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Cover Page Footnote
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The Spirituality of Psychodynamic Psychotherapy: A Case Study

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Although psychodynamic psychotherapy is effective and can be done briefly, it has fallen out of favor, especially with religiously oriented psychotherapists—including Latter-day Saint psychotherapists. The client in this case study is a 50-year-old, middle-class, Caucasian member of the Church. Using the case study as a framework, this paper describes and illustrates how psychodynamic psychotherapy can be seen as a spiritual endeavor that is compatible with both a traditional Christian orientation and a Latter-day Saint orientation. To the author's knowledge, this is the first case report of psychodynamic psychotherapy with a Latter-day Saint client. This report may form part of the basis for future group studies examining the effectiveness of psychodynamic psychotherapy with Latter-day Saints, and for process studies examining the effects of specific psychodynamic interventions on psychotherapy outcomes with this population.
Keywords: psychodynamic psychotherapy, gospel-centered therapy

Psychodynamic psychotherapy is often poorly understood (Shedler, 2010). Many psychotherapists assume that psychoanalytic psychotherapy is outdated and ineffective compared to newer forms of psychotherapy. The reality is much different. Psychodynamic psychotherapy is a robust form of treatment that is evidence based and empirically supported by studies that include thousands of patients (Abbass, Hancock, Henderson, & Kisely, 2006; Bateman & Fonagy, 2013; Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Fonagy, 2015; Høglend et al., 2006; Shedler, 2010; Wallerstein, 2005). For example, Shedler (2010) provided a comprehensive review of eight meta-analyses of psychodynamic psychotherapy outcomes comprising 74 studies. Effect sizes in these meta-analyses ranged from 0.69 to 1.8 (median = 0.97). The 0.97 effect size comes from a meta-analysis by Abbass et al. (2006), who included 23 randomized controlled trials (RCTs) that included 1,431 patients.[1] For a comparison with other treatments, Lipsey and Wilson (1993) reported a median effect size of 0.75 for general psychotherapy across 18 meta-analyses; 0.62 for cognitive-behavior therapy (CBT) across 23 meta-analyses; and 0.17 (nine studies) and 0.31 (74 studies) for antidepressant medication. From reviewing these analyses, Shedler concluded that "blanket assertions that psychodynamic approaches lack scientific support . . . are no longer defensible" (p. 106).

Furthermore, Shedler (2010) reported meta-analytic data showing that the benefits of psychodynamic psychotherapy tend to increase over time after therapy is over, while the benefits of other (nonpsychodynamic) empirically supported therapies tend to decay over time.

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As an example of this in a more recent study, British researchers Fonagy et al. (2015) reported an RCT of 129 patients with treatment-resistant depression. Patients were randomly assigned to treatment as usual (TAU) according to UK national guidelines or TAU with adjunctive long-term psychoanalytic psychotherapy (LTPP). Although outcomes were equivalent at termination, the LTPP patients were significantly better at follow-up (24 months: 38.8% vs. 19.2%, $p = 0.03$; 30 months: 34.7% vs. 12.2%, $p = .008$; 42 months: 30.0% vs. 4.4%, $p = 0.001$).

In spite of this substantial and growing body of research supporting the efficacy of psychodynamic psychotherapy, and even though it can be done briefly as well as longer-term (Lemma, Fonagy, & Target, 2011; Stadter, 2004; Strupp & Binder, 1984), this form of treatment remains out of favor. There are many reasons why this has occurred (see Lemma, 2016; and Shedler, 2010, for an overview). These reasons include the historic reluctance on the part of psychoanalysts to engage in nomothetic outcome research, the arcane nature of much of the psychodynamic literature, the historic inaccessibility of psychodynamic training and its isolation from research universities, and skepticism on the part of traditional academic researchers about the basic concepts of psychoanalysis and its methods. Shedler (2010) asserts that these factors have led to institutionalized antipathy toward psychoanalytic psychotherapy in which "everyone knows" (p. 98) these treatments do not work and there is little reason to question or revisit this belief.

This situation is exacerbated by the current reimbursement climate, in which brief, symptom-focused therapies are often covered by insurance and longer-term, depth-focused therapies are not covered or are only partially covered (McWilliams, 2004). This situation is also exacerbated by the naive but common view of consumers that every problem has a rapid solution if only one can find an expert advisor who can give one the right "tools."

In addition to falling out of favor in the mental health world, psychodynamic concepts have historically fared poorly in the Christian world. As Bland and Strawn (2014) point out, psychoanalysis challenged Christian ideas about the nature of man, the purpose and causes of human behavior, "the purpose and meaning of human life, the causes of psychological problems, and what it takes to cure these problems" (p. 14). Although Freud came from a Jewish background, his ideas conflicted directly with religion, which he assumed was a remnant of primitive societies and represented an obsessional neurosis driven by the need to resolve guilt and defend against existential anxiety (Jones, 1991).

In addition to faring poorly in the wider Christian world, psychodynamic ideas have fared particularly poorly in the Latter-day Saint world.[2] To many members of the Church, personality is part of one's eternal spirit, all behavior is under conscious control because people have moral agency, meaningful dreams come from God, guilt is always a signal that one has done something wrong, thoughts or ideas that apparently arise out of nowhere represent divine inspiration, and if one tries hard enough to be good he will be able to eliminate the natural man and find favor with God. By contrast, psychoanalysis says that personality is formed by the interaction of instinctual forces and early relational experiences, behavior often stems from unconscious conflicts, meaningful dreams are the mind's attempt to resolve those conflicts, guilt can be a neurotic artifact of those same conflicts, insight can arise from the unconscious mind, creativity represents the sublimation of libidinal forces, and the conflict between instinctual impulses and societal proscriptions never entirely goes away. Because of the apparent conflict between these sets of concepts, Latter-day Saint psychotherapy clients may tend to be more comfortable with cognitive-behavioral and solution-oriented approaches that lend themselves to a practical, straightforward, and conscious effort rather than psychodynamic approaches that focus on unconscious forces working in the transference. Furthermore, as strong believers in self-reliance, Latter-day Saint clients tend to be almost phobic about anything that smacks of dependency, such as a longer-term therapy in which therapists become significant figures in their patients' lives and significant fixtures in their minds. In addition, Church leaders have historically been wary of so-called secular psychotherapy and have been reluctant to refer members to practitioners who are not members of the Church.

Similarly, psychodynamic ideas have traditionally fared poorly among Latter-day Saint psychotherapists. In my own personal experience, Latter-day Saint

therapists rarely attend psychodynamically oriented trainings or continuing-education events. Psychodynamic concepts have not received favorable attention, or in some cases any attention, in Latter-day Saint publications of which I am aware. At Latter-day Saint mental health conferences, most educational presentations rely heavily on cognitive behavioral approaches. During my master's program at BYU, psychodynamic ideas were not mentioned even once by the professors. To be fair, the same was true during my doctoral program at the University of Utah, where only one of my professors was a member of the Church.

