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Series Preface

Tony Rousmaniere and Alexandre Vaz

We are pleased to introduce the Essentials of Deliberate Practice series of training books. We are developing this book series to address a specific need that we see in many psychology training programs. The issue can be illustrated by the training experiences of Mary, a hypothetical second-year graduate school trainee. Mary has learned a lot about mental health theory, research, and psychotherapy techniques. Mary is a dedicated student; she has read dozens of textbooks, has written excellent papers about psychotherapy, and receives near-perfect scores on her course exams. However, when Mary sits with her clients at her practicum site, she often has trouble performing the therapy skills that she can write and talk about so clearly. Furthermore, Mary has noticed herself getting anxious when her clients express strong reactions, such as getting very emotional, hopeless, or skeptical about therapy. Sometimes this anxiety is strong enough to make Mary freeze at key moments, limiting her ability to help those clients.

During her weekly individual and group supervision, Mary's supervisor gives her advice informed by empirically supported therapies and common factor methods. The supervisor often supplements that advice by leading Mary through role plays, recommending additional reading, or providing examples from her own work with clients. Mary, a dedicated supervisee who shares tapes of her sessions with her supervisor, is open about her challenges, carefully writes down her supervisor's advice, and reads the suggested readings. However, when Mary sits back down with her clients, she often finds that her new knowledge seems to have flown out of her head, and she is unable to enact her supervisor's advice. Mary finds this problem to be particularly acute with the clients who are emotionally evocative.

Mary's supervisor, who has received formal training in supervision, uses supervisory best practices, including the use of video to review supervisees' work. She would rate Mary's overall competence level as consistent with expectations for a trainee at Mary's developmental level. But even though Mary's overall progress is positive, she experiences some recurring problems in her work. This is true even though the supervisor is confident that she and Mary have identified the changes that Mary should make in her work.

The problem with which Mary and her supervisor are wrestling—the disconnect between her knowledge about psychotherapy and her ability to reliably perform psychotherapy—is the focus of this book series. We started this series because most therapists experience this disconnect, to one degree or another, whether they are beginning trainees or highly experienced clinicians. In truth, we are all Mary.

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To address this problem, we are focusing this series on the use of deliberate practice, a method of training specifically designed for improving reliable performance of complex skills in challenging work environments (Rousmaniere, 2016, 2019; Rousmaniere et al., 2017). Deliberate practice entails experiential, repeated training with a particular skill until it becomes automatic. In the context of psychotherapy, this involves two trainees role-playing as a client and a therapist, switching roles every so often, under the guidance of a supervisor. The trainee playing the therapist reacts to client statements, ranging in difficulty from beginner to intermediate to advanced, with improvised responses that reflect fundamental therapeutic skills.

To create these books, we approached leading trainers and researchers of major therapy models with these simple instructions: Identify 10 to 12 essential skills for your therapy model where trainees often experience a disconnect between cognitive knowledge and performance ability—in other words, skills that trainees could write a good paper about but often have challenges performing, especially with challenging clients. We then collaborated with the authors to create deliberate practice exercises specifically designed to improve reliable performance of these skills and overall responsive treatment (Hatcher, 2015; Stiles et al., 1998; Stiles & Horvath, 2017). Finally, we rigorously tested these exercises with trainees and trainers at multiple sites around the world and refined them based on extensive feedback.

Each book in this series focuses on a specific therapy model, but readers will notice that most exercises in these books touch on common factor variables and facilitative interpersonal skills that researchers have identified as having the most impact on client outcome, such as empathy, verbal fluency, emotional expression, persuasiveness, and problem focus (e.g., Anderson et al., 2009; Norcross et al., 2019). Thus, the exercises in every book should help with a broad range of clients. Despite the specific theoretical model(s) from which therapists work, most therapists place a strong emphasis on pantheoretical elements of the therapeutic relationship, many of which have robust empirical support as correlates or mechanisms of client improvement (e.g., Norcross et al., 2019). We also recognize that therapy models have already-established training programs with rich histories, so we present deliberate practice not as a replacement but as an adaptable, transtheoretical training method that can be integrated into these existing programs to improve skill retention and help ensure basic competency.

About This Book

Within the series, this book is a guide for incorporating deliberate practice into the training of psychodynamic trainees and clinicians. To begin, it is important to state that there is no one psychodynamic psychotherapy. Contemporary psychodynamic psychotherapy comprises a diverse family of treatment approaches. This aspect has made writing this book somewhat difficult. The authors needed to come to a more-or-less common understanding of the concepts, ways of formulating, and interventions of psychodynamic psychotherapy that they were going to focus on as a basis for their deliberate practice exercises. Fortunately, there are core common elements that the various psychodynamic approaches share (e.g., importance of conflict, early childhood development, unconscious processes). The psychodynamic therapy (PDT) deliberate practice skills that they have chosen for this book all pertain to these common elements (see Chapter 1 for more details). Consequently, practicing these skills should enhance the development of proficiency in any form of psychodynamic treatment, including both long-term and short-term therapies. In addition, in deriving the skills for this book, they have relied

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on an attachment-based, relational-psychodynamic treatment that incorporates all the common PDT elements—time-limited dynamic psychotherapy (Binder, 2004; Binder & Betan, 2013, 2022; Levenson, 2017).

By following the 12 skill exercises in this book, trainees can apply these PDT interventions with real patients more rapidly and smoothly than has been the case with traditional training methods, characterized by an awkward jump from classroom to actual therapy settings. Deliberate practice can help therapists integrate core PDT skills into their repertoire and into their own unique style. Deliberate practice as espoused in this book is intended as an enriching addition to PDT traditional training comprising course work, supervised therapy with real patients, and the therapist's own therapy. The PDT skills set forth in this book are not intended to comprehensively cover all relevant therapeutic skills. They have been chosen from a wide range of skills that capable PDT therapists must learn to offer psychodynamic treatments that are responsive to their patients' needs, contexts, and backgrounds.

The authors find this an exciting time to be doing PDT. Psychodynamic ways of thinking have now become so adopted into mainstream society that we hardly can appreciate how revolutionary they were when Freud and his colleagues conceived of them. Freud was a neurologist who hoped to create a neuroscience-based explanation of how the mind worked. His 1895 *Project for a Scientific Psychology* was, as they say, way ahead of its time (Freud, 1950/1895). Freud had to abandon this project because the understanding of the brain/mind during his lifetime was so rudimentary. We have had to wait until modern times to have sophisticated methodologies and noninvasive neuroimaging techniques to begin to explore the neurological correlates of some of the basic ideas behind psychodynamic practice. Today we are discovering that many of the central tenets of contemporary psychodynamic theory and practice (unconscious processes, defenses, transference, the centrality of conflict, representations of self and others, a relational mind, the importance of early development, psychological causality, corrective emotional experiences, and memory) may have neurological correlates. Recent developments in the cognitive neurosciences, neuropsychoanalysis, and developmental psychology have fostered a renewed interest in empirical foundations of psychodynamic forms of psychotherapy with their implications for practice (e.g., Cosolino, 2012; Damasio, 2012; Roffman & Gerber, 2009; Solms & Turnbull, 2011). As opined by Siegel (2017), "Freud is smiling from his grave." Modern science is beginning to support some of what he proposed, albeit in a very contemporary form. In addition, the authors agree with neuroscientist Eric Kandel (1999), who won the Nobel Prize in Medicine in 2000, that psychoanalytically oriented ways of conceptualizing and intervening "still represent[s] the most coherent and intellectually satisfying view of the mind" (p. 505).

One last, prefatory word—the methods of precise rehearsal required of deliberate practice may appear out of place or even off-putting to teachers and supervisors who are training students to work in a field that cherishes awe, reverie, and unplanned "moments of meeting" (Lord, 2017; McWilliams, 1999; Stern, 2004). Nonetheless, the authors invite those with a skeptical attitude and critical eye to try this book, assess the reactions of the trainees and their patients, and then evaluate its usefulness for themselves.

