Transference and Countertransference

The most frequent transference reaction of depressed patients is abandonment and hunger for a closer connection with the therapist. This transference pattern is especially common for patients with great feelings of emptiness and loss. It is frequently associated with a dependency reaction, where the patient feels profoundly helpless and has a desperate sense of needing the therapist. Some depressed patients idealize their therapists, and see them as endless sources of emotional supplies. But, the other side of the dependent transference reaction is anger and disappointment. Here the patient is filled with a sense of rejection and disappointment, and previous losses are reexperienced with the therapist now in the role of the absent or hurtful parent. Patients with substantial anger and guilt are more likely to experience the therapist as critical and rejecting.

There are many kinds of countertransference responses a therapist may have, but there are some that are typical with patients with particular core problems. It is common to develop a rescue fantasy in response to working with depressed patients. This fantasy reflects a powerful personal belief that one can make the patient better. This countertransference reaction may involve the therapist feeling he or she can help the patient become whole through their close relationship, and the feeling that the therapist’s interest and warmth will make the patient feel life is worth living. Some patients feel so deprived on entering therapy, and are so pleased with the therapist’s attention, that they unconsciously reinforce the therapist’s caretaking behavior by making him or her feel like a savior. Of course, this can go too far. There is a big difference between trying to help by exercising professional and personal skills, and being driven by a feeling that you have the special mission to rescue a desperate
The Therapeutic Alliance and the Core Psychodynamic Problem

After all, every patient must take responsibility and do work on his or her own, and the therapist's job is to support that. Other counter-transference reactions include feeling angry at the level of demand of the patient, or feeling exhausted and depleted by not being able to nurture the patient back to health.

Obsessionality: Controlling Feelings

Obsessional patients are preoccupied with rules, ideas, and procedures, and are typically distant from their feelings. It is not that they do not have feelings—they do have very strong emotions, but they regard emotions as “inconvenient” and upsetting. Obsessionals aspire to focus only on what is logical and rational, and what adheres to rules.

The main explanatory concept in the psychoanalytic literature on obsessionality is struggle and discomfort with aggressive feelings and the use of specific defenses to manage them. Originally, psychoanalytic writers proposed that obsessionality had its origins in problems occurring during the anal phase of development (Freud, 1908) and pointed to the obsessional neurotics’ tendency to value order, ritual, and thought over emotion, similar to the child’s preoccupation with these qualities during toilet training. Subsequent thinking emphasized the obsessional patient’s notion that anger is bad and must be gotten rid of, controlled, and disarmed (A. Freud, 1966).

Anger is often associated with guilt, and this seems especially true for these patients, who try to manage their anger and guilt through the alchemy of obsessional defenses. The five obsessional defenses are (1) intellectualization, the focus on complex cognitive processes rather than gut feelings; (2) isolation of affect, the separation of thoughts from feelings; (3) reaction formation, the substitution of a positive feeling for a negative one; (4) displacement, the shifting of feelings and conflicts from one situation onto another that is unrelated (e.g., road rage after a family argument); and (5) doing and undoing, the tendency to express something (verbally or through behavior) and then undo it by expressing the opposite. Each of these defenses operates unconsciously and results in the patient feeling less angry, guilty, and conflicted.

Salzman (1968) observed that patients with obsessional problems maintain, and feel a need to maintain, strict control over their emotions. They also control others in order to control their experience of relationships.

In summary, all of the psychodynamic conceptualizations of obsessionality include the notion that the patient struggles with anger, feels guilty, and tries to control his or her inner experience as well as the world around them. So, it is not a surprise that the biggest dilemma in
developing a therapeutic alliance with obsessional patients is their difficulty in tolerating and experiencing emotions. Anger is the most difficult emotion, and obsessional people worry they will lose control and their anger will come spilling out with disastrous results. They tend to feel this has already happened, which leads them to worry about retaliation by others. The goal of psychodynamic therapy for obsessional patients is to experience more pleasure, spontaneity, emotion, and autonomy, and less sense of pressure, guilt, anger, and fear.

**Technique**

All psychotherapy patients may benefit from psychoeducation, an explanation of the treatment and how it will help with the problem. Obsessional patients are particularly interested in this preparation for therapy because of their love of rules, procedures, and ideas. A good, simple explanation of what psychotherapy is, how it is done, and how change occurs will set the stage for treatment. The patient’s main responsibility—talking about thoughts and feelings as they are happening—is emphasized as a simple prescription.

