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The Lay of the Land

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Learning to do psychotherapy can be daunting. There are many different kinds of therapy, and some of them have elaborate theoretical underpinnings, along with quite a bit of unnecessary jargon. Many of us struggled as beginning therapists to see the forest among all the intimidating trees. This first chapter will help you get the "lay of the land." In other words, what do you need to know about the "forest" of psychotherapies to not feel lost as you begin studying and doing therapy? In this chapter we will discuss:

1. What is psychotherapy?
2. What are the challenges (and rewards) unique to learning psychotherapy?
3. What are the core features of most psychotherapies?
4. How does psychotherapy work?
5. Does psychotherapy affect the mind or the brain?
6. What are the advantages and disadvantages of psychotherapy, compared with other kinds of treatments?

WHAT IS PSYCHOTHERAPY?

I remember being a beginning therapist and trying to explain to my new patients what psychotherapy was, while feeling unsure I could answer this question for myself. One of the reasons why it is so challenging to learn psychotherapy is that there is no universally accepted definition of "psychotherapy." It is an umbrella term used to encompass a wide range of different treatments. In that regard, Merriam-Webster[17] defines psychotherapy in an understandably broad and inclusive way: "Treatment of mental or emotional disorder or of related bodily ills by psychological means." In other words, psychotherapy is a treatment for a wide range of presentations (physical, mental, emotional) and that it is psychological—as opposed to physical,

nutritional, pharmaceutical, etc. This definition is certainly true, but it leaves us with many questions. What are the "psychological means" through which therapy works? How are these "psychological means" created in the relationship between a therapist and a patient? And how is this relationship both like and unlike other important and helpful relationships in a patient's life?

Every student in a mental health training program has brought some preconceptions about psychotherapy. Sometimes those preconceptions are based on your own prior experience in psychotherapy. If so, you may have had a vivid experience of what a particular type of therapy looks like in the hands of one clinician. One of the learning goals in this book is to help you put that specific experience into the larger context of psychotherapy. However, for other trainees, your only prior exposure to psychotherapy may have been through depictions in popular culture. And depending on whether this has been through *The Sopranos* or *Frazier* or any of hundreds of other movie, TV, or literary therapists, you may have dramatically different ideas of what psychotherapy will look like. Sometimes, the picture is of a generally silent and reserved figure who listens, says very little, and yet somehow peers into the dark depths of the soul. In other instances, the therapist appears as a wise and warm sage who provides guidance—spiritual, moral, practical—that will finally set the patient on the right path. And unfortunately, sometimes the image is of a charismatic but unbalanced healer who uses electrifying interventions, but whose work is always balanced on the razor's edge and where boundaries exist just to be dramatically broken. We assume that you come to this subject with a similar task of sorting out an array of inspiring, confusing, disturbing, and contradictory depictions of psychotherapy.

Our patients are no different in that they also bring their own preconceptions into therapy. Sometimes, they have already been in psychotherapy and expect their new treatment to be like the previous one. Sometimes, they have absorbed the same stereotypes from pop culture described previously. Other patients expect that psychotherapy will be like their other physician visits—a description of the problem, a diagnosis, and then instructions. They will need you, as their new therapist, to help them understand what they are actually signing up for.

In some ways, defining "psychotherapy" will take this entire book. But, here are some ideas I have found useful to organize my own explorations of therapy that may be helpful to get you started. *In psychotherapy, we try to help a patient with some problem that matters a great deal to them, is often difficult to talk about initially, and has already failed to be helped by their usual resources. We create a unique kind of relationship, so that we can use listening, talking, and being together to purposefully initiate relief, change, and growth.*

CHALLENGES AND REWARDS UNIQUE TO LEARNING PSYCHOTHERAPY

Most of us who have been doing therapy for a while can still vividly remember how anxious we were with our first patients. Part of this anxiety was uncertainty about our own competence, but we were also unsure what "good psychotherapy" was supposed to look like! In most areas of health care, a provider will watch someone else perform a procedure—generally at least several times—before attempting to provide the treatment themselves. For example, a physical therapist treating you has

previously watched someone else conduct this same type of therapy from start to finish, and this would be a fair expectation. In other areas of health care, training in simulation laboratories has become essential—the trainee will often have watched and practiced the treatment procedure on a mannequin or a simulated patient before they try with a real patient.

