal with that aspect of your psyche in order to grow which I don’t think you would hear that in a lot of other systems because most people think, “Oh, depression is bad. This is horrible. You

P4 read books throughout therapy. The premise of one particular book she read concerned valuing her depression and suffering as a way to understand more about herself and grow. The book continues to stimulate her thought and her own work with clients.
should take a pill and then you’ll feel better.” And some need it. I think I did end up taking an anti-depressant at that point because I couldn’t sleep. That was bad. I mean I had a kid. I had to go to work. I had to do that. I think that the Descent to the Goddess, and I think there’s other books that had a similar style, is that it’s sort of like there’s not a madwoman in the attic aspect but like, it’s very Greek tragedy oriented. You find figures where women have to go raging in the woods lost, almost like an insanity is some benefit to find yourself. Does that make sense? I don’t totally agree with it. I think there’s some value in it that I think people have to go through stages of dealing with grief or sadness or anger or depression to find themselves to some extent or, to grow and develop, to individuate, to find the wholest or most full of yourself. I think for me that makes a lot of sense because that’s something I still think about even though it’s been, boy how long has that been, seven or eight years. It’s something I also use in my work. Because it’s sort of a path that I went down and it makes it easier to guide other adult females through it to some extent. It’s like a frame, a template to use to see people going down that path.

I began to realize that I couldn’t “run” things at work, be a parent and still have a fun life without getting over-stressed. I had to realize that my life of full-time work was over to some extent. I began to work part-time, focus on my private practice more, have a flexible schedule that worked with time for my son, for my work, and for my husband.

R: I got a sense that in your description where you were writing that there wasn’t enough time for your son, there wasn’t enough time for your husband, you

P4 realized that she could not possibly direct affairs at her full-time job and care for a child while still attempting to participate in enjoyable activities without feeling significantly stressed. P4 thus focused on her part-time private practice work, and constructed a flexible schedule that allocated adequate time to engage with work, with her husband, and with her son. P4 also built time for herself into her schedule, which initially consisted simply of being without commitments; e.g., sleeping, listening to music.
weren’t having as much fun as you could of with them. Are there any examples of that change where you were having more fun with these significant others?

P4: Well, I quit working full-time. I mean I think that was the main thing. I think my son was in day care to some extent. So even though I felt kind of bad about it, I’d just stay home and sleep. I would go and put on music and I would sleep for a couple hours until I had to pick him up. And I felt bad about it. But it was just like if I don’t do this I won’t be able to take care of him. Well, it wasn’t like I couldn’t take care of him, but I didn’t need to be anymore depleted. So, I would just sleep. I went through a period where I was cocooning. It reminded me of something a professor of mine had said in graduate school where he said he went through a year in his back yard where he just like sat there, digging things or going into this almost vegetative state. So, that’s sort of what I felt I did. I just played. I started to not have to do everything all the time, not looking at my watch all the time, that kind of thing. Just time to vegetate, just time to sit, time to listen to music and just read or lay on the couch. Because sometimes when you have a small child you go from having all the time in the world to not having hardly any at all, especially with a young child. So like having time to myself which I hadn’t had really done because I was always working or I was always picking up my son or I was cooking dinner or I was just doing everything. So there was no time for me. I had to build that in. I had to realize that this has to be a priority and I have to build that in or I won’t be standing.

R: What was striking me was an interrelationship there. So, you were developing a time for yourself, a time
where you’d be able to read, a time where you’d be able to play, a time for self and

**I looked at my guilt about my life overall, and came to see the difference—anxiety and depression as a reminder to take care of myself.**

R: I was wondering about you seeing depression and anxiety as a reminder to take care of yourself and

P4: Depression yes, anxiety no, I think for me the cognitive model works better for anxiety. I think you can look at what the reasons might be that you are anxious but I don’t think they’re all based in childhood. I think some of them are just genetic and neurochemical. I think for me and rational. I think there’s a cognitive model type strategies you can use too to reduce that. So, I’ve found that using what’s the worst thing that could happen is sort of the standard treatment like Beck type model works much better for me for anxiety. I also think if you’re individuated and if you’ve come to accept yourself and like yourself and all your aspects that there’s much less reason to be anxious because you’re not going to be. I think there’s a very childlike quality sometimes to some anxiety that’s like: I’m going to be found out and punished. I was raised Catholic so I think depending upon whether you’re raised Catholic or Jewish I think there’s a very guilt oriented model that operates from when people are raised to some extent and that’s something they sometimes have to conquer. I suppose there’s some aspect of self-acceptance as a way of reducing anxiety of accepting your whole self or your fuller self in all its aspects that you’re fine, you’re going to do well, you’re not going to be exposed like someone who doesn’t know what they’re doing whatever it might be. But I

P4 found after therapy through her readings and practice that cognitive therapy techniques (i.e., Beck) helped to decrease her symptoms of anxiety. P4 thought that psychodynamic therapy could reduce anxiety through the development of self-acceptance, since her experience of anxiety also related to feelings of guilt and the fear of being discovered and punished.
think in terms of actually reducing aspects of anxiety I found the cognitive strategies more helpful in the long run I think than the psychodynamic. 

R: I was curious too, what did that realization about depression look like in the therapy? You wrote about something that seemed like a big realization for you about depression as a reminder to take care of yourself. How did that come about in the process of therapy?