You must listen closely for emotional reactions and gently work to elicit them with obsessional patients by directly inquiring, tactfully pointing out their body language, and trying to open up the subjective experience of each type of feeling and each experience. In other words, the therapist needs to help the patient recognize the feeling that is being avoided. For example, “When X did not return your call, how did you feel?” or “When he asked you to take on that task, what was your reaction?” You may comment on typical reactions people have to situations the patient is in and ask him or her whether this resonates and helps him or her identify current feelings.

As the treatment continues, you can focus more on the feelings of resentment and anger, and ask what it feels like; for example, “What are you afraid of when you are feeling this way?” Emotional experiences are clarified and named. Active acceptance and explicit validation of the patient’s feelings is helpful, as obsessional patients are harshly self-critical and prone to shame. It is important to remember that these patients are focused on what they *should* feel and do what they can to avoid what they *do* feel.

Treating obsessionality requires persistence and activity. Patients may debate a course of action over weeks, and it is important to encourage taking a chance and making a best guess. Later the impact of the decision can be examined and dissected. The obsessional patient’s tendency to ruminate rather than act needs to be met with a firm guiding hand, encouraging practice and exploration of life, trying new
behaviors, and experimenting. You can easily get into a control battle with these patients although you started with good therapeutic intentions. Therapists should do their best to guide and encourage with a light touch, avoiding a potential counterproductive control struggle. The goal of these techniques is to bring out the emerging conflicted emotions and support the patient’s ability to tolerate them.

**Transference and Countertransference**

Obsessional patients need to control the therapy and the therapist because this allows them to control themselves and their feelings. They are trying to manage the possible emergence of bad and dangerous feelings. This need for control may account for the sometimes dry and detached feeling of the interaction. Obsessionals are highly sensitive to feeling controlled and may struggle for control to preserve their freedom and autonomy. They will rebel or avoid you as though you were set on stamping out their autonomy. They may test you or try to control you. There may be indirect expressions of anger and hostility, or it may be more obvious.

Feeling frustration with the patient and a sense that he or she is deflecting and not engaging with you is quite common. The therapist can feel angry and have the urge to push through the patient’s carefully constructed defenses, being just as aggressive as the patient imagines he or she is. Or one may feel boredom and distance. Sometimes the therapeutic game of cat and mouse feels futile and pointless. One may find oneself responding to the patient’s underlying anger, which is expressed indirectly or passive-aggressively, with more anger oneself.

**Fear of Abandonment**

Fear of abandonment involves insecure attachment to others with a painful vulnerability to separation. Patients with fear of abandonment are desperate to avoid feeling loss and aloneness. They try to tolerate these painful feelings but often revert to dysfunctional strategies to stay connected with others. If you constantly feel alone and are scared of losing what little you have, you may appear unstable to others because of the strategies you employ to stay secure. Some patients have quite chaotic behavior, but fear of abandonment also shows itself in functional individuals who have anxious inner experiences but manage to maintain relatively adaptive behavior.

The traditional psychodynamic and psychoanalytic literature draws a direct link between abandonment fears and the diagnosis of borderline personality disorder. There were originally two major psychodynamic frameworks used to understand fear of abandonment—Bowlby’s
attachment theory and Kernberg’s object relations perspective (e.g., Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989). Like an ethologist studying animal behavior, John Bowlby observed the behavior of those in attachment relationships and described what he saw. The clarity of his model provides a remarkably useful, experience-near account of abandonment and how children (and adults) respond to it. Bowlby observed toddlers separating from and returning to their mothers. He observed their behavior and emotional expression, and identified three common types of attachment: (1) secure attachment, in which the toddler leaves the mother, feels good alone and reunites comfortably with the mother when she returns; (2) anxious attachment, in which the toddler responds to the separation from the mother with definite anxiety and then clings when the mother returns; and (3) avoidant attachment, in which the child keeps his or her distance from the mother when she comes back into the room, as though fearful of feeling connected and then abandoned again.