Thank you for including us in your journey toward psychotherapy expertise. Enjoy your learning, enjoy the process! Now let's go practice!

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CHAPTER 1

Introduction and Overview of Deliberate Practice and Psychodynamic Therapy

It's almost 10 a.m. on a Sunday morning in the San Francisco Bay area. I've finished reading the front-page section of *The New York Times* along with my cup of Peet's coffee, and I'm setting up my computer on the kitchen table to get on Zoom to connect with Jeff Binder and Volney Gay, who are in Nashville, Tennessee. We have been meeting like this for 2 years now—almost overlapping entirely with COVID's sheltering-in-place protocols. I've known Jeff for more than 40 years since my early days at the San Francisco VA Medical Center, which was my first real-time job after I became a clinical psychologist. There I was responsible for training students and doing outpatient therapy mainly with Vietnam-era veterans. As part of my training responsibilities, I was heading up a Brief Psychodynamic Therapy Program for psychology predoctoral interns and third-year psychiatric residents. As part of this program, each trainee was assigned to work with one patient in a time-limited therapy (maximum 20 sessions). All sessions had to be videotaped, and trainees engaged in a group supervision every week where they would share portions of their videotaped sessions for that week. I would stop these tapes at critical junctures and ask the group members what they would say or do now and why. I would routinely call on the students to share their thoughts, feelings, and behavioral inclinations about their patients and about their colleagues' patients (what I called their *interactive countertransference*). We would often use those reactions to hypothesize how down the road they might "get hooked" (Kiesler, 1988) into reenacting some dysfunctional dynamic with the patient. There was a lot of focus on learning microskills, the absence of which became starkly clear during the drama of actual sessions.

It was during this time, in the early 1980s, that I heard about a National Institute of Mental Health (NIMH) study that was being conducted at Vanderbilt University in Nashville (which came to be nicknamed "Vandy II"). And that's how I met Jeff Binder. I invited myself to Nashville to see what was happening. Jeff was conducting the NIMH study with Hans Strupp, already a giant in the field of psychodynamic research and scholarly writing; they were in the process of supervising experienced therapists in how to do a relational form of time-limited dynamic psychotherapy (TLDP) that was designed to help therapists manage their countertransference reactions when seeing "difficult patients."

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Deliberate Practice in Psychodynamic Psychotherapy, by H. Levenson, V. Gay, and J. L. Binder
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It had been noted in "Vandy I" (a study done some years earlier) that certain patients (especially those who were outwardly hostile, demeaning, or otherwise unpleasantly provocative) were very adept at undermining their therapists' competent use of clinical skills. Therapists facing these difficult patients found that they were so preoccupied with managing their own emotional reactivity to their patients' demeaning or hostile stances, that they lost their therapeutic perspective and became enmeshed in their patients' *mishigas* (a Yiddish expression loosely translated as "their own neurotic stuff"). Jeff went on to write the now-classic book with Hans, *Psychotherapy in a New Key: A Guide to Time-Limited Dynamic Psychotherapy* (Strupp & Binder, 1984), that explicated this model of modern psychodynamic–interpersonal therapy designed to help therapists formulate and intervene without becoming unwitting accomplices to their patients' dysfunctional pushes and pulls in the therapeutic relationship.

So when Tony Rousmaniere approached me to write a manual for beginners to learn psychodynamic skills through deliberate practice, I immediately thought of Jeff as a coauthor. Jeff had by this time written his own papers and books on how to teach clinical competencies, and I admired how his mind worked. Just as personal computers were becoming available to the public, Jeff wrote about using hyperlinks to teach psychotherapy skills. I knew I had met an exceptional thinker when he suggested that "common sense" could be a very helpful therapeutic tool.

When I contacted Jeff to tantalize him into working on this endeavor with me, he immediately replied that we needed to involve a third person, Volney Gay, in the project. He described Volney as a Renaissance therapist's therapist who had held professorships in psychology, religious studies, and anthropology, as well as being a training and supervising analyst. The minute Volney showed us a video of how to learn to ride a bicycle step by step (hint: the first step doesn't involve pedaling), I knew we had found our third musketeer—a training analyst, who while seeing the infinite complexities of connecting with another human mind, could also envision clinical learning as incorporating discrete microskills.

Back to me at my kitchen table zooming in to meet with Jeff and Volney for our regularly scheduled 2-hour Sunday meeting to discuss the skill we were working on that month for this book. There would be laughter, discussions of philosophies of human nature, and pedagogical methods, interspersed with working on the conception, composition, and testing of scores of exercises—12 of which made it into this manual. There were times we were daunted by what we were trying to do, and then there would be flashes of encouragement and relief as we watched videos of trainees trying out our exercises and exclaiming, "Hey, we're beginning to get it!"

Adding up the years the three of us have been teaching, supervising, and doing clinical work, the number is around 150! When we started out in this profession, our hair was darker and there was more of it. But as we came together to write this book, we were still just as excited and eager to venture into uncharted territories as when we began our careers. We are pleased to introduce this enlivening way to learn in a field that we promise will never be tedious or monotonous, but rather continuously challenging and enriching.

Overview of the Deliberate Practice Exercises

This book focuses on 14 exercises that have been thoroughly tested and modified based on feedback from psychodynamic therapy (PDT) trainers and trainees. Each of the first 12 exercises each represent an essential psychodynamic skill. Table 1.1

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TABLE 1.1. The 12 Psychodynamic Skills Presented in the Deliberate Practice Exercises

Intermediate Skills	Advanced Skills
1. Engaging in a therapeutic inquiry 2. Therapist awareness of counter-transference reactions 3. Deepening emotional experience 4. Making process comments 5. Pointing out defenses and inquiring about underlying fear 6. Introducing the rationale for treatment	7. Making transference interpretations 8. Using metaphors 9. Exploring fantasy 10. Case formulation: gathering data for the cyclical maladaptive pattern 11. Using supervision to recognize reenactments 12. Providing a corrective emotional experience

presents the 12 skills that are covered in these exercises. The last two exercises are more comprehensive, consisting of an annotated psychodynamic-relational transcript of an actual case (Exercise 13) and improvised mock therapy sessions (Exercise 14). Together they teach students how to integrate these 12 skills into more expansive clinical scenarios.

In these exercises, trainees work in pairs under the guidance of a teacher and role-play as a patient and a therapist, switching back and forth between the two roles. Each of the 12 skill-focused exercises consists of 15 patient statements grouped by difficulty—beginner, intermediate, and advanced—that calls for a specific skill. For each skill, trainees are asked to read through the description of the skill, its criteria, and some examples of it. The trainee playing the patient then reads the statements, which present possible symptoms, problems, and emotional states. The trainee playing the therapist then improvises a response that meets the criteria that define that particular skill. The one exception to this format is Exercise 11, where the role-plays are between a trainee playing the supervisor and a trainee playing the therapist.

After each patient statement and therapist response couplet is practiced several times, the trainees will stop to receive feedback from their teacher. Guided by the teacher, the trainees will be instructed to try statement–response couplets several times, working their way down the list. In consultation with their teacher, trainees will go through the exercises, starting with the least challenging and moving to more advanced levels. The triad (teacher–patient–therapist) will have the opportunity to discuss whether exercises were too hard or too easy and adjust them accordingly.

In consultation with teachers, trainees can decide which skills they wish to work on and for how long. On the basis of our testing experience, we have found practice sessions should last about an hour for maximum benefit. Anything longer can cause trainee fatigue and reduce learning efficiency.

We envision these exercises being done during an hour of class time or as homework assignments. We found that using the internet (e.g., Zoom calls) provided an easy way to partner with another classmate and provided a simple way to record the sessions for later review or viewing by the teacher. We understand that in the pragmatics of teaching many students at once, the teacher or supervisor may not be available for students while they are practicing. In that case, the exercise will be the therapist–patient dyad alone. Anticipating this adjustment, at the end of all exercises, we provide a few plausible therapist responses so students can judge whether they have met the skill criteria. It is best for the role-playing therapist to improvise responses before consulting the possible responses provided, staying true to the tenets of deliberate practice.

