Chapter 5. Time-Limited Dynamic Psychotherapy and God Image

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SUMMARY. Time-Limited Dynamic Psychotherapy (TLDP) is an empirically supported treatment that can be used to conceptualize and address God image difficulties. This article provides an introduction to TLDP and outlines how the God image develops and can be modified through this method of psychotherapy. A case study is also provided to practically illustrate the TLDP process, treatment plan, and technique.

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This chapter conceptualizes the God image through the lens of time-limited dynamic psychotherapy (TLDP). TLDP was created and empirically tested by Hans Strupp and colleagues at the Vanderbilt University Center for Psychotherapy Research in the 1980s. Hanna Levenson (1995) defines TLDP as “an interpersonal brief psychotherapy. Its goal is to help the patient move away from replicating dysfunc-
tional interpersonal patterns by facilitating new experiences and understandings within the context of the therapeutic relationship” (p. 30). It is a brief, psychodynamic form of treatment that focuses on the here-and-now relationship between therapist and client.

The primary assumptions that underlie TLDP are that interpersonal problems develop in past relationships, are continued in present relationships, and are acted out in the therapeutic relationship (Levenson, 1995). The client reenacts their problematic way of relating with the therapist by recreating a “microcosm” of their world in the therapy office (Yalom, 1985, p. 28). For example, a client who is dependent and pulls on others for overt guidance will also be submissive and pull on the therapist for direct guidance. Therapists are naturally and unconsciously “hooked” into acting in a manner that is similar to how other people respond to the client. So, the aforementioned therapist would respond to this client in an overly direct manner that reinforced the client’s dependency pattern.

Psychotherapy consists of the therapist becoming aware of this problematic way of relating and offering a different, curative response. In the above example, the therapist would recognize that she feels pulled to tell the client what to do. She would then offer a healing response by relating in a way that encouraged the client to be more independent.

TLDP also offers a practical framework to understand how the God image develops and how God image difficulties are maintained. From this perspective, the client’s same interpersonal problem that was learned in the past, maintained in the present, and played out with the therapist is also going to be acted out in their relationship with God. That is, their interpersonal style not only colors their current relationships, but also colors the way that they emotionally experience God. Using the example from above, the client who feels weak and like others need to control her, will have a paralleled personal experience of God in which she feels weak and like God needs to control her.

TLDP therapists use techniques to both indirectly and directly change the God image (Tan, 1996). Indirect techniques focus on the client and do not explicitly address the God image. However, indirect techniques alter the self and, as a result, implicitly modify the way that clients experience God. Direct techniques explicitly address the God image. This chapter discusses both indirect and direct techniques. In addition, a life example of “Debbie,” a 39 year-old divorced, evangelical, Caucasian female, is used to illustrate how techniques are used to change the God image through the TLDP process.
BACKGROUND

TLDP has its roots in three main areas. The first is psychoanalytic thought. The second is the brief therapy paradigm and the third is empirical research.

TLDP has been heavily influenced by the spectrum of psychoanalytic theory that has spanned from Freud to the contemporary interpersonal theorists. Freud created drive theory and suggested that psychological problems occur because people repress threatening impulses originally experienced in childhood (Freud, 1923). He sought to correct these problems through free association and the analysis of the transference. Freud believed that it was possible to remain objective and keep a blank slate presence on which the patient would project their issues. Then, through the process of interpretation, the repressed drives would naturally surface and be integrated into the person’s life in a healthier manner.

The process of psychoanalysis required a considerable personal and financial commitment. Analysands would meet with Freud multiple times a week for a number of years. This process was very expensive. Today it would cost approximately $16,000.00 a year. Freud predicted that psychoanalysis would one day be modified so that it was less intensive and more common, but he stuck to his core assumptions and despised attempts by others to change his dogma (Strupp & Binder, 1984).

Nevertheless, many theorists questioned his assumptions and sought to make psychoanalysis more effective and practical. Salvador Ferenczi and Otto Rank were some of the first dissenters (Strupp & Binder, 1984). They suggested that analyzing repressed impulses from childhood should be lessened and more of an emphasis should be focused on the client’s experience of emotion in the therapeutic relationship. It wasn’t necessary to spend days digging up the past when it could be captured in the here-and-now dynamics that occurred between client and therapist. They also differed from Freud in that they recommended a more active and empathic therapeutic stance. Clinicians should see the relationship as a two-way dialogue in which they impact the client rather than see it as a one-way dialogue where they remain neutral. In addition, they advised clinicians to avoid acting in a manner that exasperated a client’s interpersonal difficulties (Strupp & Binder, 1984). For example, if a client had a distant parent, then they would advise them to be emotionally available rather than withdrawn. These differences would have significantly altered Freud’s psychoanalysis. They were met with resistance from Freud and others. So, the technique of analysis...
remained the same despite these early attempts to more efficiently focus and resolve the client’s transference neurosis.

Alexander and French (1946) revived Ferenczi’s and Rank’s idea by fleshing it out and making it more practical. They suggested that the core relational problem has to be alive and acted out in the therapeutic relationship for it to be resolved. Clients need to experience their problem in the therapeutic relationship and then experience a curative response from the therapist. For instance, if a client had a distant parent, then they would work through the transference of seeing the therapist as distant and then emotionally experience the therapist as close and caring. This cathartic experience would then be paired with a cognitive interpretation of what occurred; thus, the “corrective emotional experience” provided clients with a new affective experience and a new intellectual understanding (Alexander, 1956).