Although it is true that some of the assumptions of psychology, psychotherapy in general, and psychodynamic psychotherapy in particular do run counter to gospel principles, there is much in the psychodynamic world that can be valuable for psychotherapists who are members of the Church. In the balance of this paper, I will suggest ways that important psychodynamic concepts can perhaps be part of a gospel-centered therapy and how their implementation can actually be a spiritual practice, a manifestation of the pure love of Christ (Moro. 7:47, The Book of Mormon). However, in the meantime it is worth mentioning that many of the concepts and techniques that all therapists, including Latter-day Saint therapists, use every day originated with Freud and the psychoanalysts who came after him. These include the existence of the unconscious mind, the power of unconscious motivations, the nature of internal conflict, the importance of psychological defenses, the effects of early life experience on the developing personality, the technique of careful listening, and the ubiquity of transference and countertransference. Indeed, Freud (along with his colleague Josef Breuer) essentially invented our profession, whether we see ourselves as psychodynamically oriented or not. As the esteemed and internationally influential Latter-day Saint psychologist Allen Bergin (1973) once said of Freud, "He was a great man and one not to be ignored by LDS [*sic*] scholars" (p. 15).

Outline of the Paper

As a framework for the paper, I will first introduce the case of "Jeff," a patient whose story and therapy lend themselves to illustrating the psychodynamic concepts I will discuss. I have disguised or removed any information that would allow him to be recognized. In addition, Jeff has read this paper and given permission for me to use his story. In order to establish a basis of understanding, I will describe the object-relations perspective in psychodynamic thought and its relevance for Latter-day Saint counselors and clients. I will also discuss some core psychodynamic concepts from the object-relations perspective using illustrations from Jeff's case and elsewhere. These concepts include projection, introjection, projective identification, containment, transference, and countertransference. Although these concepts may be familiar to some readers and a discussion of them may be found in any basic text on psychodynamic psychotherapy (e.g., Gabbard, 1990; Lemma, 2016; McWilliams, 2004), I review these ideas here through a Latter-day Saint lens, which, to my knowledge, has not been done before. For each concept, I will give an example that illustrates the concept in a Latter-day Saint light and show how the concept might be useful for Latter-day Saint therapists. Next, I will explain how I think the stance and activity of the psychodynamic psychotherapist is a spiritual endeavor. Finally, I will provide some material from a session with Jeff to illustrate some of these principles in action.

The Case of Jeff

Jeff is a 50-year-old, Latter-day Saint man whose internal dynamics interfere with success at work. Although he is talented, well educated, and extremely bright, he has not achieved a great deal professionally. He has had several professional jobs, but for various reasons these have not lasted. In an attempt to improve his situation, he has enrolled in several professional development courses but has stalled out. He is a talented artist, but he has trouble finishing his projects. When he finds the motivation to work on one of them, he becomes highly self-critical and cannot continue. He is very ashamed of his level of achievement. In self-critical moments he sees himself as a failure.

Jeff is often depressed. He has a very strong internal critic (i.e., an internal rejecting object) that flogs him relentlessly. He gets so discouraged at times that he thinks about dying. However, he loves his family, and his love deters him from self-harm.

Because he is so hard on himself and fears failing, he often has panic attacks at work. (These have decreased somewhat over the course of treatment.) He imagines others are critical of him, and he fears displeasing or disappointing them, especially his boss. At times he is so anxious and irritable that he has to leave work to calm down. At other times he titrates these emotions by arriving late, avoiding important projects, or spending time on nonessential tasks.

Similar patterns arise in his relationship with the Church. He loves the Church and has a temple recommend, but he often feels anxious or irritable in meetings. He has ambivalent feelings toward his bishop, and he copes with his internal conflict about Church authority by occasionally breaking the rules in small ways, such as having a cup of coffee on the way to work or using colorful language. He believes in God, but he is exasperated by what he sees as God's failure to bless him in the ways he needs.

Jeff grew up in a very troubled family. His father was an unhappy alcoholic who drank himself into a stupor every night after work. He was very hard on Jeff, questioning his masculinity, ridiculing his interests, and being impossible to please. Jeff had a close relationship with his mother, but she was lonely and depressed. She relied on Jeff for emotional support. He enjoyed the closeness but hated feeling responsible for her emotional stability.

I have been working with Jeff for about two and a half years. Some years prior to seeing me, he received standard CBT/supportive therapy but didn't like it. Hence, he was ambivalent about returning to therapy. However, he decided to try working with me because of my theoretical and spiritual orientations and because I was helpful to someone he knows and trusts.

I found Jeff to be bright, psychologically minded, and open to exploring his issues. He is also very well read and familiar with some psychodynamic concepts, which gave us a basis for understanding. However, he was also guarded at times as well as pessimistic about treatment. In many early sessions, he wanted to talk about how therapy was supposed to help. He was easily irritated with me if he sensed misattunement. In the countertransference, I felt pressure to be a helpful source for solving Jeff's problems. However, at the same time I felt afraid of his anger. I experienced a strong pull to offer solutions, but he would become quiet or angry if I suggested something. Sometimes he would unconsciously cast me as his critic and would hear my comments as devaluing. For a long time, there was a feeling of strong anxiety in the room at the start of every session as he settled into his seat, organized his belongings, and began to focus his attention. Initially I responded to the anxiety by taking the lead, often asking a question to get things going. Eventually I learned that my questions distracted and irritated him. Now I sit in silence and wait for him to begin.

His ambivalence about therapy, his hopelessness, and, I think, his fear of being vulnerable have led him several times to consider stopping treatment. Initially we met weekly, but this proved to be too difficult logistically. We cut back to meeting every other week. When he becomes discouraged, he again considers stopping altogether.

Although we have had some difficult moments, we have also had some very good ones: moments of true connection and powerful insight. We like each other. We are both metaphorical thinkers and have created some vivid metaphors to understand his inner world. At times we are both in tears. At the end of some sessions there is a feeling of hope and oneness. Sometimes this feeling fades between sessions, and sometimes it persists.

Compatibility of Object Relations with a Latter-day Saint Perspective

Freud and his "orthodox" followers understood human nature in terms of basic drives, primarily sexuality and aggression, with the biologically based goals of pleasure and tension reduction. By contrast, object-relations theorists, especially Melanie Klein and R. W. D. Fairbairn, departed from traditional Freudian thought by positing that the primary drive is not to obtain pleasure, but to form secure relationships with other people. These people are referred to, somewhat infelicitously, as "objects," i.e., the objects of the attachment drive. There are two types of objects: (a) actual people in the real external world and (b) the internalized representations or aspects of them. Experience with objects, i.e., relational experiences, become internalized and form the basic structure of personality. Each of us has many internalized experiences. Our unconscious mind organizes them according to

the emotional tone of each experience. Internal object relationships that are too anxiety provoking or need exciting are usually kept out of conscious awareness through repression. (See Kernberg, 2005; McWilliams, 2011; and Scharff & Scharff, 2005 for excellent summaries of object-relations theory.) In Jeff's case, we could say that he internalized his difficult relationship with his father in such a way that a part of his mind, which we might call his "internal critical father" and which object-relations theorists would call a "rejecting object," continues to persecute another part of his mind, which we might call his "internal angry or frightened child" and which object-relations theorists would call the "anti-libidinal ego." Some aspects of this internal persecution are kept out of consciousness, such as how Jeff is mystified by the cause of his panic attacks at work. He understands that they occur when he fears he might displease his boss, but until the underlying dynamic was made conscious in therapy, he didn't realize he was projecting the critical father role onto his boss. Parts of his relationship with his critical father had been repressed because they were too anxiety provoking. The repressed parts seemed to include both Jeff's terror and his rage.