P4: I think that that’s true in general. I think sometimes if you look at it from a multifactorial standpoint there are a lot of reasons that people sometimes get depressed. I mean it’s biological, physiological, there’s stressors, there’s people not getting enough help, people thinking that they think it’s much more common for women who I think tend to kind of allow themselves to get into that position more. From the therapy standpoint, I think it was more of the aspect of if you look at your full self or if you look at depression as a reminder. I think in some aspects, one of the aspects that I would think about with the *Descent to the Goddess* was that you’re not paying attention to the dark side. You’re not paying attention to stuff that you don’t like about yourself. I think that sometimes people, I mean absent all the other factors, you get dragged down there because you need to be dragged down there. I don’t think that’s a common viewpoint. Among other people, people other than people who have that orientation that you’re going to end up down there because you haven’t been down there. Because you’re up here on top in the non-shadow part. And that there’s this whole other part of you that you’re not paying any attention to. 

P4 came to see her experience of depression as a reminder to take care of herself, and in general, as an indication to attend to herself in the fullness of her being.
(I can use this now: going with the feeling and letting emotions more through you, instead of overanalyzing help).

P4: Another aspect of it was that the idea of sitting with the feeling because I think a lot of people tend to be very afraid of feelings especially intense sad feelings. I think people tend to push those things away or do whatever of the Freudian defense mechanisms because they don’t want to feel pain especially emotional pain. So, one of the useful things from that therapy for me was the idea that you would sit with it and feel it and experience that feeling and see what information it gave you. I think one of the phrases that the woman I saw used was, what does it teach you or let the information come to you from a feeling, a body-feeling sense that can kind of either tells you of where or what the origins of some of those emotions are, or how it feels to allow them to move through you. That’s the feeling, in fact that’s actually, like that’s a phrase sometimes I use in my own work to say, “You got to sit with it and you have to allow that feeling to move through you and not be afraid of it. And if you have to sit there and feel really crappy that’s okay because you’re going to learn something from that.” It’s going to take you somewhere emotionally that you might not have been willing to go before. I think there’s a very healing quality to that. Whereas I think what I’ve seen here in my office sometimes and probably in my own experience when I think people are very sad and crying and they’re at that real low point, often people are very embarrassed by that, they’re very uncomfortable with exposing that or feeling that way. But I think that once they go through that, it’s very healing. So, what I would do once I kind of got used to that idea, and I think

| P4 initially felt anxiety and shame concerning her experience of certain feelings like sadness. Her therapist instructed P4 to allow these feelings to move her after an event and to be curious about what the feelings taught her. P4 therefore arranged a time and place to attend to her experience of feelings when needed, and she found this process cathartic. She would further discern their psychological significance for herself and her world. |
|---|---|

| 458 |
that’s something I hadn’t seen when I had seen her previously I think that was kind of new at least for my experience of it. What I would do for a good time after and I still do this sometimes is I would go sit somewhere like in a park or something and just allow that time to occur, go down within my emotional self to see what was there. It has almost like a cleansing aspect. I don’t know, if you’ve ever seen Broadcast News where Holly Hunter sits and cries. It’s sort of like that but I think it’s less shallow. It’s just time for yourself, time for analyzing. So, that was one aspect. I still do that a lot and I found it very useful in my own life in listening to myself because I think sometimes in our culture we don’t allow time to listen to ourselves, we don’t allow time to experience emotions fully, we’re afraid of sadness, like we’re supposed to be all: he, he, he. We don’t allow some things to, one of the terms she used was move. You have to let something move. That sort of fits with something I was saying before that you have to let that emotional state move through you or if some event occurs in your life you have to allow that state to have an effect, be it someone you ran into or an old friend or some fight you had with your partner or whatever it is. Moves the psyche, almost like the psyche is malleable, sort of in the transference sense. Are you guys big into transference, because most people aren’t big into it. Most people probably think it’s crap. They don’t, they just think that’s some weird. I don’t know what they think it is. They just think it’s bullshit, right. But that transference aspect fits in with the movement that there’s almost a psychic communion or communication between therapist and patient or the patient or that any individual might have when they deal with people in their life or elsewhere. And I think you get sensitized to that

Her therapist interpreted some of P4’s more fantasy-based reactions as stemming from the transference and P4 made thematic her feelings at these times. P4 found such work interesting in light of its significance for the acquisition of self-knowledge.
transference. And that’s also a point of information not just in therapy but when you deal with anyone else. That would probably be another aspect and it sort of fits with the moving aspect and the emotional awareness aspect: transference and what it can teach you, right, not just about a client that you are working with but about yourself. I’ve always found transference fascinating. This woman I saw was the first, I think when I saw her the first time it was the first time she, that someone had ever said to me, “That’s the transference.” Like if you had a reaction to somebody if you’re mad at somebody or discussing the fee or whatever it is in your work, in your therapeutic work. I still remember her saying to me, “That’s the transference.” Because it sort of feels like butterflies or anger. I mean and it’s fascinating, but no one analyzes it. I’m sure there are plenty of books where people analyze it, but my work even with the kind of experiential counseling program I went to transference wasn’t discussed I don’t think. So I think that’s another aspect of like depth-psychology where you kind of have to pay attention to what that information tells you as an individual in therapy or as someone who does therapy. I think that that’s been real useful. I mean because sometimes I can remember one time when I was doing therapy way before this because I’ve done family therapy for like fifteen years. I remember I could sit sometimes with people say a parent and child who were like very contentious and I still remember one time when I knew that the mom was going to flip out and leave the room and she did. Like you know, again that brings you information in your therapeutic work as a practitioner and also in your own therapeutic work as a patient. I still remember I’m like, “She’s going to get up and she threw her hand down on the table
and leave.” Yeah that’s just what she did. I’ll be damned. Or if you’re dealing with someone who’s a borderline, which I don’t other than the parents, I don’t treat borderlines. But I’ve treated borderlines in the context of treating their children and you can tell when they’re going to blow. You can feel it, so there’s that sort of again self-awareness in dealing with again your own issues and in an interactive sense your body will tell you what somebody’s going to do. I think that depth psychology is much more useful in supporting the use of that or teaching the use of that than sort of what’s in vogue now.]

