Psychodynamic Therapy

THE TALKING THERAPIES UK PRACTITIONER SERIES



Psychodynamic Therapy

The complete practitioner pathway, from foundation through to advanced practice

Advanced level · 50 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

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First edition, 2026.

This manual accompanies the Psychodynamic Therapy course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 8. This printing was set on 10 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

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How to use this manual

This volume gathers the whole of the Talking Therapies UK pathway in Psychodynamic Therapy into a single book. Each of its parts is a complete course from the practice's training library, and each chapter is a lesson from that course, so the volume covers the subject in the order in which it is taught, from foundation through to advanced practice. It is written for psychotherapists, psychologists and other qualified psychological therapists, and it assumes a caseload and access to supervision.

The constituent courses are: Psychodynamic Foundations; Psychoanalytic Foundations; Working Psychodynamically; Advanced Psychodynamic Practice; Applied Psychoanalytic Thinking.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at advanced level and carries 50 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Trace psychodynamic thought from Freud through object relations to attachment and relational schools
- Explain unconscious process, defence and internal object relations in contemporary language
- Describe the frame and analytic attitude: reliability, neutrality rightly understood, and abstinence rightly understood
- Recognise transference, countertransference and enactment in clinical vignettes
- Use the two triangles to read clinical material psychodynamically
- Distinguish psychodynamic therapy from psychoanalysis and state what each offers whom
- Explain the structural model: id, ego and superego, and its clinical descendants
- Describe Klein's positions, projective identification and their clinical use
- Explain Winnicott's contributions: holding, transitional phenomena and the true and false self
- Describe Bion's container-contained and thinking under fire
- Compare ego psychology, object relations, self psychology and relational schools
- Read classic case material with a working grasp of technique debates
- Formulate presenting problems psychodynamically, linking current difficulty, defence and early experience
- Work in the transference: recognise it as it arises, and judge when and how to interpret it
- Use your countertransference as data while containing rather than enacting it
- Make interpretations that are timed, dosed and framed so the client can use them
- Work with dreams, resistance and enactment in ongoing therapy
- Manage beginnings, breaks and endings as clinical material rather than administration
- Conduct sustained psychodynamic work with personality-level difficulty and early relational damage

- Work with primitive defences, projective identification and powerful countertransference pulls without losing the analytic stance
- Judge the balance of supportive and expressive technique for each client and moment
- Use object relations and attachment thinking to understand and survive negative therapeutic reactions
- Hold the frame under attack, and think clinically about fee, boundary and contact pressures
- Critically engage with the psychodynamic evidence base and its contemporary integrations
- Apply analytic concepts in once-weekly and time-limited settings honestly
- Use brief dynamic models, including Malan's and Davanloo-informed focus, with selection care
- Work analytically in organisations: consultation, groups and institutional dynamics
- Apply analytic understanding to supervision and reflective practice
- Relate analytic ideas to neighbouring evidence, from attachment research to mentalizing
- Judge which clients need intensity you cannot offer, and refer well

PART 1

Psychodynamic Foundations

The unconscious, defences and the therapeutic relationship

CHAPTER 1

The unconscious and internal conflict

The psychodynamic tradition begins with a claim that, despite its apparent simplicity, reshapes every subsequent clinical move: a substantial portion of mental life unfolds outside conscious awareness, and that unconscious material is not inert but dynamically active. In the earliest formulations, Sigmund Freud described the unconscious as a repository of repressed wishes and memories, a "psychic cellar" that could be excavated through free association and dream analysis (Freud, 1915). Later theorists such as Anna Freud and Melanie Klein refined the picture, portraying the unconscious not merely as storage but as a field of forces that continuously exert pressure on the conscious mind. The adjective "dynamic" is therefore essential; it signals that the unconscious is a living system of wishes, fears, fantasies and prohibitions that constantly negotiate with the ego, shaping what a person notices, wants, avoids and repeats without the person's explicit knowledge of why. Contemporary research on implicit memory and affective priming supports the notion that affective information can influence cognition and behaviour without entering conscious awareness (Bargh, 1994). Thus, the dynamic unconscious is a scientifically plausible construct that bridges classic psychoanalytic insight with modern cognitive neuroscience.