Alexander and French’s ideas, like those before, were not celebrated (Strupp & Binder, 1984). Once again, the core dogma held sway over the minds of the majority of analysts. Nevertheless, these early attempts created space for future analysts to experiment with new techniques. They showed that progress only comes with change and laid a foundation for later clinicians to introduce, test, and practice new forms of psychoanalysis.

These innovative thinkers helped pave the way for what would be the second major influence that shaped TLDP—the brief therapy paradigm. TLDP was affected by the theory and research that supported short-term psychotherapy as a viable alternative to long-term treatment. A number of factors helped dismount long-term treatment as the only option. Although nowhere near an exhaustive list, these initial issues influenced the development of TLDP.

First, many clinicians were finding that they were doing “brief” therapy by default (Budman & Gurman, 1988). They did not plan to only go 20 sessions, but many clients opted out of therapy at around this time. This led many theorists to change their models so that therapy was brief by design, not happenstance.

Next, the rise of insurance companies and HMO’s required more fiscal accountability. This business motivation drove psychotherapy models to develop treatments that could be measured, so that cost-effectiveness could be assessed. This required clinicians to prove that psychotherapy was worth healthcare dollars.

Another factor that contributed to the move towards a short-term model of treatment was that research comparing long-term and short-term models of treatment showed little difference in terms of symptom-
atic change. Clinicians found that many of the long-term curative factors could be condensed into short-term treatment (Davanloo, 1995, Malan 1979; Mann, 1973).

In addition to psychoanalytic thought and the emergence of brief therapy, TLDP was also heavily influenced by empirical research. Strupp (1958, 1980a, 1980b, 1980c) undertook numerous studies that helped shape and validate TLDP. He, along with fellow researchers, conducted the Vanderbilt I study to see if there were differences between specific therapeutic factors (i.e., particular techniques) and non-specific factors (i.e., interpersonal factors; Strupp & Hadley, 1979). They divided a group of 30 patients who struggled with anxiety, depression and/or social introversion into two groups. The first group was seen by trained therapists and the second group was seen by empathic college professors. After treatment, there was not much difference between the two groups. However, there was a difference between the affect therapists and professors experienced towards non-challenging patients and challenging patients. The non-challenging patients readily aligned with the therapists and professors and also experienced greater amounts of change. The challenging patients had much more difficulty aligning with the therapists and professors and experienced little to no change.

Strupp and colleagues ran a number of other analyses and concluded that difficult clients are the ones that need psychotherapy the most, but are the most at risk of not receiving it because they tend to annoy, aggravate, or otherwise frustrate their therapists. They developed TLDP as a form of treatment that could help therapists quickly identify and treat ingrained, problematic, behavior patterns. They then conducted Vanderbilt II to see if training in TLDP affected how clinicians treated difficult patients (Henry, Strupp, Butler, Schact, & Bidner, 1993). The general finding showed that specific training did result in successfully teaching therapists to use TLDP techniques. Other findings led the authors to conclude that less experienced therapists will internalize TLDP strategies more efficiently than more experienced therapists, because they have less to unlearn. In addition, not surprisingly, the study displayed that specific focused feedback increased the internalization of TLDP more than general, vague, feedback (Levenson, 1995).

Levenson (1995), along with Bein, tested TLDP by using it in the VA Short-Term Psychotherapy Project. Many of the 101 patients had longstanding issues and characterological problems. They found that “60% . . . achieved positive symptomatic change . . . At termination, 71% of the patients thought their problems lessened [and] . . . 21% of the patients achieved clinically significant interpersonal improvement” (Levenson, 1995, p.
Long-term follow-ups showed that the majority of the patients maintained treatment gains. In addition, other analyses showed that patients valued TLDP congruent interventions over non-congruent TLDP techniques. For example, they perceived greater benefit from TLDP strategies that focused on here-and-now interpretations of problematic interpersonal patterns than they did on non-TLDP strategies like giving homework or direct suggestions.

ASSUMPTIONS

There are seven assumptions that underlie TLDP. Each assumption has its roots in psychodynamic thought with strong emphases from object relations, attachment therapy, and interpersonal theory. The first assumption is, “The patient needs an interpersonal therapy for problems stemming from disturbed interpersonal relationships” (Levenson, 1995, p. 30). The need to connect with others is seen as one of the primary drives in life. People often experience difficulties learning how to meet this need. They can avoid others, withdraw when it becomes too intimate, or emotionally suffocate people. TLDP posits that an interpersonal treatment is needed to solve these and other interpersonal problems. Cognitive, behavioral, or humanistic approaches may be helpful, but they will not be as direct in solving relational problems.

The next assumption is, “dysfunctional styles were learned in the past” (Levenson, 1995, p. 30). People learn how to relate to others based on their early experience of their caregivers or parents. The brain is fluid in childhood, so that it can quickly pattern itself after the environment that it is found in (Grigsby & Stevens, 2000). As the individual matures, the brain becomes less flexible and patterns become more rigid. John Bowlby (1969) and Mary Ainsworth (1978) masterfully showed how these attachment patterns develop and affect how individuals relate to others.

A third assumption is, “dysfunctional styles are maintained in the present” (Levenson, 1995, p. 30). People crave consistency. Some of the need for consistency occurs consciously, but most occurs on an unconscious level. People will maintain a sense of consistency even if it is painful. If feeling worthless marked one’s childhood, then maintaining that sense will be an unconscious priority in adulthood. If a person had a distant parent that they conformed themselves to please, then they will find a distant partner who they will conform themselves to please. Fa-
Familiarity is comfortable, so it is better to feel hurt and consistent, than healed and inconsistent.