**It took about a year to start to feel like “myself” again—more energized, positive, and hopeful about the future.**

R: I was also wondering about something else. What was striking me in the description was you writing about feeling exhausted and tired before you entered therapy but after the course of therapy feeling energized again. And I was wondering if there were any instances concerning this change, this more bodily change.

P4: I think some of it had to do with medication and getting more sleep. It took a while. I saw her for like a year. It took a couple of months I think before I started to feel better. Because I think I was a little resistant to it. I was like, “Oh god, do I have to do this again.” I sort of didn’t want to go through it. Understandably a lot of people don’t want to go through that process. I think it was a feeling that it was okay to feel like this and that it wasn’t the end of the world and that I could make the changes I need to make. Because I had to leave, I had to quit my job, which was good in a way. I

Before therapy, P4 had felt moderately depressed, but toward the end, she felt better. At the beginning of therapy, P4 came to accept her experience of depression, and to trust that she would feel better and could make changes to this end. In this way, P4 felt hopeful by the end of the work. She also felt more positive about her life and less of a sense of depletion, as she had quit her full-time job. P4 felt more energized too in light of her only working part-time and taking an antidepressant that helped with her insomnia.
started working part time and actually I still do that. I still do consulting and work part time. So, that turned out to be a really good thing, at the beginning it was like, “Oh my god. I can’t do this. This is what I’ve always done.” I was sort of clinging to my old way and not really wanting to let go of that. I think it was when I started to see that it was okay, that I would feel good again. I mean I think one of the difficulties is sometimes with that kind of therapy when you go down into those low places you’re thinking you’re not coming out and you have to allow yourself to know that you will come out. I think that took a little while. Because sometimes I’d leave there in the beginning feeling like crap and I would be like, “Oh my god.” I think too it was spring. I’m thinking to that it was spring or something like summer. I think the seasons changed, I was feeling better, I was getting more sleep, I wasn’t working, I wasn’t depleted to the same extent. I can’t exactly say when that occurred, I don’t know if there was a defining moment per se. It was more gradual. It took a while.

R: It sounds like a gradual change at which point you were feeling more energized.

P4: Right, it took a while though. I was pretty far down there. It was like a moderate depression. I still remember when I decided I couldn’t work anymore. I would just sit there. It’s like the classic you just couldn’t move, you couldn’t do anything. It was bad.

R: From what you were saying before, it sounded like there were different phases of therapy. The first phase where you were more exhausted and less energized, and then another phase
P4: I think I was ready to talk though. Because I think I was ready for her to hear me. I can’t remember, well, I think even though the first or second session is when she said to me this is similar to what you said before in your previous therapy. And it was worse, right. So, I remember laughing. I mean it must have, I mean I think there was an insight aspect where I was like, “Oh my god did I do this again?” Because she had read me a description of something I had said or maybe a form I had filled out the first time and it was the same stuff. I said, “Oh my god, right.” I did this to myself again and I made it worse. It’s worse than it was.

R: So, for you, it seems like a realization of the continuity between this course of therapy and your previous course of therapy.

P4: Right or a pattern of behavior that changed to some extent but hadn’t. Well it had but it, I mean it’s like not taking stock of all the stressors and the fact that I couldn’t do everything.

My therapist was open about her own life and had a less “medical model” style, less psychiatric approach to therapy that was very different from the approach common now.

R: That’s what I was wondering about too. What was your experience of your therapist’s presence and the therapeutic relationship like?

P4: She’s kind of a wild character. She’s very open like. Especially toward the end of my therapy because she knew that I was a psychologist, so she would tell me stuff about her own personal work, which usually you don’t see therapists doing that.

The therapeutic relationship consisted of a felt bond between P4 and her therapist. P4’s therapist had a more eccentric demeanor and had a less medically oriented or authoritarian approach. On occasion, her therapist made personal disclosures, such as revealing the news of her mother’s death most likely during a discussion about parenthood, and these seemed appropriate at the end of therapy and after their chance meetings in the community.
And I, not in the beginning, but we’d been friends, not friends, but we liked seeing each other off and on. I’d see her at art shows. She’s a very alternative character in some ways. She’d even tell me about when she was having a rough time, but not a lot. But that’s very rare for therapists to do that. She didn’t have the blank wall, kind of what I joke about in here as that, “Tell me about your feelings.” I really despise the sort of blank slate form of therapy. I mean I suppose maybe for borderlines it might work. But I don’t think it’s really an honest way of communicating with someone. Especially because they’re in here spilling their guts to you and you offer them nothing in return. It doesn’t seem right to me. I think she was, I don’t know. We had a nice bond.