Kernberg et al.’s (1989) conceptualization is based on clinical experiences with patients with borderline personality disorder, who struggle with intensely unstable interpersonal relationships and a constant fear of loss. He emphasized the aggression that is stirred up in people who are abandoned and described the terrible dilemma children have when they experience this. If their anger takes over, they feel there is no one who will take care of them and love them, so they must desperately try to reconnect with a loving object. The chaos that surrounds these patients results from their chief technique for dealing with this intense anger and loss—they try to control relationships and feelings, both internally and externally. This often involves splitting—a psychological defense where the patient separates out a good and bad self-representation and a good and bad object representation. This helps the patient maintain an inner beacon of love and hope as well as a positive feeling about others untainted by anger and hatred. Splitting maintains the inner and outer possibility of goodness. But, of course, this defensive operation causes a tremendous amount of collateral damage as well.

Many abandonment-sensitive patients have less severe symptomatology; they use more mature defenses and do not employ pathologic splitting. Bowlby’s concepts of clinging attachment and avoidant attachment are helpful explanations here. This milder version of fear of abandonment looks more like a proneness to dependency. Thus, our understanding of the core problem of fear of abandonment includes those with more severe attachment problems who might have the diagnosis of borderline personality disorder as well as others with vulnerability in this area with less dysfunctional coping strategies.
The treatment goals for fear of abandonment are more stable relationships, a more consistent and integrated (good and bad) image of self and other, and less emotional reactivity (see Gunderson, 2000). In other words, the goal is to help these patients contain their destructive emotions, develop an increased ability to be effective in the world outside treatment, and increase their ability to reflect and “mentalize” (Bateman & Fonagy, 2004, 2006), that is, understand their own and others’ needs and feelings.

**Technique**

In the treatment of a patient with fear of abandonment, there is a trend from early attention to support, behavioral control, and guidance on reasonable and healthy pragmatic choices, to a later focus on relationships and ultimately on the patient’s own inner painful feelings. Gunderson’s (2000) description of the stages of treatment of borderline personality disorder is clear and practical, and the stages are appropriate for the more dysfunctional patients with fear of abandonment. The initial phase is devoted to developing the treatment contract, and fleshing out this understanding usually involves some testing of the therapist. The goal is to develop the therapeutic alliance so that the feeling of consistent connection is stabilizing and does not excessively stimulate feelings of dependency and vulnerability to abandonment.

Next is a phase of relational development, which means that the patient and therapist begin to engage on a deeper, more emotional level. The intense fantasy-laden transference starts to show itself more, and the goal is to help the patient talk about it rather than act on it. Countertransferences are intense, and there is an increasing awareness of the attachment problem.

The phase of positive dependency follows and the patient begins to use other relationships to try out new self-perceptions and perceptions of others. The therapist encourages this, while helping the patient contain the intense feelings of impending loss or anger. The patient practices the ability to be connected and close to someone else, and the therapist is careful not to stimulate too much regressive dependency.

The last phase of treatment involves a more mature collaborative relationship between patient and therapist. Gunderson refers to it as an achievement of the therapeutic work that has occurred so far. The patient is now able to engage in more traditional psychodynamic insight-oriented attention to the past, present, and transference, with less of the coaching and support that has been required until now.

Another set of techniques helpful for working with patients with
fear of abandonment is borrowed from mentalization-based therapy (MBT; Bateman & Fonagy, 2004, 2006). This is a psychodynamically derived treatment that frames the same process described above using somewhat different concepts and a different language. In MBT, there is a primary emphasis on the here and now with less interest in interpretation and understanding the past. Health is achieved through containment of destructive affects and increasing acceptance and awareness of emotions in the self and others. The therapist’s technique focuses on helping the patient to accept and tolerate emotions, increasing his or her ability to reflect on and process them, and on avoiding interventions that stir up the patient affectively.

**Transference and Countertransference**

Patients with fear of abandonment often see their therapists as loving and giving, like the parental figures they longed for or, alternatively, as the worst possible version of what they experienced (e.g., as selfish, evil, dishonest, and frightening). These reactions oscillate and reflect the patient’s split internal object representations. These swings are especially common in patients with more severe attachment problems. Those with less severe abandonment feel dependent on the therapist and angry about it.