Another assumption is, “the patient reenacts interpersonal difficulties with the therapist” (Levenson, 1995, p. 30). Patients unconsciously recreate their relational patterns with the therapist. They instinctively “show” the therapist their issues by acting them out in therapy. Patients may verbally state that they have a tendency of annoying others, but they will also display this annoying behavior in therapy, which will result in the therapist feeling annoyed with them. In this manner, therapists get a visceral experience of what other people feel when they relate to the client.

The fifth assumption is that “the therapist is a participant observer” (Levenson, 1995, p. 30). Harry Stack Sullivan (1963) coined this term to describe the two, simultaneous roles of the therapist. The first part involves actively participating in the relationship. This is a different stance from what early analysts held. TLDP therapists recognize that they impact the client, whereas early analysts believed that they were able to remain neutral. The second part involves observing the relationship as it develops. Therapists strive to be aware of the process that occurs in the relationship. The therapist is actively engaged, while, at the same time, observing how the dynamics unfold between them. The goal is to enter and genuinely engage in the relationship, so that it can be changed from the inside-out.

The next assumption is that, “The therapist becomes hooked in to reenacting difficulties with the patient” (Levenson, 1995). This assumption lies at the heart of TLDP. Therapists automatically get pulled into acting out the client’s main interpersonal problems. This happens naturally and on an unconscious level. The countertransference is complementary to the client’s transference. For instance, if the client is irritating, then the therapist will feel irritated. Once the therapist gets hooked, the therapist has to get unhooked. They have to recognize that they were unconsciously repeating the interpersonal problem that brought the client into treatment. Instead of reinforcing the problem, the therapist needs to offer a different response that encourages the client to act in a new manner. For example, the irritating client that annoys others will also annoy the therapist. The therapist needs to get unhooked by becoming aware of his or her annoyance. Then, the therapist should respond in a manner that is different from how other others respond. That is, if others distance themselves and get annoyed, the therapist has to stay close and work through that annoyance, so that the problem is resolved and not repeated.
The last assumption states “there is one identifiable, problematic interpersonal problem” (Levenson, 1995, p. 30). TLDP therapists practice “benign neglect.” There are a variety of relational problems to focus on, but they instead focus on the core problem. Changing the larger problem will result in changing the other smaller problems. Once the primary problem is resolved the healing effects will trickle down and correct the secondary problems.

**GOD IMAGE DEVELOPMENT AND GOD IMAGE DIFFICULTIES**

TLDP draws upon many different strands of psychoanalytic theory, so using this model to conceptualize God image development involves many insights originally gleaned from psychodynamic and object relations theory. Freud (1927) started it off by publishing many controversial, and arguably pessimistic, works on the God image and psychoanalysis. His central thesis was that the God image has its roots in projection and wish fulfillment. People have difficulty dealing with pain, so they project that there is a God who cares for them. D.W. Winnicott (1971) implicitly countered some of Freud’s assumptions and provided a context in which positive aspects of the God image could be better understood. Ana Maria Rizzuto (1971) built upon Winnicott’s work and developed the first, comprehensive, God image development theory by integrating object relations and Erik Erickson’s developmental theory.

Dynamic theory views the person as developing through a number of stages. When the task of the first stage is adequately met, the person can move onto the next stage (Erickson, 1980). The successful resolution of each stage provides the person with a new of way relating to the world. The unsuccessful resolution of a stage results in fixation. In general, the earlier the fixation at a particular stage, the more challenging the problem is to overcome. Some theorists see these stages as more rigid, whereas others see them as more flexible. However, the easy majority hold to the main assumption that early relationships teach people how to relate to others and those ways of relating are carried on into future relationships.

The God image develops along with the changing self. Each developmental stage affects how the God image is experienced by the person.
There are a number of developmental stages; however, this chapter focuses on what this author considers to be the most important.

The first stage is trust vs. mistrust (Erickson, 1980, Rizzuto, 1979). This stage influences whether children learn to trust or mistrust others and God. The primary caregiver, usually the mother, plays the main role here. If the caregiver loves, accepts, and meets the needs of her infant, then the infant concludes that others, the universe, and God can be trusted. If the caregiver neglects or abuses her infant, then the infant will conclude that others, the universe, and God cannot be trusted.

When this stage is successfully resolved children move onto the separation-individuation stage (Mahler, Pine, & Bergman, 1975). This stage influences whether or not children learn to follow their internal drive and slowly psychologically separate from their caregivers. If they do not feel safe, then they will feel that they need to remain with their caregiver. They will not grow and emotionally separate from the caregiver, but will instead feel that growth is threatening. They may fear that if they separate from their caregiver, then bad things will happen.

This stage has a tremendous impact on the God image (Rizzuto, 1979). Children, later as adults, will play out this same pattern with God. If they can trust and separate from their caregiver, then as an adult they will experience God as mature and encouraging of their autonomy. If they cannot trust and separate from their caregiver, then they will later experience God as immature and possibly needy. They may not be aware of this, but their behavior will be characterized by a fear that if they grow too much or become too independent, then God will be unhappy and abandon them.

