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Active psychodynamic psychotherapy: moments of high receptiveness in working with emotions

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ABSTRACT

Moments of High Receptiveness (MoHR) offer support to active dynamic psychotherapy. Without disregarding the value of interpretive interventions, addressing the emotions and the procedural components is central within the therapeutic process: both in situations of great emotional intensity as when it disappears as in ideoaffective dissociation.

The active creation of moments of high receptivity is shown through clinical examples as a technical tool that facilitates access and modification of symptoms resistant before. Regardless of the various forms of intervention on emotions proposed: sequence of emotional states; allow uncritical emotional expression without analysis of the underlying content; use of triggering stimulus; use of self revelation; or experiential coupling among others.

Key words. Dynamic psychotherapy, moments of high receptiveness (MoHR), active technique, sequence of emotional states, experiential coupling.

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RESUMEN

Los momentos de alta receptividad (MAR) ofrecen soporte para una psicoterapia psicodinámica activa. Sin desechar el valor de las intervenciones interpretativas, dentro del proceso terapéutico, el abordaje de las emociones y del componente procedimental ocupa un lugar central: tanto en las situaciones de gran intensidad emocional como cuando esta desaparece, como en la disociación ideoafectiva.

Se muestra con ejemplos clínicos cómo la creación activa de momentos de alta receptividad representa una herramienta técnica que facilita el acceso y la modificación de síntomas resistentes hasta ese momento. Todo ello con diversas modalidades de intervención sobre las emociones: secuenciación de estados emocionales, permitir expresión emocional acrítica sin análisis de los contenidos subyacentes, el uso de un estímulo desencadenante, el uso de la autorrevelación o el acoplamiento experiencial entre otras.

Palabras clave. Psicoterapia psicodinámica, momentos de alta receptividad, técnica activa, secuenciación de estados emocionales, acoplamiento experiencial.

INTRODUCTION

De Iceta et al. define the Moments of High Receptiveness (MoHRs) as[1]:

"... The activation of multiple mnemonic elements (semantic and/or procedural; implicit and/or explicit) spontaneously (such as the now moments of Stern et

al.[2]) or through different stimuli. That activation opens a temporary window during which, regardless of the motivational value of an intervention[3], the patient is in a state of greater receptiveness (with greater potential for the occurrence of therapeutic change). Receptiveness is specific in terms of the production of change (or damage) to certain emotional states or thematic areas. It is not generalized to any intervention".

This concept is drawn from incorporating the progress of neuroscience in the knowledge of memory bases for psychotherapy: the theory of the reconsolidation of memory[4,5], labile memory theory[6], and experiential coupling[7]. Its interest lies in the fact that it offers support to active dynamic psychotherapy[1], through a two-way process which allows a new experience to remodel an old one, whilst simultaneously allowing the old experience to provide the new with organization and meaning, both perceptually and affectively.

This work deals with the implementation of this active technique in the phases of the therapeutic process where feelings (and the expression thereof) rather than language prevail.

That should not question the value of interpretive interventions as producers of psychic change in psychotherapy, as the modular-transformational approach of Bleichmar[3] or, more recently, Méndez and Ingelmo[8] have shown.

Conceptual framework

Besides the groundbreaking contributions to active technique of Ferenczi and Rank[9] and Alexander and French[10], several authors have claimed that, moments of intersubjective encounter between patient and therapist[2,11-13], and the development of transferential-countertransferential phenomena[14], play a central role as engines for therapeutic change. As Mitchell[15] would say, the psychoanalytic process constitutes an interactive matrix.

A deeper understanding of the therapeutic relationship comes from the study of early mother-child interactions as an analogy for the therapeutic relationship[2,11,16]. It is no longer possible to continue regarding feelings that appear in session as merely transferential, in the classic sense[17-21].

An ongoing process of modulation of the patient's and analyst's emotions occurs in the therapeutic bond, whether in a positive or a negative sense. Working on those emotions constitutes a key element, regardless of whether these emotions appear spontaneously or are actively sought by the analyst. The emotional implication is shared by both, and only if the emotions are coordinated (tuning) will the treatment be successful[2,7,22].