From the existence of a dynamic unconscious follows the second foundational idea: internal conflict. The mind is not a monolithic agency with a single, harmonious agenda; rather, it resembles a parliament of competing purposes. Desire collides with prohibition, attachment with anger towards the object of attachment, ambition with the fear of surpassing a parental figure, the wish to be known with the terror of being seen. In Freud's structural model, these collisions were mapped onto the id, ego and superego, with the ego mediating between instinctual drive and internalised moral standards. Later formulations, such as those of Heinz Kohut's self-psychology, re-conceptualised conflict in terms of deficits in the self-object relationship, while Donald Winnicott emphasised the "true self" versus the "false self" as a compromise between authentic feeling and the need to comply with external expectations. Regardless of the terminology,

the clinical essence remains: symptoms, inhibitions and enduring character traits are best understood as compromises, the terms of a settlement between forces that cannot both be satisfied. A person who is relentlessly kind may be honouring a genuine value while simultaneously imprisoning an unacceptable anger; the compromise works, but it incurs a psychic cost that often emerges as anxiety, somatic complaint or relational difficulty.

The third pillar of the model is the conviction that symptoms carry meaning. Where a purely medical psychiatry might read a panic attack as a malfunction of the autonomic nervous system, the psychodynamic clinician reads it also as a communication, a solution that the mind devised under earlier constraints. The symptom is therefore a load-bearing structure, not a decorative ornament. For instance, a recurrent depressive episode may encode a mourning for a lost parental figure, while a pattern of choosing unavailable partners may preserve a loyalty to an unavailable caregiver, replaying an early relational script in the hope of mastering it. The meaning of a symptom is not a post-hoc rationalisation; it is the very purpose the symptom serves in the psychic economy. To dissolve a symptom without grasping its function risks its return, its substitution by another symptom, or the exposure of the patient to the internal situation the symptom was protecting against. This explains why psychodynamic work is often less interested in rapid symptom relief than in uncovering the internal settlement that renders the symptom necessary.

The practical implication of these ideas is a particular mode of listening that can be described as “listening beneath the surface”. The clinician attends to the manifest content of the patient’s narrative while simultaneously attuning to its music, its gaps, its repetitions and its anomalies. A sudden shift in tone when a patient mentions a seemingly innocuous detail, an affect that does not match the story, a word that is chosen oddly, or a silence that follows a particular theme—all become hypotheses about what the surface is managing. This stance has been likened to the “third ear” (Bion, 1962), a doubled attention that monitors both what is being said and what the saying is doing. Each observation is held tentatively, never as proof, and is tested against the broader clinical picture, the patient’s history and the therapist’s own counter-transferential responses. The therapist’s curiosity is guided not by a checklist but by a reverence for the patient’s unconscious logic, a willingness to follow the thread wherever it leads.

To illustrate how these concepts coalesce in practice, consider the case of a thirty-six-year-old accountant, Maya, who presents with chronic insomnia that began abruptly six months ago. She reports that the sleep difficulty “just started” after she was promoted to senior manager, a role that places her above the position once held by her mother, who died when Maya was sixteen. In the initial interview, Maya describes her mother in neutral terms, saying, “She was practical, she liked numbers, she never showed much emotion.” When the therapist gently probes the emotional tone, Maya’s voice becomes tighter, and she briefly looks away before returning to a factual recounting of her mother’s habits. The therapist notes the discrepancy between Maya’s flat description and the subtle affective shift, hypothesising that the promotion may have re-activated an unconscious rivalry with her mother, now expressed as a sleep disturbance.

Further exploration reveals that Maya’s mother, though competent, was emotionally unavailable, often using work as a shield against intimacy. Maya’s own early relational experiences, as recounted in a later session, include a pattern of seeking approval through achievement, a strategy that earned her praise but never genuine affection. The therapist therefore formulates a provisional hypothesis: the insomnia represents a compromise between Maya’s newly awakened wish to surpass her mother’s professional standing and an internalised prohibition against overtly exceeding a figure who, in her unconscious, still holds a position of authority. The symptom, in this view, serves to keep Maya’s aggressive ambition at bay, protecting her from the guilt associated with surpassing a parent who could not be repaired. The therapist communicates this formulation to Maya, inviting her to reflect on the possible link between her sleep difficulty and the unspoken feelings towards her mother.