The next main stage of development is the Oedipal phase. It occurs between the ages of 4 to 6, and is marked by intense feelings for the parent of the opposite sex (Brenner, 1973). In a healthy family, the child is able to navigate this conflict with success. He will slowly come to the conclusion that he cannot have his mother all to himself. This is a great loss to the boy, but instead of facing this reality entirely, he unconsciously transfers all of his feelings over to his father. He no longer longs for his mother, because he sensed he could not safely win all of her attention; instead, now, he hopes to win all of his father’s attention. Gradually, he becomes aware that this is not going to occur either. The boy then realizes that he will have to wait until he is older to have an adult relationship. At that point, he will see his parents from a more objective stance.
The child who grows up in a dysfunctional family has a much more difficult time with this conflict. Because his fundamental needs were never satisfied, he will not be able to let go of his desire to wholly possess another. As a result, he will constantly seek out others in an attempt to complete himself. This feeling of wholeness will never be captured. As he moves into adolescence, he will potentially lock onto his God image to satisfy this deep longing. His relationship with God may be “highly charged.” Unfortunately, this relationship will not satisfy his inner needs.

Rizzuto’s thoughts are helpful in understanding how the God image develops throughout the lifecycle. Her views are very traditional and emphasize that the self and God image are more or less solidified at age 6. Most dynamic theorists see these initial years as very important, but no longer believe that the self and God image are crystallized in early childhood. The self and God image are now seen as more fluid, adaptable and able to change.

Two recent studies support the shift towards thinking that the self and God image are not fixed in childhood, but can significantly change through therapy in adulthood. The first study, by Tisdale et al. (1997), focused on the effectiveness of an inpatient object relations based program on self-esteem, level of object relations development, and God image. The researchers found that treatment significantly improved the clients’ view of themselves as well as their view of God. The second study, by Cheston, Piedmont, Eanes, and Lavin (2003) sought to test whether short-term psychotherapy (without explicit intervention to change the God image) would result in a decrease in symptoms and improvement of the God image. They found that the treatment did result in a decrease of symptoms and did improve the clients’ God images. After therapy, the God image was experienced as significantly more loving and compassionate.

**GOD IMAGE CHANGE**

The self and the God image are closely interconnected; as the self changes, the God image changes. Clients learn to have a problematic sense of self and God image through early unhealthy relationships with their caregivers. Similarly, clients can learn to develop a healthy sense of self and God image through a healing relationship with their therapist. Maladaptive ways of relating result in God image problems, whereas corrective ways of relating result in the resolution of God image problems.
God image change occurs through internalization, which is the gradual process by which people learn to treat themselves as others treat them. If a client is raised by perfectionistic parents, then he will treat himself in a perfectionistic manner and also experience God as perfectionistic. TLDP utilizes the same process of internalization that occurs in the parent-child relationship to change the way a person treats themselves and to change the way that they experience God. The goal is for clients to internalize the character of the therapist to learn to treat themselves as the therapist treats them (Blatt & Behrends, 1987). Through this process, the harsh internal voice of the caregivers becomes replaced with the empathic voice of the therapist. This changes the way the person treats themselves and also changes the way that they emotionally experience God. The client’s God image was initially shaped by the parent. As therapy progresses, the God image becomes patterned after the therapist. As a result, the God image becomes empathic and accepting, rather than disinterested and rejecting.

The first step the therapist takes to facilitate this process is to identify the client’s cyclical maladaptive pattern (CMP; Strupp & Binder, 1984). The CMP outlines four quadrants of interpersonal information and helps identify the client’s primary interpersonal problem. Levenson (1995) details each aspect:

2. Expectations of others’ reactions—this pertains to all statements having to do with how the patient imagines others will react to him or her in response to some interpersonal behavior.
3. Acts of others toward the self—this consists of the actual behaviors of other people, as observed and interpreted by the patient.
4. Acts of the self towards the self (introject)—this refers to the patient’s behaviors or attitudes toward herself or himself—when the self is the object of the interpersonal dynamic. That is, how the person treats him or herself (p. 49).

Levenson furthered this model by adding a fifth component, which is Countertransference Reactions. Moriarty (2006) adds a sixth part, Experience of God image.

5. Countertransference reactions—includes the way you feel in relationship with the client. How do you feel being in the room with the client? What are you pulled to do or not do? (p. 50)
6. Experience of God image—refers to the thoughts and feelings the client experiences when relating to his or her personal experience of God.

After the therapist fills the client’s information into the above six components, they analyze the relational data to determine the client’s main interpersonal problem. There might be a variety of relational problems, but the therapist restricts their attention to the primary problem. If they change the one major problem, then the results will generalize and resolve the other minor interpersonal problems.

Once the therapist has identified the main interpersonal problem, they construct the 4 main goals of spiritually-oriented TLDP: (1) New experience of self and therapist (Levenson, 1995); (2) New understanding of self and therapist (Levenson, 1995); (3) New experience of self and God image; (4) New understanding of self and God image. The focus on experience and understanding has its roots in Franz Alexander’s (1956) corrective emotional experience. His thesis is that client’s need both an emotional experience and intellectual insight to achieve long-term change in their interpersonal patterns.

The emphasis on experience is important for a couple of reasons (Levenson, 1995). First, it allows clients to experience themselves in a different, more adaptive, manner. If a client usually experiences herself as weak with others, then it can be very empowering for her to experience herself as strong with the therapist. Second, it allows them to experience another person—the therapist—in a different, healthier, way. If a client usually experiences others as rejecting, then it can be healing for her to continuously experience the therapist as accepting.

