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Review Article

Brief Dynamic Psychotherapy with a Psychological Analytical Communicative Orientation

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Abstract

The authors proposed a form of Brief Dynamic Psychotherapy with a Psychological Analytical Communicative orientation. Firstly, they illustrated a preliminary reference to the operational and research unit constituted by Luborsky's CCRT, as elaborated by H. Book in his Brief Dynamic Psychotherapy theory. Subsequently they focused on an original Jungian concept, the Complex, and highlighted its similarities and differences with Luborsky's CCRT. In particular, they underlined the difference between the two concepts constituted by the dimensional organization of the Complex. Finally, they documented their proposal with the description of a clinical case of Fraternal Complex, using the derivative as the clinical operating unit, in the sense of R. Langs.

Keywords: Brief dynamic psychotherapy; CCRT; Complex; Derivative

Introduction

Current life always poses us new problems that influence our daily life in an unexpected way. The dizzying pace of social changes, determined by the progress of technology, qualifies our era as the era of information and real time. This has simultaneously changed the mental state of the entire individual and collective consciousness as well as the universal unconsciousness. For example, conscience is now under the aegis of the single thought identified as the "Interpreter" by the neurocognitive science [1] and the unconscious undergoes its parcelized fragmentation which poses important questions about the conception of the world, contextual to the disintegration of ethical cornerstones [2-3]. The presence of ethics, previously shared and valued, preserved both the integrity of the social fabric and the organization of individual life through clear and well-defined rules in the Western world. The American psychoanalyst Robert Langs spoke of "Basic Rules of Life", i.e. rules "that have obtained constant validation for derivatives[1] by patients in psychotherapy and psychoanalysis" [4-5]. Piaget theorized that the child learns ethical rules from his parents and, from play with his peers, the absolute necessity of a system of shared rules that makes interaction with other children possible, overcoming egocentrism and self-referentiality [6]. Kohlberg, in line with Piaget, spoke more about moral development which makes the mature moral person capable of assuming an impartial and detached perspective, as well as capable of reasoning in the Kantian sense on abstract and universal principles [7]. These concepts today appear increasingly blurred.

However, the weakened importance of the ethical system has also occurred in the psychodynamic field and now goes hand in hand with the abolition of metaphysical research in the philosophical field and of the divine in the religious-theological field. This happens in favor of an anthropologization of metaphysical concepts and with a correlated syntonic vision that is no longer transcendent but immanent of a god fragmented into many gods with 1000 faces [8] each with its own identity, its own cognitive method and its own ethical attitude. This resulted in a fragmentation of the concept of truth into single individual beliefs that characterize different views, homologating them all to "relative goods". However, these are understood as goods only because in possession of their existence on the anthropological level they are a devaluing scotomization of the simple common sense that would distinguish in many cases, though not all, what is good from what is bad. Even the latter today is given a positive value, however, only because it exists. Just look at the proliferation of negative protagonists that is raging in the literature and in the most popular filmography in the younger generations who have replaced the figure of the hero of previous generations.

In this jumble of psychic phenomena and theories, psychodynamic theory runs the risk that the concept of healing abandons, as in surrenders, the field, in place of the more reassuring concept of improvement, understood as the relief of the socially maladaptive and/or individually oppressive symptom and to limited, but significant, changes in character [9]. In our view, faced with such a psychological framework, the psychodynamic perspective of the mind on one hand needs an update which, in tune with the fast pace of today's frenetic life, aims at solving these maladaptive symptoms in the quickest way. On the other hand, it is essential and characterizing that it maintains the solution to the ethical problem related to these symptoms as its specific trait. The ethical conflict is unveiled by a motivational theory of the psychic universe, that is precisely a psychodynamic theory.

For many years, especially in the institutional setting, with our Group we have therefore been experimenting with forms of brief

[1]We will talk about the concept of derivatives later in the article.

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psychodynamic psychotherapy to solve the aforementioned problems and make psychodynamic work more agile, by adapting to the logic of local health services which do not support excessively long and consequently expensive psychotherapy, in terms of effectiveness/efficiency.

The method proposed here, which guides our training school, starts from a profoundly Jungian cultural perspective and makes use of the indispensable contribution of Langs for the communicative aspects, interpretative and setting, in the clinical approach. We will later explain some salient aspects of our method also with a clinical case.

Brief Psychodynamic Psychotherapy. From Book to Brief Psychodynamic Psychotherapy Centered on the Concept of Complex by Carl Gustav Jung

It seems important to define that brief psychodynamic psychotherapy also represents a political response to a variety of scientific and economic forces which in recent decades have strenuously and deliberately marginalized psychoanalytic therapies in favor of other forms more adherent to the rooted scientific principles of this new century [10].

It is beyond the scope of this brief essay to enucleate the methods and strategies with which this marginalization is now accomplished, not only in Italy. For this it suffices to look at the literature that was published quite recently [11-17]. However, we would just like to briefly mention that the document produced during the Consensus Conference sponsored by the Istituto Superiore di Sanità, which took place in Italy in 2022 on psychological therapies for anxiety and depression, formally sanctioned the value of psychotherapy in the Italian National Health System [18], in line with the English program Improving Access Psychological Therapies IAPT [19]. This value is not seen only in clinical terms in the strict sense, but also in economic terms, precisely in relation to the efficiency/effectiveness ratio with the correlated savings in public spending. The Consensus Conference identified Brief Psychodynamic Psychotherapy, together with Cognitive and Behavioral Therapy (CBT) and Interpersonal Therapy (IPT), as the only exclusive psychotherapies based on the highest levels of efficacy for "Common Mental Disorders" DCM or "Common Emotional Disorders " DEC. In other words, brief psychodynamic psychotherapy enters fully among the EST psychotherapies- Empirically Supported Treatments - unlike psychodynamic therapy which, although validated [20], is now practically considered obsolete.

There are many forms of Brief Psychodynamic Psychotherapy. In the 50s and 60s the Tavistock group, including Balint, Malan, Mann and Goldmann and, later, Davanloo, began systematic studies on fixed-term psychotherapy, reaching the conclusion that it could grant excellent results. In particular, Davanloo, continuing Malan's work, set up a method called IS-TDP-Intensive Short-Term Dynamic Psychotherapy-reaching excellent results [21-25]. More recently, Sifneos [26] and the Brief Interpersonal Dynamic Therapy by Lemma, Target and Fonagy have been added, which in the intentions of the authors was developed "to optimize the practical integration of a psychodynamic approach with a focus on the symptoms of the current participants and users of psychological therapy services, without compromising its theoretical tradition and its unique mechanism of therapeutic action" [27].