R: Yeah, so there was a bond there.

P4: Yeah, and I think I learned a lot the first time and so the second time it made sense to go back to her, right. And I think a lot of people do that. I mean I’ve had people here that have come back a couple of times for what I call a tune up. I call it a tune up. I think because you already have that relationship established. And I think it was interesting and I think there’s a very nurturing quality to it. One of the interesting things about her was I think she, I remembered her mother had died. I remember her telling me about her mother dying, which was very interesting. And I don’t remember what the context of it was. I think she was having a rough time in terms of that or her mother had died when she was young or something, which is something therapists don’t usually tell you. It wasn’t like my mother had died or anything like that but I really don’t know what the content was. Probably a lot of nurturing discussions and discussions...
about parenthood. She always found it interesting that I treated kids because that’s mostly what I have done in my career. She found that really positive, which was good because at the time I didn’t always think of it as positive. I’d think of it as, “Oh my god, could you imagine.” Sometimes I would go to my husband and I wouldn’t tell him details, “Oh my god you won’t believe what I heard today,” because sometimes like you just hear this horrible stuff.

R: When she was sharing stuff with you like her own personal experiences, what was that experience like for you?

P4: Oh, it was a little odd at first because of my orientation. Because I don’t share, I share some personal stuff, but I don’t go real deep in. Because that’s not how, even though I went to a hippie group process experiential program, you don’t really do that. I mean you have to watch that. But I think we’d known each other long enough and we’d see each other occasionally out in the community because she lives in Y where I live. So, I’d see her out and we’d chat and stuff like that. Not like we were friends, but we were acquaintances almost outside of that. So, I think it was easier to accept that from her. Here’s an interesting thing. I think she’s probably the first therapist I ever met who said they feel that drinking takes people into that same dark space that people need to go to. It opens up a lot of emotional stuff, which I don’t think you’ll hear too many therapists say that. I thought that was interesting because it’s a very different orientation than the blank slate. I know best kind of, you know, limited dialogue. I always thought that was kind of interesting. Because I think there’s some truth to it that sometimes they drink, they probably drink to medicate and therefore they go
into this space where boundaries are relaxed and stuff, inhibitions are loosened. So for some people probably for them drinking is a way for them to get to that point where as they wouldn’t be able to otherwise.

R: So, it does seem like there was a bond there.

P4: Yeah, she’s an odd woman in some ways, which is funny because I’m very open minded and a left-wing, arty type, punk. I mean I know lots of alternative people. She was really into a lot of alternative, a lot of interesting alternative stuff. I can’t say, I don’t know if I had warm feelings toward her. Because sometimes with transference, sometimes it was a little bit prickly. So, I don’t know. Yeah, I mean it was very useful. I still have a lot of affection for her. But I can’t say it was like, how some people get so caught up in the transference that they can’t see anything else I, wouldn’t say that that was true for me. She was a very interesting woman.

R: Yeah and there was work with the transference in therapy. You remember instances of transference work.

P4: Sometimes, it’d usually be about money for some weird reason. I remember one time she said to me, “You didn’t give me the check.” And I was like, “Oh.” For some reason I got mad at her and I’m like, “Well, I always give you money, what’s the issue?” Because sometimes transference comes out in really weird ways. I think being heard, especially since I’d been so besieged by these other things. And my husband, he and I were doing a certain amount of arguing at that point because I think we were both stressed with being first time parents and

P4 sometimes felt angry and reacted firmly regarding issues with the fee. She identified her reactions as emanating from the transference relationship.

Her therapist had an attentive and caring presence. P4 sensed that her therapist understood her suffering and that her therapist was nurturing and guiding her. Their therapeutic discourse centered on dreams and symbols, yet P4 thought the
all these changes. And my husband was working in Z and he hates driving. And he was like, “Oh god, I hate Z.” So we were both miserable for a while. What was my point? I had a point there. Because you were asking about her right? I forgot what I was going to say, something about stressors, sorry. It’s gone. I’m trying to think of anything else about her per se. I think she was like really good at, oh, oh, transference, I think too in the sense of like nurturing somebody guiding me because we had had this relationship before. I think the thing with the dragonfly like I think that was a point where I allowed myself to get focused on dragonfly aspect of it. Instead of her staying to me, “You need to change.” It was easier to look at this image of change, this dragonfly. I think I remember that when, I don’t know if she specifically told me to pick out one of these images, but I just think she had them out there and I remember focusing on one. And for some reason I think after that there was a little shift for me where I could start to see the light at the end of the tunnel a little bit. I mean it wasn’t real overt and it wasn’t real cognitive or anything. It was very symbolic. So, I think that aspect of the therapy had a very symbolic quality. That’s what I meant before in that I’d write down these dreams but I think the point wasn’t real cerebral. I mean the therapeutic aspect of it wasn’t. There was discussion. I mean we discussed a lot of things. But there was this cerebral, there was this underlying symbolic organic aspect that really had a nice positive effect that you couldn’t always put your finger on.