The new experience of the therapist also translates to a new experience of the God image. If before she felt weak and rejected by her God image, she will now feel strong and accepted by her God image. Similarly, she will also experience her God image in a new way. It will no longer be rigid and inflexible, but will instead be fluid and flexible. The God image can be more than rejecting and demeaning. It can also be empathic and empowering.

The emphasis on a new understanding is also very important (Levenson, 1995; Strupp & Binder, 1984). A new experience is essential, but clients have to understand why that experience is significant. A new experience, without a rational understanding, results in change that quickly fades, whereas a new experience with understanding results in long-term change (Alexander, 1956). Cognitively framing the situation puts
handles on the problem, so clients can more easily grasp it and guard against experiencing it again (McCullough-Vaillant, 1997).

If the client has this understanding, then they can more readily identify when they are experiencing their God image in a harmful manner. This map allows them to see how these difficulties originally arose and provides them with a means to correct painful God image experiences. The intellectual framework, puts it in perspective and allows them to act on the situation rather than feel powerless to change it.

LIFE EXAMPLE

Presenting Problem

Debbie is a 52-year-old, divorced, evangelical, female who sought treatment for help with anxiety and feeling like God is mad at her. She worried about many things and frequently feared that others were going to reject her. She had a hard time making decisions for herself and would often get people to tell her what to do. In addition, she was a very devout Christian who regularly engaged in prayer and church activities, but continually sensed that God was displeased with her.

Client History

Debbie grew up in a working class family. Her parents had a very traditional relationship and often kept themselves separated from her. The boundary between her and her parents was wide. She often felt isolated and alone, even when they were with her.

Her father was a hard worker who spent most of his time in the machine shop. She thought they had a good relationship, but did not feel like she spent enough time with him. Her mother was very domineering and had rigid ideas as to how children should behave. There was not a lot of room for play and imagination. Instead, Debbie was expected to behave as a little adult. Her mother supplied her with a long list of chores each day and expected her to busily complete her duties.

Debbie’s mother was very emotionally inconsistent. Sometimes she would be kind, but at other times she would become extremely angry for what seemed like no reason at all. She would then either lash out or emotionally withdraw. Debbie never knew what to expect. She learned to cope by doing all her chores, always smiling, and being as nice as possible.
People tended to like Debbie because she had a natural ability to tune in to what they wanted. She was quiet and friendly throughout her school years. Teachers thought she was well mannered and friends found her very trustworthy and eager to listen.

She met a man who was a little older than her after graduating from high school. He had a strong personality and was very controlling. Before she knew it, they had married and moved away from her childhood home. Shortly thereafter she realized that her new husband was unpredictable. There were times when he was happy, but other times in which he would get very angry. He did not talk a lot, but he still communicated exactly what he wanted. Debbie intuitively picked up on his desires and gradually shaped herself to please him. The only problem was that he, like her mother, could not be pleased. He eventually left her for another woman. Ironically, Debbie blamed herself for their unsuccessful marriage.

Debbie’s active church life was one of the main things that helped her cope. She felt needed and respected at church. However, she also often felt overwhelmed because many people requested too much of her. She belonged to a very dogmatic church that clearly spelled out the “right” and the “wrong” way to believe. This structure fit her personality, because she craved direction and strongly desired the guidance of others. She loved her church, but she had an internal struggle that she did not often discuss. Her pastor always talked about a loving God, but this was not the God she encountered when she closed her eyes. Her God was harsh, critical, and very difficult to please. She tried desperately to make her God happy, but always felt like she failed God.

Debbie started therapy when she was at her “wit’s end.” She had been divorced for several years, but she still worried about her ex-husband. She enjoyed her work, but always felt like she was going to be “disciplined,” even though her evaluations were consistently stellar. Debbie was also frustrated in her walk with God. She wanted to know the gracious and accepting God that she so often heard of and believed in, but seldom experienced.

**Case Conceptualization**

The best way to conceptualize Debbie is to use the CMP.

1. Acts of self–Debbie tends to please others at the expense of herself. She overworks and often does whatever people ask her to do,
even if she does not want to. She always “wears a smile,” is often
tired, feels anxious, worries frequently.

2. Expectations of others’ reactions–Debbie expects to be rejected if
she doesn’t please others by being overly nice to them and doing
what she feels they want her to do.

3. Acts of others toward the self–people ask her to do a lot of extra
things, they frequently feel comfortable telling her what to do.

4. Acts of the self towards the self (introject)–Debbie criticizes her-
self for not accomplishing enough at work. She tells herself that
other people do not like her.

5. Countertransference–Debbie acts out her people pleasing behav-
ior with me. As a result, I feel idealized and pulled to tell her what
to do.

6. Experience of God image–Debbie experiences God as demand-
ing, critical, frustrated, and rejecting. Her God image expects a lot
from Debbie and makes her feel guilty when she does not accom-
plish everything she sets out to accomplish.

Now that we have Debbie’s CMP spelled out, the next step is to iden-
tify the one main interpersonal problem. Debbie’s main problem is that
she is skilled at getting others to tell her what to do. There are a variety
of other problems that Debbie experiences, but the main theme that con-
tinually emerges is that she sacrifices herself to focus her efforts on
pleasing others. She is driven to please others for she fears that if she
does not they will abandon her. As a result, she ignores her own needs
and invests considerable time and energy trying to please others by do-
ing what she feels they want her to do.