MOMENTS OF HIGH RECEPTIVENESS: AN OPPORTUNITY FOR HANDLING EMOTIONS IN TREATMENT

MoHRs offer a way to modify material with high emotional content which is inaccessible at other times, especially with respect to the procedural component inscribed in these situations. In addition to watching out for their spontaneous appearance, we propose the active creation of these significant moments for the patient during certain phases of the therapeutic process.

One of the ways to achieve this is to encourage the patient to relive a memory* in the Freudian sense of *lived experience*[23]. That is, to re-experience the memory with all its emotional weight[7,24].

* *A wider list of triggering stimuli or possible situations in which MoHRs can be expected was published by de Iceta et al (2015)[1], including:*

- *"Visual images — These include the use of photos as mnestic stimuli; Freud frequently asked patients for photos and mementos. It also includes using the cinema as a therapeutic instrument.*

- *Smell — Scent is highly evocative and of great relevance to many patients with post-traumatic stress. Patients who have been victims of fire, for example, find the smell of burning intensely evocative. Smell also may be a trigger patients who have suffered sexual abuse, for example, when exposed to the abuser's cologne.*

- *Sound — Music can conjure memories, as the Emmy Lou Harris song did in the case of Mr. P presented by Altman (2002).*

- *Texts — Rereading books (as in the M case, when the patient refers to excerpts of a book), letters, or case history, may access a moment of receptiveness.*

- *Disruptive moments in the therapeutic process due to errors on the part of the analyst — These are moments in the transferential-countertransferential process during which an element of self-revelation by the analyst opens treatment to new emotional elements that connect to situations important to the patient.*

- *Interpretations adequate in terms of semantic and emotional content, and timing — These occur right after that a new emotional state with new associations*

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emerging configure a moment of high receptiveness. At this point, the only risk is the therapeutic enthusiasm on the analyst, if he/she ignores the emotional impact on the patient. One could remark the insight achieved, put an experiential bookmark and work on self-regulation.

- *Moments of meeting — These are quite the same as in the previous point (including the risk on the analyst).*

- *Dreams — These are especially useful when working in the present tense and trying to obtain the most experiential memory possible (see de Iceta & Méndez, 2003).*

- *Events in the patient's reality — These include trips, passing by certain places, reunions, contact with events in the lives of significant people, including those that occur in the life of the analyst, for example, a therapist's pregnancy, maternity/paternity leave, mourning the passing of a loved one, absence due to attending a conference (Fried, 2008) or a serious, possibly terminal illness (Brokaw, 2008).*

- *Variables prior to treatment — These triggers can involve contacts that may have influenced the patient before beginning therapy, such as the person who recommended the therapist or the prestige of the therapist.*

- *Initial interview — With all the variables in play during a first meeting (environmental and personal factors, managing anxiety, etc.), it is possible that one of these will elicit a MoHR.*

- *Group interviews with emotionally significant people for the patient — These people include parents, partners, etc.".*

In the same paper, as well as the underlying metapsychological and neuroscientific basis for the concept, there is a list of characteristics of the therapist for recognizing and using of MoHR, guidelines for its recognition, and some suggestions to make the most of them.

As detailed by de Iceta et al.[1], new understanding of the mechanisms involved in memory "reconsolidation" shows that, at the moment of remembering, memory enters a "labile state" which allows new memories to restructure the old, producing a genuine physical reorganization of the memory as opposed to simply adding a new one. Bleichmar[7,22], and later on de Iceta et al[1] have taken these developments forward to their application in clinical psychoanalytical work.

CLINICAL CASES

The first case concerns A., a man of 38. He sought consultation to overcome the depressive state he experienced when he was not taking anti-depressants and also to deal with aggressive outbursts he felt powerless to control. Along with an explosive personality, he presented a fundamental distrust, both of himself and of those around him. This lack of trust was largely a result of his experiences growing up with a mother who suffered from paranoid personality disorder and a father who was absent from family life, immersed in a job which took up most of his time.

He had been experiencing the aggressive outbursts since his youth, but they became worse when he started working and had to shoulder professional responsibilities. They were generally set in motion when he felt the effort he made for others was not reciprocated. He needed constant self-approval, as well as to fight against the feeling that the world outside was evil and cruel. He experienced and expressed all of this with a high level of emotion, with very intense feelings of rivalry and envy.