From a Latter-day Saint perspective, the traditional Freudian view that man is governed primarily by biological instincts and unconscious forces seems incompatible with the Latter-day Saint doctrine that man's spirit is the offspring of deity and has agency. Hence, the object-relations view, in which people are "wired" to form relationships and are profoundly influenced by them, seems more consistent with gospel ideas about relationships, namely that developing our relationship with God and learning to relate to others in a Christlike way is a main purpose of life and a way of growth and development. The object-relations view also coincides with the fact that relationships are part and parcel of human existence, experience, and eternal progression. The idea that some object relationships might need to be repressed should not be foreign to any therapist who has treated a victim of childhood abuse or authoritarian parenting. For Latter-day Saint therapists, the object-relations idea (see below) that the therapeutic relationship is a laboratory for exploring clients' current and past relationships and the structure of their minds can be seen as an extension of the belief that Christlike relationships with significant others can heal psychological wounds.

Another important development in psychoanalysis and psychodynamic psychotherapy is an orientation called *intersubjectivity*. Intersubjectivity has its roots in object-relations theory and self psychology (Kohut, 1971, 1977). Its central idea is that patient and therapist cocreate something that is unique, relational, and greater than the sum of its parts. According to Stolorow and Atwood (1992), intersubjectivists believe that there is no "isolated mind" (as cited in Hicks, 2014, p. 137) but that the mind of the child is created and developed within a relational matrix that influences what flourishes and what is repressed. In the relational form of psychodynamic treatment (Hoffman, 2014) that grows partly from an intersubjective orientation, therapist and patient create and inhabit a unique relational matrix. The intersubjective/relational therapist seeks to avoid any preconceived notions about who the patient is or what might be going on at depth and "simply" allows the unfolding of a unique relationship in which arrested or derailed development can get back on track. Although therapists' theoretical concepts can be part of their mindsets, these concepts are to be loosely held, taking a back seat to what is actually cocreated and coexperienced in the session. In this approach, transference and countertransference are understood as an outgrowth of the relational matrix, not just an artifact of a past relationship that is being projected onto the therapist, and the therapist and the patient are understood to be feeling *with* each other. (For a more detailed overview, see Hicks, 2014.)

Intersubjectivity and relational psychodynamic therapy seem potentially compatible with Latter-day Saint theology, in which the Atonement is ontologically relational. In Latter-day Saint theology, exaltation is an endeavor shared by the individual and the Savior, who are friends (D&C 88: 62–63, The Doctrine and Covenants). In this deep, loving friendship, the Lord's justice, love, and mercy combine with the person's broken heart, contrite spirit, and willingness to abide by sacred covenants. This combining produces a shared result that neither entity could produce without the other. Although beyond the scope of the present paper, further exploration of the kinship between intersubjectivity and Latter-day Saint theology may yield a fuller rapprochement between psychoanalytic thinking and

the gospel. This work is already being done in regard to traditional Christianity (Hicks, 2014; Meissner, 2009; Strawn & Bland, 2014).

Applications of Core Psychodynamic Concepts to Psychotherapy with Latter-Day Saints

Introjection in Jeff's Treatment and in the Culture of the Church

According to McWilliams (2011), "introjection is the process whereby what is outside is misunderstood as coming from inside" (p. 112). It is the act of importing something and experiencing it as though it were part of the self. *Identification* is a form of this. For example, children routinely and unconsciously internalize the feelings of the adults around them and experience them as their own. Most of us have seen an infant start to whimper or cry in the presence of a parent who is crying. Children may unconsciously acquire the mannerisms of their parents such that years later their relatives may say, "Your way of walking reminds me of your father." On a more conscious level, a child may adopt the nickname, team jersey, and jargon of an admired sports figure. In less benign circumstances children (or any person) might internalize the idea that they are ugly or unlovable, that they are to blame for the feelings or behavior of others, and so on.

Various kinds of mental contents, attitudes (especially toward the self), and relational experiences can be introjected, including warm and positive experiences with others. In the case of Jeff, however, he introjected a great deal of negative material, primarily from his father. In our work we have come to understand that Jeff's father felt like a failure and suffered from intense internal criticism, having himself been reared by a cold, harsh father. Jeff's father, in turn, without conscious awareness, projected his feelings about himself onto (and into) Jeff. He did this by treating Jeff harshly (though not as harshly as his own father had treated him) and belittling Jeff. This began happening at a very early age when Jeff had no ability to defend against it. These paternal introjects, as they are called, became lodged in Jeff's mind in such a way that he identified with them; they felt (and still feel, at this stage of the therapy) like part of his true self. Furthermore, they prey upon any good feelings he has about himself and upon any movement toward success, leading to chronic self-criticism, self-doubt, and self-defeating avoidance.

It is important for therapists who are members of the Church to recognize how introjection and identification happen in group contexts as well, including our clients' church contexts. Understanding this can also help therapists who are not members of the Church increase their multicultural awareness. For example, Latter-day Saint bishops often call adult leaders who are in their 20s and 30s and are devout and charismatic to serve in the Young Men's and Young Women's programs. The hope is that the youth will come to love these adults and desire to be like them. A personal example was my teacher in the Language Training Mission (now called the Missionary Training Center). Elder Taylor was a charismatic young returned missionary who was confident, expert in Portuguese, and a sharp dresser. He knotted his tie in a simple but dapper-looking four-in-hand knot, much different from the boringly symmetrical full Windsor knot I had learned from my father. I started tying my ties like Elder Taylor and do so to this day. I was not just copying him; I wanted to be like him. I had identified with him in the unconscious hope that I could incorporate his traits into my own personality.

Another unconscious process, *idealization*, can be associated with identification. Idealization is both a normal developmental process and a defense. From a psychoanalytic perspective one reason we idealize others is so we can identify with them and thus feel as though we are incorporating their positive traits into our own identity. Idealization can also be a feature of defensive *splitting* (full name: *splitting of the ego*), which is the process whereby "good" and "bad" self and object pairings are kept apart to protect a positive sense of self. Mild versions of splitting are seen in the common "cognitive distortion" that CBT therapists call "all or nothing thinking" (Burns, 1980, p. 40).

Idealization is inevitably temporary when a person is faced with the nuances of the idealized figure's actual personality. Some degree of disillusionment is a common experience that is usually a part of ordinary maturation. For example, we see disillusionment in children who recognize that their parents are not perfect, in teenagers who recognize that their teachers do not know all the answers, and in young couples who

have progressed past the honeymoon stage of their relationship. At times we see disillusionment in people who become distressed upon learning certain aspects of Church history. In the clinical context, we see it to some degree in many patients and to a high degree in some borderline patients. Borderline patients are famous for rapidly alternating between idealizing and devaluing their therapists (American Psychiatric Association, 2013). When idealization collapses, disillusionment and anger can set in. This is made more powerful by identifications: The person may feel that an important part of himself has been lost. The pain of disillusionment and the resulting anger depend, in part, upon the degree of the idealization, the extent to which it has served as a defensive function, and the patient's general level of disturbance.