**Treatment Plan**

TLDP utilizes a style of treatment planning that is flexible. In the age
of HMOs most people think about treatment plans as containing spe-
cific interventions with measured outcomes. Most dynamic clinicians
balk at this type of treatment planning because they feel that it defines
the person and the therapy process in an unhelpful manner. TLDP ther-
apists view treatment planning in a broader, less rigid, manner that is
based on core goals. These goals are framed in response to the main
interpersonal problem.

The first goal is a new experience of self and a new experience of the
therapist (Levenson, 1995). This goal would be met if Debbie experi-
enced herself as assertive (i.e., non-people pleasing) and me as caring
for her when she is not trying to please me. This will be challenging because Debbie will repeat the same interpersonal pattern with me that she acts out with others. Remember, I cannot help but naturally react to what a person pulls for. What would Debbie’s hook be? How would I feel pulled to respond to her? When Debbie first started therapy, she interacted with me in a manner that pulled for me to tell her what to do. I found myself making strong suggestions and being overly directional. I was too forward with my recommendations and saw Debbie as less strong and resourceful than she was. This is exactly what the CMP would predict. Debbie’s main problem is that she is skilled at getting others to tell her what to do. That is what she was doing with me. She was replicating her main interpersonal problem by working hard to please me, just like she works hard to please others and God.

Once I realized I was hooked, I needed to get unhooked. I had naturally fell into her interpersonal problem and needed to get out of it to help her. Through discussing the dynamics of our relationship, Debbie was eventually able to see what was occurring. She recognized that she was ignoring her own real struggles to try to figure out what I wanted so that she could please me. After this realization, Debbie took risks and focused on her own needs. She allowed herself to be more assertive and confident. Debbie expected me to reject her and was shocked to find out that I still cared for her. She had a new experience in which she felt valued for being herself and not for pleasing me.

The second goal is a new understanding of self and therapist (Levenson, 1995). The new experience is essential, but it needs to be complemented with a solid cognitive understanding to result in lasting change. To cement this change, Debbie and I spent time talking about how her interpersonal problem developed in past relationships and is maintained in current relationships. We came to the conclusion that her tendency to get others to tell her what to do had its roots in her critical relationship with her mother. At that time, it served as a survival mechanism to help her remain connected to her mother. She had to bend and conform herself to his mother’s wishes in order to keep a relationship with her. A painful relationship was better than no relationship. We also concluded that her interpersonal problem is maintained through her relationship with her colleagues. People ask too much of her and never seem to be pleased with what she does. As a result, she repeats the same problem with them that she learned with her mother. That is, she ignores herself and works doubly hard to please her colleagues. This problem is also maintained in her relationships with fellow church members. They have
high expectations and she regularly sacrifices herself to take care of their wishes.

Debbie realized that she did not have a choice in her childhood relationship with her mother. She needed to repress herself in order to stay connected to her mother. However, she did have a choice as an adult. She did not have to ignore her needs in order to please others. Debbie could take steps to care for herself. She could abstract herself from being the caretaker and give other people the opportunity to learn to meet their own needs.

The third goal is a new experience of self and God image. This goal parallels the first goal in that the new experience of the self and therapist is the same as the new experience of self and God image. As Debbie took risks with me she was also able to take risks with God. She indicated that she more readily shared authentic thoughts and feelings with God. As a result, she felt her relationship with God became more genuine. She was no longer acting weak and passive, but was instead strong and active. This new experience of God loving her, even when she is genuine and confident, allowed her to learn to relate to God in a new manner.

The fourth goal is a new understanding of self and God image. Debbie needed a cognitive understanding of the dynamics that played out with her God image, so that she could monitor them and challenge negative relational experiences that occurred between her and her God image. We talked about the basic process of projection and Debbie readily understood how her negative experience of God helped her to maintain a sense of consistency with her past. She saw God as demanding and difficult to please, because she experienced her mother as demanding and difficult to please. Debbie was also more able to believe her evangelical theology. She became comfortable with the idea that she did not have to act passive and dependent to secure God’s love.

Interventions

I used both implicit and explicit interventions with Debbie (Tan, 1996). Implicit techniques do not directly address the God image, but they still indirectly change the God image through changing the self. Explicit techniques directly address the God image and explicitly change it by incorporating the God image into the interventions.

One of the main explicit techniques I used was based on the work of Janis Morgan Strength (1998) who expanded Menninger’s (1958) triang-
gle to a square to offer interpretations addressing the person’s relationship with God. She listens for the repetition of the same theme in a person’s current relationship, past relationship, therapeutic relationship, and relationship with their God image. Each piece of information represents a side of the square, which she connects before she offers an interpretation:

- Past Relationship
- Current Relationship
- Therapeutic Relationship
- God Image Relationship

Direct change of the God image occurs through calling attention to this and connecting each side of the square. For example, Debbie repeated a theme of letting people down and, as a result, feeling overwhelmed with guilt. I offered this interpretation to Debbie to bring this to awareness:

It seems like you are frequently afraid that you are not doing enough to maintain your relationship with your co-workers (current relationship). When you recall your adolescence, you have expressed a similar regret surrounding your inability to accomplish enough to stay connected to your mother (past relationship). You also consistently experience God as upset with you because you feel you let God down when you do not achieve as much as you hope to (God image relationship). And, even today, you have indicated that you think I am disappointed with you because you are not making enough “progress” (therapeutic relationship). There appears to be a theme that runs through each of these relationships in which you feel guilty because you do not fulfill what you feel others expect of you.