We owe to all these studies the improvement of the short-term dynamic psychotherapy techniques which are currently integrated with long-term analytic psychotherapy interventions.

Brief psychodynamic psychotherapy, in our opinion, has found in Book [28] an attentive scholar who, compared to the other authors cited above, approached our dynamic method which we will describe later on. Book was inspired by another author, James Mann [29], to define the duration of the treatment in 16 sessions, agreed at the beginning with the patient, and identified Luborsky's CCRT [30,31] as the method of clinical approach.

The CCRT sees in the symptom the expression of intra-psychic conflicts, originating from the representations structured during childhood and conserved for the entire life. Normally and generally the individual's adaptation changes according to social demands through the flexibility of internal representations: this is a basic assumption of the CCRT theory. According to the author, these representations become rigid and incongruous at a certain point, giving rise to the development of a conflict, even if in reality the American psychologist does not give an explanation of the reasons why this conflict occurs. For Luborsky, the CCRT forms "a central conflictual relational theme", that is, a model of relationships that is ready to be implemented automatically and unconsciously, inadequate to the needs of the moment.

We find it important to point out that the objective and purpose of brief psychodynamic psychotherapy, built on the CCRT proposed by Book, is the satisfaction of the desire without the need for the symptom to appear. The use of the CCRT, according to the author, determines a particularly significant impact in the field of clinical applications, on the one hand satisfying the criteria of an EBM (Evidence Based Medicine), and on the other it gives the possibility, in the field of research in psychotherapy, to "operationalize" the psychic variables brought into play, i.e. "the choices". Book underlined in this regard that the method is not aimed at changing the structural aspect of the relational scheme of the CCRT, but only of the contents created by it, for example the affective tone of the representation. The focus of therapy is on identifying symptom-related CCRT. Listening to and carefully recording discrete relational episodes, i.e. of a categorical nature, allow the therapist to elaborate the recurring relational theme. The CCRT method brings together the common therapeutic factors, transversal to the different clinical orientations and consequently allows to stimulate the specific transformative contents. From this arises, for this method, the possibility to evaluate the progressive modifications of the treatment, as well as the opportunity to identify what works best in the therapeutic relationship. Thus the cost/benefit ratio can be ascertained and a current clinical paradigm based on both the efficacy and efficiency of psychotherapeutic treatments becomes feasible. According to Book, the concept of CCRT is therefore of vaster and more comprehensive dimensions than the cognitivist model, because it is the component of desire that guides the entire associative and/or interactive sequence, the relational pattern of behavior, and in this lies the difference between the schematic-cognitive and supportive-expressive psychodynamic (CCRT) [28].

Continuing along this line of thought we propose, in a Jungian perspective of communicative orientation [32-33], a form of brief psychodynamic psychotherapy with a psychological-analytical-communicative orientation; as we consider the Freudian analytic conception of a purely instinctual individual, we believe Luborsky's CCRT can be amplified, whose essential components are the wishes and expectations of the subject, the actual or presumed responses of the object and the reactions of the subject to the object's response. Therefore, with CCRT, we always move from a drive point of view, also the new element is that it is well contained within relational schemes.

Jung theorized the libido not only as drive, but in a broader sense, and the Complex since the year 1915, following the experiments and related discoveries in the field of experimentally-used verbal associations [34]. Comparing the Complex and CCRT we believe that the latter represents only a subsystem of the Complex. Let's start with what the Complex is. In 1934, Jung described for the first time the concept of Complex in an article [34]. In summary, the author wrote that:

1. the method of analysis of the Complex has a greater cognitive importance than its object in modern psychology;
2. the principle of this way of proceeding is - cum grano salis - that of the natural sciences in general;
3. almost everything depends on the methodological premise and the result is mainly imposed by this premise. The object of study, in an experimental situation, does not behave as it would, as an autonomous reality, in a natural situation without interference;
4. a certain experimental disposition does not immediately grasp the psychic process, but a certain psychic condition insinuates itself between this process and the experiment which we could define as an "experimental situation". This "situation" can in some cases put the whole experiment into question, as it assimilates the experimental organization and even the purpose that underlies the experiment. By the name of "assimilation" Jung means an attitude of the researcher who misunderstands the experiment itself, for "an initially invincible tendency to assume that it is a "test" on intelligence or an attempt to cast an indiscreet look behind the scenes" [34].

Jung recalled his experiments on associations, aimed at establishing the average speed and quality of the reaction to stimulus words, to denounce how the method is invalidated by the automatic behavior of the psyche, i.e by the phenomenon of "assimilation". It is important to underline that in this automatic factor, the Swiss analyst psychologist discovered assimilation, the affective-toned complex that he had previously indicated as a reaction error. In principle, Jung did not question the value of the experiment, but critically circumscribed it. The pure mechanism of reflexes does not give the necessary time for the phenomenon of assimilation to occur, so the experiment is not invalidated by it, while in the field of intricate psychodynamic processes, possibilities of an indefinite number emerge which give rise to a constellation. Jung explains that he referred the term constellation to a "predisposition to wait" from which one will react in a perfectly defined way [34]. For Jung, the constellated contents are defined Complexes, that is, to quote Book about CCRTs, discrete units, which possess their own specific affective tonality. The Complexes will influence the experiment, determining a disturbing reaction or a specific reaction modality which disregards the meaning of the word stimulus, associating the stimulus words with a series of disturbing symptoms, an operation due to the effect of their Complex. Jung went on to state that: "the association experiment represents the psychic situation of the interview with approximately exact quantitative and qualitative evaluations". Once the existence of Complexes in a person's unconscious has been found, Jung gave the following definition: "the Complex is a set of internal representations of the individual, unconscious and with a strong affective tone" [34]. After this definition, the author outlined the following characteristics of the Complex, using his preferred language, that is, asystematic, full of ingenious intuitions, but poor in incisiveness as regards to the force of penetration and impact on the reader:

