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Commentary on Getting into the ACT with Psychoanalytic Therapy: The Case of "Daniel"

Promoting Psychological Flexibility by Practicing Flexibly: The Therapist as Model

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ABSTRACT

In this discussion of Dr. Robert Cohen's (2016) case study of his client Daniel, several integrative shifts over the course of the long-term, psychoanalytic treatment are noted. Initially, a shift from a traditional psychoanalytic model to a relational model was initiated in order to respond to Daniel's lack of responsiveness to a therapy focused on transference interpretation; and later a shift to employing strategies from Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2012) was implemented in order to address ruminative thought patterns and accompanying social inhibition. The therapist describes his own process of exploring options flexibly, allowing the reader a rare view into this clinical decision-making process. The treatment as a whole is conceptualized as fostering both mentalization and mindfulness skills in the context of the secure attachment that an intensive treatment tends to foster. The possibility that a shift to ACT provided a bridge to a termination process is discussed.

Key words: psychoanalysis; acceptance and commitment therapy (ACT); psychotherapy integration; attachment; mentalization; homework; termination; case study; clinical case study

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As therapists, we ask our patients to examine whether the way they are moving through life is working for them. We try to promote the kind of psychological flexibility that enhances the capacity for a rich and meaningful life. The clinical work presented in Dr. Robert Cohen's (2016) case study of Daniel is no exception. In addition, Dr. Cohen's case study also outlines the process of a therapist who questions with humility and open-mindedness what he himself is doing to help his client. It is a vulnerable and highly ethical undertaking, and I feel privileged to have the opportunity to comment on Dr. Cohn's and Daniel's work.

The reader may find that Dr. Cohen's journey is as illuminating as that of his client. From the outset, Dr. Cohen had to find alternatives to his preferred way of working. In spite of his interest at the start of therapy in doing intensive interpretive work, Dr. Cohen is flexibly accommodating to Daniel's preferences. He engages Daniel in a twice a week treatment, the

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highest frequency that Daniel will agree to. Daniel is unable to engage in much reflection on the treatment relationship, and transference interpretations tend to fall flat, so Dr. Cohen is unable to use some of the favored tools of the psychoanalyst. Even as Dr. Cohen manages his concern that there are things this therapeutic pair should or could be doing, Daniel votes with his feet about the importance of the therapy relationship. He keeps coming back, and he keeps progressing. They both invest deeply in their therapeutic relationship, which is reliable, constant, and focused on Daniel's well-being. Given Daniel's history, we can be reasonably sure that this is the first time that Daniel has had such an experience.

THE SHIFT FROM TRADITIONAL TO RELATIONAL PSYCHOANALYSIS

Daniel's willingness to seek out a stable therapeutic relationship, and Dr. Cohen's willingness to offer the most that Daniel can accept, is to my mind the first curative process that has taken place. I imagine that given Daniel's ability to make some sort of life for himself in spite of his deprivations and emotional distress, he could easily have fallen through the cracks of the mental health system. After all, he had the basics of a successful adult life in place, a relationship and a job. It is fortunate that Daniel found out that he could do better than a constantly changing cast of therapists, because he was clearly in search of the kind of generous and steady context for therapy that Dr. Cohen strove to provide.

The treatment starts with a challenge to the therapist. Daniel is not going to be able to work in Dr. Cohen's preferred modality, a more traditional, intensive psychoanalytic approach. Dr. Cohen's first integrative move is to adopt some of the premises and practices of relational psychoanalysis (Mitchell, 1988). In the relational framework, anonymity and abstinence on the part of the therapist, high frequency treatments, and the use of the couch, interpretation, free association and other technical interventions that once typified analytic work all become intentional options to be interrogated, used or not, in particular treatment situations, as opposed to the inevitable essence of analytic work. Rather than adopt the stance of the traditional analyst, whose objective is to create conditions that heighten internal conflict and bring it into the room so it can be analyzed, Dr. Cohen ultimately takes the stance of the analyst who offers direct help and encouragement. His move from a more classical to a more relational position is a familiar transition to the many psychodynamic practitioners who have welcomed these revisions in analytic thinking and practice. It is a move that allows Dr. Cohen to retain his analytic frame for understanding Daniel, but broadens the range of interventions that he engages in to more supportive and psychoeducational ones, as well as allowing Dr. Cohen to engage with Daniel in a more spontaneous and open fashion than is generally considered technically correct in a more classical analysis.