TLDP interventions use immediacy to target how the client’s dynamics unfold in the here-and-now relationship between therapist and client. To illustrate how this works, I have cataloged a number of TLDP interventions that I used with Debbie. Again, direct interventions incorporate the God image, whereas indirect do not.

One TLDP intervention, “encourages the patient to explore feelings and thoughts about the therapist or the therapeutic relationship” (Levenson,
1995, p. 241). In addition, it can also be modified to help clients explore their feelings about their God image.

Me: I wonder how you are feeling towards me?

Debbie: I really like you and I’m really glad to be working with you.

Me: I wonder if there is something you don’t like about the therapy relationship. Something you are not crazy about or would like to change?

Debbie only allows herself to experience positive feelings toward others. This problem has its roots in her relationship with her mother who could not tolerate any form of negative feedback. Debbie quickly learned that she could only state things that made her mother feel good about herself. This problem was maintained with her husband before their divorce and is currently maintained with her friends and fellow churchgoers. Debbie experiences negative feelings and thoughts towards others, but she quickly denies them. She would never actually express them for fear that she would be immediately rejected. Debbie thinks that I will become enraged if she offers a slight criticism. When she took the leap and expressed negative feedback, she was shocked to find that I could hear and appreciate the feedback. That I was still connected to her and that our relationship was stronger because it is more honest and genuine. Providing Debbie with this new experience allowed her to begin to integrate negative thoughts and feelings.

Debbie was also afraid to express anything other than positive feelings towards God. Unconsciously, she saw God like her mother. After processing some of her frustration towards me, we were then able to process some of the things she is not too pleased about in her relationship with God. She gradually tolerated being able to be more authentic with God. She eventually recognized that God is not going to lash out at her for having non-plussed feelings or thoughts. She learned to value genuineness and reported feeling closer to God after she prayed and discussed things that she had unconsciously been keeping from God.

Another TLDP intervention, “encourages the patient to discuss how the therapist might feel or think about the patient” (Levenson, 1995, p. 241). Debbie projected that I felt the same way towards her that she imagines others feel about her. According to the CMP, Debbie expected rejection and believed she had to please me to gain my approval. My
goal was to provide Debbie with a new experience in which she felt accepted and cared for regardless of her performance. Visualize how this intervention played out when she was late for a session:

Debbie: Sorry I’m late.

Me: How do you think I feel towards you?

Debbie: You are probably very frustrated with me for being late.

Me: What makes you think I am frustrated with you?

Debbie: Well, I’m late. I’m irresponsible. You cannot count on me to do things right. I feel really bad for letting you down.

Me: What do you think I want to say to you?

Debbie: Probably that you think I’m worthless . . . that you regret accepting me as a client (Notice the transference: it sounds like she is expecting me to respond as her mother would have).

Me: Have there been other people in the past or present who have told you that you are worthless for making a mistake? Have you ever experienced God in that way?

Debbie: Oh yeah, my mother was always telling me I’m worthless. I sometimes feel like God thinks I’m worthless too. I know He doesn’t, but I feel this way especially after I feel like I’ve failed Him in some way.

Me: So, you learned from your mother that if you make a mistake you are worthless. You also experience God in this way too. Similarly, you expect me to be angry with you for being late. Can you see how that is a pattern?

Debbie: Yes I can. I do. I really expect you to be mad at me and reject me . . . just like my mother would have. Are you mad at me?

Me: No Debbie, I’m not mad at you. I like you just as much as I did before. How does it feel to hear that?
Debbie: It feels weird . . . weird, but good . . . different. I don’t know if I’ve ever been accepted after making a mistake.

Me: Can you imagine God accepting you after you miss the mark?

Debbie: Yeah, yeah, I can. I just have to let myself feel Him in that way.

Debbie expects me to reject her for being late. Notice that I did not counter this right away, but instead allowed it to build up to get her in touch with her feelings. I then used the triangle of person to make connections to his past relationship with her mother, relationship with her God image, and transference with me. This allowed Debbie to recognize the interpersonal pattern. Then I offered her a different response by telling her I still cared for her. I stayed connected to her and helped her get in touch with that feeling. This provides Debbie with the new experience of feeling accepted after making a mistake.

Another TLDP intervention utilizes self-disclosure counter-transference reactions to help the client see how his or her behavior affects others (Levenson, 1995, p. 241). As mentioned earlier, clients evoke in the therapist the same feelings that they evoke in others. The therapist’s goal is to become aware of this and then react in a manner that is healing. Through using Debbie’s CMP, I predicted that she would sacrifice herself to please me. I was initially hooked into this by being very pleased with her, but then realized that she was neglecting herself in order to be the perfect client. I then gave her feedback, so that she could experience herself as being cared for even if she was not perfect.

Me: Debbie you are an excellent client. You work hard all the time, ask insightful questions, and are very committed. I find myself feeling very pleased with you, but I am wondering if this might be part of the problem.

Debbie: What do you mean? Problem?

Me: Well, you often sacrifice yourself to make others happy and I’m wondering if you are sacrificing yourself in here to make me happy. I know you have some real hurts and issues you are struggling with, but you seldom bring them up. You always give a positive report, but I’m wondering if you avoid these issues out of fear that I’d be displeased with you for discussing them?
Debbie: I realize that. I’m afraid that if I’m honest with how I really feel, you will grow tired of me. I want to open up about my real issues, but I’m scared you will grow frustrated with me if you knew the real me.