Countertransference reactions are intense and can cause the therapist to express or enact feelings of powerlessness, resentment, helplessness, guilt, or defensive detachment. This is as potent a cause of compromise to the therapeutic alliance as the patient’s transference reactions. The aphorism “If you don’t make it worse, it will get better,” captures the therapist’s task well. It is our job to manage our powerful countertransference feelings, and to use them to increase our empathy and understanding of what is going on with the patient. It is easy to see how feelings are stirred up in the therapist by the patient’s struggle with powerful alternating split-off experiences of merger and abandonment. Young parents of toddlers in the separation-individuation phase are confused by their children’s alternating need and rejection, and the therapist with a patient who is struggling with attachment issues feels something analogous. It is not easy to maintain a healthy clinical detachment.

In our field, there can be a culture of criticizing these patients for their interpersonal dysfunction, and it is surprising how frequently trainees and faculty make derogatory jokes about patients with fear of abandonment. Of course, this distances the therapist from the patient and blames the victim. Vaillant (1992) observed that the diagnosis of borderline personality disorder can be used as an epithet and as a way of expressing unrecognized countertransference.
The essence of the core psychodynamic problem of low self-esteem is insecurity and loneliness that are managed through self-preoccupation and self-oriented gratification. We do not use the clinical term narcissism here, because that refers to a compensatory strategy used by patients with low self-esteem, rather than the problem itself, and because it has a critical and shaming connotation.

Kernberg (1975) observed that narcissistic patients show grandiose, entitled, excited, and ambitious attitudes. Different from the borderline good-and-bad self, these patients have a hugely exciting and magnificent self, along with a sad, small, depleted, shameful self. Kohut (1971, 1977, 1984) suggested a new paradigm for understanding these patients when he sensitively observed that many aggressive and entitled patients are so filled with shame, inferiority, embarrassment, and low self-esteem that virtually everything they think, feel, do, and say is directed at trying to feel better about themselves. He saw entitlement as a reaction to childhood feelings of powerlessness, loneliness, and fear, rather than a reflection of the child’s anger toward frustrating parenting figures. He postulated that parents perform a “selfobject” function in early childhood, empathizing with the child’s experience and providing an optimally frustrating environment that allows the child to develop the capacity to self-soothe. The selfobject function involves a balance of empathy and appropriate distance.

Developing a therapeutic alliance with patients with low self-esteem is not just the beginning of the psychotherapy, it is the essence of the treatment. Because these patients are so sensitive to criticism and rejection, building the alliance is a careful, slow process, with painstaking attention to empathy and its disruptions. Not surprisingly, given the nature of the problem, the treatment goals for patients with low self-esteem are a more reasonable and accurate self-image and the ability to tolerate vulnerability in relationships.

Technique

The psychotherapy of low self-esteem is organized around the need to support and empathize with the patient’s vulnerability and easy bruisability. We watch for and deal actively with the patient’s inevitable disappointment, hurt, and anger in life experiences and in the therapeutic relationship. The extensive literature on ruptures in the therapeutic alliance (e.g., Muran & Safran, 2002) suggests that although these ruptures may be inevitable in psychotherapy, they may be most problematic in patients with fragile self-esteem. If one feels insecure, one will be especially
sensitive to criticism and rejection by one’s therapist. Recognizing ruptures when they occur is essential to the successful maintenance of the alliance, and each rupture, the precipitants, the feelings stirred up by it, and its repair are like a “teachable moment,” when another empathic building block of security and self-esteem is added.

We encourage the patient to verbalize the feelings associated with the rupture and develop a clear chronology and picture of what happened. This awareness, along with the therapist’s understanding and empathy, will typically go a long way toward resolving the hurt. The repeated experience of the alliance repair cycles helps the patient with low self-esteem develop internal confidence and conviction about the value of his or her feelings and responses and helps to build self-esteem.

The therapist also helps patients try new skills in interpersonal relationships. Through the discussion of many current and past relationship experiences, you will remind them of their impact on others, something they tend not to be aware of because of their low self-esteem. You help patients increase their social effectiveness by reminding them of what is really happening in an interaction from both sides and support them in the healthy expression of their needs.

Transference and Countertransference

Kohut (1971) described the common reactions of the patient with unstable self-esteem in therapy, and suggested that these transferences help us recognize the problem. The “mirror transference” refers to the intense need for admiration, empathy, and attention that is a replay of old needs that went unfulfilled. Regarding the therapist as someone who will unconditionally admire them is actually a rather controlling and insistent way of interacting which the patient employs to help manage painful feelings of shame and unlovability. The second major transference reaction Kohut identified is idealization. Idealizing the therapist soothes the patient because it evokes a feeling of being close to and part of someone so special, loving, and wonderful.