1. it is the image of a single psychic situation characterized in a lively emotional sense which is moreover incompatible with the habitual condition or attitude of consciousness; in our view, the Complex in this realm of meaning is no different from Luborsky's CCRT.
2. it is characterized by a strong affective tone, another element similar to the CCRT.
3. it has a strong internal compactness, its own completeness and a relatively high degree of autonomy; we reiterate it is a discrete unit like Luborsky's CCRT.
4. it behaves like an animated " corpus alienum " that can be repressed by consciousness, but not eliminated.
5. it also has his own specific memory and its own definite character trait; ultimately Jung argued that it sees no difference in principle between a partial personality and a Complex.
6. it is never stable; in dreams it appears personified; in certain psychoses it becomes sonorous like a "voice".
7. it has its own specific physiognomy whose causes originate from traumas or emotional shocks that have caused the detachment of a part of the psyche from the domain of consciousness; such traumas are generally produced by " a moral conflict ", determined by the impossibility of giving access, in conscience and in behavior, to the "totality of human nature". Even CCRT is caused by stressors, but Luborsky does not take into consideration, unlike Jung, the moral conflict as a trigger, as for him environmental events can be. Therefore, the power of assimilation of the Complex can result in a modification, a change that Jung defines as "identification" with the Complex. Then we witness a habitual slip of the Complex "up to the violent blasphemous curses of an obsessive compulsion". It is only a difference of degree. The presence of Complexes acting from the unconscious on the conscience demonstrates, of the latter, a more or less accentuated degree of un-freedom [34].

Let's continue our journey by addressing the functioning of the complex. Jung, in his 1934 dissertation on the Complexes, ended up asserting that the royal road to the unconscious is not constituted by dreams or free associations, but precisely by the Complexes. However, the author also underlined that "the fear of the Complex is a bad guide", because it always distracts from the unconscious and sends the individual back to his conscience [34]. No man can be persuaded that the unconscious instinctual forces of a Complex can mean something good. It then follows that the study of CCRT tends more to search for evil and less to underline the positive aspects. Also in the Jungian field, the work on the Complex can therefore be oriented more towards the deconstruction of its negative aspects, rather than towards its restoration in a positive sense - the choice which potentially generates good effects from a physiological perspective. Jung also defined the fear of the Complex as a very strong prejudice, preventing itself from being considered as "a normal vital phenomenon" [34]. This fear results in a strong substantial resistance, indicating itself as something dangerous, and a feeling of resistance which connotes itself as something repugnant [34].

Dangerousness and repugnance are also the obstacles, encountered by the patient along the royal road that leads to the unconscious. These obstacles were described both by Freud in drive repression, as well as by Jung with the threat of the unconscious complexes against the conscious order. For Freud, tendencies that are incompatible with

conscience due to their immorality, fall under the effect of repression. Jung, on the other hand, attributed its scotomization in the unconscious and its projection onto the outside world to the danger and repugnance of the Complex. For the concept of Complex, he also referred to the writings of important philosophers such as Leibniz, Kant, Schelling, Carus, Von Hartmann[2]. Finally, the author arrived at the bold conclusion that complexes affect the life of us all, including researchers, and that complexes will also be the decision-makers of a psychological conception. In other words, it precisely represents the limit of their psychological point of view which Jung defined as the observer's "personal equation". It can be deduced that the researcher's theory of reference has the same character of Complex. For this reason, "the violent reciprocal reactions between psychologists of different theoretical orientations provoke "strongly emotional" debates also in the field of scientific debate" [34]. The Swiss psychologist ended up claiming that all theorists of psychology run the same danger, because they touch an untamed element of man - the nouminous which constitutes the central affective nucleus of the Complex and of the Archetype from which it originates. He thus openly declared that where the area of complexes begins, the freedom of the ego ends. In this sense, according to the author, there are three problems raised by his theory of Complexes: the therapeutic one, the philosophical one and the moral one, still open to discussion today [34].

Structural Levels of the Complex in a Dimensional Clinical Perspective In Brief Psychodynamic Psychotherapy with a Communicative Jungian Orientation

Among the Complexes, for the purpose of using a clinical case as an example, we will mention particularly the fraternal complex. Adler was among the first Freudian psychoanalysts, later founders of their own autonomous path of thinking, who were interested in the consequences on the psyche of the birth of a brother or sister, underlining its effects on the character's formation. According to Adler, in fact, the eldest son/daughter would retain the traits of competitiveness and independence from the struggle for supremacy over his brother/sister, while the younger brother/sister would always harbor his own inferiority complex which he would try to compensate in the form of the will to power [34,35].

After a long period of reduced interest in the subject, in recent years, psychoanalysis has witnessed a significant revival of interest in the problem of the fraternal dynamics. In particular, we report the interesting contribution of the French psychoanalyst René Kaes [36]. According to the author, a major reflection on the unconscious psychic dynamics between and with siblings was determined by the significant transformation of family structures, in connection with the cultural, economic and social changes that have affected the Western world since the end of the 19th century. Nonetheless, the French author pointed out that psychoanalytic contributions on the fraternal complex are rare, hypothesizing that this position somehow guaranteed Freud the supremacy of the Oedipal problematic.

Kaës, on the other hand, believed that the fraternal complex "does not overshadow and does not exclude" Oedipal conflicts, but rather, the two "Complexes" continuously cross each other while each maintaining its own specificity and role in the construction of the personality, the defense, the identification and the internal objects, up to the construction of object ties and group relationships. Mythology itself reminds us of this, leading us to the figures of Antigone and Ismene, Eteocles and Polynices, sons and brothers of Oedipus. The conflicts that developed in the relationship between Eteocles and Polynices (brother-brother), between Antigone and Creon (nephew-father), between Antigone and Ismene (sister-sister), between Creon and Haemone (father-son) and, finally, between Creon and Eurydice (husband-wife), are of a purely moral nature, initially arising from the incestuous dynamics of the Oedipus Complex, subsequently assuming a greater and more complex relevance precisely in the dynamics related to the fraternal complex, in a circuit that is self-perpetuating [37]. The Oedipus complex, therefore, is the founding nucleus that animates all family relationships that develop in the characters who are also interior representations of the human being in his conscious and unconscious identity, including the fraternal complex.

