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Commentary on Integrating Time-Limited Dynamic Psychotherapy and a Buddhism-Inspired Aversion/Attachment Model of Client Suffering: The Cases of "Beth" and "Amy"

A TLDP Therapist Meets the Buddha on a Road and No One Is Killed

THOMAS E. SCHACHT [a,b]

[a] James H. Quillen College of Medicine, East Tennessee State University

[b] Correspondence regarding this article should be sent to Thomas E. Schacht, P.O. Box 70308 ETSU, Johnson City, Tennessee 37614
Email: schacht@etsu.edu

ABSTRACT

Samlin's (2016) case studies demonstrate the creative integration of Time-Limited Dynamic Psychotherapy (TLDP) and selected Buddhist psychological concepts. In this commentary I analyze epistemological, theoretical, cultural, and clinical complexities involved in this integration from the perspectives of patient recruitment and selection, therapeutic alliance, diagnostic and outcome assessment, and the nature of the Cyclic Maladaptive Pattern (CMP) concept.

Key words: Buddhism; Buddhist; psychotherapy; time-limited; Time-Limited Dynamic Psychotherapy (TLDP); treatment; intervention; mindfulness; meditation; psychotherapy integration; case studies; clinical case studies

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With two exemplar cases, "Beth" and "Amy," Jason Samlin (2016) demonstrates a creative integration of selected Buddhist psychological concepts with Time-Limited Dynamic Psychotherapy ("TLDP"). The hybrid treatment grafts three Buddhist-inspired techniques onto TLDP, which serves as the primary therapeutic "home." [1] These techniques include mindfulness meditation (modeled after eight week programs developed by others), "turning towards" difficult experiences, and "skillful means." Of these techniques, mindfulness meditation is the most clearly operationalized, while "turning towards" and "skillful means" are conceptually defined but not clearly operationalized. However, the treatments were video-recorded for supervision purposes and, if the videos still exist, they could provide material for pilot development of an observational adherence scale that could document the reliable judgment of different raters on the presence and fidelity of "turning towards" and "skillful means" interventions.

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[1] Samlin is not the first to explore potential relationships between TLDP and Eastern traditions. See, for example: Li, W. (2003). *Confucius on the couch: Time Limited Dynamic Psychotherapy and the Chinese American population.* Dissertation: Wright Institute Graduate School of Psychology. UMI Number 3118200.

The following comments address selected issues from Samlin's demonstration cases involving patient recruitment and selection, therapeutic alliance, and diagnostic and outcome assessment in relation to the concept of a Cyclic Maladaptive Pattern ("CMP").

PATIENT RECRUITMENT AND SELECTION

Samlin's two demonstration patients were selected because they satisfied Levenson's (1995) generic inclusion /exclusion criteria for TLDP and because they "communicated willingness to be involved in an experimental treatment and engage in mindfulness practice." Details of patient recruitment and how "willingness" was assessed (informed consent) were not reported. Such details could be noteworthy since participation in psychotherapy research may involve potentially confounding extraneous motivations that, in turn, may give rise to problematic attitudes and relationship enactments (Schacht,1983). While such idiosyncratic and extraneous factors may washout in a study of large groups, differences along these lines could have an outsized effect when comparing only two cases.

Another issue involves Samlin's choice to apply only TLDP-related substantive inclusion/exclusion criteria. It appears that the Buddhist-inspired interventions were implicitly regarded as appropriate for any patient who appeared suitable for TLDP. While this may be true, suitability determination in the context of a new integrative treatment is ultimately an empirical question. It seems reasonable to wonder if the two patients may have differed from each other with respect to core personality characteristics that, in turn, may have some bearing on amenability to meditation practices. For example, Barkan et al. (2016) reported that personality traits of agreeableness and openness to experience, as measured by the NEO Five Factor Inventory, predicted greater use of Mindfulness-Based Stress Reduction both during the eight week training and at a six month follow-up.

Further, the case descriptions do not address the patients' cultural, spiritual, or religious backgrounds. This is problematic because such factors may inform or affect participation in a Buddhism-related therapy.[2] Samlin's stated goal was a "secular" adaptation of Buddhist-inspired psychological practices, but this aspiration does not control the potential for patients to attribute non-secular meanings. There is no assurance that patients will approach Buddhist-inspired techniques without preconceptions or biases related to Buddhism's status as a complex cultural, religious, philosophical, cosmological, spiritual, and ethical system, or even its association with some martial arts.

ALLIANCE

Samlin does not detail whether or how his proposed therapeutic integration affected the setting of the treatment context or socialization of patients into therapeutic participation. How did the addition of Buddhist-inspired techniques shape patients' understanding of their role or

[2] Beth is described as "Latina" and Amy as "Caucasian" but these limited descriptors do not substitute for assessment of religious, spiritual, or cultural background, which may include beliefs and practices related to prayer, altering consciousness, attitudes toward Buddhism, and so on (e.g. Campesino & Schwartz, 2006).

their expectations for the process and mechanisms of change? The importance of these early activities to formation of a productive working alliance is difficult to overestimate (Orne & Wender, 1968).