But, neither multiple observations nor simulations are likely to occur before your first psychotherapy session with a patient. Why is that? Part of the reason is practicality. A very short course of psychotherapy might be 10 to 20 sessions, and these will be spread out over many weeks. That is a lot of time to devote to observation or simulation. In fact, a training program may arrange for a therapy to be observed behind a one-way mirror, or for a therapy to have been filmed so that the trainees can watch. There is a great deal to be learned this way, but even that approach has innate limitations. One of the strange things about psychotherapy as a treatment process is that the therapy that is observed or filmed is never exactly the same as it would have been without the observers or the cameras. The patient will behave differently, and the therapist will also. Sometimes people are more inhibited, sometimes they become more performative, but either way, you are not going to see what would have happened if the therapy had been conducted in the usual cocoon of therapeutic privacy.

Another difficulty is psychotherapy is an incredibly complex process. Although you can be taught theoretical principles, rules of thumb, techniques, and specific interventions, each moment in psychotherapy has too many possible meanings and too many possible helpful responses for a trainee to successfully "script out" what should happen. This has important implications for learning therapy. Watching one therapy session—or even several—will not fully prepare you for conducting your own psychotherapies because the combination of your own personality, your specific patients, and your therapeutic approach will all differ. This is one of the wonderful paradoxes of psychotherapy. While there are many profound commonalities to all human beings, each person is still absolutely distinct and has a story no one else has ever told. This is part of why many therapists still find their work fascinating, even after decades of practice.

Both sides of this tension turn out to be great sources of personal growth and fulfillment for therapists. On the one hand, therapists find truth in the old saying by Terence, "Nothing human is alien to me."[18] All of us share longings to be loved and to love, to have a valued identity, and to be appreciated for our work. All of us need to feel we belong—to a family, a community, a congregation, or a political party, etc. All of us feel frightened when vulnerable or threatened, and all of us become angry when hurt or attacked. All of us feel regret and guilt when our actions fall short of our standards, and all of us feel shame when we are faced with something about ourselves that seems unacceptable, defective, or disgusting. When we meet with patients, we come in touch with the things that make us all human. *It is a moving and humbling privilege.*

And yet, no individual can be reduced to any schematic or equation defined by these needs and feelings, because the story of each person is always irreducibly unique. And, that story is critical to each person's understanding of themselves. Sometimes, the patient's story that they convey in psychotherapy sounds more like a myth or fairy tale. Other patients may tell you a story that fits the kinds of fiction and movie genres that we are all familiar with—they tell their life as if it were a tragedy, or a heroic quest, or a romantic comedy. And yet other patients will tell a story that defies genre, because it is complex and nuanced, or because it is fragmented and

confusing. What all of these stories have in common is that they attempt to answer fundamental questions of existence and cause—"Why am I who I am?" and "How did I get to be where I am in life?"

Another difficulty in learning psychotherapy is it can resemble many other experiences people have outside of treatment. Psychotherapy is surely not the only way in which people engage with each other with the goal to help, to learn, to grow, and to comfort. This occurs within parent–child relationships, friendships, romantic relationships, teaching, mentoring, and many other ways of relating. In all those instances, two (or more) people are talking and the goal is to help and be helped. In fact, many learners find themselves in psychotherapy training programs because they have in the past shown some particular aptitude for listening and helping in these spontaneous and less formal relationships. Often, someone has told the student or resident, "You should think about being a therapist!"

Patients will often, quite understandably, expect therapy to proceed like those other spontaneous and natural helping relationships. That would mean, for example, that there would be the degree of reciprocity and mutuality found in a friendship. Or that there would be a strong emphasis on advice-giving, like a parent or a mentor or executive coach would provide. It helps to remember that patients usually come to therapy already having tried to address their problems through these other, more typical channels. It is only when these other approaches are not sufficient that a patient seeks out a mental health professional. So, an important part of the task in learning psychotherapy is to understand how it will be actually different from all those other helping encounters and relationships. What is it that we will offer that goes beyond the help found in all those other arenas? Or to put a sharper point on it, what is that we are being paid for?

MAKING SENSE OF THE VARIETIES OF THERAPY

So, if we are not providing advice about important decisions, and we are not forming the usual kinds of reciprocal social relationships that people enjoy or lean on, what in fact are we doing for our patients? What happens in psychotherapy that actually helps the patient? Let us imagine a person who comes to therapy looking for help with some kind of distressing thought, or mood problem, or troubling behavior. Our new patient is probably not only suffering from the direct impact of their symptom or behavior. They often feel ashamed of their situation, alone and isolated by it, and afraid that nothing can be done. I am going to suggest that we will help this new patient in two very different ways. There is risk that this will oversimplify a complex topic and, like with any rules of thumb, there will be exceptions. Nonetheless, it is helpful when approaching a new and intimidating field of study to have a basic scaffolding to hold onto and on which to place the many details.