R: Yes, that’s the impression I’m getting. There seemed to be, whether it be the therapist or the books, or your own work, it seemed like it was providing a guide...
**almost like a light. But the work itself seemed like it occurred on this other level.**

P4: Well, I think too there’s the talk level and there’s the meeting level and there’s the interaction level. But I think a lot of work takes place outside. A lot of work is on this psyche level or maybe even an ultra-symbolic level that you can’t really put your finger on, which is really cool. I mean sometimes I think people just leave the session and they feel like they’re heard, they feel nurtured, whatever it might be. I think too the aspect of somebody really paying attention to hearing someone’s pain or just wanting them to get better or whatever it might be. I think that there’s, I mean you think that there’s, in some ways that’s inherent. But I think that people don’t always think about that aspect. It’s interesting because I used to go see her and I’d leave there and then come here. I’d be sometimes seeing people myself. So, it’s really interesting to be doing your own work and then be going into the situation where you’re on the other side of the chair or on the other side of the table. So, that was interesting too.

**Looking at dreams and images was very helpful, writing them down helped.**  
**Write some poetry to increase my love of music again. Previously, I had used dream images to write songs when I was in a band.**

P4: Because I used to be in a band and I didn’t have time to do music anymore. I got sick of rock and roll, which is funny because I thought that was something I’d never get sick of. I played drums and stuff like that. I’d been in a punk band for a long time. I started to have time to pay attention to those things again.

P4 had played in a band for about a decade and wrote songs that espoused feminine strength based on images from her dreams. She had also written poetry. During and after her pregnancy, P4 no longer engaged with music or creative writing to allocate more of her time for childcare. Through therapy, P4 articulated the way this choice was informed by her ideal of the self-sacrificing mother, which was based off her experiences with her own mother. Her therapist also highlighted that her well had run dry and P4 understood this to mean that she was not nurturing herself. She started to allow time for writing down
R: Through the process of therapy, you were developing time for yourself and you got into music again as well.

P4: Well, I was in a band for a long time. It’s interesting because when I was first in the band the first time I went to see her we had made an album. We made a couple of albums of indie-type albums. I used to write songs, and I like poetry, inner girl poetry or a political kind of thing. And I had a song. And it ended up on one of our records. And this was an image I had used in therapy before where I was like, it’s like a face but only it has a whole bunch of eyes. It’s a common, sort of mythological symbol. And I had seen that symbol as like awareness to some extent or that’s sort of what I came to think. I remember the woman thinking this was so cool. Oh, this is really cool. I had made a drawing of it one time. And like I think it was a dream image actually because I used to use dream images to write songs all the time. I didn’t write a lot of songs but the ones I did had that quality about goddesses and muses. I’m a feminist, so I had that quality. And I think later on I started to pay attention to that side of myself again. Because I had to shelf it. I had to retire. My girlfriend and I both got pregnant about the same time. She was also in the band and we just had to retire from being punk rockers and from being women musicians. We had to quit doing that. We’d done it for ten years so that was a big change and I guess I started to allow myself to have time to write. I had had these dreams and I’d get up and write them down in the morning and sometimes I’d try to make songs out of them. Just to revisit, regain that part of myself. I had to put these parts of myself. Another aspect of this is I had to put these parts of myself aside or at least I thought I did. I thought I don’t have time for this anymore. I think her dreams and poetry, which stimulated her love of music and creation of songs. P4 reconnected with this more creative facet of herself and reintegrated such engagements in her life.
it was my image of what I thought parenthood should be. Probably similar to maybe self-sacrificing parent, you know, mothers of the fifties and sixties. Because my mom didn’t work outside the house, never went to college. But very bright, read all the time and wanted us to go to college and stuff. And I think when I became a parent I think I adopted some of that aspect of, “Well, I have to put myself aside.” It’s like, “No, you can’t put yourself aside.” It’s really dangerous to put yourself aside or to put things that you love or aspects of life that are important to you aside, like music, like spending more time with friends, whatever it is. You don’t necessarily have to give up, when you become a parent you don’t have to give up everything that you already had before. Maybe you do for the first couple months or something because you’re pie-eyed. But for me, it was like I had to regain. So, I was reintegrating and regaining parts of myself that I had shelved. And I thought, “Oh I can’t do that anymore. I’m too old. I’m a parent now,” which is absurd because I don’t think I would have thought that before. Part of me is like I can do all of this. And then it’s like no I can’t do any of this because I’m either too tired or I don’t have time or whatever, so, reintegrating.

R: Yes, your renewed interest in music was part of this broader reintegrating of parts of yourself.

P4: I remember thinking that I’d hear what I’d call whiny boy rock, love rock on the radio and going, “Oh god those people are so stupid. I can’t believe it.” That’s sort of been a big part of my life, but that I’ve always liked that kind of thing. Then as a parent I was just sick of it. I’d listen to a lot of things, but I was just sick of it. Probably because I felt bad, but partially
it’s just like, “Oh for god’s sake.” Thinking that suddenly I’m super grown up right now because I’m a parent. Thinking that I had to shelve and get rid of all those parts of myself that always kept me healthy even though for years I’d worked for X for a couple of years. I’d always been a therapist with kids and seen a lot of really problematic stuff and I think music for me was always my way of staying sane. It balanced everything out. So, when that was gone I was like ah oh what am I going to do now? I don’t have time for these things that nurture me. So, I guess there’s a kind of self-nurturing quality too that I had to re-find. It sort of fits with what I was talking about before.