In my personal clinical experience, helping angry, disillusioned patients understand the role of idealization and identification in personality formation can (in cases where the underlying pathology is mild to moderate) help them become more able to tolerate the discrepancy between the idealization and the reality. (In more severe cases the therapist is called upon primarily to tolerate the patient's oscillations using primarily supportive interventions until the patient becomes able to tolerate and make use of more interpretive interventions.) By contrast, challenging the logic of the patient's conclusions using a cognitive approach may only convey defensiveness and lack of empathy on the part of the therapist. Of course, the therapist's ability to hold and metabolize the patient's outrage will depend partly on the therapist's own ability to tolerate discrepancies and disillusionment, something psychodynamically oriented therapists are specifically trained to do.

Projection in Jeff's Treatment and in the Culture of the Church

Quoting McWilliams (2011) again, "projection is the process whereby what is inside is misunderstood as coming from the outside" (p. 111). It is the act of exporting something from inside one's own mind onto another person and experiencing it as though it were part of the other person. In its mature forms, projection is the basis for empathy. However, projection in its problematic forms can create dangerous misunderstandings and contribute to traumatic experiences. For example, a father might say to a child who wants to eat candy before dinner, "You do not want that now!" In this case, it is the father, not the child, who does not want the child to have candy at that moment. However, the father essentially disavows his own feeling and locates it in the child, perhaps in an attempt to justify the feeling and to relieve his guilt about denying the child something she wants. This example is relatively benign; however, many such experiences accumulated over the course of childhood could contribute to great difficulties for that person as an adult. In less benign circumstances, a person who relies heavily on projection—i.e., a paranoid person—might imagine that his neighbor wants to cheat him or harm him in some way when in reality the paranoid person has intolerable, aggressive feelings toward the neighbor, feelings from which he protects himself by locating them in the neighbor and then reacting defensively or aggressively. Clients can learn to better function in their families and Latter-day Saint communities once they understand how they, and others, are projecting.

As with introjection, various kinds of mental contents can be projected, including warm and positive feelings, parts of internal objects, parts of the self, and so on. Projection is also involved in transference.

In the case of Jeff, projection occurs a lot at work. He "exports" his critical paternal object onto his bosses and others, experiencing them as critics even though they do not have critical feelings toward him. He imagines they are like his father and feels anxious, panicky, and rebellious, just like he did toward his father.

Jesus talked about projection. Knowing that we are prone to see the faults of others and not our own, he counseled us to "first cast the beam out of thine own eye" before calling attention to the speck of dust in the eye of another (Matt. 7:3–5, King James Version). Partly because of the pervasive influence of Christian teachings in traditional Western culture, the concept of projection is well understood by most people both outside and inside the Church. However, we do not often talk about the way desirable parts of the self can be projected and disavowed in the self. For example, sometimes members of the Church sell themselves short when they see the virtues of others all around them but cannot see the virtues in themselves, leading to shame and discouragement.

Projective Identification in Jeff's Treatment and in the Culture of the Church

Projective identification (PI) is a complex concept that can be very difficult to understand (Scharff, 1992). However, for our purposes, we can think of PI as what happens when projection on the part of one person and introjection on the part of another person work in tandem such that the person who is the target of the projection is subtly induced to think, feel, or behave in accordance with the projection. PI is the reason why feelings are contagious. For example, borderline patients in the throes of painful anxiety may feel like they, the world, other people, and especially their newly minted therapists are bad and that people do not care enough and will continually disappoint them. They burst out with angry accusations that the therapists do not care, projecting their feelings of badness, unlovability, and disappointment (or, stated differently, their "bad selves") onto the therapists. The therapists, who try hard to care about people and like this about themselves, but also have doubts about themselves—due to newness or other issues—immediately take in the badness and experience it painfully as their own. The feeling of badness gets into therapists because it finds a ready docking point in their own self-doubts. Stated differently, individual parts of therapists identify with the feeling, and it plays upon one of their deeper anxieties: the fear of not being good enough. Furthermore, therapists may feel the impulse to defend themselves or even fire patients, thus "confirming" patients' beliefs that they themselves are bad people, that they are unlovable, and that others will always disappoint or reject them. Thus the patients have induced their therapists into behaving according to their (the patients') projections.

In the case of Jeff, we could say that his father's feelings of failure and self-loathing may have been projectively identified into Jeff such that Jeff came to believe deeply that he himself was the failure and deserved the internal criticism he was receiving. This may have led to repeated enactments of failure wherein Jeff unconsciously behaved in ways that led to problems at work, not finishing things he started, and so forth.

Some projections do not get inside the target person and can be brushed off easily. For example, if someone called me a Christmas tree, even in a derisive tone, nothing much would happen inside me because the premise is absurd. However, if someone accused me of being "one of those Mormon hypocrites," I might take this in and feel anxious, quickly reviewing past mistakes and thinking that perhaps the accuser is right. I would probably also feel defensive and have the impulse to argue. The point here is that projections can get into the target person by the process of identification when the target person has a *valency* (Bion, 1952) for the projections.[3] For Jeff, his father's constant belittling probably created a valency for taking in anything that could conceivably be construed as devaluing, such as constructive criticism at work, and experiencing it as an attack upon the self.

PI happens all the time in everyday relationships, not just troubled ones, and can include the sharing of positive feelings as well as painful ones. For example, when two people like each other, they can both sense it and they may become friends. If these feelings are intense enough and are accompanied by sexual attraction, the parties may fall in love because each can accept the other's projections (Scharff & Scharff, 1991). In close relationships, PI can serve as a communication, a method of bonding, and/or a source of conflict (as when a couple becomes locked in a cycle of mutual blaming). PI is also the basis of the transference-countertransference dynamic between patient and therapist.

As an example of how PI can happen in a Latter-day Saint context, suppose there is a ward member who is somewhat rigid and sees things in a polarized way. One Sunday he gives a sacrament meeting talk on covenants. He says that people need to do a better job of keeping them with exactness. In the congregation, there is a conscientious and guilt-prone woman who begins to feel guilty even though she knows intellectually that she has done nothing wrong. She might go home feeling vaguely uneasy or bad about herself, having taken in (identified with) the unconscious guilt of the speaker. In effect, the speaker "exported" his own unconscious guilt and feeling of inferiority, and the woman "imported" it without recognizing it as coming mostly from the speaker. If this woman goes to therapy with a Latter-day Saint therapist who understands PI, an interpretation about this could greatly relieve her by helping her to locate the feeling where it belongs, i.e., mostly in the speaker, not so much in herself.

As another example, I remember a time while serving as bishop when a young visitor couple wanted to talk with me after sacrament meeting. For reasons that

are not relevant to this discussion, they asked me to make an exception to established Church policy and move one of their membership records into our ward even though that person did not intend to reside there. When I refused, the woman accused me of being rigid, unreasonable, unwilling to extend the Christlike help to which she was entitled, and no different from the "bad" bishop who had previously refused. I held firm but felt so bad after the interview that I had to consult with my counselors to get a reality check about my decision. In this situation, unconscious bad feelings that resided in one person became located in another through projective identification.

Transference and Countertransference in Jeff's Treatment and in the Culture of the Church

For object-relations theorists and practitioners, transference starts with projection. The patient unconsciously imagines that the therapist is similar to someone from the patient's past and then reacts as though this were true. Stated differently, the patient projects an internal object onto the therapist, in effect, pasting a picture of someone else's face onto the therapist and reacting as if the therapist were that person. In the case of Jeff, sometimes I sense that he is experiencing me as though I were his critical father. On many occasions, he has avoided eye contact, hemmed and hawed about something he could not quite say, but finally disclosed it cautiously as though he assumed I would criticize him.