First, we help our patients by *providing comfort, safety, and support.* As a result, they feel more hopeful and less alone. These effects are often referred to as some of the "common elements" of psychotherapy[1-3] (there will be much more on these common elements later). Second, we *help our patients learn something new*, something that they would not be able to learn in any other relationship or setting. The specifics of what is learned and how can vary enormously from one therapy to the next. Some

FIGURE 1.1 The tree of psychotherapies.

authors have suggested the metaphor of a "tree" of psychotherapies, with the common elements of comfort and support being the trunk of the tree, and the specific therapies with their different kinds of learning the branches (*Figure 1.1*). A similar metaphor is the "Y model," where the stem of the "Y" is the common elements/supportive therapy and the two upper branches are the two major approaches of psychodynamic and cognitive behavioral therapy[4] (these specific therapies will be discussed in later chapters) (*Figure 1.2*).

For example, in cognitive behavioral therapy (CBT), the therapist teaches the patient quite directly.[5] The therapist may teach the patient to identify distorted patterns of thinking and how to correct them. Or, the therapist may teach the patient techniques for modulating emotions, desensitizing themselves to anxious situations, or changing maladaptive behaviors. The learning may continue between appointments as well if the therapist assigns an "action plan" or "homework" to the patient. In contrast, a psychodynamic therapist tends to help the patient learn in a more indirect way. The therapist believes the patient needs to learn about aspects of their own mind that are under the surface, and typically inaccessible to conscious introspection, perhaps because they are too disturbing for the patient to be fully aware of.[6] In that case, the therapist creates a process where unconscious material can be discovered and learned about together. In the process, the therapist and patient will also learn about the patient's ways of being with another person, patterns that the

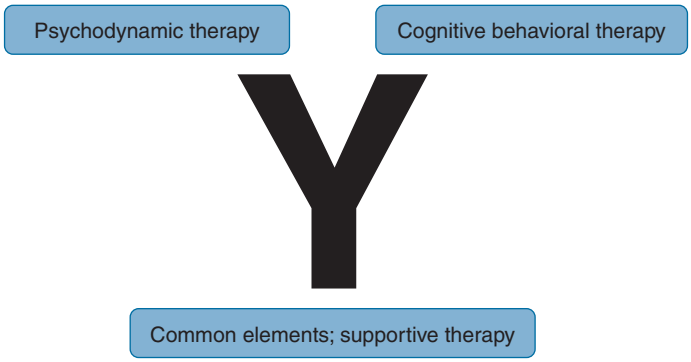

FIGURE 1.2 The Y model of psychotherapy.

patient may also have been unaware of, and the possibility of learning different ways of relating begins to open. Regardless, both rely heavily on a solid trunk of common factors and a comforting, safe, and supportive psychotherapeutic relationship.

As you can see from these two examples, the kinds of teaching and learning that happen in different approaches to psychotherapy can be very distinct, and you will learn much more about these in the chapters on psychodynamic therapy, cognitive behavioral therapy, supportive therapy, and social systems approaches to psychotherapy. It is our hope that this book will provide a solid platform from which you can also learn about and explore many other psychotherapy approaches, which are beyond the scope of this introductory book.

THE IMPORTANCE OF COMMON FACTORS OF PSYCHOTHERAPY

It is useful to understand the vital importance of common elements of therapy when thinking of the very first meeting between the patient and their prospective therapist. As new therapists, it is very common to feel preoccupied with what we do not know how to do and thereby feel that what we have to offer is inadequate. The good news is that this is not true. What you bring to the patient even at the beginning of your training is already quite powerful. New therapists are often surprised when a patient returns for the second session and reports that they felt much better after that first encounter. *How can the patient feel better when I, the therapist, felt overwhelmed and inept?* The fact is we actually do not have to do anything fancy or brilliant for the patient to get some real relief at that first meeting.

Those of us who come to therapy through medical school can usually remember experiences as beginning medical students where we met with patients for the first time to "take a history." Often we felt guilty for intruding or for wasting the patient's time, as we were not able to offer the patient a diagnosis or treatment plan. And yet, we were surprised when the patient later thanked us, or told the attending physician how helpful we had been. Similarly, psychotherapy researchers described a wonderful study where college professors with no training in counseling or therapy met with distressed students and, lo and behold, the students felt better.[6] Why is it that patients can feel helped by a well-intentioned—but still untrained—student or college professor?