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Ideally, learners of psychodynamic–interpersonal theory and practice will both gain confidence and achieve competence through practicing these exercises. *Competence* is defined here as the ability to perform a psychodynamic skill in a manner that is flexible and responsive to the patient. We have chosen skills we view as essential to PDT and that beginning practitioners often find challenging to implement.

The skills identified in this book are not comprehensive. They do not represent everything one needs to learn to become a competent psychodynamic clinician. Far from it! A short history of psychodynamic–interpersonal approaches and a brief description of the deliberate practice methodology will be provided to explain how we have arrived at the union between them.

The Goals of This Book

We have three primary goals: (a) to familiarize trainees with the format of deliberate practice so that they can draw on deliberate practice throughout their professional careers, (b) to help trainees achieve competence in core psychodynamic–interpersonal skills, and (c) to introduce the background and function of deliberate practice to teachers/supervisors and thereby encourage its use.

In addition, these deliberate practice exercises are designed to achieve the following:

1. Help therapists-in-training develop their ability to apply the skills in a range of clinical situations.
2. Move these skills into procedural memory (Squire, 2004) so therapists can access them even when they are tired, stressed, overwhelmed, or discouraged.
3. Provide therapists-in-training with an opportunity to exercise a particular skill using a style and language that is congruent with who they are.
4. Provide the opportunity to use these skills in response to varying patient statements, presenting problems, and affects. We designed them to build confidence to adopt skills in a broad range of circumstances within different patient contexts.
5. Provide therapists-in-training with many opportunities to fail and then correct their failed response on the basis of feedback. This helps build confidence and persistence.
6. Finally, this book aims to help trainees discover their personal learning style so they can continue their professional development long after their formal training is concluded.

Who Can Benefit From This Book?

This book can be used in multiple contexts, including in graduate-level courses, supervision, postgraduate training, and continuing education programs. We assume the following:

1. The trainer is knowledgeable about and competent in PDT.
2. The trainer can demonstrate how to use PDT skills across a range of therapeutic situations, via role-play and/or video. There are numerous accessible American Psychological Association (APA) videos illustrating psychodynamic strategies and techniques

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that can be used for this purpose (e.g., Beck et al., 2012; Levenson, 1999, 2008, 2010; McCullough, 2005; McWilliams, 2008; Safran & Carlson, 2008, 2009; Wachtel, 2007).

3. The trainer can provide feedback to students regarding how to craft and improve their application of PDT skills.
4. Trainees will have accompanying readings, such as books and articles, that explain the theory, research, and rationale of PDT and each particular skill. Recommended reading for each skill is provided in the sample syllabus (Appendix C).

The exercises covered in this book were piloted many times in various training sites. This book pertains to trainers and trainees from different cultural backgrounds worldwide. For guidance on how to improve one's skills in dealing with multicultural issues, see the forthcoming book *Deliberate Practice in Multicultural Therapy* (Harris et al., in press).

We wrote this book for those in all stages of formal training (from never having seen a patient to postdoctoral settings). However, it will be of interest to seasoned therapists as well. Experienced therapists know that to do clinical work competently, one needs to pursue lifelong learning approach. All exercises feature guidance for assessing and adjusting the difficulty to precisely target the needs of each individual learner. The term *trainee* in this book is used broadly, referring to anyone in the field of professional mental health seeking to acquire PDT skills.

Deliberate Practice in Psychotherapy Training

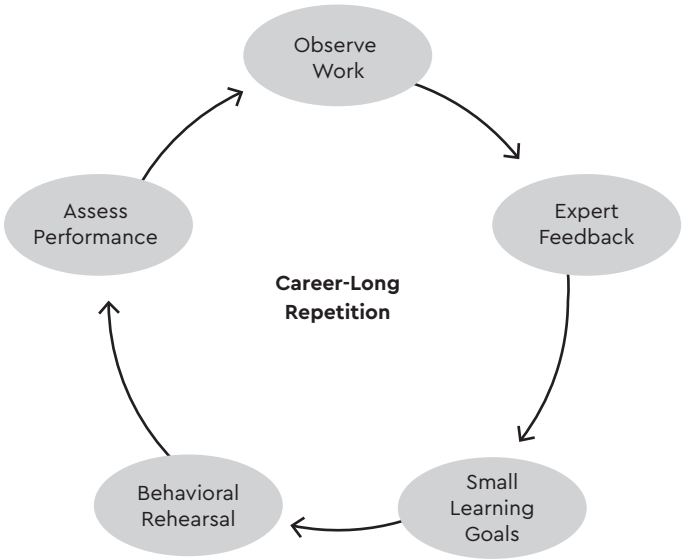
How does one become an expert in a professional field? What is trainable and what is simply beyond one's reach, due to innate or uncontrollable factors? Questions such as these touch on our fascination with expert performers and their development. A mixture of awe, admiration, and even confusion surround people such as Mozart, Leonardo da Vinci, or more contemporary top performers such as basketball legend Michael Jordan and chess virtuoso Garry Kasparov. What accounts for their consistently superior professional results? Evidence suggests that the time spent on a particular type of practice is essential to developing expertise in virtually all domains (Ericsson & Pool, 2016). "Deliberate practice" is an evidence-based method that can improve performance in an effective and reliable manner.

The concept of deliberate practice originated in a classic study by K. Anders Ericsson and colleagues (1993). They found that the amount of time practicing a skill and the quality of the time spent doing so predicted mastery and acquisition. They identified five key activities in learning and mastering skills: (a) observing one's own work, (b) getting expert feedback, (c) setting small incremental learning goals just beyond the performer's ability, (d) engaging in repetitive behavioral rehearsal of specific skills, and (e) continuously assessing performance. Ericsson and his colleagues termed this process *deliberate practice*, a cyclical process that is illustrated in Figure 1.1.

Lengthy engagement in deliberate practice is associated with expert performance across various professional fields, such as medicine, sports, music, chess, computer programming, and mathematics (Ericsson et al., 2018). People may associate deliberate practice with the widely known "10,000-hour rule" popularized by Malcolm Gladwell in his 2008 book, *Outliers*, although the actual number of hours required for expertise varies by field and by individual (Ericsson & Pool, 2016). This "rule," however, perpetuated two errors. The first is that the number of deliberate practice hours needed to

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FIGURE 1.1. Cycle of Deliberate Practice



Note. From *Deliberate Practice in Emotion-Focused Therapy* (p. 7), by R. N. Goldman, A. Vaz, and T. Rousmaniere, 2021, American Psychological Association (https://doi.org/10.1037/0000227-000). Copyright 2021 by the American Psychological Association.

attain expertise is fixed. On the contrary, there is considerable variability in how many hours are required in different domains.

The second error is asserting that engagement in 10,000 hours of work performance will generate expertise in that domain. This error applies to psychotherapy, where the number of hours of clinical work has traditionally been used as a measure of proficiency (Rousmaniere, 2016). However, research suggests that the number of hours of experience does not predict therapist effectiveness (Goldberg, Babins-Wagner, et al., 2016; Goldberg, Rousmaniere, et al., 2016). It seems more likely that the presence or absence of deliberate practice is a key factor.

Recognizing the value of deliberate practice in other fields, psychotherapy scholars have incorporated deliberate practice into training for mental health professionals (e.g., Bailey & Ogles, 2019; Binder & Betan, 2013; Hill et al., 2020; Rousmaniere et al., 2017; Taylor & Neimeyer, 2017; Tracey et al., 2015). There are good reasons to question analogies made between psychotherapy and other professional fields, like sports or music. In comparison, psychotherapy is complex and free-form. Sports have clearly defined goals, and classical music follows a written score. In contrast, the goals of psychotherapy shift with the unique presentation of each patient in each session. Therapists do not have the luxury of following a score.