Just as transference starts with projection, in a complementary way, countertransference starts with introjection. Therapists internalize material coming from their patients and notice that patients are reacting toward them as though they were, say, a father or mother. In addition, patients' projections might induce thoughts or feelings in therapists that are similar to what the father or mother might have felt. This is projective identification at work. Going further, therapists might even find themselves behaving as though they were the father or mother. Ideally, therapists will have been trained to notice the way projective identification is playing out in the therapy, understand it, and interpret it for their patients rather than enact it. If therapists can contain their reactions, reflecting instead of acting, they will have learned something important about the early life and internal dynamics of each patient. If, based on countertransference, therapists offer an interpretation about how their patients might be feeling and how this might be influencing patient perceptions and behavior, therapists will have enlarged their patients' self-awareness and agency to choose something other than enactment.

In the case of Jeff, he has often worried that I would be critical of him, as though I were the critical father and he were the frightened child. At other times he has been irritated with me. In some of those situations, I have felt as though he was enacting the role of the frustrated child who is angry at the neglectful parent, as represented by me. In those cases I may feel guilty that I have neglected or misunderstood him or angry that he does not appreciate my earnest efforts to help him. I may have the urge to defend myself. At other times I may feel critical of him and have the urge to confront him sternly about something, as though I were the critical parent and he were the bad child. My countertransference reactions and the urge to act upon them reflect my identification with the father "object" Jeff has temporarily installed in me by way of projective identification. My awareness of these dynamics has helped me stay reflective and resist the urge to act out my countertransferential feelings. My awareness has also allowed me to understand what Jeff's internal world is like: He is routinely persecuted by an internal critical father "object" and has the urge to act out. When I say things that signal my awareness and describe his internal experience accurately, he feels understood and connected to me. In those moments I feel the connection as well.

Freud and many of his followers thought of countertransference as evidence that the therapists themselves had not received enough personal treatment and that countertransference should be minimized or eradicated. Today, however, we understand that both transference and countertransference are inevitable, vital elements of the treatment process that can be used to understand the patient and formulate interventions (Wishnie, 2005).

Therapists who pay attention to transference and countertransference recognize that these processes actually happen in all close relationships. Every close relationship exists in a field consisting of mutual projective and introjective identification. In this dyadic field, the partners are constantly and simultaneously

"exporting" and "importing" unconscious material. In healthy relationships this contributes to understanding, empathy, and intimacy. In pathological relationships this contributes to blaming, defensiveness, and escalating conflict. For example, distressed marriage partners may unconsciously locate their bad internal objects in each other in two ways. They may see them in each other but not in themselves (projection). Going further, they also may project them onto each other and then behave in ways that cause the recipient to "import" them, that is, experience them as originating in the self (projective identification). At the same time, both partners are resisting or defending against what is incoming. Each blames the other and neither accepts anything in what amounts to a game of emotional tennis with a ticking time bomb.

As I have discussed elsewhere (Morris, 2011), interesting—and sometimes problematic—manifestations of transference and countertransference can occur in the religious realm. For example, most Latter-day Saint therapists have had clients who had a malevolent or indifferent father and therefore have trouble believing in a benevolent, involved Heavenly Father. As another example, many of us as therapists have been transferential stand-ins for someone's insensitive bishop or pushy "Mormon" neighbor. These sorts of transferences are usually easy to spot and work with. However, perhaps because religion is so central to a Latter-day Saint identity, countertransference enactments based on religion can easily arise and be difficult to manage. For example, suppose a 16-year-old, inactive Latter-day Saint female client is in a sexual relationship with her boyfriend. The therapist, an active Latter-day Saint woman, has warm maternal feelings for the client but is aware of them and works to avoid acting like a worried mother. She also keeps in check her impulse to sermonize about the spiritual dangers of violating the law of chastity. However, one day the therapist is taken aback upon learning that the client is pregnant and intends to have an abortion. The therapist's maternal feelings and religious values may compromise her ability to preserve a neutral space where the client can think through her options without having also to cope with the therapist's anxiety.

As another example of a religiously based countertransference situation, let us say a young Latter-day Saint returned missionary who grew up active in the Church has decided to leave it, citing concerns about Latter-day Saint history and policies. He is starting to realize that he has felt stifled by his well-meaning but anxiety-ridden parents, whose happiness seems to depend upon his conformity. One day in a therapy session he angrily states, "Mormons stifle their kids! The Church says it believes in free agency, but it does not act that way!" The Latter-day Saint therapist, a devout man whose own children have not all stayed in the Church, is triggered by the client's unfair generalizations. He feels a strong impulse to defend the Church, its members, and (unconsciously) himself. If he makes the mistake of saying something defensive, he may scuttle the therapeutic relationship. On the other hand, if he refrains from reacting defensively and instead says something like, "Given your experience with your parents I can see how you would be angry at the Church," he may preserve the therapeutic relationship and move the therapy forward.

Coping with religiously based countertransference can present a particular difficulty for the Latter-day Saint therapist. Membership in the Church, like membership in some other faiths, is far more than just a set of beliefs; as stated above, it becomes part of one's identity. It constitutes a committed Latter-day Saint individual's worldview, occupies much of that individual's time and energy, and requires a considerable financial commitment. It immerses members in a rich social network. Committed Latter-day Saint therapists who are heavily invested in the Church emotionally, spiritually, philosophically, temporally, and socially may have to work a bit harder than a secular humanistic therapist to manage their reactions to client behavior when it deviates from their cherished norms or to tolerate with kindness a client's verbal challenges to their religious views. Understanding psychodynamic concepts and attending to unconscious relational dynamics can help therapists be more attuned to their clients, more able to set clear relational boundaries, more able to model Christlike ways of relating to others, more able to respect client agency, and more able to avoid unconscious countertransference enactments that can potentially harm clients.

From early in my career, I remember an inactive Latter-day Saint man in his 30s with schizoid traits whose only meaningful contact with other people was when he used the internet to find married couples who

wanted to engage in sexual threesomes. In some of these encounters, he received a measure of tenderness and affection without the "danger" of emotional intimacy or commitment. When with enormous embarrassment he finally disclosed this, I was shocked and did not know what to say. I did, however, manage to keep my cool during the rest of the session. After it was over, I thought long and hard about how to handle this material. I did not want to appear to condone the behavior, but neither did I want to shame the client or shut down his halting narrative. I finally decided that I needed to meet him where he was, think of the behavior as a poignant attempt to have a "safe" form of loving human contact, and appreciate his trust in me. Even though I had found a way to think about the behavior, I still had to work with myself to avoid saying anything with words or actions that might scare him away. I had to be careful with my religiously based countertransference in order to protect the therapy.

Containment in Jeff's Treatment and in the Culture of the Church

Wilfred Bion, a British WWI hero and a brilliant psychoanalyst, contributed many vitally important concepts to our understanding of the mind (Bion, 1962a, 1962b,1965; or see Brown, 2012, for a more accessible summary). He thought that the mind contains primitive anxieties and other proto-thoughts, which he called *beta elements*. To convert these into actual thinkable thoughts, which Bion called *alpha elements*, the mind uses a process called *alpha function*. Using the alpha function, the mind "digests" beta elements (unthinkable thoughts) into alpha elements (thinkable thoughts), which can then be reflected upon, considered, and acted upon in the way we ordinarily experience the workings of our conscious mind. Borrowing an analogy from Ferro (2007), consider what happens when raw vegetables, let us say tomatoes, are fed into the receiving end of a food grinder. As the operator turns the handle, the tomatoes become tomato puree, which comes out the other end. The puree is more digestible than the raw tomatoes and can be used as an ingredient in soups, sauces, and dressings.