There are several basic things that help make our initial meetings with a patient therapeutic. Some of these elements can seem so basic that you might easily overlook them. One is that the patient told you what is troubling them. You then proceeded to take them seriously and showed that their concerns matter to you. This is known in the psychotherapy research literature as the Hawthorne effect: being seen as worth another person's careful attention is powerful.[1] Another fundamental element is that you did not recoil in shock or horror when the patient talked about the material they find disturbing or shameful. You might take for granted that you would not think of responding that way, but your response to the patient may make a profound impression. In fact, you probably even asked them to tell you more about the things that they feel are most terrible and off-putting. The last fundamental element is that you seemed to have at least some (even if vague) idea about how psychotherapy is going to be helpful to the patient and conveyed some confidence

in the process. Notice these fundamental elements do not include great insights about the unconscious meanings of their problems, or the ability to describe an explanatory model of their symptoms, or that you made a profound connection between their distress and their early developmental experiences. None of that is necessary to lay the groundwork for successful therapy during the first meeting.

If the initial meeting has included some of these fundamental elements, the patient is likely to leave the meeting in a very different state than they were in at the beginning. First, the patient may have been feeling alone with their distress, and now they feel that you are in this with them. The two of you are together in bearing this problem, whatever it turns out to be. Second, they may have been feeling that their experience or symptoms make no sense, or as people often put it, that they are "crazy." At the end of the meeting they feel you actually could understand something of what they are going through. Third, they may have felt ashamed, or freakish, because of what they are experiencing. At the end of the meeting, however, they feel you were able to accept them as they are. And finally, at the beginning of the session they may have felt desperate and hopeless, having tried everything they could think of to cope and having it fail. But at the end of the meeting, they feel hopeful and tentatively expectant of some kind of change.

Those four effects—(1) Together (not alone); (2) Understood (not incomprehensible); (3) Accepted (not rejected); (4) Hopeful (not demoralized)—are of course not limited to the initial meeting. They will be repeatedly reinforced throughout the entire treatment. One of the most important research findings about psychotherapy is not only that all therapies have these elements in common, but these elements also account for much of the beneficial impact of any specific therapy.[2] That is worth repeating, because it is counterintuitive. Even though you will be spending a great deal of time and effort to learn the theory and technique of specific psychotherapies, *most of the benefit is actually going to be generated by careful attention to promoting these common elements.*

Now here is a strong caveat to what was just stated—this does *not* mean that the effort to learn and apply a specific therapy is not time well spent. First, specific therapeutic techniques do account for a substantial part of the effect, and you and your patient will want to be making use of every kind of treatment advantage available. But just as important, it is not possible to optimize the full extent of the common effects of therapy unless you are also providing a specific therapy. Your capacity to help the patient feel understood will draw on your understanding of some theory of what has gone wrong. Similarly, I described the crucial importance of the patient feeling hopeful about the plan. This can only come about because you convey that the specific psychotherapy you will be using has a specific method of some kind and that you will be applying this method together, in the service of alleviating the patient's suffering.

Jerome Frank's classic text, *Persuasion and Healing*, emphasized the importance of the specific theory and method, or what he called "myth" and "ritual."[7] Frank found that when he looked at psychotherapies of different kinds they shared certain characteristics with therapeutic relationships that occur in spiritual or cultural traditions of helping around the world. These characteristics are as follows: (1) A conceptual scheme (or myth) that provides a plausible meaning or explanation for the problems. This results in a possibility of mastery and decreasing helplessness. (2) A ritual or procedure that is believed to be effective. This ritual provides both a direct source of hopefulness, and an opportunity to work together on shared tasks that generate incremental gains.

To review, a patient may come away from their initial psychotherapy sessions feeling better in some predictable ways—less alone, less ashamed, and more hopeful. Taken together, common factors theories and research serve as a solid "trunk of the psychotherapy tree" that can further be developed by learning specific therapies (or "branches") to improve outcomes. However, what is it about human beings that creates the conditions for these common elements to have such profound effects, and for psychotherapy to therefore "work"?

THE IMPORTANCE OF ATTACHMENT IN PSYCHOTHERAPY

One of the reasons the unique relationships within psychotherapy produce change lies in the fact that we are primates, and primates are born with an attachment system. Thinking about attachment is very helpful for understanding how the common elements are rooted in our deepest nature. Psychotherapy schools in the 20th century were slow to appreciate the importance of attachment. Some early schools of therapy (such as psychoanalysis) emphasized how people were driven by the biological urges of hunger, sex, and aggression, while other early schools of therapy (such as behaviorism) were more focused on the ways reward and punishment could be used to modify behaviors. The idea that every human being was built to seek out a secure attachment during development was not on their radar. John Bowlby and Mary Ainsworth were pivotal figures in influencing the field of mental health and behavior toward the centrality of attachment.[8]

Bowlby drew on clinical experience as a therapist, on naturalistic observation of children, and on laboratory studies of primates.[9] Especially important were observations of children who had suffered from deprivation of parental care or from disruptive separations. Acutely, such children could seem listless, needy, and anxious, while over the long term they might have problems with depression, aggression, or antisocial behavior. These observations were also completely consistent with Harlow's famous studies of infant monkeys. In response to separation from their mothers, films showed the baby monkeys clinging desperately to the most minimal available substitutes, such as a wire frame covered with a thin towel. In both human and other primate young, separation resulted in a common set of reactions—first the baby would cry or call out in protest, then seem sad and despairing, and finally become detached from the caregiver, but with significant emotional and behavioral scars.