Readers who are unfamiliar with psychoanalytic history may be unaware of how hotly the question of what constitutes psychoanalysis has been debated, and therefore unaware of what a complicated move on Dr. Cohen's part this can be. Psychoanalysis has long been bedeviled by definitional problems, as seen in the way that practice was divided into "psychoanalysis" and "psychodynamic therapy," with the implication that the psychoanalysis (meaning classical practice) was the more valued therapy (Aron & Starr, 2013). This hierarchical approach to

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different ways of working within an analytic frame has at times made it difficult to regard different approaches to psychoanalytic work as equally valuable, and the unfortunate cost of this, seen most often during training years, has been that therapists themselves may be critical of their own work when they work flexibly. It's unclear from the information we have how much tension there was for Dr. Cohen in choosing between traditional analytic options and more contemporary ones. In a way that might surprise many non-analysts, these choices can feel like complex integrative decisions within an analytic frame.

Robert describes the stance he ultimately took with Daniel as one of an affectively present, accepting and empathic mentor. I would like to expand on Dr. Cohen's thoughts about what this stance afforded Daniel from the perspective of attachment theory, and its outgrowth, Mentalization-Based Therapy (Allen, Fonagy, & Bateman, 2008). It seems likely that Dr. Cohen's way of working served, for Daniel, as an opportunity to develop the capacity to understand and reflect on his internal experience and the experience of others, in other words, to begin to mentalize. We see evidence of this in several of Dr. Cohen's statements, for instance, that Daniel began to understand the members of his family of origin and began to construct a coherent narrative about where he came from, as well as in the descriptions of Daniel and Dr. Cohen noting together Daniel's harshly self-punishing reactions to not living up to his own expectations and his speculations about what his friends were thinking about him. This capacity to think about one's own experience or the experience of others from a meta-cognitive position is a hallmark of the securely attached individual (Allen, Fonagy & Bateman, 2008).

My only question about this phase of the work is that I wonder if Dr. Cohen over-relied on the use of historical interpretations for Daniel's present day behavior, and I wonder about whether Daniel was weighted down or helped by some these linkages at times that was the case. This question is a general one regarding psychoanalytic work, as all too often clinicians seem to overvalue the transformative potential of such interpretations (and are disappointed when interpretation alone does not produce movement). The exploration of Daniel's life is certainly more useful than not, as stated already, for it is part of his acquiring a crucial capacity for mentalizing. And I do not mean to assume that there has been an over-reliance on referencing history in this treatment, only to caution that this may be a place where the analytic therapist can fall into a relatively unproductive yet comfortable technique without closely tracking the impact of doing so.

Certainly, Dr. Cohen himself had begun to feel that the therapy had become stagnant. Robert's questioning what to aim for or expect out of the therapy with Daniel contains a mix of hope and melancholy. Along with maturity can come a respect for our limits and the limits of our endeavors. Freud (1937) understood this, for instance, in *Analysis Terminable and Interminable*, where he wrote,

> Our aim will not be to rub off every peculiarity of human character for the sake of a schematic "normality," nor yet to demand that the person who has been "thoroughly analysed" shall feel no passions and develop no internal conflicts. The business of the analysis is to secure the best possible psychological conditions for the functions of the ego; with that it has discharged its task (p. 249).

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How do we determine what is enough? Dr. Cohen grapples with this complex question, approaching it from many sides. Is there an inherent limit in this dyad and what they can accomplish together? Have these two gone as far as they can? Or have they simply reached the limits of the usefulness of the analytic approach? This question is not asked with despair, after all, Daniel has made many gains. He understands the historical roots of his way of moving through the world, and he is able to think about himself in connection with others and to make more adaptive choices in relation to others. In one important instance, understanding his first girlfriend's effect on his felt well-being, Daniel has been able to break up with her and seek out someone who is more affirmative. This very significant accomplishment speaks to one of Daniel's strengths, the ability to resist the temptation of settling for less from other people that is expressed in his choosing an intensive treatment, as well as his resisting the wish to just isolate and play video games.

THE INTRODUCTION OF "ACT" THERAPY INTO THE PSYCHOANALYTIC TREATMENT

Dr. Cohen's serendipitous introduction to Acceptance and Commitment Therapy (ACT; Hayes, Strosahl & Wilson, 2012) is well-timed. Allowing for the attitude of openness to surprise that is the hallmark of the integrative thinker (Safran and Messer, 1997), Dr. Cohen is curious about what another patient has brought to his attention. Following this patient's comment that ACT work seems to mesh well with the psychoanalytic work she is doing with Dr. Cohen, he begins to explore ACT, and imagines that it might be helpful to Daniel.