Instead, good psychotherapy is more like improvisational jazz (Noa Kageyama, cited in Rousmaniere, 2016). In jazz improvisations, a complex mixture of group collaboration, creativity, and interaction are coconstructed among band members. Like psychotherapy sessions, no two jazz improvisations are identical. However, improvisations are not a random collection of notes. They are grounded in a comprehensive conceptual understanding and technical proficiency that is developed only through continuous deliberate practice. For example, prominent jazz instructor Jerry Coker (1990) listed 18 skill areas that students must master, each of which has multiple discrete skills including

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tone quality, intervals, chord arpeggios, scales, patterns, and licks. In this sense, more creative and artful improvisations reflect previous commitments to repetitive skill practice and acquisition. As legendary jazz musician Miles Davis put it, "Sometimes you have to play a long time to be able to play like yourself" (Cook, 2005, p. 34).

We want our book on deliberate practice to help PDT therapists become themselves. The goal is to acquire skills so that you have them on hand when you need them. Practice the skills to make them your own. Incorporate aspects that feel right for you. Ongoing and effortful deliberate practice does not impede flexibility and creativity. It enhances both. Effective PDT therapists integrate previously acquired skills with properly attuned flexibility. The core PDT responses we provide as examples are meant as templates or possibilities, rather than "answers." Please interpret and apply them as you see fit, in a way that makes sense to you. We encourage flexible and improvisational play!

Simulation-Based Mastery Learning

Deliberate practice uses simulation-based mastery learning (Ericsson, 2004; McGaghie et al., 2014). That is, the stimulus material for training consists of "contrived social situations that mimic problems, events, or conditions that arise in professional encounters" (McGaghie et al., 2014, p. 375). In other words, stimuli used in training are sufficiently like real-world experiences that they provoke similar reactions. This facilitates *state-dependent learning*. Using deliberate practice, students acquire skills in an environment that evokes emotions and cognitive challenges evoked in real-life contexts (R. P. Fisher & Craik, 1977; Smith, 1979). For example, pilots train with flight simulators that present mechanical failures and dangerous weather conditions, and surgeons practice with surgical simulators that present medical complications. Training in simulations with challenging stimuli increases professionals' capacity to perform effectively under stress. In this book, the "simulators" are typical patient statements that might be presented in the course of therapy sessions and call on the same skill needed in that context. The fact that the learning is interpersonal (e.g., role-plays with peers) rather than individual, adds to the stressful environment, simulating the tension that occurs when working with actual patients.

Declarative Versus Procedural Knowledge

Declarative knowledge is what a person can understand, write, or speak about. It often refers to information that can be consciously recalled through memory and is often acquired relatively quickly. In contrast, procedural learning is implicit in memory and "usually requires *repetition of an activity*, and associated learning is demonstrated through *improved task performance*" (Koziol & Budding, 2012, p. 2694, emphasis added). *Procedural knowledge* is what a person can perform, especially under stress (Squire, 2004). There may be a wide difference between demonstrations of declarative versus procedural knowledge. For example, an "armchair quarterback" is a person who criticizes an athletic performance but would have trouble performing it at a level commensurate with their critique. Likewise, most dance, music, or theater critics can write eloquently about their subjects but would be flummoxed if asked to perform them.

In PDT training, the gap between declarative and procedural knowledge appears, for example, when a trainee or therapist can recognize and appreciate a metaphor that lands adeptly on the edge of the patient's awareness, pushing the patient forward to new insights ever so subtly. The same student struggles to provide similar metaphors with real patients. **The sweet spot for deliberate practice is the gap between**

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declarative and procedural knowledge. In other words, effortful practice should target those skills that the trainee could write a good paper about but would have trouble performing with an actual patient. We start with declarative knowledge, learning skills theoretically, and observing others perform them. Once students can do that, we seek to foster procedural learning using deliberate practice exercises. Our goal is to give therapists "automatic" access to these 12 skills so they can use them easily when necessary. Following in-class training with simulated patients, supervisors can help students further refine their skills with actual patients (Binder, 1999, 2004; Levenson, 2017).

Let us turn to some background on PDT to help contextualize these 12 skills and locate them in contemporary, psychodynamic theory and practice.

Psychodynamic–Interpersonal Therapy

Common Features

The terms *psychoanalytic therapy* and *psychodynamic therapy* for the most part can be considered synonymous. Both terms refer to a "family" of therapies that can have different views of human functioning and malfunctioning and may have variations in language, but share certain features. We base our book on a contemporary, attachment-based, relational–interpersonal approach used by a wide range of psychodynamic practitioners. More specifically, we use a model of TLDP (Levenson, 1995; Strupp & Binder, 1984). TLDP incorporates elements relevant to many psychodynamic approaches. It provides a teachable way of formulating and intervening, has a research base, and the availability of additional materials (e.g., books, videos). TLDP is compatible with short- and long-term applications, and is well-known to the authors of this manual.

What features do PDTs have in common? There are several informative sources. Blagys and Hilsenroth (2000) reviewed publications that consistently and significantly differentiated psychodynamic–interpersonal therapy from cognitive behavior therapy (CBT) in at least two studies, in at least two different research labs. These investigators delineated seven activities or focal areas that distinguished short-term, manualized psychodynamic-interpersonal therapy from CBT (see Exhibit 1.1).

EXHIBIT 1.1. Summary of Distinctive Features of Psychodynamic–Interpersonal Psychotherapy

1. Focus on affect and the expression of patients' emotion
2. Exploration of patients' attempts to avoid topics or engage in activities that hinder the progress of therapy
3. The identification of patterns in patients' actions, thoughts, feelings, experiences, and relationships
4. Emphasis on past experiences
5. Focus on patients' interpersonal experiences
6. Emphasis on the therapeutic relationship
7. Exploration of patients' wishes, dreams, or fantasies

Note. From "Distinctive Features of Short-Term Psychodynamic-Interpersonal Psychotherapy: A Review of the Comparative Psychotherapy Process Literature," by M. D. Blagys and M. J. Hilsenroth, 2000, *Clinical Psychology: Science and Practice*, *7*(2), p. 185 (https://doi.org/10.1093/clipsy.7.2.167). Copyright 2000 by the American Psychological Association.

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Shedler (2022) has described stereotyped, outmoded, and misunderstood aspects of psychodynamic practice and theory that have little resemblance to modern PDT. In a paper, provocatively titled "That Was Then, This Is Now: Psychoanalytic Psychotherapy for the Rest of Us," he explicates how psychodynamic theory and practice have developed over time. He asked, "If psychoanalysis is not a theory about the id, ego and superego, or fixations, or repressed memories, what *is* it about?" (p. 406). He then goes on to name and describe the following distinctive features of contemporary psychodynamic technique: an emphasis on unconscious mental life, the mind in conflict, the past affecting the present, transference in the therapeutic relationship, defensive processes, and psychological causation.

Similarly, when therapists representing three theoretical approaches identified essential processes for their approach (Boderhoven deHaan & Lee, 2014), distinct differences emerged. Essential features for PDT were a focus on the patient's feelings; insight; therapy relationship; recurrent themes; nonjudgmental acceptance; discussion of scheduling, fees, and interruptions in treatment; therapeutic process; interpersonal relationships; and interpretation of unconscious wishes, feelings, and ideas.

These lists from three perspectives (examination of publications, tracking development over time, and therapists' self-reports) overlap to a considerable degree. Using these research findings, we formed our operational definition of PDT. In this book, we discuss skills exemplifying these characteristic features: (a) focus on unconscious processes; (b) focus on affect and expressions of emotion; (c) identification of patterns of actions, thoughts, feelings, fantasies, and interpersonal relationships; (d) focus on defenses (i.e., coping strategies to avoid uncomfortable topics and unwittingly hinder therapeutic progress); (e) emphasis on how past experiences influence current thinking and behavior; and (f) focus on transference and countertransference (i.e., identifying how the patient's problematic patterns are manifested in the therapeutic relationship). For convenience, in this book we use the term *psychodynamic therapy*, or PDT.