During the first stage of treatment, the objective was the indispensable gathering of data to find out about his life history, his motivations, his ways of bonding with others and himself, etc.: in other words, to get to know the workings of his intrapsychic world. Significant content emerged such as his difficult relationship with his parents. In particular, a very pathological maternal figure of which he was unaware slowly began surfacing. Also of importance was his marriage to a woman from another country, with a rich family background and "*a lot of class,*" as he put it, pronounced in tones of narcissistic envy. He even went as far as to say that he wasn't sure if he had married for love or in search of a sense of security he did not possess. He described his relationship with his wife as good, except for those moments when he let loose with his fits of rage. There were recurrent references to his feelings about approval. He never considered himself to be properly valued and loved, despite having triumphed in the world of business.

This case already poses the first questions to be confronted in many clinical situations: should we give immediate precedence to an intervention focused on the content behind the emotional intensity? Or should we work on the emotional intensity of the content and how it is experienced?

In terms of the techniques to be applied when the objective is to counteract and especially to regulate intensely emotional situations, can we use the same techniques as we do in circumstances of lesser emotional intensity?

As a general indication, the level of emotional intensity with which the patient relates and experiences events is directly proportional to the level of attention this intensity should receive. However, this solution cannot be generalized across the board. There is no fixed rule governing this choice, and other approaches may be used, depending on the moment in the therapeutic process.

The above mentioned dilemma was exemplified in the case of A. The initial objective of gathering information could not be achieved properly because it was continually interrupted by successive conflict situations in which he was carried away by his volcanic reactions.

The necessity of working primarily on his episodes of losing his temper became evident. Be it fears, frustrations or doubts, A. dealt with them all by means of an aggressive reaction. Then, the focus was centered on his accounts of the many and varied aggressive conflicts in which he had become embroiled over the years. A. was asked to apply the highest possible level of emotional detail (see more above) to his descriptions. This created an atmosphere of high emotional intensity and a much closer proximity to his original feelings in the situations described.

The therapeutic objective consisted of helping him to get in touch with all the different feelings in such a way that we could identify each one individually and the order in which they appeared. The strategy applied was to leave the significant underlying motivations (conflicts, ego deficits, etc... that may generate or sustain the actual feelings) to one side, in order to shed light upon the sequence of feelings, just as they appeared during his episodes of loss of control. In this way, the patient was able to concentrate on the specific feelings that were set in motion, seeking the highest level of intensity in the affective experience and reliving this in the bosom of the therapeutic bond and in a different relational moment to that of the original experience.

The role of the therapist was to help the patient to fully recognize the factors common to all his episodes, or in other words, to reach an understanding of the fact that, though the actual situations themselves varied, the sequence of emotions was basically the same (incidentally, we suggest that this work of emotional reconstruction must be done with most of the episodes or at least with the most significant ones).

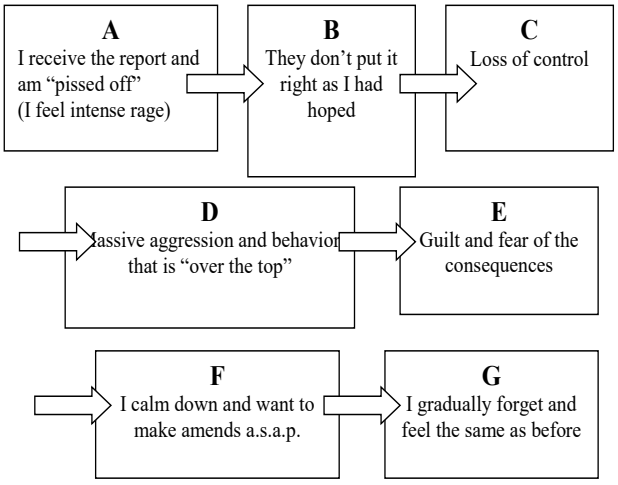
One day A. brought a serious incident at work to session. He was intensely anxious. The experiential telling of the episode in session brought about a MoHR. On noticing this, it was suggested to A. that the incident would be worked on in depth. A confrontation had arisen with various work colleagues after he received some reports in which he felt his integrity was being called into question. This produced an intense feeling of injustice and rage in his head, which was channeled into an attack on them that was completely out of proportion. At that moment, an understanding of the different underlying mechanisms which provoked his behavior was set aside in favor of an experiential account which attempted to recapture the emotions which had flooded him at that precise instant. He was encouraged to get in touch with the most procedural aspects of his behavior when he lost control. When A. began the account of what had happened, he acknowledged that he had completely lost his temper and that he regretted it because he felt guilty and also because the scale of the incident could well result in negative consequences at work.