Maya’s response is initially defensive; she insists that the insomnia is purely physiological. However, as the therapeutic relationship deepens, she begins to notice that the night before a particularly stressful meeting, she experiences a surge of anxiety that mirrors the earlier sleepless nights. In a later session, she recounts a dream in which she is climbing a ladder that suddenly collapses, and she feels a profound sense of loss as she falls. The therapist links the dream imagery to the earlier hypothesis, suggesting that the ladder may symbolise Maya’s career ascent, while the collapse reflects an unconscious fear that her advancement will destabilise the fragile equilibrium she has maintained since childhood. Over several weeks, Maya

gradually acknowledges that the promotion has awakened a sense of betrayal towards her mother, whose own career she now feels compelled to surpass. The insomnia, once understood as a meaningful compromise, loses its grip; as Maya integrates this insight, her sleep improves, illustrating how meaning-focused work can transform a symptom's function.

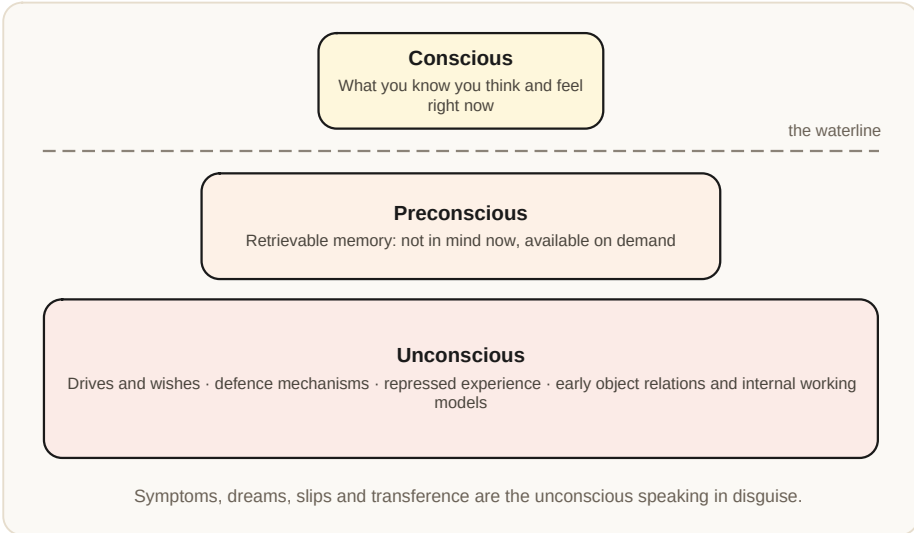


FIGURE 1.1 The topographical model: the mind as an iceberg
Freud's topographical model pictures awareness as the tip of an iceberg: a narrow band of conscious experience above the waterline, and beneath it the far larger mass the person does not see. The preconscious holds what can be recalled at will; the unconscious, widest of all, holds drives, defences and early relational templates that shape behaviour from below.

The case of Maya demonstrates the central psychodynamic process: a symptom, initially presented as inexplicable, is re-interpreted as a compromise that resolves an internal conflict rooted in early relational patterns. The therapist's role is not to eradicate the symptom by prescription alone, but to illuminate the unconscious bargain that sustains it, thereby allowing the patient to renegotiate the terms of that bargain in a more adaptive way. This approach aligns with empirical findings that psychodynamic psychotherapy can produce lasting change in symptom severity and relational functioning, often with effects that endure beyond the termination of treatment (Shedler, 2010). Moreover, neuroimaging studies have shown that insight-oriented therapy can modulate activity in brain regions associated with self-referential processing, suggesting a biological

substrate for the therapeutic restructuring of internal conflict (Fonagy et al., 2015).

A further implication of the model concerns the therapist's stance towards the patient's narrative. Because the unconscious is understood as a dynamic system of forces, the therapist must adopt a stance of reverent curiosity rather than authoritative interpretation. This stance is reflected in the concept of "holding" introduced by Winnicott, whereby the therapist provides a safe, containing environment that allows the patient's unconscious material to emerge without being prematurely judged or dismissed. The therapist's own emotional responses, known as counter-transferential feelings, become valuable data about the patient's internal world; a feeling of frustration, for example, may signal the patient's resistance to confronting a painful internal conflict. By attending to these feelings, the therapist can navigate the therapeutic alliance in a manner that respects the patient's unconscious logic while gently challenging maladaptive compromises.