Research in PDT

Regarding treatment research findings, we would like to address a widespread misconception among both psychodynamic clinicians and practitioners representing other treatment orientations. It is commonly assumed that, in contrast to CBT, which has been extensively studied and is considered evidence-based, psychodynamic therapies are not supported by empirical evidence and are therefore an inferior form of treatment. In fact, as of 2021, there had been at least 243 randomized controlled trials (RCTs) comparing the efficacy of both long- and short-term psychodynamic therapies to control groups representing no treatment, treatment as usual, or other gold standard therapies, such as CBT. RCTs and meta-analyses consistently have found psychodynamic therapies to be significantly more effective than control groups and, compared with other therapy approaches, equally effective in treating mood, anxiety, and personality disorders (Barber et al., 2021).

Conceptual Framework

To take full advantage of the skill exercises in this book, the reader should possess compatible models of personality, psychopathology, and therapeutic processes. A psychodynamic therapist must have a cognitive map or "working model" of the immediate therapeutic situation, including just enough theory to comprehend the problem

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context and design intervention strategies, but not so much as to get in the way of attunement to the patient and spontaneous reactions to the changing context. Such a mental model will provide readers who use the exercises a conceptual framework within which to see the therapeutic role that each skill plays in furthering therapeutic progress.

A Theory of Personality

Personality Structure. The building blocks of personality can be viewed as *interaction structures* that contain self-representations associated with a sense of individual identity (Beebe et al., 1997; Sandler & Sandler, 1978). These interaction structures are composed of self-representations and object-representations that are inextricably linked together by transactional scenarios characterized by particular affective tones (Mitchell, 1988). Psychological structures are not stable, impermeable edifices. Rather, they are ingrained patterns of mental activity that reflect adaptations to one's internal and external environments; they are slow to form and slow to change. Interaction structures occupy the foreground of personality, whereas cognitive and perceptual processes are conceived as occupying the background of personality. In that capacity, they function as information processors of the content contained in the interaction structures.

The interaction structures that characterize each personality are the product of the unique physiologic and genetic makeup of the person plus that person's internalization of relationships with others. From the moment of birth on, transactions with others, particularly those on whom the individual relies for protection and physical and emotional sustenance (i.e., "significant others"), are internalized. They shape the organization and content of the emerging personality structure.

The interaction structures that comprise the foundation of personality are composites of multiple, discrete internalized experiences that share common narrative elements. Although we use the word *structures*, we do not mean a static template but a dynamic process leading to action. If you took videos depicting a child interacting with parents, friends, and teachers in which the child is rejected, for example, that set of videos would be a visible, public record of the child's private, interpersonal schema. Typically, these schemas are not directly accessible to the child's conscious awareness. Many of these memory traces were laid down before the infant could comprehend speech; they are embodied. Indeed, they are procedural memories. However, they contain the rules of approved behavior, and so they dominate all later interactions. And, as learned procedures, they implicitly and silently guide one's expectations and patterns of behavior with others. In the language of cognitive psychology, they represent procedural interpersonal knowledge (Binder, 2004). While operating behind the scenes, these structures contribute to self- and object-relational units that are maintained in conscious awareness (Horowitz, 1998).

In any interpersonal encounter, an individual follows a cognitive map or *internal working model* of the situation (Bowlby, 1988). An adaptive working model is flexible and can be modified by immediate feedback as the interaction unfolds, even though it is the product of combining schematic themes and direct observations of the current situation in which the person is engaged (Horowitz, 1998). The salient themes that characterize a person's internal working models are reflected in the distinguishing features of their personality and interpersonal style. An individual's characteristic pattern of interacting with others tends to evoke a circumscribed, reciprocal range of reactions from others. These reactions, in turn, tend to reinforce the likelihood that the original

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interpersonal actions will be repeated because they tend to fulfill the expectations of the instigator of the original actions. Through such complementary transactions, an interpersonal style—for good or ill—tends to become self-perpetuating (Binder, 2004; Strupp & Binder, 1984). Wachtel (1993) termed such a reciprocally reinforcing system *cyclical psychodynamics*.

Motivation and Development. Classic psychoanalytic theory of motivation posited the reduction of sexual and aggressive tensions through the discharge of biologically based "drives." Beginning in the mid-20th century, British object relations theorists began to replace the drive theory of motivation with theories that viewed human beings as innately *object-seeking* (Fairbairn, 1952). The American interpersonal psychiatrist, H. S. Sullivan (1954) proposed that the fundamental human motivation was a sense of security produced by harmonious interpersonal interactions. By far the most influential motivation theorist was John Bowlby (1969/1982). Using attachment theory, he took an evolutionary perspective in which he postulated the existence of biologically ingrained behavioral systems whose purpose is to achieve and maintain physical proximity to caretakers to ensure protection from predators and other dangers.

Bowlby's attachment theory emphasizes the human motivation to seek connectedness with other humans. Blatt (beginning in 1974 and culminating in his 2008 book, *Polarities of Experience*), added a seemingly opposing but complementary motive, which is to seek autonomy, mastery, self-sufficiency, and self-definition. Examining the fields of personality development, psychopathology, and therapeutic process, Blatt (2008) described the dialectic tension that exists between the motives for meaningful interpersonal relatedness and the motives for a coherent and integrated self-definition. He stated, "Development in the sense of the self leads to increasingly mature levels of interpersonal relatedness that, in turn, facilitate further differentiation and integration of the development of the self" (pp. 3–4). This same sentiment is evidenced in the work of Safran and Muran (2000) on negotiating therapeutic alliances and originally in Bowlby's (1988) view of attachment. They suggest that taking independent action in the world is possible only if one is sure that a *secure base* of interpersonal intimacy awaits one's return.

A Theory of Psychopathology

Corresponding with the move of contemporary psychoanalytic theories away from Freudian structural theory (e.g., ego, id, superego) and drive theory (e.g., libido, aggression), has come a deemphasis on concepts of inner conflict, defense, and compromise formation. Instead, contemporary psychoanalytic theories of psychopathology share an emphasis on parental empathic failures in attuning to an infant's and child's developmental needs and individual temperament.

The long period in which human infants and children need adult parental figures to care for and protect them gives parental figures vast influence on the child's personality development. If the child is not under significant physiological or interpersonal stress, the child will develop representations of relational experiences that are adaptive and realistic. However, if a child endures extended stress, the child will develop impaired cognitive and perceptual functions, resulting in maladaptive person schemas. Another contribution to the development of maladaptive person schemas occurs when the parenting figures pressure the child to assume certain personality characteristics and behaviors and to avoid or disavow others. When infants or children feel compelled to shape themselves in a particular way to maintain emotional bonds with their parenting figures, their resultant person schemas will be rigidly maintained and will be interpersonally circumscribed.

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A person's self-representations and expectations of others developed while coping with early relations with parenting figures are rigidly clung to and do not adequately consider current interpersonal realities. In other words, the adult is burdened with early modes of relating that at one time were adaptive but are now maladaptive (Eagle, 2011). Or as more poetically put by William Faulkner (1951) in his novel *Requiem for a Nun*, "The past is never dead. It's not even past."

Consequently, in all its manifestations psychopathology essentially represents personality characterized by internal person schemas or working models that are rigidly adhered to and delimit the repertoire of corresponding modes of relating available to the person (Binder, 2004). Persons with impaired working models will inevitably show impairments to their cognitive and perceptual functions. Severe warping of narrative structures, synonymous with *personality disorders*, often is associated with difficulties managing emotions (i.e., overcontrol or dysregulation) and self-soothing (e.g., self-esteem problems). When insults to cognitive and perceptual functions distort reality-testing, psychotic symptoms such as delusions and hallucinations appear. These sorts of personality malformations and maladaptations are invariably associated with symptoms of anxiety and depression.