Samlin's subjects paid for their experimental treatment on a sliding fee scale according to income. The meanings of a fee, from a Buddhist perspective, may differ from the object-relational and existential meanings of money commonly considered in psychodynamic therapies, such as TLDP. Samlin offers no discussion of how the Buddhist-inspired elements of his integrated treatment might interact with the issue of fees, either from the patient's perspective or with regard to potential countertransferential reactions from a therapist's own investment in Buddhist philosophy. To illustrate the potential different meanings of money in different cultures, here is a story conveyed by a colleague: A Western traveler on a medical mission in Nepal stopped for a refreshment at a rural mountainside café staffed by Buddhist monks. A hand-written menu, in chalk, listed "tea" for $1 and "tea" for $10. The traveler asked about the difference between the $1 tea and the $10 tea and was told "no difference, same tea." In an attempt to recalibrate his stunned Western economic sensibilities, the traveler asked incredulously "why would anyone pay $10 for the same tea that could be had for $1?" The monk shrugged and replied: "Makes some people feel better to pay $10."

Samlin's patients were told that treatment would last between 5-6 months. One patient completed 23 sessions, and the other completed 20. It is not clear that either patient was given a specific termination date at the outset. One wonders how different conceptions of time might impact on using Buddhist ideas in Western-based treatment. To my knowledge, Buddhist philosophy does not embrace Western notions or experience of linear time. Indeed, Western world-views are profoundly challenged by time-related Buddhist ideas of non-local consciousness, karma, and re-incarnation. More mundanely demonstrative of the East-West differences, there is a joke that although the hands on a Buddhist clock move continuously, they always point to "Now."

While Samlin's integration of TLDP and elements of Buddhist psychology is avowedly secular and not explicitly engaged with Buddhist philosophical notions of time, the meditative practices included in his integrative treatment are recognized as capable of altering the subjective experience of time (Wittman & Schmidt, 2014). Accordingly, I think there is an open question as to how the addition of meditative practices may affect the operation of time as a psychological factor in a time-limited therapy.

As described by Samlin, two "intake" sessions "focused on information gathering" were viewed as preceding "formal treatment." A distinction between "intake" and "treatment" may be important for reimbursement or bureaucratic purposes, but from the perspective of therapy process this is an arbitrary and potentially misleading administrative compartmentalization. Psychological development of the therapeutic alliance arguably commences in the first moment the patient or therapist *imagines* the other. Alliance development is certainly not dormant during activities that therapists happen to label as pre-therapy "assessment" (Ackerman et al., 2000). A full description of Samlin's therapy should address the impact of all the contacts with the patient on the alliance.

Therapeutic alliance, although widely studied in other contexts, has received comparatively less attention in the study of mindfulness-based interventions, which has tended to focus on specific factors (Goldberg, Davis & Hoyt, 2013; but see Day, Halpin & Thorn, 2016, showing effects of common factors on mindfulness-based treatment for headaches). To any extent that meditative practice is therapist-guided, as opposed to an autodidactic endeavor, the potential impact of a therapeutic relationship on mindfulness should not be discounted. Samlin implicitly acknowledges this issue, but in a narrow way, via a supposition that his own mindfulness practice benefits the treatment relationship. It would be helpful if Samlin expanded upon ways in which mindfulness practice can impact the therapeutic alliance.

The experience of any psychotherapeutic technique is always shaped by the context of the relationship in which it is implemented.[3] Indeed, a long history of research on common versus specific factors instructs that whether a technique is experienced as salutary or damaging may be determined more by the therapeutic relationship in which it is implemented than by the technique itself. Accordingly, it is reasonable to consider how the addition of Buddhist-inspired techniques may alter or interact with the transference-countertransference dynamics of a therapeutic relationship. In discussing the outcomes of his two cases, Samlin astutely observes that Buddhist-inspired therapy techniques do not exist outside of an interpersonal matrix, and he imagines an avenue for addressing this aspect of Buddhist interventions within the TDLP therapeutic process. However, Samlin's presentation of the therapist's contribution to the interpersonal matrix is limited. On one hand, he speaks about his personal history as an experienced meditation practitioner and the "mindful presence" he hopes this brings to his work.[4] However, he is comparatively silent as to other personal history that might shape interpersonal processes and countertransferential experiences in the therapies he presents (Henry, Schacht & Strupp, 1990).[5]

At least in the case of Amy, the mindfulness component of Samlin's integrated treatment may have carried a relational meta-message that worked at transferential cross-purposes to the establishment and maintenance of a positive and effective therapeutic alliance. Amy's explicit complaint about mindfulness points to this concern: "I've tried to pay attention to my feelings, but they are still there and I still can't talk to my boyfriend or dad." With this protest, Amy conveys an implicit theory that the solution to her difficulties requires blunting her inner emotional voice, making her feelings fade or vanish, as opposed to listening to, understanding, and learning from them. In contrast, from a TLDP perspective, Amy's task is to change the way

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[3] This may be true even with self-directed bibliotherapy or with a "cyber-therapist" in the form of a computer program. In such instances, the book or computer program may be unconsciously anthropomorphized and may operate as a basis for an imaginative proxy relationship.