R: It sounded like the writing down of a dream or poetry was helpful to the process of therapy too.

P4: Yeah, it was. Because before I hadn’t really felt like that or I didn’t really have time for that. I’ve always been a bit of a diarist, because I like to write things down stuff like that or write down little snatches of poetry or song or whatever. And I don’t know exactly when I started doing that again. Probably it had something to do with writing down the dreams where you start to say oh there’s still things to learn. Because I think to some extent I might have felt like oh my life is over, my life as I knew it is over, which was true to some extent but it wasn’t true in the way that I thought it was when I was depressed. I thought oh I can’t do this anymore. Oh I can’t play music anymore. It was a very limited view of what parenthood was and I don’t exactly know where that came from, because I’m nothing, I wasn’t really anything like my mom in the same sense. I mean I worked all the time. I was doing all these different things. I don’t know if I talked to
her, I’m trying to think if I talked to her about that or not. It probably had some nurturing aspect too because I think when you suddenly have to give all your nurturing to a child you forget, sometimes its easy, at least for me I forgot to nurture myself. I think that’s an issue for a lot of people, but I think for me I needed a wake up call. You can’t nurture anyone else unless you nurture yourself, right. And that’s sort of part of that. Ah, here’s an interesting thing. When I was first in therapy, I remember the therapist saying to me: your well has run dry. That fit with the whole Descent to the Goddess thing that you have to go down into the muck and deep and stuff to start re-enriching yourself, rebuilding your psyche, reintegrating whatever it is. I think that’s a really good image too that there has to be self-nurturing and self like nourishing. So, I think that’s a good image too. I had forgotten about that.

R: Yeah, it sounds like that incident was really representative of what was working for you in that therapy? For example, her pointing out that the well ran dry had a huge power to it for you.

P4: Right, I think too maybe it made it a little easier to start nourishing. I think that’s the reason why I went back to this particular person because she and I had always had a bond.

Now I feel very positive about my life, my work, and parenthood. I am more open to life’s changes and see my past depression as a learning experience, which has helped me in my own work with patients. I started to feel happy again,

R: I was curious too about, what was the depression like after therapy? What was

P4 viewed her past struggles with feelings of depression as a learning experience, which helped in her work as a therapist. She felt pleased and encouraged about the present relationships with her work and with her child. P4 also felt more accepting of and ready for future life changes.
the anxiety like?

P4: That’s a good question. It took a while. It took a good year or two for me to really get back to feeling like I was before. It took a pretty long time because I was tired. And then I felt weird because I wasn’t working full time anymore. I felt like a part of me had just given up on what had been the defining characteristic of myself of my work life. I think the anxiety wasn’t as bad. I mean because I’d actually dealt with it. I was sleeping more. I think in my work I’d gotten to that ultra-stressed, almost slightly paranoid, almost, “Oh no, what’s going to happen when the phone rings next time.” Because I was running a certain program that was horrifying to run. I will never do anything like that again. I think there was this work quality that went away. So, I didn’t have to deal with that. But I had to deal with adjusting to the idea that I was going to run my own show, which I’ve pretty much been doing since then. So, in a sense, the whole thing ended up being a good thing because it forced me to say, “I’m going to run my own show. I’m going to do it. I’m not going to work for an agency anymore. I won’t have to sit in all these meetings. I’ll work when I want to work.” I think that was positive in the sense of having that inner locus of control aspect. Just feeling better, not feeling so stressed, not feeling so angry, less argumentous with my husband, more energy for him, more able to enjoy things, because that same level of anxiety had decreased quite a bit, although I’ve always had it. Like I said the cognitive behavioral stuff seemed to work better in the past couple of years. I haven’t really had that nearly to the same extent. I don’t go, “Oh my god, what’s going to.” I don’t seem to do that nearly as much. What I think sometimes with if I start feeling too

After therapy, P4 felt happier and was more able to enjoy meaningful engagements. Although she had to adjust to only working part-time, P4 felt a greater sense of control in her private practice work and felt a significant decrease in the severity of anxiety. She also obtained more sleep and so felt more energized in significant relationships. P4 argued less with her husband, and in general, experienced a lesser degree and frequency of anger.

Through therapy and her struggles with depression, P4 had learned to engage
stressed or too tired or whatever I take a nap. I do a little meditation, I make sure I have time to do something fun. And that’s protective. So, I’ve been trying to hold to that. Probably for a couple of years when I wasn’t at work or something if I was home before I had to pick up my son from school or something I would take a fifteen minute meditation, pretty much everyday. I insisted. I would have the dragonfly there as a reminder. I also like kept this bottle of Trazodone. I’d leave that in my cupboard as a reminder of what I do not want to do. I do not want to go there again.