After this necessary clarification, in a dimensional clinical perspective, our proposal aims to operationally conceptualize a Complex with a strong affective tone, which would result as follows:

1. A pattern of behavior, inherited from the structural characteristic of the archetype from which it comes and, as such, similar to Luborsky's CCRT concept;
2. An imaginal, emotional-relational level, aimed at building the representational aspect of the human universe that the patient has experienced since birth: father, mother, brothers, sisters, in line with the concept of Luborsky's CCRT;
3. A basic intrapsychic level assigned to the realization of psychological functions, defined by Jung as Psychological Types, aimed at the realization of one's own human identity;
4. An intrapsychic level of a higher order aimed at the realization of spiritual and religious values: it is the boundary between the Complex and the reference Archetype, assigned to the elaboration of the ultimate meaning of one's life the Unus Mundus, conception of the conscious universe and unconscious of a bio-psycho-spiritual nature in a Jungian sense.

The different reactions of individuals-RS of the CCRT, in both their normal and psychopathological expressions, have a common denominator. All individuals have reactions, dictated by a shared feeling, eg., fear. The latter as a defense can consequently generate some defense mechanisms: fight or flight behavior, self and object split, idealized and devalued, but kept separate by the split itself; polyvagal reactions of a neurovegetative nature [38], e.g. bradycardia, apnea, feigned death, fainting, to name a few; or again a refuge in imaginary environments that compensate for the state of suffering, such as in the case of manic acts of compulsive shopping, gambling and substance use. On the other hand, a negative reaction of the object-RO of the CCRT-to the expectations of the subject-W of the CCRT-can be expressed in various contexts and/or in the presence or with the participation of other figures: a wife, a mother, a grandfather, brothers/sisters, friends of the patient. Their different intrapsychic reactions will in any case be characterized by conflicting patterns shared by all, even if not the same for all. We therefore take for granted, in the very Jungian definition of Complex, its dyadicity and/or multifactoriality, determined by the polymorphism of the inner representations involved. Our basic assumption is confirmed and is implicit in Jung's definition of the Complex itself: a set of unconscious psychic representations united by a strong affective tonality of love and hate. The

[2]Jung particularly emphasized von Hartman's work Philosophie des Unbewussten (1869) which is considered particularly important.

author did not recognize its dimensionality within the complex, which manifests along a vertical spectrum that goes from the infrared of negative images to the ultraviolet of positive images, which open the Complex to the perspective of a higher spirituality. To exemplify, all the inner representations can be stripped of their concrete clothes to ascend to the higher spiritual level of the images, as Christ can be for the male figures and the Madonna for the female ones. The psychopathological description of the CCRT focuses on desire which, as we know, is the psychic representation of the drive. Conversely, the Jungian Complex includes this psychodynamic motif of desire as a psychic aspect of biological drives, but does not end with it.

The same analysis of the Complex also reveals its construens side, and not only a destruens one, and that it is structurally part of normal psychic functioning. In our clinical cases, for example, patients who defined themselves on the conscious level as fiercely atheists not only in dreams, but also in Sand Play Therapy, expressed contents of evident religious significance, in compliance with the compensatory nature of the Jungian unconscious towards the one-sidedness of conscious orientation. The patients, in that case, were tainted by, if not prey to, a religious Complex they were battling against. Therefore, it was not a drive libido at stake, but the libido in Jungian terms understood as elan vital [39], therefore of a spiritual nature. In fact, they manifested a strong and evident opposition to religious themes, but, at the same time, a contextual insurmountable difficulty in accessing the unconscious truths of a spiritual nature and the consequent moral conflicts inherent in the Complex. This same type of patients, on a conscious level, relativized all psychic contents, for defensive purposes, in an amorphous, chaotic and all-encompassing melting pot, mere matter, without any possibility of distilling symbolic essences from it. They never went beyond the partial awareness of the relationship between their symptom and the negative figure of reference, but with a notable impediment to a dimensional process of elaboration of their psychic problem.

In order to overcome the aporias deriving from the fragmentation of conscious and unconscious communications into the single basic units of the CCRT, which involves a possible falsifying use of the same by the Ego and its mainly intellectual defensive strategies, we propose an operationalization of the experimental data, identifying these last in the concept of derivative. We are therefore referring to a process operationalization achieved with a process analysis.

The Method of Treatment and Research of Operable Data

The operational and research unit is the derivative [40]. This term, borrowed from Freud, who speaks in Metapsychology of "offshoots of the original repressed" [41] and subsequently developed by Langs [42,43], refers to communications bordering on the preconscious, mainly unconscious, made up of free associations, dreams, slip of the tongue, parapraxis, physiological and pathological language of the body. The structure of the derivative consists of a communication made up of one or more subjects, one or more objects and a verb.
The verb contained in the derivative can express:

1)The request for fulfillment of a drive desire or its frustration, with correlated defense mechanisms that can be of level:

a. High: secondary to removal

b. Medium: secondary to the split

c. Low: secondary to dissociation

d. Corporeal: polyvagal and/or psychosomatic

2)The request for fulfillment of a relational/emotional desire or its frustration:

a. Acceptance and/or rejection by the object.

b. Acceptance and/or rejection of an attachment need [44,45]

3. The development or frustration of a fusional motion between the archetypal preconception of the object (i.e. the complex) and its real and concrete figure

4. The realization of a talent/aptitude of the subject [46]

5. Development and/or frustration of a religious movement having as its object transcendental/immanent or transcendent transpersonal figures.

All of these communications within the patient-therapist two-person field canbe operationalized by analogy with Luborsky's CCRT manualization. Since the distinction between derivatives and other forms of conscious and unconscious communication requires a very profound and refined study and technical-professional competence, the work of differentiating between derivatives and brooding communications, made up of beliefs, opinions, conscious experiences, justified behaviors, increasingly requires the engagement of very clinically experienced training analysts in research.

Clinical Exemplification of a Fraternal Complex Treated With a Brief Psychodynamic Psychotherapy with a Communicative Jungian Orientation

In order to illustrate the importance of ethical conflict as the basis of a psychopathological complex, below we are going to illustrate a clinical case that offers food for thought, even theoretical, on the Complex. It concerns a 31-year-old patient, affected by a sibling complex, with a correlated diffuse anxiety syndrome focused on the life of her younger sister, followed in a course of short Jungian-oriented psychodynamic psychotherapy.

Anna is a young woman, an engineer, very successful in her work due to her indisputable above-average intelligence. She has a boyfriend who works in the same IT sector, but with an operational headquarters 600 km away from where she lives. She asked her general practitioner for psychotherapy, because she suffered from increasing anxiety having learned of her sister's initial multiple sclerosis. We faithfully and integrally report the 1st and 21st sessions of brief psychodynamic psychotherapy with a Jungian communicative orientation, lasting six months, for a predefined total of 24 sessions. This exposure aims to demonstrate and document the therapeutic efficacy of this approach, as well as to identify the operable factors for subsequent clinical investigations and statistically significant research.