[4] While I would agree that, all else being equal, therapist mindfulness is probably more beneficial than not, this cannot be taken for granted. Some patients, particularly those who suffer from paranoid-spectrum difficulties and experience empathy as an invasion, may be un-nerved by the experience of interacting with an especially mindful clinician.

[5] Henry et al. (1990) showed that therapist self-reported interpersonal histories within their families of origin were associated with tendencies to engage in parallel forms of interaction with patients.

she listens to and understands her emotions, not simply to turn down the phenomenological volume.

Parallels between Amy's complaints about mindfulness training and her reported relationship difficulties with her father invite transferential hypotheses. If what she sought with her father was interaction and intimacy, then perhaps silent self-focused meditation with her therapist felt too much like the unsatisfying disengagement she experienced with her father? Samlin astutely wondered about something like this, as set forth in his discussion: "It is possible that our mindfulness practice sessions re-created the interpersonal dynamic experienced with her father, where I was the aloof authority figure and Amy was trying to please me, but was unsure of what I wanted her to do."

However, the therapist's response to Amy's complaints about mindfulness training was not to work with the apparent transference, but instead to "challenge Amy's defenses" and to engage her in imaginary role play in which she was encouraged to get *her* needs met by expressing anger and frustration to her father. Rather than organizing treatment around Amy's interpersonally positive motives (the wish that she and her father could be closer), the therapy instead pressured her to overcome her inhibitions about voicing her frustration and her anger.

Of course, if Amy's goal is to maximize the potential for openness, warmth, and affection in a relationship, then becoming a more vocal complainer may backfire and may even elicit the withdrawal by others that she fears. Moreover, by interventions that treat her inhibition as a defect to be overcome (rather than a choice made for potentially understandable reasons), Amy is implicitly encouraged to not only reject her father's behavior, but also to continue rejecting part of herself (the part that feels inhibited around her father).

What could be more helpful, from an alliance perspective, is a re-statement of the problem in a form that facilitates self-affirmation and appreciation for the adaptive origins of Amy's experience and behavior. For example, rather than joining Amy in her self-attack against her own inhibitions, a therapist might instead praise the instinctive caution inherent in her refraining from offering hostile messages when her goal is to have a better relationship. Mindful of the importance of a positive introject to therapy outcome, an adherent TLDP therapist would pursue a therapeutic re-telling that helped Amy to experience her inhibitions in the context of a positive effort to adapt to circumstances as she experienced them. Rather than requiring that Amy see herself as what might be construed as broken and defective, TDLP would encourage empathic self–understanding and then pursue change by positive means, such as by reframing her inhibitions as a well-intended, if flawed, solution that protects her relationship with her father from potentially destructive negative interaction. Her concern about hurting her father is thereby normalized and may instead be appreciated as a manifestation of intuitive and compassionate interpersonal wisdom. A lesson of Amy's therapy may be that mindfulness practice offers no safe harbor from alliance ruptures and that pursuit of mindfulness may even operate with negative transference in a harmful synergy.

The case of Beth also offers a sensitive but important example of how Buddhist techniques may lead to intervention that is potentially problematic from a TLDP perspective. Toward the end of Beth's therapy, the therapist sought to have Beth deal with termination by

using the technique of "turning toward." From a psychodynamic perspective, I wonder whether "turning toward" may at times inadvertently substitute action for reflection. In this regard, consider the description of the final session with "Beth":

> During our final session (#23), Beth and I continued the pattern of my asking how much she wished for me to insert myself into our ending … I relayed how much I had enjoyed our working together and how I had looked forward to our meeting together every week. After I had finished speaking, Beth smiled and said, "I kind of hoped I had an impact on you. It's just nice to hear that (Samlin, 2016, p. 268).

The therapist's choice to disclose his own personal gratification, juxtaposed against inquiry into how much the patient wished that the therapist "*insert myself into our ending*" (Samlin, 2016, p. 268, italics added) seems provocative. To my reading, Beth's complementary disclosure of hoped-for mutuality felt flirtatious and showed little evidence of the "mastery" and "agency" that the therapist consciously sought to promote. If I am not the only one to perceive symbolic whispers of an eroticized transference-countertransference in this narrative, then it is important to consider how this unaddressed dynamic may have shaped the data on Beth's treatment, particularly with respect to the potential for idealization to distort outcome measures.

DIAGNOSTIC AND OUTCOME ASSESSMENT

Potential for Adverse Effects

Samlin characterizes the outcomes of his two patients as "very positive" (Beth) and "moderately positive" (Amy). Such overall summative characterizations of outcome are commonly applied in psychotherapy research as well as in clinical practice. However, summative therapy report cards gloss over incredibly difficult value judgments, may reflect a bias in favor of Western needs to count and keep score, and generally obscure the nuanced subtlety and complexity of lived experience, whether in or out of psychotherapy. William James' (1902) timeless admonition that "most cases are mixed cases and we should not treat our [diagnostic] classifications with too much respect" applies equally to labeling of outcomes.