After demonstrating that this early connection was critical, Bowlby described how attachment happens, and Ainsworth later provided empirical evidence for this theory through designing experiments (the Strange Situation Classification) to assess the various attachment styles that exist between children and their caregivers. Per Bowlby's theory, both the baby and the parent had built-in behavioral systems designed to foster these connections. This is absolutely crucial, because primate babies are quite helpless when born and will not survive very long at all without a caregiver hovering nearby. When babies experience a separation, they cry. Parents find this such a disturbing sound that they immediately want to find the cause and stop it (and not just parents, as anyone who has sat near a crying baby on an airplane can attest). When the parent returns and picks the child up, the comfort, relief, and then even joy of the child is clear.

Babies also provide positive signals, such as smiling or babbling, that draw their parents (and others) to engage them and hold them. Once the baby and the parent are mutually engaged, they immediately start mimicking and responding to each other's faces. This generally happens quite automatically, but is a wonderful early experience of learning how to be attuned to another person and how to modulate each other's emotional state.

Our point here is that patients are not a "blank slate" when they present for therapy. As primates, they have an attachment system that is built to reach out for a protective other, and as primates we have reciprocal instincts to comfort in response. Of course, the patient's early attachment experiences will have a profound influence on the shape of how they seek attachment as an adult. Some will have had an experience of relatively tuned-in and reliable caregivers. These fortunate patients had a "secure attachment" and even in the face of their symptoms and distress, they will approach the therapist in a spirit of optimistic expectation. Ainsworth demonstrated through the Strange Situation research that when a secure attachment has not been possible the toddler will modify their own behaviors to cope as best they can with the pain of separation or neglect, even if these new behaviors are maladaptive later in life. Some patients who had inconsistent or unresponsive caregivers will come to their new therapist under the shadow of these "insecure attachments." They might have learned to adopt a stance of not needing anyone, although deep down there are still great yearnings to connect. Or, they might have learned to demand and grab hold tightly to any available caregiver. This is a fairly reasonable response if you could not count on your caregivers to be attuned and responsive to your needs. In our chapter on beginning a therapy (Chapter 4), we will have more to say about patients who had serious trauma as a child and how this shapes their initial experience of therapy. However, just being aware of these possibilities can help us to tolerate our patient's maladaptive ways of seeking and avoiding attachment, and help the patient use psychotherapy to learn healthy new ways of being connected.

DOES PSYCHOTHERAPY AFFECT THE MIND OR THE BRAIN?

Is psychotherapy affecting the "mind" or the "brain"? This is an area of significant and lively discussion within mental health care and research. In the past, mental health clinicians often thought of treatments as either biologic or psychosocial. This fed into a tendency to think of medications, as a clearly biologic treatment, acting on the brain, whereas psychotherapies, as psychosocial treatment, were seen as acting on the mind. Today, we should all recognize that this is a false and misleading dichotomy. Several decades of functional imaging research have made it clear that psychotherapy results in changes in brain function.[10,11] For example, functional imaging allows researchers to see whether specific regions or circuits are either overactive or underactive compared to healthy controls, by looking at the degree of blood flow or metabolism throughout the brain. Numerous studies in patients with conditions such as social phobia, obsessive compulsive disorder, post-traumatic stress disorder, and depression provide compelling demonstrations that we are generating measurable changes in brain function by talking to our patients. Clearly everything that we experience as our "self," all of our mental life, is rooted in the brain.

However, the relationship of the mind and the brain has been puzzling and vexing our greatest thinkers throughout human history. And it *still* remains a largely unresolved question! We have only the most tentative ideas about how neuronal activity, subjective feeling, and thoughts actually relate to one another. Fortunately, we do not have to resolve this question to be effective psychotherapists. It is enough if we understand from neuroscience research that all mental life is rooted in the brain.[12,13] Injuries to the brain result in changes in a person's thoughts, feelings, behaviors, personality, and even identity. And as you just read, making changes in thoughts and feelings results in physiological changes in the brain.