In order to actively take advantage of this MoHR, A. was asked to give an account of what had happened during the incident whilst trying to stick to the sequence of events in the order they had occurred. This allowed to make a preliminary approach towards the feelings he had experienced, without yet entering into a truly experiential account.

In session he was presented with a diagram sketched on the spot by the therapist, which gave a general description of the episode based on his own account (see Figure 1), following Lanza Castelli's[25] work on the technical benefits of transcribing the session.

After a joint discussion on this, he was given the diagram and asked to fill in a detailed account after the session of all the feelings he had experienced during each of the moments described. Special emphasis was placed on his writing down the exact feelings he had had during each of these moments.

Figure 1 | **Sketch made by the therapist of the episode's initial sequential account**



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He took the diagram with him. In the next session, he brought it back, fully written up (see Table 1).

As A. read through it, the therapist's interventions took the form of questions which sought to help him move deeper into his feelings and create a highly experiential atmosphere.

In episodes such as these, the analyst's participation is not limited to simply being there for the patient. It also seems necessary to actively intervene. Reliving the episode and asking the patient to write his feelings down in order to discuss them together in an experiential way in session were key. These elements set in motion the MoHR facilitating access to an uncovering of the emotional sequences.

The therapeutic intervention continued with the therapist sharing a similar episode from his own experience with the patient. The objective was not to judge, but to demonstrate that other ways of reacting can genuinely be applied.

The therapist gave an account of a work situation in which he had experienced something rather similar and the way he had subsequently acted. He described the sequence of events in detail, what the therapist had felt at the time, the decisions he took, how things developed and the final results. This self-revelation** on the part of the therapist created a second MoHR.

***This intervention sought the arousal of emotion via the type of self-revelation proposed by Maroda[26]. That is the revelation in session of the immediate emotional reaction to content and the emotions which subsequently emerge, but only insofar as this contributes to the understanding of the transferential-countertransferential interaction existing at that moment.*

Surprised by the analyst's personal confession (it was the first time something of this nature had occurred during the treatment), the patient felt not just the possibility, but the certainty that alternative courses of action were available to him. It was the procedural component, the emotional weight of the self-revelation what provided the veracity of the information revealed.

There were probably other mechanisms at work there which also contributed to therapeutic change, such as identifying with the therapist or referenced transformation[3***], but the key was a greater receptiveness to change activated by the MoHR.

****Bleichmar[3] defines referenced transformation as "the process via which someone modifies themselves taking an external or internal indicator as a point of reference". It is an unconscious, automatic process related to "mirror neurons".*

Table 1 Initial sequential account and subsequent detailed emotions

Initial sequential account	The detailed feelings in each of the stages, brought by the patient to the following session
A → I receive the report and am "pissed off" (I feel intense rage).	*Generally speaking I'm happy. I'm excited by my work, eager to help others and get on well with everyone. I like helping people out. From a young age, I have always liked making people feel good around me. Wanted my parents to be happy. But the report subverts all this. I suddenly feel that everything is skewed, that all the effort I make comes to nothing and that the fault lies with those surrounding me.*
B → They don't put it right as I had hoped.	*When I see that my explanations are not getting through, that they still so unfairly think the same as before, something deep inside me hurts, I feel betrayed, let down. As though this is something that has happened to me too often in my life.*
C → Loss of control.	*Faced with this betrayal, I defend myself by attacking, "busting their balls." That's when I start feeling like taking it out on them, and after that it gets hazy.*
D→ Massive aggression and behavior that is "over the top."	*At this point, I am no longer in control of what happens, it gets out of hand, I am consumed by rage and realize that I am not the master of my own actions. All I want is for my rage to find an outlet, all the rage I feel at that moment. I throw caution to the winds.*
E → Guilt and fear of the consequences.	*I am terrified by what I have done and especially by what I feel inside myself. I am scared because I don't know what it is that gets into me and I start backpedalling.*
F→ I calm down and want to make amends a.s.a.p.	*It's as though I've relaxed after getting it all out, I forget everything that's happened, I don't want to see the consequences. I just want to make amends.*
G→ I gradually forget and feel the same as before.	*I go back to square one. It's as though I've forgotten everything. As though nothing had happened. Now I'm saying it and I see it, but at the end of the day I'm not truly aware of it.*