Moreover, both TLDP and Buddhist-inspired techniques carry potential for unintended adverse effects that may go undetected when they occur in domains outside of the problem parameters selected for measurement at the outset of therapy. Shapiro (1992) found a dose-response relationship in which an overall majority of experienced Vispassana meditators reported some adverse effects, with the likelihood of adverse effects increasing as a function of greater meditative practice. Ironically, an increase in adverse effects concomitant with an increase in voluntary dosing conforms to the definition of addiction, and there have been anecdotal reports of overzealous meditation approximating addiction-like behavior.[6]

[6] Ancient Tibetan texts warn against spoiling the essence of mind by "intellectual and overzealous meditation" (Schaeffer, Kapstein, & Tuttle, 2013), and modern observers have warned against meditation-induced cognitive distortions leading to a "cult of mindfulness" (Brendel, 2015). For anecdotal discussions of "addiction" to meditation by practitioners, see, for example: https://www.quora.com/Is-it-possible-to-become-addicted-to-meditation-Is-such-an-addiction-bad Viewed 12-15-2016.

Traditional psychodynamic thinking emphasizes the importance of balancing exploration with support, titrating a patient's capacity to know a truth about him/herself with his/her capacity to bear that knowledge, and engaging the adaptive capacities of a working ego to find an affirmative perspective from which to move on with life. How does grafting mindfulness onto a dynamic therapy affect the therapist's role in the balancing of exploration and support? Should mindfulness ever be considered a balm against the anxiety evoked by other techniques, such as injudiciously aggressive transference interpretation (Ogrodniczuk et al., 1999)? If mindfulness increases openness to painful experience, and thereby increases subjective distress, should such paradoxical increase in subjective distress ever be discounted as a sign of meditative success? From a psychodynamic perspective, some truths, for some people, may constitute unbearable ego-disintegrating experiences. Can a mindfulness-based approach, informed by a Buddhist perspective that values minimization of "self," find virtue in a Western view that embraces the self and advocates that under some circumstances (supportive therapy) the doors of perception are best left shut?

Ultimately, Western and Buddhist traditions carry potential for fundamental conflicts in values and judgments as to whether a particular psychological effect should be considered adverse or salutary. Consider, for example, Castillo's (1990) question of whether meditation-induced depersonalization should be considered a (negative) disorder or a (positive) meditative accomplishment. Likewise, if meditation precipitates quasi-psychotic experiences (Kuijpers et al., 2007; Yorston, 2001), is this an adverse effect or merely a cobblestone on the path to growth, comparable to purported benefits of similar experiences associated with psychedelic drugs? At an extreme, it seems obvious that states of mind achievable by meditation can be put to extraordinarily controversial uses, as demonstrated by the historical Buddhist practice of transcending the body via self-immolation (Benn, 2007). In therapy cases like Samlin's, then, particular attention should be paid to such potential conflicts in Western and Buddhist sensibilities and perspectives.

The DSM

Buddhist psychology is fond of classification (Four Noble Truths, an Eightfold Path, etc.), but mapping Buddhist categories onto Western systems of classification is daunting. Buddhist emphasis on impermanence and transcendence of self is problematic for Western concepts of psychopathology. If one's apparent state of being is transitory, then change is the primary constant and the self that experiences symptoms is in perpetual flux. Assumptions regarding impermanence and constant change may frustrate Western psychometric approaches to measurement by colliding with Western notions of time-persistent diagnostic criteria and traits.

An additional issue is that the DSM has no definition of mental health other than the limited implicit equation of health with absence of symptoms. In contrast, Buddhism defines an affirmative path of personal and spiritual development. Because of this difference, I would expect DSM-based outcome measurement and Buddhist-inspired outcome measurement to look quite dissimilar. If the Buddha designed a psychotherapy outcome measure, I would expect it to be substantially interpersonal, emphasizing loving kindness toward everyone, compassion in the face of others' suffering, and unenvious joy for others. It might also include a non-interpersonal dimension reflecting equanimity in the face of life's vicissitudes.

Samlin's case studies employ the Mindful Attention Awareness Scale and the Non-Attachment Scale which, between them, capture both interpersonal and non-interpersonal dimensions of pre-therapy disposition and outcome. However, because only aggregate composite scores are reported, the interpersonal and non-interpersonal components of a Buddhist-informed outcome assessment are blended. It could be interesting to analyze potential relationships between interpersonal and non-interpersonal items of these scales, and the observable interpersonal processes versus mindfulness processes of the therapies. It could also be very interesting to see whether TLDP alone, without additional Buddhist-inspired interventions, has an impact on the interpersonal components of a Buddhist-informed outcome assessment.

Samlin describes DSM diagnoses for each of his patients: recurrent major depression for Beth, and unspecified anxiety for Amy. For unknown reasons, no personality disorder diagnoses are proposed, despite apparently ample features in each case to warrant their consideration. One might ask why Samlin used DSM diagnoses, as neither TLDP nor mindfulness require them. From a Buddhist perspective in which suffering is inevitable, the presence or absence of DSM diagnostic criteria may appear to be irrelevant noise. The particular form in which suffering is expressed is less important than the flux of cognitive and emotional habits that underlie the experience of suffering. Of course, such a Buddhist view embraces precisely the type of theoretical thinking that DSM's descriptive nosology deliberately eschews.