TREATMENT LENGTH AND THERAPEUTIC OUTCOMES

I saw Debbie for 20 sessions. We met one time a week for 50 minutes. Treatment progressed through the beginning, middle, and end phases of treatment.

The beginning stages of treatment were marked by building rapport and gathering information. Debbie experienced positive transference towards me and felt comfortable discussing her past and present relationships. In addition, she easily answered questions about her religious beliefs and readily shared about her emotional experience of God. She seemed very eager to make the most of her time and appeared willing to take steps to alleviate her anxiety and depression.

After our first few sessions, I felt I had a good understanding of her CMP and how the main interpersonal problem had developed, was maintained, and influenced her emotional experience of God. That is, I could trace the dependent pattern back to her unpredictable relationship with her mother, see how it was maintained with her ex-husband and current friends, and how it played out with her God image.

As therapy progressed through the middle stages of treatment, we began to explore how her CMP was played out in our relationship. How Debbie’s tendency to please, repress her opinions, and be compliant impacted our relationship. I disclosed my feelings towards her. How I naturally really liked her and often felt good and validated when I was with her, but how this might be part of a larger problematic pattern. We explored how this tendency developed. How it was a great survival skill that helped her cope with difficult relationships. We also discussed how that underlying pattern affected her personal experience of God. She thus had experienced both emotional and cognitive change in her experience with me, others, and her God image. Debbie clearly saw this pattern and recognized that this way of relating served its purpose, but was now outdated. I used several TLDP interventions throughout this time to capture and work through this tendency in the here and now context of our relationship.

Throughout these repeated interventions, Debbie was gradually able to experience herself in a more assertive manner. She more readily ex-
pressed her opinions and began to put down boundaries in her relationships with people in her life. When others asked too much of her, she simply said “no” and indicated that she wasn’t comfortable committing that much time and energy.

These treatment gains also translated to her God image. Debbie began to see how she had unconsciously modeled her God image after her mother. She indicated that her spiritual life changed. She did not feel compelled to compulsively pray to “make things right with God.” Her “operational theology”–the emotional underpinnings of her faith–had changed so that she could more readily believe in and experience her understanding of God’s grace and forgiveness (Jordan, 1986). She began to see God as a Being that she could share things with and not hide things from. Her God image became a source of encouragement rather than a source of perfectionism. In addition, she indicated that she felt that God had created her for a reason and that she could confidently follow her “calling” to fulfill that purpose.

The final stages of treatment were characterized by reinforcing the treatment gains she had made. We deliberately put cognitive frames on the relational changes she experienced. This provided her with an intellectual map to see how her interpersonal problems developed, were maintained, and consequently resolved. This helped her identify her triggers, so she could recognize situations that enervated her CMP. The end stages were also marked by discussions about termination issues like what it meant to say good bye. I let her know that I would be available for future consultations if needed, and also explored the pro’s and con’s of her therapy experience.

**STRENGTHS AND WEAKNESSES**

There are a few key strengths and weaknesses of spiritually-oriented TLDP. The first strength is that it offers a practical framework to understand the relational dynamics and the God image. The facile use of the CMP enables clinicians to quickly identify transference, counter-transference, and God image projections.

Another strength of the approach is that it has been empirically validated. In the age of managed care, it is important for therapists to show that what they are doing works. A third, and related, strength is that TLDP works with a spectrum of clients. TLDP works well with adjustment issues as well as characterological problems (Levenson, 1995; Strupp & Binder, 1984).
A final strength is that TLDP interventions can be easily modified to address the God image. The techniques are based on analysis of the transference and relational dynamics. These issues play out with a person’s God image, so the techniques can be used to explore this relationship in a meaningful manner.

TLDP also has a few weaknesses. One limitation is that there is a paucity of research on how TLDP can be used to affect the God image. There have been several studies that support the relationship between dynamic therapy and the God image (e.g., Tisdale et al., 1997), and studies to support non-specific treatment and God image change (Cheston, Piedmont, Eanes, & Lavin, 2003), but none specifically supporting TLDP and God image change. Despite this weakness, the case for TLDP as a useful model of treatment is buffered by these more general studies and theoretical support (Jones, 1991; McDargh, 1983; Spero, 1990).

Another weakness is that TLDP clinicians have to be fairly intelligent and patient to learn how to effectively use TLDP. Research has shown that it can be learned, but therapists need to overcome a few obstacles to fully grasp it (Henry et al., 1993). A final, and related, weakness is that clients also have to be of at least average intelligence to benefit from TLDP (Levenson, 1995).

**SUMMARY**

To sum up, TLDP is an empirically supported treatment that provides a practical framework to conceptualize and treat relational problems. In addition, it can also be utilized to understand and modify problematic God images. The main assumptions are that interpersonal issues develop in the past, are maintained in the present, played out with the therapist, and acted out with the God image.

Clients recreate their main interpersonal problem with the therapist and their God image. The therapist responds differently than other individuals in the client’s life. This corrective emotional experience changes the client’s self and God image. For example, the case of “Debbie” was used to illustrate how spiritually-oriented TLDP modified her sense of self and God image. Debbie’s main problem was a dependent personality pattern in which she minimized her autonomy and maximized the control of others in her life. She had a parallel experience of God in that she felt God was domineering—
much like her mother, ex-husband, and colleagues. As treatment progressed, Debbie continuously experienced me as supportive and herself as increasingly independent. These experiences corrected her idea of herself and her emotional idea of God. As a result, she experienced herself as confident and autonomous and her God image as affirming and supportive.

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