The results were clearly apparent in the following sessions. A lively debate, immersed in an intense emotional climate of interconnection, of cooperation , was opened up in which the pros and cons of each possibility were contemplated. There was in detail discussion of how one feels when things go one way or the other. At this stage he began to reflect upon his impulsive behaviours and put them into words. This is where the explicit can meld with and modify the implicit.

Obviously, this intervention did not instantly transform his way of reacting. It is no simple matter to erase ways of feeling that have been learned procedurally. However, an alternative to the uncontrolled way he had of coping with what happened to him had appeared, which expanded the range of possible responses. The tone during subsequent exchanges when other situations in which he lost control presented themselves was different. His emotional understanding of these situations increased, and that facilitated the most experiential way of working on the rest of his issues, especially those concerning the consequences for his relationship with his mother or his wife.

The patient acknowledged later on that his *"out of control side"*, as it was referred to, was still alive and kicking and needed constant monitoring, but it was not as strong as before.

Now we present the case of B., a man of 30 who sought therapy to address his social phobia. He had tremendous difficulty with social contact, had not managed to sustain a stable romantic relationship and had very solitary pastimes. He was generally very reticent, both in and out of session.

One day he brought a clash he had experienced in work to session. It had been provoked by the intense feeling that his ideas were not taken seriously and he had reacted aggressively. Up to that point he had put up with such situations, but on this occasion, he had entered into a massive confrontation with his bosses and workmates.

This was an isolated incident in an overall behavioral pattern characterized by inhibition due to social phobia. However, subsequent work uncovered the fact that these episodes, were actually not that exceptional.

As though someone had ignited a box of fireworks, this incident set off a chain reaction of memories that exploded one after another inside his head, most of which came from his childhood. They all had in common the same feeling of not being taken seriously (what Bleichmar[3] calls affectively dependent memory). A genuine fit of narcissistic rage ensued[27]. This explosion flooded the treatment for weeks. He appeared to be completely transformed. Initially, he tried to maintain his reserved demeanor, but his rage began emerging explicitly. Over the course of the sessions that followed this incident, the tone of his discourse became critical and defiant.

With regard to the technical approach, first of all a foray into identifying the motivations that had set off the specific episode *("the content")* was attempted. That did not go well. B. offered abundant rationalizations. Furthermore, once the emotional "fireworks" had gone off, they seemed impervious to any work being done on the underlying motivations.

He was further infuriated by the very notion of *"being placed in [the context of] factual reality,"* as he put it. The analyst's impression was that this type of focus was causing emotional distance within the therapeutic bond and recreating (re-traumatizing) past experiences in which the patient had felt that both his words and feelings were being ignored, regardless of whether or not he was right.

It gradually became clear that the only way to attenuate the emotional disruption that had been set in motion was to allow the emotions to unfold without judgment on the part of the therapist. Consequently, the patient was encouraged to carry out an emotional reconstruction of the episodes as he remembered them and brought them to session, describing them with the highest level of emotional detail possible, in the first person and using the present tense.

In one of the episodes, B. mentioned an encyclopedia from which he had gleaned much of his childhood knowledge and still kept. He was encouraged to bring the book to session. As he read extracts of his own choosing, B. relived with great intensity clashes he had had with his father, remembering how he had always been ready to "*fill in the gaps of what I did not know about each subject, whilst I felt we never talked about what I had learned and what I had to say.*" This work continued over the course of the following weeks, bringing back different situations to mind, which always related to his bond with his father.