Dr. Cohen is correct that there is very little communication between the contemporary psychoanalytic world and the contemporary cognitive behavior therapy (CBT) world, meaning that he would have been unlikely to happen upon ACT in his daily clinical life. Many analysts are unaware of newer, so-called "third wave" CBT models, models that are far more compatible with the basic assumptions of contemporary psychoanalysis than the earlier iterations of CBT; and ACT therapists may be even less informed about the sea changes that have taken place in psychoanalysis over the years, given the current marginalization of psychoanalysis in the field of psychotherapy (Aron & Starr, 2013). Members of each school regard the other as frozen in time, with only a few bridge builders such as Stewart (2014) actively investigating what might be common to both, or where they might complement one another.

ACT theorizing is quite sophisticated, and it shares with contemporary psychoanalysis a fundamentally contextual theoretical basis (Bresler, 2015). The two models are unlike early iterations of both psychoanalysis and CBT. In these earlier models the clinician starts with a set of a priori assumptions about what he will find in the mind of the patient, whether Freud's Oedipal conflict or thoughts found on one of Aaron Beck's lists of common dysfunctional ideas. The newer models are quite open-ended, each assuming that the patient's point of view is the result of specific historical experiences, assimilated into existing mental activity in an ongoing fashion. ACT is embedded within a framework that encompasses not only treatment, but a general understanding of the human condition and also a stated interest in linking therapeutic work with contemporary science, characteristics it shares with relational psychoanalysis. ACT, like psychoanalysis, stresses the ubiquity of human suffering, suffering that often defies

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comprehension, especially when it occurs in the context of a life full of richness and possibility. And relevant to Dr. Cohen's work with Daniel, a shared fundamental tenet of ACT and psychoanalysis is that in order to live fully, we must be able to experience our thoughts and feelings, to the extent possible, without avoidance.

Psychotherapy using contemporary attachment theory as an underlying framework offers a paradigm for uniting relational analytic work with mindfulness-based behavior therapies. In *Attachment in Psychotherapy*, Wallin (2007) outlines the ways in which deficient caretaking by adults who do not have the capacity to understand and mirror their children's reactions, even when they are very small, contributes to impairment in the attachment capacities that are a bedrock of a felt sense of well-being. Daniel did not grow up in a household in which his reactions to interpersonal experience were made understandable through his parents' appropriate resonance. But he has had this experience with Dr. Cohen, and it has made him more confident and more capable of moving through his interpersonal world. Even though Daniel has resisted discussion about what transpires between himself and his therapist, Daniel has been exposed with great care to the process of thinking about thoughts and feelings, and learning to making sense of the social world rather than just experiencing its impact. This experience, the gift of a securely attached childhood, is also one of the possible gifts of an analytic treatment.

In spite of his insight, Daniel is struggling socially, trying to choose between accepting the safety of his small social network or the challenge of forging ahead with developing closer ties to others. He is not comfortable with what he is thinking when he is around others, notably his friend Matt. Daniel is quite ruminative, allowing himself to go around and around with his private thoughts on what is happening in the minds of others. His ruminations impede his social life, as the discomfort of anxiety about what others may be thinking becomes a reason to avoid closeness with them. Although to imagine the mind of the other is a necessary skill, it can be problematic if the client routinely imagines that what is in the mind of other's is negative, and if the client cannot tolerate the discomfort of such thoughts enough to behave in ways that might discomfirm them. It seems that if Daniel were less convinced of the validity of his thoughts, and more willing to tolerate the discomfort of habitual negative thoughts, particularly his ideas about what they might think of him, he would choose more closeness with others.

One of the values of introducing new theories and practices into our work is that alternate models force us to notice and engage with familiar things about our patients in new ways. It appears that Dr. Cohen has been familiar with Daniel's ruminative style for a long time, but it is not so clear that he has had a way to specifically target it or think about how to disrupt it. We might argue that in some cases, psychoanalytic treatment, which normalizes the practice of sharing internal process, runs the risk of providing a dead end for a patient like Daniel in the form of a becoming a forum for ruminative thoughts to run free and unchecked. The ACT paradigm addresses this potential pitfall very well, in offering a way of thinking about rumination that is direct and easy to comprehend. With its focus on the cognitive process termed "fusion" and on its techniques for "defusion," ACT provides an incisive way to potentially disrupt and retrain a mental operation that is long-standing and maladaptive.

Dr. Cohen and Daniel begin working within the ACT model, shifting to a focus on ACT exercises. As described, Daniel finds this phase of the therapy helpful, and in new ways. While

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the work they have done prior has given Daniel skill in mentalizing, this work helps him become more mindful. Daniel begins to practice skills that allow him to hold his thoughts lightly, noticing them but experiencing them as part of a stream of thought, rather than fusing with them in a way that is debilitating personally and socially. Indeed, we find that as Daniel is able to develop some skill at allowing his more disruptive, dysregulating and socially alienating thoughts to come and go without determining his behavior in such an avoidant way, he persists in developing his friendships.