A Theory of Psychotherapy

Congruent with contemporary PDT's theories of personality and psychopathology, the primary PDT in-session or process goal is to identify salient, maladaptive interaction structures and corresponding maladaptive patterns of interpersonal relating. The primary *outcome goal* is to modify these maladaptive internal representations and interpersonal patterns and replace them with new, more adaptive and satisfying ways of experiencing and relating to self and to others. The ultimate therapeutic aim is to help patients remove impediments to their ability to make choices that will, at least, provide an opportunity for increased satisfaction and happiness (Binder, 2004; Eagle, 2011; Levenson, 2017).

Contemporary psychodynamic therapists seek to engage actively with their patients and display a more overtly emotional connection, characterized by empathy and nonjudgmental acceptance. The therapist actively listens to the patient. This interpersonal stance on the therapist's part is often a novel experience for the patient. It contributes to *corrective emotional experiences* in which the therapist's attitudes and behavior disconfirm the patient's maladaptive and negative interpersonal expectations. Another powerful "corrective" experience occurs when therapists realize they have been unwittingly recruited by the patient into playing a role in the patient's maladaptive scenario and begin to disembed themselves (Kiesler, 1988; Levenson, 2017; Muran & Barber, 2010; Safran & Muran, 2000; Strupp & Binder, 1984). These interactions disconfirm the patient's negative expectations and so weaken the maladaptive interaction structures producing them (Alexander & French, 1946; Eagle, 2011). These corrective emotional experiences, which may be a function of memory reconsolidation, are considered to be a primary change agent (Levenson et al., 2020).

In addition to experiential learning, another primary change agent is *insight*, or increased awareness of one's idiosyncratic views of self and others, as well as one's own motivations, expectations, assumptions, feelings, and behavior (Binder, 2004; Levenson, 2017). There is now solid empirical support for the association of increased insight and positive outcome in PDT (Barber et al., 2021). Related to increased insight are changes for the better in measures of internal interaction structures or *quality of object relations*,

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less reliance on immature defenses, and increase in *mentalization* (i.e., increases in the capacities for self-reflection and for empathizing with others), the ability to comprehend one's own and other's mental states, and to use that information to explain and guide interpersonal behavior (Barber et al., 2021; Fonagy & Bateman, 2006).

From empirical and clinical points of view, the change agent most consistently predictive of positive treatment outcomes is the *therapeutic alliance*. Contemporary psychodynamic approaches differ regarding how they conceptualize the therapeutic alliance. One view is that a positive alliance is a necessary interpersonal context for the therapist's technical strategies to be effective; another view is that a strong, positive alliance is necessary and sufficient to produce therapeutic progress. Safran and Muran (2000) proposed another way in which the therapeutic alliance is associated with therapeutic progress. They posited that during any psychotherapy, ruptures to the alliance will inevitably occur and the therapist's identifying and resolving these ruptures is essential for a positive therapy outcome.

Therapeutic alliance ruptures are, to a great degree, synonymous with transference–countertransference enactments (Safran & Muran, 2000). As previously mentioned, a primary distinguishing feature of psychoanalytic therapies is their focus on analyzing transference patterns. Originally, transference was conceptualized as the projection of the interpersonal manifestation of the patient's core unconscious conflicts onto the "blank screen" of the therapist. A contemporary conceptualization of transference appreciates the ubiquitous nature of that process and how the person of the therapist inevitably cocreates enactments. From the same vantage point, the therapist's countertransference can be viewed as a combination of one's own personal issues (classic countertransference) and an understandable reaction to the patient's evocative transferential behavior (interactive countertransference; Binder, 2004; Levenson, 1995; Safran & Muran, 2000; Strupp & Binder, 1984). Hence, transference and countertransference are inextricably entwined.

The classic technical strategy for initiating a therapy discourse is "free association"—directing patients to verbalize unedited whatever comes into their mind. The theoretical rationale was that because drives sought discharge, unedited verbalizations would contain drive derivatives that would serve as clues to important unconscious conflicts. Contemporary PDT bases its technical strategy for initiating discourse on findings of cognitive science research; most cognitive activity, particularly problem solving, goes on outside of conscious awareness. Therefore, encouraging the patient to lead the therapeutic discourse as spontaneously as possible serves to evoke underlying affective and interpersonal themes. The therapist's overriding technical aim is to further the therapeutic dialogue, providing the ground on which change processes such as insight, corrective emotional experiences, and enhanced mentalization can occur.

By now you can appreciate how much a psychodynamic therapist must do during the course of a psychotherapy session; everything from interpersonal pattern recognition, to self-monitoring one's own personal reactions, to deciding which specific types of interventions are going to evoke the most productive responses from the patient. Psychotherapy researchers used to be enthusiastic about searching for "the best techniques" leading to improved outcomes. Today they recognize that a potentially more fruitful research strategy is to study what personal and professional characteristics make for an effective therapist (Wampold & Owen, 2021). Furthermore, more researchers and psychotherapy trainers are realizing that many of the traits that make for an expert psychotherapist are shared by experts in other complex performance domains, such as sports, music, and medicine (Ericsson et al., 2018).

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The skills that you will practice and ideally acquire from this text are foundational parts of the psychodynamic therapist's competent and then expert performance. Mastering these skills is not easy, and the effort is not always pleasant, but we guarantee you will appreciate the outcome.

Psychodynamic–Interpersonal Skills in Deliberate Practice

Drawing on the central features of contemporary PDT enumerated earlier, we have chosen to include exercises on facilitating the goals of insight and corrective emotional experiences; deepening feelings and emotions; pointing out defenses and the therapeutic process, focusing on transference and countertransference; making interpretations, using fantasy and speaking directly to the unconscious, and gathering data on recurrent interpersonal and intrapsychic patterns.

Following recommendations from the editors of this deliberate practice series, Drs. Rousmaniere and Vaz, we picked skills that trainees commonly have trouble using in actual clinical sessions, based on our experience as teachers and supervisors. For example, we have been surprised how often trainees avoid following up on what the patient is saying out of a misguided assumption that they should know what the patient is talking about and need to fake such knowledge. It still amazes us to see how "polite" our trainees feel they need to be, waiting indefinitely for patients to raise a topic "in their own time." They do not (yet) know how straightforward inquiries can not only help therapists understand patients better but, just as important, help patients learn and understand more about themselves—their unstated expectations, unacknowledged longings, and unexpressed feelings. Therefore, we have developed skill training focused on asking simple questions.

Another set of skills emanates from our clinical experience and the results of empirical studies—namely, how a little negative interpersonal process between therapist and patient goes a long way to undermining therapeutic progress (Binder & Henry, 2010; Henry et al., 1986). Therefore, several of the skills in this book speak to averting or repairing therapeutic ruptures. We focus on skills that facilitate therapist emotional awareness, especially using supervision to manage the supervisee's vulnerability to be pushed and pulled into reenactments of dysfunctional patterns of engagement with difficult patients. Also, we present skills that help the therapist speak to the patient's unconscious processes and thereby lessen resistance. And finally, we include skills that foster empathy for the patient, so that the therapist's tendencies toward being frustrated, angry, or even hostile toward patients are lessened.

In choosing the skills in this book, we have privileged those skills with an empirical basis. We recognize how the field of psychotherapy has been advanced incrementally by scientific scrutiny. For many years, most psychodynamic practitioners believed that the practice of PDT was not researchable. PDT was considered an art as much as anything else. However, through empirical work in child development, neuroscience, and therapeutic process, PDT now has a large research base.