It is important to acknowledge that the psychodynamic view of the unconscious does not imply that patients consciously choose their symptoms as a form of self-punishment or manipulation. Rather, the symptom belongs to the patient, woven into the fabric of their history, loves and terrors, and can therefore be understood rather than merely suppressed. Understanding, in this tradition, is not an intellectual luxury but the specific vehicle of change. When a symptom's meaning is made explicit, the psychic economy that once required its presence can be reorganised, and the symptom loses its necessity. This principle underpins the therapeutic technique of interpretation, which, when delivered with empathy and timing, can catalyse the patient's capacity to re-author their internal narrative.

The lesson of the dynamic model of mind, therefore, rests on four interlocking pillars. First, the dynamic unconscious is an active field of wishes, fears and memories that continuously influences conscious experience. Second, internal conflict arises from the clash of competing psychic forces, and symptoms represent compromises that resolve these clashes at a cost. Third, symptoms carry meaning as solutions the mind devised under earlier constraints, and this meaning is load-bearing rather than decorative. Fourth, the clinician's listening must attend both to the manifest content of the patient's words and to the underlying unconscious processes, a practice that can be described as listening with a third ear.

Mastery of these ideas equips the therapist to move beyond a purely symptom-focused approach towards a deeper, more enduring transformation of the patient's internal world.

For practitioners whose primary training has been in structured, symptom-focused modalities, the psychodynamic model can initially appear either mystical or accusatory, as if patients were being told that their suffering is secretly intended. Neither impression survives contact with competent practice. The model does not claim that the patient deliberately creates their symptom; it asserts that the symptom is a meaningful part of the patient's psychic architecture, a compromise that can be explored, understood and ultimately re-negotiated. The therapeutic journey, therefore, is not a battle against the symptom but a collaborative excavation of the unconscious forces that gave rise to it, guided by a listening stance that honours both the spoken narrative and the silent, dynamic currents beneath it.

In the broader curriculum of psychodynamic foundations, this lesson serves as the bedrock upon which subsequent topics are built. The next steps will involve examining the defensive operations that protect the unconscious settlement, tracing the early relational experiences that shape the terms of internal conflict, and exploring the remarkable fact that the therapeutic encounter itself becomes a stage upon which the patient's oldest relational patterns are re-enacted, offering a live laboratory for change. By grounding the learner in the dynamic unconscious, internal conflict, symptom meaning and the art of listening beneath the surface, this lesson equips them with the conceptual tools necessary to engage with the deeper layers of human experience, fostering a practice that is both scientifically informed and profoundly humane.

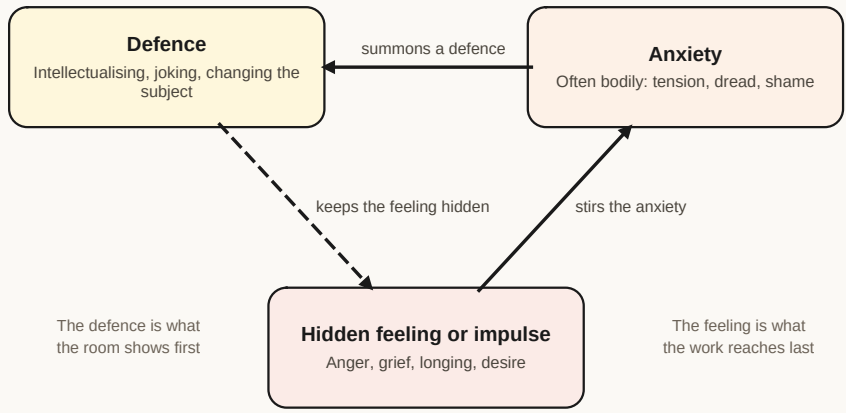


FIGURE 1.2 Malan's triangle of conflict

A hidden feeling or impulse stirs anxiety; the anxiety summons a defence, and the defence works to keep the feeling out of awareness. The chain runs one way, which is why the visible clinical material is almost always the defence. Psychodynamic work therefore reads downwards: name the defence, approach the anxiety, and only then help the true feeling be experienced and expressed.

Points worth keeping

- The dynamic unconscious
- Internal conflict
- Symptoms as meaningful
- Listening beneath the surface

PRACTICE TASK

Note one symptom and hypothesise the conflict it might express.