This can further be illustrated through the neurobiology of both attachment and learning. Attachment and "social pain" is an area of research that clearly demonstrates the connection between mind and brain. It turns out that experiences of social pain—the humiliation, anxiety, and confusion that accompany feeling rejected or excluded—have a remarkable overlap with the distress of physical pain.[14] The brain uses opioid receptors to signal the distress of both a physical injury and an interpersonal one, and then uses endogenous opiates to relieve the distress. In experiments that involve isolating puppies and causing separation distress, administering a low dose of morphine is as effective on distress as it would be if the puppies were in physical pain. And, reuniting mothers and puppies increases endogenous opiate levels in both mother and puppy. The same part of the brain that regulates and represents the experience of physical wounds—the anterior cingulate cortex—also regulates and represents our patients' experiences of the pain of rejection and isolation. Given how absolutely essential attachment is for baby primates—and therefore how extreme the danger of separation—it makes sense that the brain would call into service these older mechanisms for protection from physical pain. These same brain mechanisms for monitoring and soothing social pain are ready for the therapist and patient to activate when they meet, even for the initial encounter.

As we discussed earlier, all psychotherapies involve new learning of one kind or another, and research on learning also shows the convergence of mind and brain. Eric Kandel and others were able to demonstrate how the brain changes when animals learn, a process known as "plasticity."[12,13] These changes can involve growth of new synapses (connections between neurons), pruning of existing synapses (reduction in the number of connections between neurons), or changes in the strength of specific synaptic connections. Kandel eventually received the Nobel Prize in Medicine for this work. Furthermore, Kandel himself thought this was directly relevant to psychotherapy: "Insofar as psychotherapy or counseling is effective and produces long term changes in behavior it presumably does so through learning, by producing changes in gene expression that alter the strength of synaptic connections and structural changes that alter the anatomical pattern of interconnections between nerve cells in the brain."[12]

However, what is learned is encoded into memory through two very distinct neurobiological systems.[13,15] Both of these memory systems are important to our work in psychotherapy and need to be highlighted. First, some memory is called "declarative" or "explicit." This is the memory of specific facts or events that we can consciously bring to mind. The hippocampus and the neocortex are particularly crucial to this kind of memory and learning. The second kind of memory is called "procedural" or "implicit." This kind of memory is used for learning how to do something or encoding relational patterns and generally operates without conscious awareness. For example, attachment patterns and expectations are held as procedural or implicit memory.

To use a simple analogy, when I drive to work on my usual route I am using implicit memory for both the task of driving itself and for following the route. I do not have to think about either operating the car or finding my way, leaving me consciously free to talk to a companion, listen to a news story on the radio, or reflect on a challenging situation at work. However, if my usual route is blocked by an accident, I may need to think very explicitly and consciously about how to find a new route and how to do it safely.

Many patients come to therapy because, for whatever reason, their established and automatic ways of relating or being in the world are no longer working. When they discover those "routes" are blocked, they need to learn new options. One of the very exciting things about therapy is that sometimes this learning occurs very explicitly, with the patient and the therapist talking about obstacles to trust (for example) in their relationship and resolving them together. However, much of the time the patient may also be learning implicitly.[15] You as the therapist may not feel that much is happening and you may wonder whether you are really having an impact. But the patient, through the repeated experience of your reliability and steady interest, might be having a very profound experience of implicit learning about what might be possible within healthy attachment relationships. Fortunately, therapy clearly utilizes both the brain structures and circuits that manage procedural/implicit memory as well as those that support conscious/explicit memory.

THE ADVANTAGES OF PSYCHOTHERAPY

Some patients seek psychotherapy as the intervention of choice because they wish to avoid the risks or side effects of other treatment modalities. Other patients, however, are reluctant to consider psychotherapy, perhaps because they hoped for a treatment that will be faster or more focused than "just talking." Where does psychotherapy fit among the array of possible treatments aimed at alleviating mental suffering? There are, after all, other ways to have a therapeutic impact on the mind and the brain. Psychotherapy is not without real risks and costs, but it also has some very distinct advantages that include its capacity for highly focused intervention.

Although there are many medications that produce crucial and sometimes lifesaving changes in patients, it is important to realize that medications are the bluntest possible instrument. When a patient is given a medication that works on dopamine or serotonin or GABA receptors, that medication will be administered to every circuit and neuron throughout the entire brain that uses that neurotransmitter. In addition, most medications also have lesser effects on other, nontargeted neurotransmitters and receptors, often resulting in side effects. Some are nagging and minor, but others can be quite profound. The loss of sexual function in a young person trying to recover from depression is no small thing. The subjective dulling of creativity or aliveness that some patients with bipolar disorder report from mood stabilizers or antipsychotic medications can feel like a great loss. In this context, the capacity to use some of the newer neuromodulation interventions such as transcranial magnetic stimulation to target a specific structure or circuit in the brain could be a great advantage.