Bion (1962a) also described a process he called containment, wherein one mind can serve as a container for the projections and primitive anxieties of another. The "owner" of the container uses alpha function to process this material and return it to the originator (via PI) in modified, digestible form. Following Ferro, we can imagine a modern blender that has both holding capacity and a grinding or pulverizing mechanism at the bottom. After the raw material is put into the blender and ground up, it becomes a "smoothie" that is more palatable than the raw ingredients. Thus, containment is not just passive storage. It is active emotional and cognitive work, at least partly unconscious, that can help make something bearable, either for the owner or for someone else.

Mothers and fathers provide containment for babies, spouses do it for each other, families and groups do it for their members, mentors do it for students, therapists do it for patients, and so forth. For example, consider a parenting situation. Little Johnny runs screaming into the house, bleeding from a skinned knee. He hurts, and he is frightened. His father hugs him and says, "Oh. I bet that hurts. Let me have a look." Father carefully and calmly examines the wound and says, "How about if we put some medicine and a Band-Aid on it. I promise it will not hurt too much." Johnny is calmer by now and bravely endures the first aid. Father holds him for a few minutes. Johnny feels better and goes back out to play.

What happened here? First, this healthy father experienced an identification with Johnny's pain. He took in the pain and connected with it because he has experienced similar things. However, with his years of life experience and his developed alpha function, he was able to turn the raw pain into something that could be thought about and reflected upon. He realized that Johnny's injury was painful but not serious. Although the physical first aid happened when the disinfectant and Band-Aid were applied, the emotional first aid happened when Father uttered his very first empathic syllable ("Oh.") with a certain inflection that conveyed the message: "I see that this hurts, I understand, and it is not as serious as it seems." Father took Johnny's raw tomatoes, as it were, ran them through his own internal food processor, and gave them back to Johnny in a bearable, digestible form. Father became Johnny's auxiliary ego for a few moments. Johnny's physical pain persisted, but his emotional pain subsided. Over hundreds or thousands of iterations of this process during childhood, Johnny learns that (a) my feelings matter and are welcome; (b) my feelings are understandable

and manageable; and (c) I am secure and loved. In addition, and most importantly, Johnny internalizes his father's alpha function, which he can then use on his own. This is how children (and our patients) learn affect regulation and mentalization (Fonagy, Bergely, Jurist, & Target, 2002), which is the capacity to tolerate, reflect upon, and downregulate one's own emotional states and those of others.

By contrast, if Father's alpha function is impaired and he copes by repressing his feelings, he might try to induce Johnny to repress Johnny's feelings by saying, "Stop crying! You are making a big deal out of nothing! Big boys do not cry." This might help Father manage the distress he feels when Johnny is upset, but it would teach Johnny that feelings do not matter, are shameful, and must be repressed.

If Father's alpha function is impaired and he copes by exporting (projecting) his distress, he might overreact: "Oh my gosh! You are bleeding! We had better call the doctor!" This would escalate Johnny's distress by forcing him to take in Father's distress and manage it along with his own, thus being responsible for taking care of himself and his father. Johnny might grow up to be a therapist (Sussman, 1992).

In the case of Jeff, we have come to understand that his parents were not adequate containers for the distress he experienced growing up. Not only did they cause most of it, they were so full of distress themselves that they made Jeff into a container for their feelings rather than being there to help him contain his own. This is precisely the situation that Miller (1997) has described so eloquently: the child cannot develop normally because the parent cannot tolerate and accept the child's needs and feelings but instead requires the child to contain both the child's needs and feelings and those of the parent.

Containment is an important part of what happens in therapy. In the intersubjective field of the therapy relationship, patients and therapists are passing things back and forth via PI. Therapists, with their presumably better-developed alpha function and enlarged capacity for containment, receive the patients' projected bad internal objects and experience them as painful. However, they do not retaliate but simply observe, metabolize, and "feed" them back to patients in modified, detoxified forms as clarification or interpretation.

For example, let us imagine the following clinical situation. A therapist who is usually punctual arrives late for a session with her patient, a man in his 30s with borderline personality organization (Yeomans, Clarkin, & Kernberg, 2002). The patient, apparently caught in the throes of a painful negative transference, says vehemently, "I cannot believe you are so thoughtless! You know that my whole life I have been let down by people who were supposed to love me! You are just like all the rest of them! You are a terrible therapist and this will probably be our last session!" The therapist, a skillful, conscientious person who thought the therapy had been going well, feels a stab of excruciating guilt. For a moment she wonders whether the patient is right. However, because she knows that she does in fact care about the patient, understands how to work in the transference, and has a well-developed alpha function, she can with some effort metabolize the incoming feeling of badness. She does so by (a) recognizing her own feelings, (b) calming herself down by trying not to take the accusations personally and by reassuring herself that she is not a bad person or a bad therapist, and (c) reflecting on what the patient is feeling and why. This processing would be partly conscious, partly unconscious, and it would happen in just a couple of seconds. Having metabolized and detoxified the feeling of badness that was put into her, the therapist might then say, "I was indeed late and I am sorry. That was a mistake. You are so angry and disappointed that you feel like firing me. Maybe I deserve it and maybe you will decide to leave. Is there more you would like to say?"

Psychodynamic therapists might disagree about the specific wording or the level of self-disclosure in the above intervention, but we can see the three key elements: (a) the therapist takes in the badness that is being projectively identified into her, (b) uses her alpha function to process and detoxify it, and (c) returns it to the patient in more palatable form. In the process the patient learns that the therapist is emotionally engaged, has feelings, and is robust enough to contain the patient's feeling of badness. The patient also learns that he can be cared about in spite of feeling defective, that ambivalence can be tolerated, that therapy is a safe space where he can fully be himself, and so on. This experience is qualitatively different from what the patient likely experienced growing up

where the emotional environment may have been invalidating (Linehan, 1993), shaming, or even abusive. Over many iterations of this process, something shifts inside the patient. He recognizes that the therapist is both caring and sturdy, flexible and firm. He gradually internalizes the therapist as a good-enough (Winnicott, 1953) object who can be carried with him internally for support in times of distress. He borrows and then internalizes the therapist's alpha function, that is, her capacity to mentalize, regulate affect, tolerate ambivalence and ambiguity, and respond nondefensively to the ordinary imperfections and misattunements involved in close relationships. He is able to get on with his psychological development.

In the case of Jeff, I have been called upon many times to internalize and contain his painful states of mind. These include despair, frustration, anger, confusion, and hopelessness. Although I am not trying to "reparent" him, I am seeking to give him the experience of having someone understand him and sit with his distress rather than try to dismiss it, minimize it, or fix it. This can be difficult at times because there is a strong pull to fix it. By not trying to fix it, but instead trying to understand it, I am seeking to help him learn that his feelings are bearable, less dangerous than he imagined, understandable, and survivable. Ultimately, he may internalize something of my alpha function and be able to use it at both a conscious and an unconscious level in coping with distress.