The therapist is a trainee resident who works under the supervision of a training analyst.

1st Session:

[Patient arrived early, but was only allowed to enter at the agreed time]

T: we had an appointment at 8:00, I'll receive it at 8:00. You can sit here and if you need the bathroom, it's right in front of you.

P: okay

The session begins at 8.

T: how are you?

P: good

T: what brought you here?

P: we had already talked about it with Dr. X, an unexpected event happened. In February my sister was diagnosed with Multiple Sclerosis. A cold shower, my way of seeing things has changed, now I'm pessimistic, even before maybe I was, but now I'm worse. I'm also starting to have physical symptoms on my body, I'm always tired, apathetic, and I feel powerless.

T: what kind of tiredness?

P: as if I were about to pass out [polyvagal defense][3], I don't want to do things, I only do the indispensable things [depressive defense], I get headaches, stomach aches; lately I also have swollen glands and rashes on my skin.

[Negative Derivative: Psychopathological Body Language]

I feel guilty, I feel awfully guilty that it happened to my sister and not to me. [Negative derivative: psychopathological language of the mind, guilt]

T: how old is your sister?

P: 26.

T: do you live together?

P: no, my sister lives with my parents and I live alone.

T: how is your sister now?

P: looking at her, she's fine, she's better now, she's solved the problem she had with her knee, my sister is strong, aggressive, determined.

T: how did your sister notice the illness?

P: in a rather bad way, she had some knee problems which they thought were due to movement; then once an osteopath, at the gym where she went, suggested she get an MRI and the plates came out there. It's shocking, for many years it was thought to be a muscle problem and no one thought about it.

T: How much time has passed from the onset of knee pain to diagnosis?

P: less than 1 year, there has always been an improvement, my sister has been very strong, we have all been very strong, especially towards my mother.

T: why?

P: she called me in tears, there was a strong fear and pain on his part and anguish, and a lot of worry and agitation; for my part, but no, I was trying to be strong and calm to support my mother, I had to hear her crying and her outbursts.

T: what did her mother tell you?

P: she said he didn't understand why it was happening to my sister, she couldn't explain it, she felt the world collapsing on her

[Negative derivative: associative role reversal, asking for support rather than giving it]

T: what fears do you have?

P: that my sister could lose her mobility and independence, even my mother is afraid of this. In the end, though it could have been worse, now she's recovered.

T: does your sister take medicines?

P: she receives intravenous medication once a week, but at home, now we no longer go to the hospital. The time in the hospital was a nightmare, we had to stand in line, be around people for a long time, an infinite bureaucracy. I suffered a lot in that period, I was anxious about waiting and queuing in the hospital, but now it's over, thank God.

[**Negative derivative: waiting between sessions experienced as too long**]

T: do you have other brothers and sisters?

P: no.

T: what does your father say?

P: nothing, he doesn't express much, he never lets off steam.

[**Negative derivative: not expressing emotions from the father]**

T: and towards your sister?

P: normal, he didn't tell her anything, he gives her strength but without excess or anguish, he is the opposite of mum.

[**Positive derivative: of a transferential nature on the psychotherapist**]

T: have you had the opportunity to express yourself and confront with someone?

P: yes, with my boyfriend. My sister wanted her illness to be kept private; therefore, only my boyfriend and I know, not even our relatives know, she didn't want to.

T: maybe your sister doesn't want to be seen as weak or fragile?

P: my sister doesn't say anything, she's not weak or fragile, she just doesn't want to be talked about. Not even my best friends know, I couldn't tell them.

T: with whom does your sister have the opportunity to confront?

P: with some of her very close friends and with me.

T: do you feel supported instead?

P: I don't know, I don't know if I should be supported or if I should be expected to be, she is the sick one. I don't even talk that much with my boyfriend about this situation. I don't like talking about it, every time I talk about the pain, the displeasure, I feel bad.

T: but if you don't think about it, your body will think about it.

[3]The square brackets contain the evaluation of the individual conscious and unconscious communications, as required by the model presented, by the supervisors.

[The patient has tears in her eyes]

[**Positive derivative: physiological body language, crying]**

T: if you want to cry, feel free to cry, it doesn't mean that you always have to talk.

T: What's your job?

P: risk manager, I'm an engineer, I work on motorways.

T: how long have you been with your boyfriend?

P: about 4 years. We met when I was working in another foreign state, there I came from a story in which I had recently broken up, I wouldn't have wanted another story but then I met him and so we got together as a joke. We live remotely, he works in another southern Italian city, we see each other on the weekends when we can. I feel alone, I hope 2023 will be the breakthrough year for us. It wasn't easy to go about so much, I was very independent.

T: What comes to your mind about your profession?

P: once before, yes, I was good, I did everything on time, I graduated within 5 years. Now I'm listless, I don't want to do things, my priorities have changed after my sister's illness, I no longer invest in my work like before; before I was very fussy and precise, now I feel sloppy. Before I wanted to succeed, I was independent. Now I feel less strong than before.

T: what work do your parents do?

P: dad works in a mechanical workshop for mopeds, mom is a hairdresser.

T: is your sister studying?

P: yes, but she hasn't finished university yet, she has been intermittent, she has done a few jobs here and there, now she resumed studying, but now with the illness I don't really know what she wants to do and this thing distresses me.

[**Negative derivative: psychopathological language of the negative mind, identification with the sister in the disease]**

T: have you been dreaming lately?

P: I often dream but I don't remember them, lately I dreamed of my dog in a garden full of light smiling at me, but I don't remember the others.

[Positive derivative: the dog smiling at her hints that she has already established a relationship with the therapist]

T: bringing dreams to therapy can be useful, if you want when you wake up, you could write them down in a notebook so you won't forget them.

P: I'll try.

T: the session is about to end, the sessions will last 45 minutes and will be on Monday morning at 8:00, like I said

P: OK.

T: okay then we say goodbye.

[At 8.45, on time, the session ended]

21st session:

[Patient arrived on time]

P: Good morning, it's been a long time since we've seen each other. Last time it was my fault, I was terrible. Then, when I was sick I thought, that she was sick too, I wondered if it was the same disease. I had gastroenteritis, or rather that we had the same disease.