On the other hand, if we treat DSM diagnosis as relevant, then Samlin's cases present additional issues worth noting. For example, although Beth reported a history of bulimia, there was no diagnosis of eating disorder, even as "in remission." Instead, features of reduced appetite and negative body image were attributed to depression. While diagnostic parsimony is generally a virtue, in this case it seems reasonable to wonder whether parsimony may have been overdone. A history of combined affective disorder and bulimia is different from bulimia alone (e.g. Hatsukami, et al. 1986). Moreover, even when symptoms like weight loss and body image disturbance overlap, there are real differences between depression and bulimia that argue against diagnostic lumping. Examples include increased likelihood of subtle neurocognitive deficits and co-morbid multi-impulsivity and kleptomania in bulimics, as well as increased likelihood of pathological secrecy and related issues potentially affecting the therapeutic alliance (Vandereycken & van Houdenhove, 1996; Wiederman & Pryor, 1996; Wu et al., 2013).

A DSM diagnostic issue in Amy's case relates to the offering of an anxiety disorder diagnosis despite the fact that her scores on standardized self-report instruments all failed to reach clinical cut-offs. By the case description, this striking finding appears largely unexamined. Do the low scores reflect defensiveness, lack of insight, or something else? "Fake-good" presentations are routine in certain contexts (fitness-for-duty examinations, child custody disputes, or examinations related to conditional release from incarceration), but they are less common in a treatment context. If Amy suffers from an anxiety disorder, but was truly unable to engage in commensurate self-report of subjective states, as could be inferred from her performance on the assessment instruments, did she possess sufficient psychological mindedness to be suitable for the offered treatment?

Amy's comment that she felt unable to speak candidly and openly to her boyfriend "while she is sober," was construed as only a communication problem. However, this description

also provides sufficient reason to consider an alcohol use disorder in the differential diagnosis, and adds alcoholic denial to the list of potential explanations for Amy's benign responses to self-report instruments.

At least phenotypically, Samlin's descriptions of Amy sound consistent with alexithymia-spectrum deficits in awareness, identification, differentiation, and expression of emotion, restrictions in imagination, and related tendencies toward constricted and externally-oriented thinking. Indeed, at one point Samlin characterizes Amy as demonstrating an "extreme, almost pre-verbal difficulty in turning toward her felt experience" (2016, p. 276)." Some research has shown a negative correlation between alexithymia and mindfulness (Baer et al., 2006); but this begs the question of whether mindfulness practice can operate as an antidote to alexythymia, or whether alexythymia is more likely to operate as a barrier to the development of mindfulness, or both.

Samlin's description of Amy as experiencing anxiety sufficient to cause "muscle soreness" at the same time that she fails to elevate self-report measures of anxiety raises a reasonable question about possible somatization dynamics. If present, somatization would add to a circumstantial case for concern about alexithymia. [7] To extend this diagnostic hypothesis a bit further, consider that Amy's CMP includes her complaint of feeling unable to "read" other people. What if this inability to "read" others is not a product of avoidance/aversion, but instead reflects developmental or neurocognitive limitations in social information processing? Moreover, if Amy is alexithymic, then since genetic influences contribute to alexithymia, there is some increased likelihood that her father shares the same trait (Jorgenson et al., 2007). If so, then communication is impaired, in part, not because Amy and her father are hopelessly different (as she imagines), but rather because they are ironically too much alike.

An anxiety disorder diagnosis locates the problem inside Amy and thereby risks iatrogenically aggravating her existing tendencies to blame herself for whatever is transpiring (or not transpiring) between herself and her father. Locating the problem inside Amy may highlight formulations grounded in concepts of deficient self-regulation. Such concepts may also express therapeutic allegiance bias to any extent that the research context gave the therapist an interest in pursuing interventions focused on emotional self-regulation (in Amy's case, the idea that she is over-regulated and that it would help her to surrender inhibitions that were presumed to have no useful function).

Alternative formulations are worth considering. Because Amy's complaints are highly focused on family relationships, particularly with her father and brother, V-code diagnoses of "Parent-Child Relational Problem" and "Sibling Relational Problem" could be appropriate. If such diagnoses were added, this could prompt some alternative systems-thinking about what may be transpiring in Amy's life and could shift the perceived risks and benefits of certain interventions. For example, construing Amy's problem as excessive inhibition leads to a

[7] The case reports are silent as to each patient's medical history, use of prescribed and over-the-counter medications, caffeine, and so on. Such factors would have to be weighed in any consideration of somatization.

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treatment plan that she overcome her inhibitions by confronting feared experience through expressing anger and frustration to her father. Yet, as the case is presented, Amy is encouraged to confront her father despite the therapist knowing nothing about him except as he is represented by Amy. Why should a therapist assume that father is a normal individual capable of responding appropriately to a confrontation from his daughter? [8]

Note that Amy's expectation of her father is that if she carried out the therapist's advice, his response would be "completely flat" and she "wouldn't get anything back from him." If Amy's expectation is not discounted as a distorted description, then isn't Amy conveying that something is seriously amiss with her father? Rather than pushing ahead and treating Amy's resistance to confronting her father as a problem, perhaps the therapist should consider whether Amy's reticence and inhibition might reflect some unarticulated intuitively empathic wisdom that should be respected.