For example, let us consider a patient who presents with all the classic signs of a major depressive episode after suffering a humiliating loss in his career. We can give him a serotonin reuptake inhibitor that will work throughout every area of the brain where serotonin is involved in circuits, which is very extensive. Or, we can consider a targeted neuromodulation such as a transcranial magnetic stimulation to activate or quiet a specific brain structure or circuit.

However, it is important to remember that there already is a procedure that is more specific than either neuromodulation or psychotropic medications. It is a procedure that evolved alongside the brain itself, over millennia of evolution, as the primary means of affecting highly specific and crucial change in the brain. In the face of life's greatest pains and losses, relationships and talking are how our brain was "designed" to be comforted, repaired, and healed.

One of the things that may have drawn you to mental health was appreciating that even though losses can lead to depression, and depressions can have similar symptoms from one patient to the next, no two depressed or grieving patients are ever the same. The details of their stories and therefore the specific meaning of the loss are unique. This meaning is encoded in the brain at the level of organization of synaptic networks that can only be selectively reached through the use of language and behavior.[16] When we ask the patient in psychotherapy to talk about their subjective experience of a recent loss, we can activate that highly specific synaptic network. We will be able to impact just those neurons associated with each other through the memory of the specific events, their association to past events that magnify or mitigate the impact, and their association to specific implicit ideas about his identity, value in the world, and value to other people he cares about. This is one of the ways that psychotherapy can do things that no other biologic intervention can do.

THE RISKS OF PSYCHOTHERAPY

While it is true that psychotherapy has the advantages of specificity and avoiding many of the side effects of other treatments, it also has disadvantages or risks of its own. These are important to recognize, because when we invite a patient to begin therapy, we are also asking them to take on these costs. First, psychotherapy as it is traditionally provided is expensive to patients and requires significant resources. Even if we offer the lowest fees we can, it is still a very time-consuming process. And time is a "zero sum game"—the time spent commuting to and from and attending therapy is time that cannot be used for work, studying, caring for children or the elderly, in hobbies, in community, etc. Second, therapy is almost always painful, at least at some point in the process. If the patient is addressing the truly painful parts of their story, they may leave the session still hurting emotionally for some time. Third, therapy is not always successful in alleviating suffering, nor is it always the best treatment approach. At times, we choose a therapy approach that is the "best" treatment available per the current research, only to see it fail because it does not fit with the patient's values or expectations. Psychotherapy is not a cure-all, nor is it appropriate for all patients at all times.

Finally, the same mechanisms that underlie the impressive power of the common elements of therapy—trust, hope, attachment—also make the patient vulnerable. Although we make use of the power of attachment to support and to heal, that experience is confined to the therapy hour. They may experience the pain of disappointment as they face the limits of the therapy relationship. Although patients can "internalize" this experience, and carry the mental image of the therapist with them throughout the rest of the week, this is still a far cry from having you actually there when they are in pain. In the chapter on starting therapies (Chapter 4), we will discuss why it is necessary to have these limits and boundaries—they make it possible for therapy to happen. When those limits are not maintained by the therapist, we can cause great harm to the patient, including experiences of exploitation, abuse, and exacerbation of the presenting illness. These "boundary violations" are perhaps the greatest potential risk of psychotherapy and should be taken very seriously by the new therapist.

Conclusion

In this chapter, we have seen that psychotherapy is a general term that covers an array of approaches, but that all psychotherapies all involve one person trying to help and heal another person through talking about important, distressing matters. Psychotherapy can be challenging to learn because both the therapist and the patient will bring preconceptions (and misconceptions) to the process, based on media and cultural depictions of therapy, and based on analogies to other helping relationships. Psychotherapy can also be difficult to learn because we need to embrace both our common humanity and each patient's profound uniqueness. We then saw that we can begin to orient ourselves by thinking about how therapy works. There are some beneficial effects that all therapies share, including reducing aloneness, shame, and hopelessness. These "common effects" are partly rooted in a universal human capacity to seek out and to provide attachment. We also saw that there are therapeutic benefits specific to each kind of therapy rooted in learning. Learning is a crucial part of therapy but what kinds of things we want the patient to learn can be very different. Because attachment and learning are both well-described neurobiological processes, we found it makes little sense to confine the work of psychotherapy to either the brain or the mind, or divide treatments into "biological" or "psychosocial." All mental life is mediated through brain function, and psychotherapy generates clear changes in the brain. Finally, we looked at the significant advantages that psychotherapy offers as a treatment modality, especially the capacity for a degree of specificity and focus unmatched by any other intervention. We also noted, however, that psychotherapy is a powerful process, and there are real costs and risks that must be respected as well.