In writing this book, we did encounter an issue that speaks to how PDT differs from many other therapeutic approaches. When the series editors gave us templates for the skills, we understood that they wanted us to compose a client statement to which the trainee role-playing the therapist would give a response that met the criteria for that skill. The implication was that there would be an appropriate intervention that the trainee could practice with a variety of client statements. However,

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in PDT there is rarely a one-size-fits-all intervention. In other words, in most cases, there could be no generic client statement that would receive a "good-enough," generic therapist response. What a psychodynamic therapist would say to one patient who said "X" would not be the same as what would be said to a different patient who said the same thing. To decide on a useful intervention, clinicians need to know the dynamics of the case—who is this person, what is their life experience, what is their attachment style, what is their internal working model, and what is the tone of the therapeutic alliance, for example. To construct PDT-relevant exercises, we needed to provide the therapist-in-training with enough of a patient's backstory to make the task more realistic (albeit, more demanding)—what would one say to this patient, at this time, in this way? To provide a variety of cases, we sorted through patient profiles with unique personality styles corresponding to their placement on an interpersonal circumplex model built around the two orthogonal dimensions of control (dominance, power) and affiliation (friendliness, warmth; Wiggins & Broughton, 1985. As one moves around the circle, each octant reflects a blend of the two axial dimensions, permitting a mixture of agreeableness and dominance. In this manner, we were successful in presenting a range of patient dynamics. In addition, we focused on three patients in particular in our more advanced exercises, so that trainees could have the experience of incrementally gathering information sufficient to formulate a patient's dynamics.

Before turning to the specifics of the 12 skills, we wish to discuss our decision to use the word *patient* throughout the book instead of *client*. As Shedler (2006) pointed out, "in truth, both words are problematic, but *patient* seems to me the lesser of evils" (p. 10). The Latin root of patient is "one who is suffering," and it seems to us that the work of the therapist is to ease suffering and restore robustness. In addition, we believe that the doctor–patient relationship implies more responsibility than the more business-like relationship between people offering services and their clients. In PDT, we do not provide clients with a range of professional services, leaving it up to them to choose those they prefer, like a manicurist asking their client to pick out a color of nail polish. As therapists, we have a responsibility to determine what might be causing the pain and then to choose appropriate methods and interventions that would minimize distress and promote health and healing, while taking into account the patient's preferences and cultural identities (broadly defined). Because we see so much of the cause of a person's suffering is out of their awareness, trusting them to choose a remedy does not make sense. In fact, most people come into therapy because they are avoiding feeling and doing the very things that would be ameliorative. In addition, our society, laws, and mores place a great deal of power in the hands of a therapist. With this enhanced power comes greater responsibility. Our whole therapeutic endeavor demands trust—trust that we will put the needs of our patients before our own.

However, by using the term *patient*, we are not implying a hierarchical power relationship where "doctors" perform procedures on passive patients. The psychodynamic model we are presenting demands a deeply interpersonal and intertwined collaboration. Nonetheless, if the term *patient* is aversive to you because it implies sickness, helplessness, or some other negative connotation, please replace it with whatever term you prefer.

The Psychodynamic–Interpersonal Skills Presented in Exercises 1–12

Other books in the APA deliberate practice series have divided the skills into three difficulty levels—beginner, intermediate, and advanced. However, it struck the editors

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of this series that because interventions in PDT needed to consider certain patient and relationship factors as a matter of course (i.e., demanding therapist responsiveness from the get-go), there would only be two levels of skills—intermediate and advanced.

Intermediate Skills

Skill 1: Engaging in a Therapeutic Inquiry. In PDT, one of the therapists most useful skills is asking good questions. Deceptively, this looks like an easy skill. This exercise combines three inquiry skills so that the therapist learns to ask the patient questions designed to "help me see it as you see it," "help me understand it as you understand it," and "help me see the implications of it as you do."

Skill 2: Therapist Awareness of Countertransference Reactions. This skill is considered fundamental when conducting PDT because patients can exert strong emotional and interpersonal pulls and pushes on the therapist, and yet the therapist needs to maintain responsive equanimity. The therapist must track not only the patient's thoughts, feelings, and behaviors but also their own thoughts, feelings, and behaviors that the patient may have triggered. In PDT, the therapist's internal and external reactions can provide information about the patient. Although therapist awareness is placed as the second skill in this book, trainees should realize that this is a complex skill because it involves being mindful of one's own experience while simultaneously listening to the experience of the patient. As Safran (2012), an analyst, researcher, and leader in the field of the contemporary relational movement, stated,

> Over time I have come to believe that one of the most important skills for therapists to develop is an *internal skill*, *rather than a technical one*. This internal skill involves attending to our own emotions when working with clients and cultivating the ability to tolerate and process painful or disturbing feelings in a nondefensive fashion. (p. 111, emphasis added)

Safran reasoned that by processing and managing the powerful feelings evoked in us by patients (c*ontainment*), we can help regulate our patients much as parents do with an overwhelmed child. Exercise 11 builds on this skill by allowing trainees to practice how they might share their countertransference experiences with supervisors.

Skill 3: Deepening Emotional Experience. The psychodynamic therapist must be an emotional detective/midwife/catalyst—capable of evoking and deepening emotion so that the patient's nascent emotions can be recognized, named, and processed. There are several strategies for intensifying the patient's most poignant feelings, and this skill will allow the trainee to try out four of them.

Skill 4: Making Process Comments. Beginning therapists often get caught up in the content of what the patient is saying. But in an interpersonal PDT, the therapist privileges attending to the process of what is going on between therapist and patient. Paying attention to the process of such transactions is a window into the patient's implicit internal working model. *Commenting on the here-and-now, in the here-and-now*, is an invaluable skill for the therapist and one that will be called forth in many more complex skills, such as those in Exercises 5 and 7.

Skill 5: Pointing Out Defenses and Inquiring About Underlying Fear. Defense mechanisms are self-protective acts; they are used to avoid experiences that were linked to danger at an earlier developmental level. Unfortunately, these idiosyncratic avoidance processes begin to feel like a part of one's personality. That makes it difficult for people to

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change, even when it comes at a cost to their authenticity. Recognizing and pointing out such defenses are fundamental skills in a therapist's armamentarium.

Skill 6: Introducing the Rationale for Treatment. Therapists can use this skill unprompted or in response to patient inquiries about how PDT works and what will happen in the sessions. You may wonder why explaining the treatment rationale is Skill 6 rather than Skill 1. Here is our reason: Patients enter therapy for myriad reasons—most are nervous and unsure about what they are getting themselves into. To begin therapy takes courage, and for many it is still (unfortunately) associated with stigma, failure, or downright terror of being found crazy. To explain something as complicated as PDT in a few sentences is difficult enough, but to explain it to a person who is having intense feelings and who might be dealing with them by being defensive (e.g., placating, challenging, self-recriminating) is a daunting task. And of course, explaining a treatment rationale is not a one-time-only event; rather, it should be used as needed, especially when a patient expresses confusion about or doubt in some aspect of PDT. We suggest learning this skill midway in the book but also repeating it after completing all 12 skill-based exercises. It is one of those skills that serves many purposes, such as facilitating repairs of relational ruptures.

Advanced Skills

Skill 7: Making Transference Interpretations. Transference as a process is ubiquitous—people see others through a lens that is largely determined by their preexisting, significant-other representations. There has been a great deal of controversy, however, about therapists' interpreting transference when they suspect it. Present research evidence suggests that low to moderate levels of transference interpretations are highly effective. Nonetheless, learning this skill will help you become aware of the transference dynamics that occur in-session. That knowledge is invaluable for understanding who you represent to the patient at any point in time, regardless if you interpret it or not.

Skill 8: Using Metaphors. Metaphors are deceptively simple. Because emotion so often infiltrates metaphors and because of their power to capture how the speaker feels viscerally, exploring metaphors in PDT is invaluable. Furthermore, metaphors can often effectively paint a powerful picture when ordinary phrasing with words is inadequate to convey a sense of what is happening, what is hoped for, and what is feared. In therapy, metaphors used by both the patient and the therapist greatly enhance the depth of the communication. This exercise will give trainees three ways of practicing using metaphors: staying within the patient's metaphor, stating an implicit message behind the metaphor, and creating metaphors as powerful ways to engage patients.