Amy's reticence to confront could be appropriate, for example, if her father has a significant mental illness likely to be aggravated by family expressed emotion. Or, building on Amy's comment that she can't express herself when sober, what if father is an alcoholic and spends his time too inebriated to have a conversation with his daughter? Moving further into the realm of family systems considerations, what if Amy's experience with her father occurs in the context of a simmering but unexpressed severe marital conflict between Amy's parents? If Amy's experience is the product of triangulation in an unspoken parental estrangement, that could help to explain why she reportedly can talk to her mother about "anything" but can have no conversation with her father. From a family systems perspective, mother may be as much a part of the problem as father. By remaining at home in the middle of a gridlocked parental relationship scenario, Amy's suffering could be an unconscious gift of love that keeps her parents from taking the final step toward a divorce, or worse. The potential family scenarios that could give rise to Amy's experience are almost endless, but none of them will be investigated if the problem is *a priori* diagnostically located inside Amy.

CYCLIC MALADAPTIVE PATTERN ("CMP")

My Personal Experiences and Views

I believe that the CMP shares more with Buddhism than may be appreciated from Samlin's application. To set a stage for explaining this idea, I will digress into some personal history of my own, as well as some intellectual history of how the Vanderbilt version of the CMP

[8] Ironically, Samlin's recommendation that Amy confront her father with her complaints and frustrations, despite her fears that this would hurt him, could be viewed as opposite to the loving kindness, compassionate, and acceptance responses that could have informed a deeper philosophical integration of TLDP and Buddhist psychology. Even without a Buddhist influence, TLDP does not embrace a catharsis model of emotional healing, but rather supports principles of interpersonal complementarity akin to the Golden Rule. By this model, Amy would have been helped to offer her father what she hoped to receive (engagement, affirmation, empathy) and would have been cautioned about making complaints likely to invite what she wished to avoid (i.e., complementary defensive withdrawal).

was conceived. I then will discuss potential problems with Samlin's attempt to integrate Buddhist techniques with the CMP by adding a new CMP element.

In any life, certain learning moments may emerge as transformational. In reflecting for this commentary on Samlin's model of Buddhist-inspired TLDP, two such personal experiences stand out. In the first, a new psychotherapy supervisor quietly tolerated my anxious rattling-on about various ways we might organize our work together. He then brought my task-oriented monologue to an abrupt halt with a simple expression of curiosity: "What's all this about 'work'?" While I speechlessly pondered what I retrospectively appreciate as a koan, the supervisor smiled, handed me a small book from his shelf, and waved me out of his office, stating: "We're done for today. Read this. I'll see you next week." The title: "Zen in the Art of Archery" by German philosopher Eugen Herrigel. In the second learning moment, after listening patiently to my obsessively over-prepared seminar presentation, a brilliant philosophy professor gently cracked my cosmic egg: "Mr. Schacht," she said, "that was exceptionally well-argued, but I am wondering, do you think you may have succumbed to your own point of view?"

Moments like the foregoing, and what they set in motion, stand for me as a paradigm of how psychotherapy works. In my view, life problems, or "suffering" from a Buddhist perspective, persist when we are captured by or become stuck in our own limited or troublesome points of view (a.k.a life narratives) and their associated self-sustaining patterns of living. The art of psychotherapeutic helping is about transforming those problematic narratives and patterns into something more useful. Although "narrative" ordinarily connotes a story told in words, in the context of psychotherapy the story may encompass all forms of mental representation, experience, and imagination—whether psychic, bodily, interpersonal, or otherwise. As patients and clinicians labor together to craft therapeutic re-tellings, they highlight hidden or overlooked truths, make some pain more bearable or some pleasure more achievable, and re-animate paralyzed perspectives so that life may feel less stuck and may proceed with a greater sense of "flow" (Csikszentmihalyi, 1990).

Perhaps because hermeneutic reframing lies at the heart of therapeutic narrative, it should come as no surprise that, Sisyphus-like, our profession engages in a perpetual retelling of the story of psychotherapy itself. By seeking to retell the story of psychotherapy in a less fragmented and compartmentalized manner, psychotherapy integration is "therapy" for a profession that frequently seems to be on the verge of impossible complexity and cognitive dissonance. At best, deep integrative retelling can evoke moments of profound understanding. At worst, pseudo-integrative thinking may render us prey to a curse of Babel, characterized by distinctions without a difference that merely assign new words to old phenomena.

In the abstraction-laden world of academic discourse it is easy, when considering psychotherapy integration, to overemphasize theory and to under-emphasize or even ignore the fundamental fact that *production of therapeutic narrative, like the art of archery or that of music,*

is ultimately a performance skill.[9] Moreover, therapeutic narration is not a solo performance. Psychotherapy joins therapist and the patient together as partners in an ensemble. Depending on the particular treatment, therapeutic ensembles may play with varying degrees of freedom. Highly prescriptive manualized treatments are similar to playing the notes from a written composition; other approaches, more like jazz, involve disciplined improvisation. But regardless of the balance between prescription and improvisation, to avoid cacophony it is essential that ensemble players continuously listen to and adjust to each other and perform within an agreed and mutually understood framework. Most importantly, the performance of an ensemble is inextricably embedded in the relational histories of the participants, both with each other and with previous ensembles.