[**Negative derivative: identification with the therapist in illness as with the mother in anxiety**]

P: apart from the fact that I've been sick, this has been a quiet week, after Easter I'm moving to my new house. We'll start the move from next Tuesday, I should be done already from Wednesday, apart from the inconveniences, the delays, it seems that many things will close this week, the long-awaited moment has arrived with so much enthusiasm, I'm going home with the minimum, it's not finished yet, but it's livable, I'm happy. I wonder if last week's illness, when I was sick, was anxiety.

[**Positive derivative: she moved from the mental environment of guilt and anxiety to that of independence into anxiety-free well-being and her healthy identity**]

T: in the other session, the issues you mentioned highlighted how the fact of having warned you of my absence late at night generated anxiety and anguish in you which consequently led you to behave in a similar way, warning me at the night after of your subsequent illness.

P: yes, I'm anxious. Now the dog is fine too.

[Positive derivative: allusion to the recovery of trust in the therapeutic relationship]

P: when I warned you I felt guilty while writing. Maybe I didn't understand the your feeling with which you wrote it that evening, but reading your message that time I immediately thought that something bad had happened, that something serious and sudden had happened to you and so I was worried, but that's my approach. Always anxious that surely is to be reviewed.

[**Negative derivative: presence of anxiety even if induced by the therapist's behavior**]

P: yesterday too, when I was in Puglia with my boyfriend, a couple of friends called us to tell us to have a coffee at 12 and I immediately panicked because I immediately thought of an unexpected event or something serious; instead, they just wanted to let us know they were getting married and wanted to invite us to the wedding.

[Positive derivative: the therapist's recognition of the inappropriateness of the late night call, as an implicit recognition of countertransference aspects, from which she deduced a deep union with the patient]

P: however, compared to the past, I'm much better because at least now I start doubting the notion that things are always negative. I started having this doubt after 10 minutes, before instead I didn't. Since we started the therapy there has surely been a positive change.

T: from what you said that you are moving to a new house, you are symbolically communicating to me that here in therapy there is something new, constellating in your psychic situation. Together we have reached the minimum goal, i.e. the resolution of the absolute

domination of anxiety, we have laid the foundations. We can stop therapy.

P: we started our journey in October which coincided with my father's birthday. Ever since we have made progress, especially in the emotional world. I'm very happy. I do want to work on myself and on the world of my emotions. Regardless of the path, we will take it together. Last time we talked about emotions and about living them. If I put myself in front of a wall I will never live these emotions; I propose to live them, to know them. I want to experience this, I liked this interpretation; so I'll take it home.

[**Positive derivative: adopting the therapist's interpretation, regardless of whether to continue psychotherapy or not]**

T: what goes on inside you about experiencing emotions?

P: having had bad ones in the past, I'm afraid of getting hurt especially if I don't live them. I instead drag them along. If I had fully experienced my sister's illness I wouldn't have dragged it all this time, it was just procrastination. I moved back to my parents' house about ten days after we started therapy. Who knows if it was a coincidence, alone it would have been a stunner, living with my parents and my sister. You have helped me a lot. Let's hope that no more negative emotions happen, but surely now I feel like I have more tools to deal with them. Right now, every time I come here, I feel like emptying a vase and then I feel better. I'm much lighter. I'm going to Puglia for Easter and it will be the first time not spending Easter with my parents, apart from when I was away for work. I'm really glad I bought a house away from all these "in-laws" (including parents!). The day before yesterday was M's sister's birthday, at lunch there were his parents and relatives. His mother took me by the arm and said: so I'm your mother-in-law, how nice. I don't want all this closeness, it makes me a bit anxious. I don't like all this interference in the couple's dynamic, as my relationship isn't something I'd like to share. So M's mom said to me, oh well, I'll be your friend. It makes me a little anxious. It annoys me that you call him even on Sundays if you don't see him for two days. I view family a bit as an obligation, in the sense that one is obliged to frequent it; I have to find a balance on this family thing. For now I have escaped.

[**Positive derivative: agitated flight/avoidance towards an intrusive mother figure**]

P: Having a home saves me from my mother, who keeps asking me questions. Every time I'm with her, she prods and hassles me insistently with questions when I get back from work. She's intrusive.

[**Positive derivative: I distanced myself from my mother**]

T: Do you think I asked you invasive questions?

P: no, indeed you ask very little. In fact if you asked for more it would be better. My mother is like a continuous ticking with these questions, eventually leading you to push people away. The relationship with my parents is very conflicting, I wonder if my way of doing things isn't also linked to their distorted relationship and to what happened in the past. I also reflected on the fact that I often don't talk about M with my parents maybe because it's okay and there's no need to talk about it, except for the one time when we discussed it. I want to focus my energy on my future family and what the new relationship will be like with them. In the end, I now regret leaving my dog and sister there.

[**Positive derivative: acceptance of dependence on the therapist and pain of separation from her identification with her sister]**

T: When you leave home it is normal to feel sorry for your parents. However it also opens a new path, like you said, which might help you look at the relationship with your parents in a more serene way, in which you are under less pressure being alone.

P: yes it's true, I'm sorry and now I feel the need to do it.

T: we're done for today, see you on the 17th.

P: will you be there on the 24th or would you take a day off before the holiday?

T: I'll be there.

P: how nice, goodbye.

[The session ends on time]

A Proposal for an Operational Analysis of the Single Case According to the Procedural Criterion related to the Symptom

The Complex, as the basic unit of our method and in our way of seeing, offers the discrete analysis of the process, immediate data and operational conscious factors, allowing us to correlate to the symptom's reduction and disappearance, with the modification of the distribution of the derivatives and not of the simplistic occurrences which are almost always the result of falsifying operations of the conscious ego. In this case, it is a study aimed at verifying the efficacy on the symptom, which confirms the outcome of the psychotherapy with the sole resolution of the symptom. This type of statistic is, for operationalized data, exposed precisely to the falsifying operations of the conscious ego. Differently, in the analysis of the Complex, we prefer to adopt a discrete study based on the analysis of the process (for example in the single case that we will try to analyze), in which the basic unit is the derivative.