Skill 9: Exploring Fantasy. Fantasies can provide, like dreams, a "royal road" (Freud, 1900/2010) to understanding the unconscious activities of the mind. Some psychoanalytic therapists view fantasies as a way of getting a relatively uncensored window into the patient's wants, desires, and needs that often do not get expressed in rationale discourse. Fantasies (along with wishes and dreams) are one of the seven ways Blagys and Hilsenroth (2000) distinguished what psychodynamic therapists focus on versus clinicians who use other treatment models. There are many ways of working with fantasies in therapy at various levels of manifest (on the surface) and latent (hidden) content. Exercise 9 provides one way of making use of daydreams that come up in sessions.

Skill 10: Case Formulation: Gathering Data for the Cyclical Maladaptive Pattern. Over time PDTs have developed a variety of theories about what makes people tick, each

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focusing on different phenomena (e.g., instinctual urges, failures in empathic responsiveness, self–object representations). Because PDT is a multimodel theoretical system, there are multiple ways to formulate a case, and there is an expansive literature devoted to the different methods for formulating cases, each with its own sources of data. For example, Pine (1990) specified four of them (drive, ego, object relations, and self-experience), each with its own "complex, in-depth view of the mind" (p. 3). Messer and Warren (1995) differentiated between those models that focus on conflict and those that are relational. What is common among all of these, and what we have based our formulation exercise on, is the process of looking for recurrent themes that occur in the patient's current, past, and present relationships, including those with the therapist.

Skill 11: Using Supervision to Recognize Reenactments. Exercise 2 focuses on helping trainees become aware of their interactive countertransferences as an inner skill. Exercise 11 builds on that skill. Here we are using the vehicle of talking to one's supervisor about one's overwhelming or interfering feelings that are evoked in sessions. Unfortunately, many trainees do not speak to supervisors about their difficult feelings. This exercise was designed to accomplish three goals: (a) have trainees become more aware of feelings that get evoked and provoked by patients, (b) see supervision as a way to metabolize such feelings, and (c) be encouraged to approach their supervisors to have what might be difficult (yet rewarding) discussions about difficult feelings.

Skill 12: Providing a Corrective Emotional Experience. The last exercise in the skill series involves one of the main curative change agents in psychotherapy. Although much has been written and discussed about the importance of insight in PDT, here we give the corrective emotional experience its due. Alexander and French (1946) defined the *corrective emotional experience*, almost poetically, as "reexperiencing the old, unsettled conflict but with a new ending." Bowlby (1985) perhaps said it best:

> Our [therapists'] role is in sanctioning the patient to think thoughts that his parents have discouraged or forbidden him to think, to experience feelings his parents have discouraged or forbidden him to experience, and to consider actions that his parents have forbidden him to contemplate. (p. 198)

Over the years and from various theoretical vantage points an impressive body of research (e.g., Castonguay & Hill, 2012) has supported the importance of this in-session "new ending." Now we are beginning to understand the neuroprocesses (i.e., memory reconsolidation) that may scaffold such mutative change (Levenson et al., 2020).

A Note About Vocal Tone, Facial Expression, and Body Posture

PDT clinicians attend carefully to the nonverbal and paralinguistic cues expressed by both patient and therapist. Silence is also valued and used strategically. Among the overarching aims of this book is the hope that learners will develop the ability to apply skills in a range of clinical situations and use this as an opportunity to exercise the skills using a style and language that are congruent with who they are. Just as we encourage those who are role-playing the patient to adjust the difficulty of the stimuli (e.g., their tone and the intensity of affect), we also encourage those role-playing the therapists to adjust and experiment with their vocal tone, facial expressions, and body postures. We do know that one of the ways PDT has changed over time is that there

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is less importance placed on maintaining a neutral tone and posture. Especially with relationally focused PDT, the therapist's emotional expression and tone of voice can be used to speak volumes. Research has indicated that therapist's emotional expression is positively associated with treatment outcome (e.g., Peluso & Freund, 2018). There are also helpful articles with extensive patient–therapist transcripts illustrating how to incorporate more emotionally focused interventions into PDT (e.g., Levenson, 2020). Because so much cannot be conveyed by the written word, PDT learners will find it useful to watch recorded examples of experts performing therapy (e.g., APA's clinical training video series) so that they can observe these key principles in action, as well as to record their sessions, so that they can watch them privately, and/or show them in supervision.

Overview of the Book's Structure

This book is organized into three parts. Part I contains this chapter and Chapter 2, which provides basic instructions on how to perform these exercises. We found through testing that providing too many instructions up front overwhelmed trainers and trainees. Therefore, we kept these instructions as simple as possible. Further guidelines for getting the most out of deliberate practice are provided in Chapter 3, and additional instructions for monitoring and adjusting the difficulty of the exercises are provided in Appendix A. **Do not skip the instructions in Chapter 2, and be sure to read the additional guidelines and instructions in Chapter 3 and Appendix A once you are comfortable with the basic instructions.**

Part II contains the 12 skill-focused intermediate and advanced exercises (see Table 1.1). Each contains an overview of the exercise, example patient–therapist interactions to help guide trainees, step-by-step instructions for conducting that exercise, and a list of criteria for mastering the relevant skill. We present patient statements and sample therapist responses organized by difficulty (beginner, intermediate, and advanced). The statements and responses are presented separately. This gives the trainee playing the therapist more freedom to improvise responses without being influenced by the sample responses. Exercises 4, 9, 10, and 12 present recurring patients—Mr. Hiram Johnson, Ms. Ann Lee, and Dr. Nevell Ingram[1]—so that trainees can see how cases develop over time in PDT. The case of Mr. Johnson has been presented in four chapters (Levenson, 1995) and there is a commercially available video with an actor playing Mr. Johnson (Levenson, 1999). Ms. Lee's six-session therapy and case formulation have previously been discussed (Levenson, 2017), and a commercially available video of the entire therapy with the actual patient is available through APA (https://www.apa.org/pubs/videos/4310871). In addition, Ms. Lee's therapy has been the subject of several empirical investigations (Friedlander et al., 2018, 2020; Levenson, 2020; Levenson et al., 2020; Luo et al., 2022). These additional resources can supplement the exercises in this book, along with the APA video of the first author discussing the skills-based approach and illustrating it with video examples (Levenson & Friedlander, in production). The final two exercises in Part II provide opportunities to practice the 12 skills within simulated psychotherapy sessions. Exercise 13 provides two sample psychotherapy session transcripts (of the case of Ms. Lee) in which the PDT skills are used and clearly labeled, demonstrating how they might flow together in an actual therapy session. PDT trainees are invited to run through the

1. The patients' identities have been disguised to protect confidentiality.

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sample transcripts with one playing the therapist and the other playing the patient to get a feel for how a session might unfold. Exercise 14 provides suggestions for undertaking mock sessions, as well as patient profiles ordered by difficulty (beginner, intermediate, and advanced) that trainees can use for improvised role-plays.

Part III contains Chapter 3, which provides additional guidance for trainers and trainees. Chapter 2 is more procedural, whereas Chapter 3 covers big-picture issues. It highlights seven ways to get the most out of deliberate practice. In it, we discuss the importance of appropriate responsiveness, attending to trainee well-being and respecting privacy, and trainer self-evaluation, among other topics.

Three appendixes conclude this book. Appendix A provides instructions for monitoring and adjusting the difficulty of each exercise as needed. It provides a Deliberate Practice Reaction Form for the trainee playing the therapist to complete to indicate whether the exercise is too easy or too difficult. Appendix B includes a Deliberate Practice Diary Form that can be used to during a training session's final evaluation to process the trainees' experiences. However, its primary purpose is to give trainees a format to explore and record their experiences while engaging in additional, between-session deliberate practice activities without the supervisor. Appendix C presents a sample syllabus demonstrating how the 12 deliberate practice exercises and other support material can be integrated into a wider PDT training course. Instructors may choose to modify the syllabus or pick elements from it to integrate into their own courses.

Downloadable versions of this book's appendixes, including a color version of the Deliberate Practice Reaction Form, can be found in the "Clinician and Practitioner Resources" tab online (https://www.apa.org/pubs/books/deliberate-practice-psychodynamic-psychotherapy).