Self-Study Questions

1. How do we define psychotherapy? How is it similar to and different from other important relationships in a patient's life?
2. List and describe at least two "common factors" of psychotherapy.
3. Describe why the concept of attachment is important in psychotherapy.
4. List at least two risks and two benefits of psychotherapy as a treatment approach.

RESOURCES FOR FURTHER LEARNING

Etkin A, Pittenger C, Polan HJ, Kandel ER. Toward a neurobiology of psychotherapy: basic science and clinical applications. *J Neuropsychiatry Clin Neurosci.* 2005;17:145-158.

Feinstein R, Heiman N, Yager J. Common factors affecting psychotherapy outcomes: some implications for teaching psychotherapy. *J Psychiatr Pract.* 2015;21:180-189.

Fonagy P. *Attachment Theory and Psychoanalysis.* New York, NY: Other Press LLC; 2001.

Frank JD, Frank JB. *Persuasion and Healing: A Comparative Study of Psychotherapy.* 3rd ed. Baltimore, MD: Johns Hopkins University Press; 1991.

Lieberman MD. *Social: Why Our Brains Are Wired to Connect.* New York, NY: Broadway Books; 2013.

Plakun EM, Sudak DM, Goldberg D. The Y model: an integrated, evidence-based approach to teaching psychotherapy competencies. *J Psychiatr Pract.* 2009;15:5-11.

REFERENCES

1. Feinstein R, Heiman N, Yager J. Common factors affecting psychotherapy outcomes: some implications for teaching psychotherapy. *J Psychiatr Pract.* 2015;21:180-189.
2. Wampold BE. How important are the common factors in psychotherapy? An update. *World Psychiatry.* 2015;14(3):270-277.
3. Nahum D, Alfonso CA, Sönmez E. Common factors in psychotherapy. In: Javed A, Fountoulakis K, eds. *Advances in Psychiatry.* Cham: Springer; 2019.
4. Plakun EM, Sudak DM, Goldberg D. The Y model: an integrated, evidence-based approach to teaching psychotherapy competencies. *J Psychiatr Pract.* 2009;15:5-11.
5. Beck JS. *Cognitive Behavior Therapy: Basics and Beyond.* 2nd ed. New York, NY: The Guilford Press; 2011.
6. Cabaniss DL. *Psychodynamic Psychotherapy: A Clinical Manual.* 2nd ed. Chichester, England: Wiley Blackwell; 2016.
7. Frank JD, Frank JB. *Persuasion and Healing: A Comparative Study of Psychotherapy.* 3rd ed. Baltimore, MD: Johns Hopkins University Press; 1991.
8. Fonagy P. *Attachment Theory and Psychoanalysis.* New York, NY: Other Press LLC; 2001.
9. Bowlby J. *A Secure Base: Parent-Child Attachment and Healthy Human Development.* New York, NY: Basic Books; 1988.
10. Etkin A, Pittenger C, Polan HJ, Kandel ER. Toward a neurobiology of psychotherapy: basic science and clinical applications. *J Neuropsychiatry Clin Neurosci.* 2005;17:145-158.
11. Schore AN. "*Toward a new paradigm of psychotherapy*". In: *The Science of the Art of Psychotherapy.* New York, London: WW Norton and Company; 2012.
12. Kandel E. A new intellectual framework for psychiatry. *Am J Psychiatry.* 1988;155:457-469.
13. Kandel ER. Neurobiology and the future of psychoanalysis: a new intellectual framework for psychiatry revisited. *Am J Psychiatry.* 1999;156:505-524.
14. Lieberman MD. *Social: Why Our Brains Are Wired to Connect.* New York, NY: Broadway Books; 2013.
15. Fuchs T. Neurobiology and psychotherapy: an emerging dialogue. *Curr Opin Psychiatry.* 2004;17:479-485.
16. Kendler KS. Explanatory models for psychiatric illness. *Am J Psychiatry.* 2008;165(6):695-702. doi:10.1176/appi.ajp.2008.07071061.
17. Merriam-Webster. *Psychotherapy.* In: *Merriam-Webster.com Dictionary.* n.d. Available at https://www.merriam-webster.com/dictionary/psychotherapy. Accessed March 1, 2020.
18. Williams R. *Latin Quips at Your Fingertips.* Barnes and Noble Books; 2001.