R: It sounds like after therapy you really set up your world in a certain way that really

P4: Well, I felt like I had to. Well, it’s funny because I still remember her saying to me: “Well, you could probably work full time if.” She said to me, you probably don’t want to do, and here’s what you don’t want to do. I remember feeling a bit resentful about it at the time, but I mean she was right. And in some way it is the best thing that I ever did was to say, “I can run my own practice.” I don’t have to be at the mercy of all the idiotic managers, ridiculous meetings about paperwork, and that kind of thing. Also my husband started working full time. And he got health insurance so I had a little more flexibility to go and do things at my son’s school and stuff like that. It ended up turning out to be a good thing. It just took a while for me to start to see it as a good thing. So, in some way, the whole thing was a really good but a painful wake up call that made me go, “Oh my life can be different.” I mean I took the difficult way down there and through it but it turned out well on the other side. There’s a light at the end of the tunnel kind of thing. So it

| more carefully with others and work and to not over-involve or over-stress herself in this new phase of life. To this end, P4 continued only to work part-time, as her husband worked full-time and acquired health insurance. She consequently had more time to be involved with her son and his schooling. She also had more time for herself to engage in enjoyable activities, napping, and meditation, especially when she felt stressed. P4 kept an empty bottle of her antidepressant to remind herself to stay mindful of the scope of her engagements. |
was. And since that time I’m real careful. I just don’t. I think that’s learning to be older, learning to come into this different phase in my life as a parent, as a professional women and stuff like that, that I couldn’t do things the same way and that was okay. That I learned a lesson, I learned a valuable lesson and I’m very careful to take care of myself and make sure that I have time for myself. And actually have more control over what is going on with me overall so that I don’t have to go through that again, knock on wood. I mean I’m not the same person as I was then, which I think is like a cliché. But I think we’re always changing and growing. Sometimes, it would be nice if it wouldn’t have had to behave as such a storm and draught kind of thing, but you know, that’s life, right?

**but was careful not to overdo and overstress myself. My husband started to work more and get health insurance so I didn’t have to work full-time. I have had time to spend with my son, his school, and have fun.**

I try to listen to my deep emotions.

R: Yeah, and what was coming across to me in your reading of the books was you were mentioning that they taught you to honor what you were going through, to honor your suffering, and then your therapist taught you to sit with it and let it move through you. You even said concretely that that would come about during the course of therapy when you gave yourself time to go somewhere and sit with what you were feeling.

P4: Right, like not always afterwards, but well sometimes. Like more after I was done with therapy or in the course of when I was finished as a way of maintaining health or paying attention to

After therapy, P4 did meditation, yoga, and tai chi for relaxation and well-being. She performed these practices or just sat quietly in order to attend to herself and become more aware of feelings that were significant yet prethematic. P4 also reintegrated engagements that she enjoyed such as music, and attempted to stay optimistic about her life in general.
myself. I always found myself as pretty insightful and pretty emotionally aware, but I think there are always more levels you can move to. And I think that in terms of the way our culture is now people have to take that time. People don’t take meditation time. They don’t take quiet time. They don’t do any of those things they need to do because they just rush like mad people from thing to thing. I think there’s real value in that meditative aspect or sitting quietly with yourself and seeing what is their emotionally aspect.

R: It seems like that was helpful for you to sit with your emotions. It seemed like the books provided an ideal of sorts, some guiding

P4: I just think it’s paying attention to what’s inside you. If you don’t pay attention to what’s inside you emotionally it will come and bite you on the ass. That’s more for me if I didn’t pay attention to that I’d end up being in therapy again. Or going through, like making some of the same mistakes that I had made before or not growing even. I mean I think that really helps people to grow emotionally to take that time to listen to yourself.

I am more aware of my need for quiet and time to de-stress with meditation and let my brain “relax” each day. I try to see life in a more positive way. I started to do tai chi and yoga again for relaxation. This made me more aware of my body/emotional stress. I also started to swim again, play music, and to “reclaim” parts of my life that gave me joy.

A6.3 Integration of Central Themes

1. P4 started a new job when pregnant. She was directing a program that necessitated a lot of local travel and working another part-time job as well as performing household tasks. When her child was born, P4 was also taking care of her son.

2. P4 felt anxious and bodied forth such anxiety in her acid reflux difficulties. She worried about her job and experienced early morning waking at 3 a.m. P4 also felt exhausted and eventually became unable to engage with work.

3. P4 felt negative toward and detached from her life. P4 had little quality time for herself, for her husband, or for her son, and consequently, she and her husband were frequently arguing.

4. Due to anxiety and exhaustion, P4 took a medical leave of absence from her job.

5. P4 went to her primary care physician for assistance, since she assumed her symptoms could be explained medically. Her physician prescribed a tricyclic antidepressant to treat her insomnia, which she took for around six months. P4 also went to a psychiatrist who diagnosed her with major depressive disorder.

6. P4 went to a cognitive-behavioral therapist for two sessions through her work, but she felt too depressed and anxious for the therapy to be of help. P4 went back to a psychodynamic therapist she saw ten years previously, and the therapist highlighted that P4 was presenting with the same pattern: caring for significant others and work projects at the expense of caring for herself.

7. As opposed to the symptom focus of the cognitive-behavioral therapy, the psychodynamic therapy helped P4 to address such patterns and avert subsequent symptom formation through an in-depth exploration of her development and the aspects of her development and herself that she did not want to acknowledge. In addition, the psychodynamic therapy helped her to grow by exploring and developing facets of herself that were denied when P4 cared for others but did not care for herself.

8. P4 appreciated the focus on dreams throughout the therapeutic work, which helped her develop a sense of personal and emotional complexity. P4 analyzed a dream in which she descended into a swamp-like basement and felt disgusted, as she did not want to look at the repulsive sites. P4 interpreted the dream to mean that she did not desire to acknowledge unpleasant feelings, and such a dream, like the depression, made her more aware of these. P4 analyzed another dream wherein she was a prominent Nazi figure. Such a female figure was powerful yet undesirable, and P4 interpreted the image to mean that she was denying the more assertive facets of herself. As opposed to her previously accommodating style, P4
realized that she had the strength to say no and not engage in an unrealistic amount of work, and in this way, take better care of herself.