Even though these two transference reactions are excessive in relation to adult needs, they reflect an essential aspect of the patient’s psychological life and self-esteem problem. The transference reactions need to be understood rather than corrected, and it is the therapist’s job to support these feelings, allow them to take root (as they have in so many of the patient’s other relationships), and ensure that the relationship withstands the inevitable stress when the patient feels hurt, rejected, or misunderstood.

The common countertransference reactions to patients with low
self-esteem include the fantasy that the therapist will be the first truly good person in the patient’s life and can provide the love and warmth that will make everything better. Other reactions include basking in the patient’s idealization without noticing its inaccuracy. There may be boredom with material in the session as it can be so one-sided and self-focused, or resentment about feeling controlled by the patient’s overwhelming need to be admired and protect him- or herself from being hurt by more direct and close interaction. If the transference and countertransference reactions are clear, and the ruptures and misunderstandings that take place can be explored and understood, these patients can greatly benefit from the treatment.

**Panic Anxiety**

Panic attacks are spontaneous acute paroxysms of anxiety. Physical symptoms such as shortness of breath, palpitations, sweating, and trembling may be associated with feelings of overwhelming fear, dying for air, or a sense of imminent disaster. Patients may become sensitized to the settings where the attacks occurred, with a resulting constriction in the radius of activity and the places that feel safe from panic.

Barbara Milrod and her group (Milrod et al., 1997, Busch et al., 2011) provide a psychodynamic formulation of panic disorder in which the central conflicts in panic patients revolve around separation and loss. Patients inhibit their anger about the sense of loss they experience with separation from caretakers because they fear that their complaints and demands might result in even greater loss. For neurobiologically vulnerable patients, these separations and losses, and the conflicts that surround them, result in panic attacks.

The therapeutic alliance gives panic patients an opportunity for support and serves as a buffer for the patient’s marked sensitivity to separation and loss. But the alliance is also intertwined with the patient’s struggle with the symptoms, and there is ambivalence about becoming dependent on the therapist—both a wish to be taken care of and dependent, and a reaction against this wish.

The goal of psychodynamic treatment for panic is to help the patient understand the conflicted feelings of dependency and resentment toward early caretakers which have heretofore largely been unconscious, and see how those patterns are repeated in their current experiences. This will help the patient’s ability to manage close relationships in a more constructive and adaptive way. With increased healthy assertiveness and greater independence, the panic dynamics are evoked less by current circumstances and become less relevant, and the intensity and frequency of symptoms lessens.
CHAPTER 11

THE REAL ELMER FUDD

A Case of Low Self-Esteem

C. PACE DUCKETT

Matt, the insecure young man depicted in this case, tried to live out a typical male fantasy of money, girls, and sports cars, only to find that he felt lonely and anxious. The case history describes a distinct presenting problem, a nicely developing engagement with the therapist, increasing insight with new, more accurate perceptions of others, and finally, real behavioral change. The arc of this successful psychotherapy demonstrates a classical coherence that is rare, as treatments are rarely so clear and well-characterized.

The therapist recognized a powerful ongoing positive transference that is both an expression of the patient’s problem and a therapeutic experience in its own right. There are a couple of rather dramatic moments in the patient’s life in which his sensitivity to rejection becomes so apparent that he cannot escape it. In the second of these incidents, enough work had already been accomplished in therapy that he was able to behave quite differently from his usual pattern, and this new experience further consolidated his therapeutic gains.

CHIEF COMPLAINT AND PRESENTATION

As the crisp fall air set in to Manhattan, Matt found himself walking absent-mindedly down the bustling New York streets. He had only been there for 2 weeks when he abruptly ran into Amber, his ex-girlfriend. The interaction was brisk, short, and awkward. Upon separating, Matt felt a pit of nothingness and despair. The following day at his new job with a small record label, thoughts began to swirl in his mind. He removed
himself quietly from the office and went out on the street corner to get some air. But with all the people passing furiously around him, his mind continued to churn. Dwarfed by the buildings, he felt Manhattan was swallowing him. He imagined he saw Amber around every corner. Was he going to bump into her? The spinning turned to dizziness, and the dizziness into . . . collapse. He was not aware that anyone had called 911, and he barely remembered the EMS ride to the ER. But once there, the doctors told him he might have had a seizure; apparently he had had some twitching and confusion while on the ground. The EEG and ECG were all within normal limits, but he ended up on a prescription for an antiepileptic nevertheless.