The evocative role of the encyclopedia, its appearance, the feel of the pages, its odor, the reading of certain definitions, or the scenario itself, all vividly reminding him of his father, represented powerfully evocative elements which doubtless activated the mnesic nodes connected to the network of childhood experiences with his father (or "spreading activation", as in[28,29]).

The efficacy of this approach was manifested in a relaxation of the patient's state of aggressive tension. This was probably due to the gradual emergence of repressed emotional memories, which could then be treated in a bonding situation that was new to him.

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In this case, the strategy was to allow his emotions, his narrative and his opinions to unfurl in an atmosphere of trust in which they were neither judged nor compared. And in this context, following the intuition to bring an object of such great significance to the patient into session actively created the appearance of a MoHR. This MoHR led the feelings hidden under his accounts to emerge. In this case, it was fundamental to try to avoid potentially judgmental interventions which could cause the patient to feel as though paternal behavior was being repeated, all this regardless of whether or not the content was correct.

Creating a MoHR by way of the vivid recollection that accompanied the reading of the encyclopedia, the resulting "labile state" of the patient's memory facilitated the insertion into the patient's psychism of the new cognitive-emotional structure, which is gradually formed by experiencing this recollection within the therapeutic link. What is intended is an experiential restructuring of the meaning of old bonds by coupling them to those that are being developed within the therapeutic bond ("experiential coupling", see[7,22]).

From here we moved to a third phase of the therapy, in which work on the content behind what had occurred could begin. New emotional content began emerging in his accounts: the memory of profoundly degrading reactions when his opinions *"took the road less travelled"*, or how great difficulty allowing for disagreement was hidden inside a supposedly understanding talk. These new discoveries allow an understanding of his emotional reactions and begin reducing his social phobia.

Finally, there are many cases where the emotional world does not appear and is substituted by rational discourse where the active search for MoHR can be particularly useful.

The case of C. published by de Iceta et al[1] exemplifies one of these clinical situations where the content becomes secondary in the face of procedural inscriptions that can only be modified in terms of their fundamental aspects, according to how the therapeutic bond develops[7].

"C., a woman of 46, had previously been in treatment. During that treatment she established some relationships between her symptoms and her childhood experiences. Despite possessing this knowledge, C. continued to re-experience the same emotional paralysis and cognitive block on almost every occasion.

C needed to relive these sensations experientially in session (which would create a MoHR), and she also needed proposals for actions she could take in real life[30] that would give her sufficient ego resources to make change possible. By reliving both the experiences of her childhood that caused the block and her new, real-life experiences, the information she already possessed about her childhood permeate her structure and act as preparatory step for further new experiences[1].

In this case, clarification and interpretation, as they are traditionally understood, had reached their limit in terms of effectiveness. The technical difficulty laid in the fact that mere verbal explanation could not compete with that which had been inscribed with such a different level of emotional intensity. Patients cannot replace certain highly emotional relational experiences for new ones simply because we suggest they do so.

MoHRs in which the patient relives (see more above) a past experience at a comparable level of emotional intensity, brought back what was absent (the emotional component) and it allowed interpretative interventions (in the wider sense) to take effect and produce change during that temporary window in which the memory enters into a labile state.

CONCLUSIONS

In this work we showed the application of active technique in psychodynamic psychotherapy and the utility of creating or using MoHRs when the therapeutic process flows through the realm of the emotions.

Different uses of MoHRs are presented. First, sequencing of emotional states employed to address an understanding of underlying response patterns; second, allowing emotion to unfold in the bosom of the therapeutic link without attending to the underlying motivations while searching for its affective elements and the use of triggering stimuli; and lastly, bringing in emotional elements to reconnect, experientially coupling the explicit knowledge which modifies the procedural component that became dissociated.

Last but not least, we want to stress prudence when using active technique. While the possibility to progress in the process increases, so also does the risk of harm. It is particularly important to pay constant attention to the patient's capacity for sustaining certain emotional states or to the deregulation that emotional intensity can cause. This attention to the regulation of the patient's state is in itself therapeutic, procedurally showing ways to self soothe, contain or reduce anxiety, to give just a few examples.

Note of authors:

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