Of course psychodynamic psychotherapy, like any effective psychotherapy, contains many more ingredients than just containment. Other important ingredients include respect, careful listening, the frame of therapy, clarification, confrontation, interpretation, evenly suspended attention, the space for the transference to develop, positive identification, and so on (see Gabbard, 1990; Lemma, 2016; McWilliams, 2004; and Scharff & Scharff, 1998). I have focused heavily on the process of containment because, as elaborated below, containment in particular can be seen as having a strong spiritual component.

In the Latter-day Saint faith, we covenant to "mourn with those who mourn" (Mosiah 18:9). Truly helping another grieve requires containment. Bringing treats, telling someone who is in distress over a loss to "cheer up," offering reassurance by saying "you'll feel better soon," or even shaming someone for continued mourning are very different from containing another's grief through listening, having empathy, and helping him sit with and metabolize his pain. Many clients who are mourning but cannot find containment in their community or church culture may be relieved to realize that others have not been "mourning with" them in a way that is truly helpful. They might find relief in a therapist who understands this and immediately provides this type of relief through containment.

Lest readers infer that psychoanalytic psychotherapists are always warm, tolerant, patient, and accepting, I add that they can at times be respectfully confrontive, insistent, limit-setting, and tough (Yeomans, Clarkin, & Kernberg, 2002). Especially with more disturbed patients, at times it is necessary to firmly confront words or behaviors that threaten the safety of the patient, the safety of the therapist, or the frame of treatment. While this can be done in the context of acceptance and caring, sometimes patients must know in no uncertain terms that certain behavior cannot be tolerated if the therapy is to continue. In addition, psychoanalytic psychotherapists may also confront patients about patterns of behavior that violate the patient's stated values and goals or which may constitute an unconscious repetition of a toxic pattern. Such an assertive and firm stance is also part of effective containment. Parents know this when they say to an angry child, "I understand you are angry, but I cannot let you hit your sister." Effective containment is both tender and tough, just as Jesus was both tender (e.g., John 8:11) and tough (e.g., Matthew 23:13).

A Side Note from Neurobiology

Recent research in the field of interpersonal neurobiology has given us a way to think about some of these psychodynamic processes on a neurological level. A full review of this material is far beyond the scope of the present paper. (See Scharff & Scharff, 2011, pp. 12–14, for a concise summary; see Lemma, 2016, pp. 22–24 and pp. 75–82, for brief discussions of the interface between psychodynamic psychotherapy and neuroscience.) Briefly, however, research is suggesting that humans have mirror neurons that cause pathways in the brain of an observer to fire in much the same way as those of a participant. Unconscious communications such as projection, introjection, projective identification, and empathy may be

happening neurologically through the action of these mirror neurons. Furthermore, it appears that partners in close relationships, such as psychotherapy, parenting, friendship, and mature love, are actually regulating each other's affect and changing the structure of each other's brains (Arden & Linford, 2010). In other words, psychodynamic processes may be more "real" in the neurological sense than previously thought.

Spirituality in Psychodynamic Psychotherapy

President David O. McKay once said, "Spirituality, our true aim, is the consciousness of victory over self and of communion with the Infinite" (McKay, 1969, p. 8, as cited in McKay, 2011, p.16). Apart from the Atonement itself, the core Christian doctrine is that we overcome selfishness and seek to love our neighbors as ourselves (D&C 59:6; Lev. 19:18; Mark 12:31; Rom. 13:9). We seek to treat others the way we would like to be treated and metaphorically turn the other cheek when offended (Matt. 5:39; 7:12). We are invited, even required, to sacrifice our pride and selfishness (3 Ne. 9:20) as we seek to develop charity, the pure love of Christ (Moro. 7:47). We covenant to mourn with those who mourn, comfort those who stand in need of comfort, and bear one another's burdens (Mosiah 18:8–9). Learning to do these things well requires a lifetime of practice and is a deeply spiritual endeavor.[4]

Few activities require the kind of victory over self that psychotherapy does. Practicing psychotherapy, perhaps especially psychodynamic psychotherapy, requires a special kind of victory over self. It requires us to sit with people in distress and feel their pain without seeking to make ourselves feel better by defending or otherwise enacting something. We do this even in the face of being attacked, criticized, and otherwise used as a container for the painful emotional states our patients are learning to manage on their own (Winnicott, 1945). Furthermore, psychodynamic psychotherapists are taught to behave in such a way as to specifically elicit transferences, even painful ones. They are taught to notice the countertransferential pull to behave in accordance with the transference (Racker, 1968), e.g., to soothe, reassure, defend, retaliate, or otherwise engage in an enactment, but instead contain the feeling, detoxify it, and return something helpful in the form of clarification or interpretation.

Seen another way, evil dwells in patients' hearts: evil that was installed there before the patients had any way of protecting themselves (D&C 93:39), evil that patients unconsciously install, or try to install, in the heart of the therapist so as to relieve themselves of it. By accepting the projection, observing it, feeling it, trying to understand it, sitting with it but not trying to fix it or defend against it, the therapist contains and detoxifies by reacting benevolently, returns beauty for ashes (Isa. 61:3). This way of relating to patients is an act of Christian charity and a manifestation of the pure love of Christ (Moro. 7:47), a truly spiritual endeavor.[5]

In order for containment on the part of the therapist to be healing it must also be sincere. That is, it must be based on respect and represent a genuine effort to understand and be helpful. A similar effort without respect and sincerity, e.g., one tinged with the therapist's defensiveness, would not be containing at all and in fact would likely amplify the patient's distress and defensiveness. This is one reason why it is hard, maybe impossible, to help clients we do not fundamentally like.

I hasten to add that I am not recommending therapist masochism, grandiosity, or a savior complex. I am not talking about untreated or unaware therapists enacting their childhood roles as therapists for and "saviors" of, say, their alcoholic fathers or mothers. I am talking about the mature, intentional, realistic, mindful responses of therapists who have become comfortable with their own limitations, who can tolerate and work through their own distress, and who can use this mature capacity to sit near the fire and take the heat, as it were, in service of promoting healing.

Psychodynamic psychotherapists do not have a monopoly on techniques that can be seen as spiritual or the capacity to tolerate patients' distress; I believe that ethical therapists of all theoretical persuasions share these techniques and do a vast amount of good in the world. Several things may set psychodynamic therapists apart, however, including their awareness of the unconscious processes occurring between patient and therapist in the session, their understanding of containment, and their willingness to sit with and metabolize the distress rather than try to fix it, trusting that the process of containment is itself part of the healing.[6]

A Session with Jeff

Some material from a session with Jeff may serve to illustrate some of the principles described above. By way of background, the day before the session he emailed me to cancel, stating that he had developed persistent transportation problems. Also, he questioned whether he wanted to continue in therapy and wanted to talk about this in our next session two weeks thence. We confirmed that appointment. Later that day he emailed again and asked if the canceled appointment had been filled because he wanted to come in after all. I had not filled the appointment, so we confirmed for the next day.

At the start of the session, Jeff said he felt deep despair the previous day due to a job situation. The feeling was so dark that he wanted to disengage from everything except his family and he had decided to withdraw from therapy. However, the despair receded a bit after he went for a walk, had lunch, and shared his feelings with his boss. He developed a plan to cope with the situation and felt well enough to arrange transportation and reschedule his appointment with me. However, as he talked about the despair, his mood dropped and he had trouble formulating his thoughts into words.