Langs defined derivatives as narrative forms that constitute the structure of free associations, dreams, lapsus, missed acts, the pathological language of the body and the physiological language of the body. It is the research unit that represents the observational data. In our view, in fact, it is not the beliefs, nor the opinions, the experiences, the conscious behaviors that constitute the significant datum to be correlated with the symptom, but the derivatives that reveal the unconscious conflict and its solution by expressing it in a symbolic code. In our specific case, we can hypothesize, through the analysis of the derivatives that the patient manages to bring her identification both with her anxious mother and with her sick sister back to the transferential relationship. This happens when the patient experiences her identification with the therapist, who is also ill, precisely in the transference relationship, which, "thanks to her counter transference", gives the patient the opportunity to perceive the realistic nature of her unconscious identification with the ill therapist, but also the realistic identification of the therapist with her patient. The dissolution of this mutual identification is obtained by the patient when she proposed to herself the dissolution of the dynamic between the two opposites. In this way, she becomed aware that with the therapist they are together in a double unconscious sick identification as generally happens also with her mother and sister. At the same time, she also accessed the

higher symbolic level of a project of union with the therapist in a new psychic home, where her identity can find space, no longer confused as it was with the sick identity of her mother and sister.

The operationalization of derivatives as positive and negative data of a first form of research proposed by us, only observational, has led to the following results:

1st Session:

Negative derivatives: 6

Positive derivatives: 3

21st Session:

Negative derivatives: 4

Positive derivatives: 7

The inversion of the values between the first session and the 21st is, in our opinion, completely evident.

Clinical Analysis of the Case According to Jung's Theory of Complexes

The stimulus event at the beginning of this analysis is a stressor, external to the patient, and here we use the term in the meaning adopted for Luborsky's CCRT, which does not take into account the possible presence, at the basis of the patient's symptom, of a conflict unconscious intrapsychic morality, determined by his ambivalence towards his sister, loved and hated at the same time. We speak of a fraternal complex where the unconscious intrapsychic moral conflict is present. The patient demonstrated both high-level defenses, such as anxiety, and low-level defenses against awareness of this conflict, such as polyvagal and psychosomatic defensive reactions: headache, stomach ache, enlarged glands, skin rash, fainting reaction (a classic activation of the polyvagal system). She also attributed psychic strength and aggression to her sister. It is obviously a matter of a force which is the expression of a hypomanic attitude of denial of the event, we would say. In the context of the Complex that has been studded with the stimulus event, the patient nourished strong self-images. The image of the mother is distressed by a state of alarm, affected by a sense of helplessness and despair: why did it happen to your sister? The patient linked her symptom, anguish, to an experience that was unleashed in its virulence both by the awareness of her sister's illness and by the period in which she accompanied her to the hospital, seen as a cold, anonymous structure. The hospital therefore acted as the symbolic equivalent of a mother who responds to the desire for warmth and affection in a cold and negligent way.

We also noted the paternal silence which, unlike the wife's anxiety, transmits strength, but without excesses or anguish. According to this point of view, the father represents a figure who on the one hand seems to manage anxiety adequately, but on the other is silent as shown by the patient's story. The defense used was the mechanism of avoiding the "sister's illness" topic, generator of pain, displeasure and malaise in her. When the therapist connected this pain, which the patient can experience only on a bodily level, with her physical symptoms, the patient could finally allow herself to experience her tears, i.e. mourning. We recall that the term mourning comes from the term lugere which really means to cry. Following this experience of pain, she questioned her sense of autonomy and independence related to her professional efficiency, which however were accompanied by a feeling of loneliness caused by the spatial distance from her boyfriend. Before her sister's illness she felt very strong, now less so. She projected onto her sister a latent aggression towards the possibility that the latter would undertake a possible profession, the impulse not to work and study anymore, which for the first time she began to feel recently. However, she had a reaction to her sister's illness, because she dreamed of her dog in a garden full of flowers and light, smiling at her, that is, an unconscious instinct for life and the light of truth. It is the only positive element in a sea of pain and suffering, related to related anxiety. However, it also represents a sign that suggests a positive prognosis regarding the resolution of her anxiety, a symptom for which she presented herself in psychotherapy. In fact, immediately after the dream of the dog smiling at her, she speaked associatively of the desire to concentrate her energy on her future family and on her new relationship with her family of origin. These are the changes she is doing in therapy to live in her new home in a completely independent way, that is, a new house like new is the individual and relational arrangement that she proposed to create. If she finds herself facing a wall from the other, a possible response from the object-therapist, having come into possession of the reading key, she will do it herself.

Conclusion

The analysis conducted with brief Psychodynamic Psychotherapy with a Jungian communicative orientation on the Complex, while revealing a development that starts from the recognition of this in the patient's communications and its consequent connotation, does not follow a conscious sequential logic defined a priori, as in the case of Luborsky's CCRT, but relies on the symbolic-associative logic of the deep unconscious, as outlined by the communicative perspective of Robert Langs.

From this point of view, the Complex differs greatly from Luborsky's CCRT. The latter is based on three very definite variables: a desire, a response from the object, a reaction of the subject to the response from the object. In the case of the Complex we take into consideration not only a desire of the subject, but also an experience, an attitude or a behavior. This is because desire alone could also be a perverse desire, and therefore it should not be satisfied tout court, but first known and then possibly ethically accepted or frustrated. Or, always the Complex could be about the realization of a talent or a necessary self-assertion of one's identity. The Complex, in its pathological meaning, would make the patient's self-evaluation reaction depend on the relational response of the object. Since, on the other hand, the latter now has the key to understanding it, it will be able to do it alone, that is, it will no longer be negatively influenced by the reactions assumed or implemented by the other, finding in the realization of its talent also the fulfillment of its authentic identity.

The fraternal complex has rediscovered its healthy functionality in the process of acquisition by the patient of the ability to experience and to possess the reading key of her positive and negative feelings, no longer polarized as opposites, but dissolved by a synthesis that has driven the patient at a higher dimensional level of her personality. Furthermore, in the last part of the psychotherapy, the patient is no longer torn apart by the conflict between love and hate towards her sister, and has rediscovered her female identity in "her new renovated house" which she will occupy outside the family context "sick of the conflict between opposites".

We conclude with Jung's words: "However, one could claim that the therapeutic method should be such as to make it possible for new orientations to occur even in subsequent moments of existence without giving rise to difficulties" [47].