But wait, one might ask, isn't psychotherapy a quasi-medical intervention intended to relieve signs and symptoms of psychopathology? Where in the DSM or the ICD are the diagnostic criteria for a broken or paralyzed life narrative? What are the functional neuroimaging correlates? Is there a CPT code for "Life Narrative Reconstruction"? The foregoing questions derive from psychotherapy's own culturally embedded meta-narratives and represent but one point of view, albeit one embedded in a dominant matrix of Western capitalist, materialist, and reductionist assumptions.

Viewed from a Western quasi-medical perspective, the CMP is an elaborated interpersonal diagnosis, a statement implicitly grounded in historical fact. In this view, therapeutic construction of a CMP yields a product—a case formulation statement—and involves pursuit of historical truth, whether recollected in declarative memory or in performance via re-enactment in the transference. While TLDP's concept of the CMP has been adapted to such quasi-diagnostic purposes, its origins were quite different, and stemmed instead from a somewhat radical embrace of the primacy of narrative truth (Spence, 1982). Of particular interest here is the potential overlap between the impermanence and flexibility of narrative truth and Buddhist epistemology.

The CMP Within the Vanderbilt Model

In my work with Hans Strupp's team on the Vanderbilt version of TLDP's concept of the CMP, this concept was created to meet a research need (Schacht, Binder, & Strupp, 1996). Advocates of short-term therapies had for some time promoted various notions of a "therapeutic focus," but this concept had not been well operationalized so as to render it accessible to empirical research. This gap between theory and method became pragmatically urgent when, as a matter of policy, the National Institute of Mental Health made it clear that no funding would be made available for research on any treatment that was not manualized.

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[9] No serious music student would expect to learn effectively by playing alone in a practice room and then later supplying a description of the performance to their teacher. Too many psychotherapists in training and their supervisors persist in treating their art as if its performance can be learned in this way (Haggerty & Hilsenroth, 2011).

Similar to the way a linguist may reverse-engineer the organization of a language by analyzing examples of native speakers' utterances in context, the Vanderbilt CMP resulted from a process of reverse-engineering the narrative structure of effective therapeutic conversations about interpersonal experiences and patterns. Just as speakers of a language proceed without conscious reference to the rules of grammar and syntax that structure their utterances, it was assumed that therapeutic conversations about interpersonal life could likewise be understood as governed by unconscious but potentially articulable psycholinguistic rules. It was hoped that if the hypothesized rule-governed nature of interpersonal stories could be made explicit, the structure for a "well-formed interpersonal narrative" might be adapted to other purposes, such as mapping onto a system for empirically analyzing interpersonal interactions (e.g. Structural Analysis of Social Behavior) or functioning as a heuristic aid to clinical practice.

When the CMP is construed as a quasi-diagnosis or a diagnostically extended case formulation, it is arrived at early and conveyed to the patient like any other diagnostic information. By his description, that appears to be what occurred in Samlin's therapies. Thus, Treatment Goal # 1 included: "Orient (P) to TLDP; identify the five sections of P's CMP and discuss with P. how her CMP is contributing to her psychological distress" (Samlin, 2016, p. 257 for Beth, p. 272 for Amy).

However, such therapist-driven case formulation is not how the CMP was originally intended to function. Rather than operating as a quasi-diagnosis provided by the therapist, a CMP was designed to offer a heuristic assistance to the process of jointly constructing therapeutic narrative. Moreover, the process of that joint endeavor was at least as important as, and perhaps more important than, its content.[10] If the structure of the CMP is understood as a generic template for systematic inquiry and reflection into interpersonal patterns, then the most important thing that the patient acquires from the joint construction of a CMP is not its particular content, but rather a meta-cognitive framework for thinking about interpersonal experiences in general. Stated differently, the CMP is more a tool used to facilitate a way of thinking rather than to examine the content of thought. In the most effective therapies, patients find themselves thinking through situations in ways that come to mirror the form, more than the content, of previous therapeutic dialogues.

If the therapist unilaterally crafts a CMP-as-product and serves it up to the patient as a finished work, then the collaborative promotion of meta-cognitive development is thwarted. If a therapist finds him/herself "telling" a patient what the CMP *is*, then the process has gone awry; and, at worst, the therapist has become a controlling authoritative expert, and the patient is subtly pushed into the complementary role of submissive and ignorant pupil. As a tool in the service of pursuing narrative truth, a CMP is a process, never finished, always a work-in-progress, and always (from a Buddhist perspective) merely the way things appear *now*.

[10] In some respects, this idea resembles Linehan's "chain analysis," which Samlin describes employing to good effect.