One particularly interesting aspect of the way that this phase of the work is conducted is that it is highly collaborative in what seems to be a new way. The two men, therapist and patient, are partners in deciding which exercises Daniel will do, and when. Trust and mutual respect are well established in this treatment, but this form of collaboration seems to promote a new relational configuration between them. Dr. Cohen and Daniel become co-equals as they are explore something new together. It may well be that an unexpected but valuable outcome of Dr. Cohen's openness to exploration of an approach in which he is not an expert is that Daniel can experience his own agency in relationship to his therapist, who has long been the expert in the room. It is likely that experiencing himself in this fashion has led to his growing confidence that he will be able to enjoy the life he wants even without the therapist's active involvement.

There is one other very compelling aspect to this phase of the treatment, and that is the way in which much of the work takes place out of the session. The ACT work illuminates one of the weaknesses of psychoanalytic treatment, the way in which there is little formal attention to how to get patients to carry out the work of analysis outside of the treatment room. While "home work" is and has been a mainstay of CBT treatments from their inception, psychoanalysts have been slow to recognize the importance of extending therapy outside the treatment room.

This oversight is probably an artifact of the injunction against suggestion, which was such a powerful tenet of psychoanalytic thinking for so long (Hoffman, 2009). This is regrettable. Behaviorists, conversant with the problem of generalizability, are extremely sensitive to the importance of gains manifesting themselves in the context in which life is lived. It is a natural extension of their theory that some of the work of therapy must be done in the natural environment. It is only by observing what is happening there that we can know if progress that we see in the session is robust.

We might ask whether mindfulness work alone would have done much of the necessary work in this treatment. Certainly, Daniel would have been a good candidate for Mindfulness-Based Cognitive Treatment for Depression (MBCT; Segal, Williams & Teasdale, 2002), an eight week group program that targets depression and rumination, and it would have been interesting to see how introducing MBCT early in the treatment might have affected the speed of progress. But I would argue in favor of a treatment that addresses both mentalizing and mindfulness capacities. Following Wallin (2007), I believe that the two skills complement one another, and it would be very difficult to use mindfulness techniques alone to achieve the secure place in the social world that can provide some insurance of emotional well-being. ACT practitioners show an awareness of the vital importance of understanding oneself in the social world, as they have made a home within their community for the practice of Functional Analytic Therapy or FAP, developed by Kohlenberg and Tsai (1991). FAP is a behaviorally framed therapy that addresses

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interpersonal transactions within the therapy process exclusively, and as the authors claim, looks like psychoanalysis in session (but not in the underlying explanation for what is going on in session).

This phase of treatment pulls for Daniel to experience his own autonomy and authority in relationship to his therapist. Daniel experiences himself in this stretch of the work as a decision-maker, likely in a different way than he has before. He picks exercises, he decides whether or not to do them, and he goes on to make many other decisions, even a decision to marry, without so much as consulting his therapist, clear evidence of Daniel's growing confidence and comfort in being his own man. In making room for Daniel's agency in this new way, this phase of therapy sets the stage for the termination process of treatment. At the end of Dr. Cohen's case study, we find that Daniel has begun to organize his own, very personal termination process. He is steadily reducing his session frequency, even planning to end treatment. We may read this as a natural outcome of a long and productive treatment, one that might have occurred in any event, but we may also read it as a consequence of the way in which the ACT work has created another vehicle by which Daniel can take care of himself better on his own. It has left him more confident, and more able to rely on his own capacities to take interpersonal risks.

All CBT therapies, in comparison to psychoanalysis, are tilted toward separation-individuation. The emphasis is on what clients can do for themselves, while relational psychoanalytic work leans toward exploring attachment and connection. It is my guess that many CBT therapists would read this account of treatment and privately think that they could have achieved equivalent results in less time by working in their own modality exclusively. While there are group research methods to address this question in general, in the case of Daniel specifically, the fact is that we will never know if they are right, and it is not an unimportant question. While as clinicians we must have efficiency as one of our values, for after all there can be no justification for prolonging suffering by using tools that are unnecessarily slow, there is also likely no way to measure the impact of the kind of multi-faceted, deeply thoughtful and intimate engagement that an intensive therapeutic relationship with an emotionally available and engaged therapist can provide. My guess is that Daniel would have something very interesting to say about this question.

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