Many months later a similar episode happened. Alone, recently unemployed, and basically hiding out in his apartment, he found himself scared about the rising pressure in his chest. With no one to call, and without health insurance, he took a cab to the nearest emergency room. But rather than going in, he sat outside, pinned against a brick wall, his heart racing, short of breath, “thoughts going all crazy.” He comforted himself by saying, “If it is a heart attack, at least I’m close to help.” Several hours passed before Matt eventually calmed down and found his way back to his apartment. Later that night he decided he needed to go home—to his parent’s home, that is. It was at this point that he also decided to seek help for his depression and anxiety.

When Matt first strolled into the office he was wearing what would later become his trademark fashion statement: a stiff brimmed black baseball cap with the boldly branded insignia “Alife.” I amused myself trying to phonetically pronounce the label staring back at me: “Alive” or was it “A life”? Momentarily frustrated, I refocused on the young man in front of me. He told me he was planning to move out of New York City and back to his parents’ suburban home in New Jersey, and he couldn’t commit to any further sessions until he had actually made the transition. He just wanted to find a therapist before he moved back to work through “some issues.”

**HISTORY**

Matt was 26 years old and had grown up in southern New Jersey. He was the only child of a Caucasian mother and an Asian father. His grandfather was an American GI who fathered a child with a local woman while stationed abroad in Asia. The biracial progeny of this relationship, Matt’s father, was apparently rejected by both parents and raised by a surrogate “godmother.” Matt alluded to his own confusion over the identity of his father’s biological mother. Matt’s mother was a child of the
60s from a straight-laced, “by-the-book” suburban family. Despite her proper upbringing, Matt’s mother eloped while away in Korea on a Peace Corps mission without telling her parents. He described his mother as an organized, competent, and intelligent woman with a high-level managerial position in academia. She was not only bright, but also protective and nurturing. He confessed that she was perhaps “too good of a mother, sometimes.” And he admitted that she made things so easy for him that he sometimes doubted whether he could survive on his own. Matt described his mother as the primary caretaker and provider for the household.

He noted disdainfully that his father had not worked for the previous 8 years and had become increasingly withdrawn and dysfunctional. Matt recognized that one of his “biggest issues” was with his dad. Seeing his father sit on the couch day after day talking about how lonely the dog would be if he were not there to give it company was excruciating. Matt occasionally lamented, “I wish this person did something. I mean, why hasn’t he done his own thing?”

But these frustrations were hard for Matt to express given the actual fragility of his father’s emotional and cognitive condition. The parallels between his father’s dysfunction and his own stagnation remained unexpressed and were easily projected out onto his father’s inadequacies. Matt conceded his father could barely communicate, and said talking with him “was like having the same conversations over and over again.” He feared there might be something deeply wrong with his father. (It was only later in treatment that his family sought out a neurologic workup that definitively diagnosed his father with Alzheimer’s dementia.)

Matt’s own childhood diagnosis of juvenile rheumatoid arthritis had left him with bouts of pain episodes throughout his youth. As he got older, he continued to fear their onset, but he also became self-conscious of how others perceived his functional limitations.

While identifying strongly with his Asian side, Matt was embarrassed that he was not bilingual. He had spent a number of years living in Asia and going to school there between the ages of 9 and 13. He admitted this was a lonely period, knowing only two other American kids abroad at the time. Upon returning to the states for middle school, Matt felt the intensity of being an outsider. He predominantly befriended the social outcasts and remembered, painfully, the accusations of being “a poser” when he dressed in skater clothes at the local park. However, this rejection and suspicion by the other boys was confusingly compounded by the attention he began to receive from the girls, who were attracted by his exotic looks. But what he didn’t see was the boys’ resultant jealousy of this outsider. Strained relationships with men continued through much of his early years, despite Matt’s efforts to be “super cool” and generous to his friends.
Matt’s college years continued some of these trends. Women apparently found his tall, dark, and mysteriously handsome leading man looks hard to resist. He fell easily into a fast crowd. Drugs, clubs, and jetsetter road trips escalated, with mom just paying off the credit card bill as it came due. With “a hottie” on his arm and a bunch of friends to hang with he finally felt he had arrived. But that outsider feeling, that question of being a “poser,” lingered below the surface. On graduating from college, Matt was presented with a surprise. His recently deceased maternal grandfather, the by-the-book suburban one, had left him a trust fund amounting to $700,000!