In the countertransference, I was feeling his despair and had impulses to say things to cheer him up. However, recognizing from past experience that this represents my internal defense against taking in and holding his feelings and that it tends to upset him, I stayed quiet and tried to reflect, allowing silence to prevail at times. I was trying to contain and metabolize the despair he was putting into me, and I was feeling quite anxious. Eventually I made a couple of clarifying comments. The words were barely out of my mouth when I sensed that they were inadequate, too small to encompass his pain. Evidently, they seemed inadequate to him as well.

With exasperation in his voice, he said he was having a hard time finding words to describe what he was feeling. I said I also felt my words were inadequate.

I sensed that he was exasperated with me as well as himself, but I did not say anything about this as yet. We were both having trouble finding the right words. I wondered whether we were both struggling to name something or if one of us was projecting the confusion into the other.

He compared himself to Hamlet, stating that the feeling was one of unrelenting darkness and irreparable badness.

As I allowed myself to associate to this evocative metaphor, an image came to me. I saw a patch of darkness sitting in the midst of a matrix of some sort. The edges of the darkness seemed to be moving, gradually encroaching on the surrounding area. I began thinking of this as an alien object, that is, an introject, that Jeff took in very early, perhaps from his father.

Using the image in my mind, I said it was as though his mind had been infected by an evil alien entity that punishes him if he does anything libidinal, i.e., assertive, creative, or energizing. With excitement in his voice, he said, "Yeah! That's it!"

At this point I felt almost instant relief from my anxiety, and I could see that he did also. I felt us reconnect, and I sensed the Spirit was working with us.

When interpretations hit the mark, the patient will often go on to elaborate. As if to corroborate my interpretation, he offered the example of trying to finish something he was making for his daughter. When he started working on it, he could only see the flaws. He found himself getting very angry, so angry that he had to set the project aside for fear he would irreparably harm his relationship with her.

As we chatted further, he thanked me several times, stated he felt understood, and then asked a question he identified as very important: "Do you think 'it' is genetic or is it an introject?" (He understands the term). I emphatically stated I thought it was an introject. That is, he was not born with it; he took it in from the environment. He seemed very relieved and thanked me profusely. When he left, he seemed moved and somewhat more hopeful. I was feeling deeply moved as well.

At the next session, he reported that the interpretation and my confidence that "it" was an introject helped him greatly. As we reflected on what happened, I told him that I experienced the previous session as a spiritual process. He thanked me for saying so and said that this meant a lot to him because he had come to trust me to tell him the truth.

Reflections on the Session

I believe my psychodynamic perspective helped me understand Jeff in a way I could not have without it. Maybe others could have, and certainly therapists of all orientations do effective work. However, with certain patients I find this perspective to be invaluable. Jeff is turned off by cognitive-behavioral interventions and even by some supportive interventions. They make him feel patronized and misunderstood. These interventions seem to elicit a father transference; he hears them as oversimplifications, as criticism, and as a discounting of all the efforts he has already made. If I had not had other skills, I think Jeff would have fired me in the early stages when we were still trying to figure out how to work together.

A purely secular therapist might say that the image of an alien invader arose from my unconscious mind because I introjected Jeff's internal experience and identified with it (that is, projective identification occurred), and my awareness of it helped me formulate the interpretation. While I do not discount this interpretation of my experience, I also believe that the Spirit was working with us in the session. Jeff and I both felt it when my interpretation hit the mark. After the session, I felt grateful: grateful to have been helpful; grateful for the psychodynamic training, which allowed me to work with my countertransference and to formulate the problem in terms of introjection; grateful to the Lord for helping me in the session and for giving me the opportunity to do this work; and grateful for the love of God I felt for Jeff.

Conclusion

In summary, psychodynamic psychotherapy has fallen out of favor for a variety of reasons, especially with religiously oriented therapists. In this paper I have explained some of the core concepts and processes of psychodynamic psychotherapy as currently practiced and attempted to show how they can be part of a spiritually oriented approach. Containment, in particular, can be seen as an act of Christian charity that requires therapists to bear the burdens of others in ways that call upon their spiritual capacity to love in a Christlike way. Although all forms of psychotherapy ask the practitioner to sit with the emotional pain of others, psychodynamic psychotherapists are specifically trained to notice, understand, and bear the unconscious processes happening in therapy sessions, thereby helping patients acquire the capacity to do so for themselves. Psychodynamic psychotherapists use these processes to understand patients' suffering more deeply and to intervene at the level of personality structure. Although psychodynamic theory and the treatment based upon it originated in the mind of an avowed atheist, these concepts nonetheless reflected his honest attempt to understand the human mind and to relieve human suffering. Since Freud's time, psychodynamic psychotherapy has evolved beyond its origins and can now be seen as a spiritual activity that calls upon us to exercise Christlike love. Furthermore, the development of intersubjectivity and the relational orientation within psychoanalysis and psychodynamic psychotherapy may offer a way to strengthen the connections between psychoanalytic thinking and the gospel. In the words of Strawn and Bland (2014), "for the Christian in psychoanalytic treatment, something much deeper [than the promotion of self-fulfillment and psychological health] is occurring. Both therapist and patient are participating eschatologically in the redemptive and reconciling work of Christ" (p. 262).

Working with patients psychodynamically can deepen and enrich their experiences and lead to spiritual moments when they feel deeply understood. In the case of Jeff, I have learned that standard supportive and/or CBT interventions invariably elicit a father transference and defensiveness. I have learned to contain my reaction so as to avoid being seen as critical and disappointing and to focus on pure analytic listening, trusting that my countertransference will lead me to understand and intervene in ways that help him. Doing so has opened a space where the Spirit helps me understand him and helps us create a deeper and more healing connection.

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Notes

1. The 2014 update of this study (Abbass et al., 2014) showed similar results across an additional 10 studies (for a total of 33) and an additional 742 patients (for a total of 2173). The authors state:

   > This meta-analysis of 33 RCTs of STPP comprised of 2173 participants found it to have modest to large effects relative to controls across a broad range of CMDs [common mental disorders]. Benefits were observed across a broad range of outcome measures including general measures and somatic symptoms, as well as depression, anxiety, interpersonal and social adjustment. (p. 18)

2. For purposes of simplicity, for the duration of this paper I will refer to "the Church of Jesus Christ of Latter-day Saints" as "the Church."
3. Bion (1952) borrowed the term *valency* from physics to describe "a capacity for instantaneous involuntary combination of one individual with another for sharing and acting on a basic assumption" (p. 235).
4. Christianity is not alone in this, of course; many religions and ethical systems espouse something akin to the Golden Rule ("Golden Rule," n.d.).
5. See McWilliams (2004) for a discussion of the role of love in psychotherapy.
6. Other aspects of psychodynamic psychotherapy can also be seen as spiritual. For example, interpretation, especially the version of interpretation that therapists of other orientations may call reframing (Alexander & Parsons, 1982), can be seen under certain circumstances as an act of grace that may allow

patients to stop flagellating themselves and use the truth to set them free (John 8:32). In the session with Jeff, an interpretation appeared to help set Jeff free from hopelessness and self-blame. Similarly, working in the laboratory of the transference can illuminate the dynamics of patients' families and allow them to work toward forgiving themselves and others.