9. When P4 presented dreams, her therapist did not over-analyze them, but questioned P4 about her feelings concerning particular aspects of or figures in the dream. These discussions stimulated P4’s interest and she searched for books to supplement the therapeutic work. The dreams as well as the books provided her with a novel perspective from which to understand herself.

10. The premise of one particular book she read concerned valuing her depression and suffering as a way to understand more about herself and grow.

11. P4 concluded that life transitions, like parenthood, and challenging experiences, like depression, call forth a personal, emotional examination and a descent into that which is undesirable in order to become better aware and grow.

12. P4 also appreciated the therapeutic focus on a particular symbol. Her therapist had organic type items throughout her office and P4 found herself preredeflectively focusing on a specific figure. Later in therapy, P4 articulated the way it had represented her need to change and to accept change. In particular, P4 felt emotionally unprepared for the difficult transition from engaging mostly with work and leisurely projects to also caring for a child. The figure was also a symbol of hope when she felt significantly depressed. After therapy, P4 adorned herself and her home with the figure to remind herself to allow change.

13. P4 came to see her experience of depression as a reminder to take care of herself, and in general, as an indication to attend to herself in the fullness of her being.

14. P4 initially felt anxiety and shame concerning her experience of certain feelings like sadness. Her therapist instructed P4 to allow these feelings to move her after an event and to be curious about what the feelings taught her. P4 therefore arranged a time and place to attend to her experience of feelings when needed, and she found this process cathartic. She would further discern the psychological significance of her feelings for herself and her world.

15. As she integrated her perception of parenthood into her sense of identity, P4 came to realize that child-care required self-care, and so she learned to end certain engagements and to share responsibilities with others.

16. P4 realized that she could not possibly direct affairs at her full-time job and care for a child while still attempting to participate in enjoyable activities without feeling significantly stressed. P4 thus focused on part-time private practice work, and constructed a flexible schedule that allocated adequate time to engage with work, with her husband, and with her son. P4 also built time for herself into her schedule, which initially consisted simply of being without commitments; e.g., sleeping, listening to music.
17. P4 had played in a band for about a decade and wrote songs that espoused feminine strength based on images from her dreams. She had also written poetry. During and after her pregnancy, P4 no longer engaged with music or creative writing to allocate more of her time for childcare. Through therapy, P4 articulated the way this choice was informed by her ideal of the self-sacrificing mother, which was based off her experiences with her own mother. Her therapist also highlighted that her well had run dry and P4 understood this to mean that she was not nurturing herself. She started to allow time for writing down her dreams and poetry, which stimulated her love of music and creation of songs. P4 reconnected with this more creative facet of herself and reintegrated such engagements in her life.

18. P4 sometimes felt angry and reacted firmly regarding issues with the fee.

19. Her therapist interpreted some of these more fantasy-based reactions as stemming from the transference and P4 made thematic her feelings at these times. P4 found such work interesting in light of its significance for the acquisition of self-knowledge.

20. In general, the therapeutic relationship consisted of a felt bond between P4 and her therapist. P4’s therapist had a more eccentric demeanor and had a less medically oriented or authoritarian approach. On occasion, her therapist made personal disclosures, and these seemed appropriate at the end of therapy and after their chance meetings in the community.

21. Her therapist also had an attentive and caring presence. P4 sensed that her therapist understood her suffering and that her therapist was nurturing and guiding her. Their therapeutic discourse centered on dreams and symbols, yet P4 thought the process of therapy also unfolded in a more prereflective manner.

22. Before therapy, P4 had felt depressed, but toward the end, she felt better. At the beginning of the work, P4 came to accept her experience of depression, and to trust that she would feel better and could make changes to this end. In this manner, P4 felt hopeful by the end of therapy. She also felt more positive about her life and less of a sense of depletion, as she had quit her full-time job.

23. After therapy, P4 felt happier and was more able to enjoy meaningful engagements. Although she had to adjust to only working part-time, P4 felt a greater sense of control in her private practice work and felt a significant decrease in the severity of anxiety. She also obtained more sleep and so felt more energized in significant relationships. P4 argued less with her husband, and in general, experienced a lesser degree and frequency of anger.

24. Through therapy and her struggles with depression, P4 had learned to engage more carefully with others and work, and to not over-involve or over-stress
herself in this new phase of life. To this end, P4 continued only to work part-time after therapy, as her husband worked full-time and acquired health insurance. She consequently had more time to be involved with her son and his schooling. P4 kept an empty bottle of her antidepressant to remind herself to stay mindful of the scope of her engagements.

25. After therapy, P4 did meditation, yoga, and tai chi for relaxation and well-being. She performed these practices or just sat quietly in order to attend to herself and become more aware of feelings that were significant yet prethematic. P4 also reintegrated engagements into her life that she enjoyed such as music, and attempted to stay optimistic about her life in general.

26. P4 viewed her past struggles with feelings of depression as a learning experience, which helped in her work as a therapist. She felt pleased and encouraged about the present relationships with her work and with her child. P4 also felt more accepting of and ready for future life changes.