References

1. Gazzaniga MS (2007) Come il cervello decodifica il mondo. Di Renzo Editore, Italy.
2. Marquard O (1986) Apologie des zufalligen. Reclams, Ditzingen, Germany.
3. Maffesoli M, Scarpellini E (1990) L'ombra di Dioniso. Garzanti, Dublin, Ireland.
4. Langs R (1973) The technique of psychoanalytic psychotherapy. Aronson J, Turin, Italy.
5. Langs R (1988) A primer of psychotherapy. Garden Press Inc, New York, USA.
6. Piaget J (1964) Six etudes de Psychologie. Gonthier, Paris.
7. Kohlberg L (1982) Moral development. In: Broughton JM, Freeman-Moir DJ (Eds.), The cognitive developmental psychology of James Marx Baldwin: Current theory and research in genetic epistemology. Ablex publishing corp.
8. Campbell J (1949) The Hero with a thousand faces pantheon books. Pantheon Books, New York, USA.
9. Book HE (1998) How to practice brief psychodynamic psychotherapy: The core conflictual relationship theme method. American Psychological Association, Washington, D.C., USA.
10. Gunderson JG, Gabbard GO (1999) Making the case for psychoanalytic therapies in the current psychiatric environment. J Am Psychoanal Assoc 47: 679-704.
11. Vocks S, Tuschen-Caffier B, Pietrowsky R, Rustenbach SJ, Kersting A, et al. (2010) Meta-analysis of the effectiveness of psychological and pharmacological treatments for binge eating disorder. Int J Eat Disord 43: 3: 205-217.
12. Paris J (2008) Clinical trials of treatment for personality disorders. Psychiatr Clin North Am 31: 517-526.
13. Patterson TL (2008) Adjunctive psychosocial therapies for the treatment of schizophrenia. Schizophr Res 100: 108-199.
14. Solomon DA, Keitner GI, Ryan CE, Kelley J, Miller IW (2008) Preventing recurrence of bipolar I mood episodes and hospitalizations: Family psychoterapy plus pharmacotherapy versus pharmachoterapy alone. Bipolar Disord 10: 798-805.
15. Deacon BJ, Abramowitz JS (2005) Patients' perceptions of pharmacological and cognitive-behavioral treatments for anxiety disorders. Behavior Therapy 36: 2: 139-145.
16. Fournier JC, DeRubies RJ, Amsterdam J, Shelton RC, Hollon SD (2005) Gains in employment status following abtidepressant medication or cognitive therapy for depression. Br J Psychiatry 206: 332-338.
17. Cummings NA, O'Donahue WT, Ferguson KE (2003) Behavioral health as primary care: Beyond efficacy to effectiveness: A report of the third reno conference on the integration of behavioral health in primary care. New Harbinger Publications, California, United States.
18. Consensus Conference sulle terapie psicologiche per ansia e depressione. Documento finale. Roma: Istituto Superiore di Sanità.
19. Clark DM (2018) Realising the mass public benefit of evidence-based psychological therapies: The IAPT program. Annu Rev Clin Psychol 14:159-183.
20. Shedler J (2010) The efficacy of psychodynamic therapy. Am Psychol 65: 98-109.
21. Balint M, Balint E, Ornstein PH (1972) Focal psychotherapy : An example of applied psychoanalysis. Tavistock, Isabel.
22. Malan D, Osimo F (1992) Psychodinamics, Training and outcome in brief psychotherapy. Butterworth Heinemann, Massachusetts, USA.
23. Mann J (1973) Time limited psychotherapy. Harvard University Press, Massachusetts, USA.
24. Goldman RN, Greenberg LS, Angus L (2006) The effects of adding emotion-focused interventions to the client-centered relationship conditions in the treatment of depression. Psychother Res 16: 537-549.
25. Davanloo H (2001) Intensive Short-Term Dynamic Psychotherapy. EFPT Psychotherapy Guidebook.
26. Sifneos EP (1972) Short-term psychotherapy and emotional crisis. Harvard University Press, Massachusetts, USA.
27. Lemma A, Target M, Fonagy P (2011) Brief dynamic interpersonal therapy.: A Clinician's Guide. Oxford University Press, UK.
28. Book HE (1998) How to practice brief psychodynamic psychotherapy: The core conflictual relationship theme method. American Psychological Association, Washington, D.C., USA.
29. Mann J (1973) Time-limited psychotherapy. Harvard University Press, Massachusetts, USA.
30. Luborsky L (1984) Principles of psychoanalyric psychitherapy: A manual for supportive-expressive treatment. Basic Books, New York, USA.
31. Luborsky L, Christoph PC (1990) Understanding transference: The core conflictual relationship theme method. Basic Books, New York, USA.
32. Grassi A (2012) Psicologia analitica ad orientamento comunicativo. Discorso su teoria e metodo clinico. Edizioni Persiani.
33. Grassi A (1999) Psicologia clinica e dinamica. Dalla Psicoanalisi alla neuropsicologia analitica.
34. Jung CG (1934) Die Dynamik des Unbewussten. Boringhieri, Turin, Italy.
35. Adler A (1908) Der aggressionstrieb im Leben und in der Neurose. Newton Compton, Milan, Italy.
36. Adler A (1929) Individualpsychologie in der Schule. Vorlesungen für Lehrer und Erzieher. Newton Compton, Milan, Italy.
37. Kaes R (2008) Il complesso fraterno. Ed Borla.
38. Porges SW (2017) The pocket guide to the polyvagal theory. The transformative power of feeling safe. Norton Professional Books, New York, USA.
39. Jung CG (1912) Simboli della trasformazione. Boringhieri, Turin, Italy.
40. Berivi S (2012) La psicoterapia comunicativa di robert langs. Paolo Emilio Persiani Editore, Bologna.
41. Freud S (1978) Metapsicologia. Bollati Boringhieri, Turin, Italy.
42. Langs R (1988) A primer of psychoterapy. Garden Press Inc, New York, USA.
43. Langs R (1973) The technique of psychoanalytic psychotherapy. Boringhieri, Turin, Italy.
44. Ainsworth MDS, Blehar MC, Waters E, Walls SN (1978) Patterns of attachment: A psychological study of the strange situauion. Lawrence Erlbaum Associates Publishers, New Jersey, USA.
45. Main M, Solomon J (1990) Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. Universiry of Chicago Press, Chicago, USA.
46. Kohut H (1971) Narcisismo e analisi del sé. Bollati Boringhieri, Turin, Italy.
47. Jung CG (1957) La funzione trascendente. Boringhieri, Turin, Italy.

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