His post college years in LA and Manhattan were cloaked in the newest styles, the most bohemian apartments, and best of all, his prized two-door Mercedes Benz CLS convertible. His first serious girlfriend in LA was a gorgeous, strong, and ambitious young woman named Amber. He was smitten. Life seemed good.

The relationship advanced rapidly and with an almost dependent level of intensity. Matt always felt compelled to be available whenever she wanted. And whatever she wanted he felt compelled to give. The clubs and restaurants were always the trendsetting spots. Buying rounds for his west coast posse just seemed like a stand-up thing to do. Pulling up in the sports car to hand the keys to the valet and escort his lady to the reserved table made Matt feel like “the man.” However, when the sun rose, and his girlfriend left for work, he was alone. Anxiety always seemed to creep up in the morning. It was a paralyzing, “can’t get out of bed,” type of anxiety.

Matt knew he needed something to do with his life. A short unpaid internship at a skateboard factory left him feeling unsatisfied and not particularly appreciated. As the relationship with Amber progressed, his doting turned to jealous suspicion. His accusations frequently led to tension and arguing. Matt preferred to whisk her away to some island adventure for a fortnight to do nothing. But, upon returning, as she went back to work, he would find himself on the couch, absorbed in self-loathing insecurity. The time seemed to be flying by, about as fast as his brokerage account was dwindling. But despite this frozen panic, Matt’s response was to focus on what more he could do for Amber. How could he keep her happy? Months drifted during what Matt described as a long extended breakup. Things ended in a vague way, with her moving to New York City to pursue a career in fashion.

Stranded, alone, plastered to an expensive black leather sofa, Matt felt depression sink in. The self-loathing he experienced led to intense feelings of guilt and worthlessness. The previously paralyzing anxiety progressed to overt neurovegetative symptoms of depression. In session he described frequent bouts of crying, “Why doesn’t anybody want to be

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around me, why doesn’t anyone ever call?” Questions of his adequacy penetrated the stillness of the night.

Matt’s relationships with his male friends suffered as well. He realized some of his tenuous ties had been maintained mostly because of his girlfriend. Without her, these “friends” seemed more like recipients of his misguided and self-absorbed philanthropy. Rounds of drinks and rides in the Benz engendered more feelings of “who does this dude think he is” rather than a genuine connection of gratitude. Matt struggled with why his super-nice-guy demeanor began to be treated disrespectfully. One day, an aggressively tense argument with his roommate left him almost paranoid and cowering in his room. During the incident, his roommate’s heated accusation that “no one ever liked you anyway, Roberts” seared its way onto his memory. Perhaps it was true, he feared.

Months passed in southern California. Matt consulted a few “Hollywood docs” who prescribed “whatever pills I wanted.” While a couple of trials of benzodiazepines took the edge off the anxiety, it was the calming effect of Percocet that eased the pain and suffering. He justified his blissfully numbing opiate dependency by attributing it to the real arthritic pain that crippled him daily. His juvenile rheumatoid arthritis had waxed and waned over the years. But connecting this worsening pain to his depression and anxiety was something he remained unaware of. He started to feel trapped inside his apartment and viewed the West Coast as part of his problem. Furthermore, he longed to work things out with Amber. So he made plans to move to New York City; perhaps he could prove his worth to Amber just by following her there.

**CORE PSYCHODYNAMIC PROBLEM AND FORMULATION**

**Part I: Summarizing Statement**

Matt was a 26-year-old male who presented to therapy with anxiety and mild depressive symptoms that were punctuated by occasional panic attacks. He described feelings of inadequacy, worry, self-doubt, and a strong need for reassurance in his intimate relationships. He sought help after a distant romantic breakup and his subsequent relocation home left him feeling very alone. Matt wasted several years after college without finding a clearly defined occupational path.