Samlin's Addition of a New CMP Element, "Attachment/Aversion Patterns"

Samlin identifies the Cyclic Maladaptive Pattern with TLDP, but promotes the Buddhist integration by adding a new CMP element called "Attachment/Aversion Patterns." As applied to his demonstration cases, both Beth and Amy were identified in this component of the new CMP as suffering from a dysfunctional style of self-reflection that is antithetical to mindfulness (rumination and self-criticism—see Nolen-Hoeksema et al. 2008). Samlin does not appear to consider ways in which rumination or self-criticism may arise within, and be maintained by, interpersonal interactions. Instead, the primary interpersonal nexus in Samlin's use of the proposed new CMP category is that the topic of the patient's ruminative thinking is interpersonal or that difficult interpersonal experiences precipitated episodes of rumination.

Samlin is correct to focus on rumination and self-criticism as important substrates for suffering and as targets for intervention, whether by mindfulness techniques or otherwise. However, in light of the foregoing discussion of the CMP, it should be clear that treating these phenomena as cognitive styles, and adding them to the CMP as a new category, is like adding a new rule of grammar to a language—not something to be undertaken lightly. Before concluding that an interpersonally-grounded CMP is incapable of capturing self-critical rumination (or any other topic related to Buddhist psychology), it would be interesting to see if these phenomena could be represented within the existing CMP structure.

For example, consider Samlin's description of Amy in the new CMP category as engaged in avoidance of sadness and fear during "interpersonal interactions" via "ruminative problem solving." The particular nature of the "interpersonal interactions" that resulted in rumination was not specified. Yet, if the rumination is viewed as a self-directed, introjective act, then it is presumed to represent an internalization of some interpersonal experience, and qualitative details of that experience are critically important to a CMP narrative. [11]

Was Amy's rumination and self-criticism modeled after the rumination and self-criticism she observed in important others? Was she effectively instructed in rumination by particular forms of interpersonal interaction (such as being disciplined by isolation during which she was told to think or pray about her transgressions?) Did adult interpersonal demands that required insight beyond her current developmental capacity promote rumination and obsessionality as a coping attempt to demonstrate effort and willingness to please? In the context of its interpersonal history, was the rumination experienced introjectively as self-affirming, self-helping, self-criticizing, self-abandoning, something mixed, or something else? [12] Any of the foregoing could

[11] Indeed, the self-regulatory capacities targeted by mindfulness training are recognized as having important interpersonal roots in even the earliest nonverbal mother-infant interactions (Feldman, Rosenthal & Eidelman, 2014).

[12] Just as the actions of one person may assist another to enter, heighten, and maintain an open, receptive, and nonjudgmental awareness of the present, interpersonal actions may introjectively evoke negative states of mind. Arriving at a satisfying story of how this happens to a particular person is the joint work of a CMP-guided narrative.

support an understanding of self-critical rumination as an introjective experience capable of being described under the existing CMP category of "Acts of Self Toward Self."

Samlin's statements of the CMP also appear to overlook an additional nexus with Buddhist philosophy around the concept of, and a patient's relationship to, desire. Per the four "Noble Truths" of Buddhism, suffering is self-inflicted, inherent to the pursuit of pleasure and avoidance of pain; both of which, in turn, flow from attachment to, and craving for, inevitably imperfect, insubstantial, and transient experiences. Hence, a Buddhist key to modulating suffering is to address its underlying roots in attachment and desire.

The Buddha's insights into relationships between attachment, desire, and suffering are not unique. I have observed them re-invented in distorted forms as elements of maladaptive neurotic adjustment. For example, many years ago, a young woman who knew nothing of Buddhism dug her fingernails into bleeding forearms and wailed to me that her treatment goal was simple: "I know what I need. I just want to stop wanting anything." Another patient disclosed a pattern of immediately damaging or breaking any new gift she received, however much it had been initially valued. Her psychological rationale for this pre-emptive strike against the objects of her attachment was to remain in control of what she regarded as an inevitable future betrayal and loss. Yet another patient, in a striking example analogous to "turning toward," revealed that for two months he had deliberately foregone any treatment for a badly abscessed tooth because he welcomed—indeed reveled in—the excruciating physical pain.

As originally envisioned, the concept of desire was an inherent feature of the CMP, albeit expressed in the traditional psychodynamic dialectic of wishes and fears, and the interpersonal matrix in which wishes and fears are expressed and persist. Therapeutic intervention in TLDP addresses the patient's introjective relationship to their wishes and fears. Psychic acceptance of forbidden wishes (while refraining from acting on them) is recognized as a potential path to greater well-being. Samlin's statements of CMP formulations omit this link to desire, speaking to what his patients felt, did, or expected, but not to what they wished or feared. Perhaps a deeper integration between TLDP and Buddhist psychology could revisit this issue in the future.

CONCLUSION

In sum, Samlin's rich case studies of "Beth" and "Amy" illustrate a creative integration of selected Buddhist psychological concepts with Time-Limited Dynamic Psychotherapy ("TLDP"). Stepping back, I have analyzed and discussed the epistemological, theoretical, cultural, and clinical complexities involved in this integration, in a variety of areas, including patient recruitment and selection, forming and maintaining a therapeutic alliance, diagnostic and outcome assessment, and the nature of the Cyclic Maladaptive Pattern concept. Samlin's work is to be commended for manifesting and exploring these complexities in concrete clinical process.

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