CHAPTER 2

The ego defences

If the mind maintains a settlement between what is wished and what is permitted, it needs mechanisms to police the border, and these are the ego defences: habitual, largely unconscious operations that keep threatening mental content out of awareness or render it bearable by disguise. Defences are not pathology. Everyone defends, constantly; a mind without defences would be a mind flayed. The clinical questions are always which defences a person characteristically uses, how rigidly, at what cost, and against what. A useful organising idea, developed in the tradition of ego psychology and elaborated by later observational research, arranges defences on a maturity gradient, from those that grossly distort reality to those that merely soften it, with the important caveat that maturity describes the operation, not the person, and that anyone under sufficient pressure will reach for cruder tools.

Repression is the foundational defence: the active, unconscious exclusion of threatening material from awareness. The adult who cannot remember whole years of a painful childhood, the name that will not come precisely because it matters, the appointment forgotten with the person one dreads seeing, all show repression's signature, a gap with a shape. Denial refuses the meaning of what is perceived: the drinker who genuinely believes the bottles tell no story, the patient who hears a grave diagnosis and plans a holiday. Projection expels what cannot be owned and finds it in another: the person seething with disavowed hostility who experiences the world as full of hostile people, the envier who feels constantly envied. Projection matters doubly in clinical work because it recruits its targets; the projected-upon often begin to feel and even act the part assigned to them, a process whose fuller elaboration as projective identification is taken up in the psychoanalytic pathway.

Reaction formation turns a wish into its ostentatious opposite: the disowned cruelty that becomes crusading, scrupulous kindness; the desire that becomes disgust. The tell is the excess, the quality of too much, too insistent, too brittle. Displacement moves a feeling from its dangerous object to a safer one: the anger at the boss delivered to the family dog, the terror of a parent's death lived out as a phobia of something small and

avoidable. Alongside these, clinicians will meet rationalisation, which dresses motive in respectable reasons; intellectualisation, which converts feeling into theory about feeling; splitting, which protects a needed good image by keeping it wholly separate from the bad, so that people are experienced as all-rescuer or all-persecutor with nothing between; and the mature defences, sublimation, which finds for an unacceptable impulse a valuable channel, humour, which discharges pain without denying it, and suppression, the deliberate, conscious postponement of attention to a difficulty, which is a defence only in the loosest sense and is often simply wisdom.

Recognising defences clinically is a matter of noticing operations, not applying labels. The clinician attends to moments where the discourse does something: the sudden vagueness in an otherwise precise narrator, the laugh that arrives with the saddest sentence, the fury at a colleague described in terms that fit the patient's own disowned behaviour, the relentless reasonableness that leaves no opening for feeling. The observation is held privately as a hypothesis about what is being kept out and at what cost, and the naming of a defence to a patient, if it happens at all, comes late, tactfully, and in the service of a question rather than a verdict, because a defence confronted head-on is a defence reinforced. The traditional formula is that one analyses defence before content, resistance before what is resisted: the path runs through helping the patient notice that they go vague, and become curious about it, long before anyone speculates about what the vagueness protects.

It helps to see a single defence carried through a whole clinical picture. A man presents with exhaustion and a marriage grown cold. He describes his elderly father, who belittled him lifelong, as a great character, visits him daily, and speaks of him with a bright, fixed admiration that never varies. He is meanwhile scathing, to a degree that surprises him, about a colleague who neglects an ageing parent, and he suffers headaches every Sunday evening before the Monday visit. Here reaction formation carries the main load: the unacceptable hatred is inverted into dutiful devotion, its excess betrayed by the brightness that never dims. The disowned contempt is projected onto and displaced into the colleague, where it can be safely despised; the body, less compliant than the conscious mind, registers each impending visit with pain. No single observation proves the reading, and the clinician who announced it in week two would deserve the rupture that followed. But the

pattern, held quietly, predicts where the work will need to go, and it explains the presenting complaints better than any account that takes the devotion at face value. Defences, in short, are not a taxonomy for its own sake; they are the grammar in which a life's contradictions are written, and learning to read them is learning to read the case. Later sessions bore the reading out: as the therapy made room for ambivalence, the headaches faded before the devotion ever wavered, and the patient's first spontaneous memory of hating his father arrived, characteristically, as a dream about someone else entirely.

Two cautions complete the lesson. First, defences are conserved because they worked; each was once the best available solution, often devised by a child with a child's resources, and respect for that history is not sentimentality but technique, since patients relinquish defences only as the dangers they were built against are revisited and found survivable. Second, the clinician's own defences are always in the room. The therapist who intellectualises under pressure, or turns helpfulness into a reaction formation against irritation, will find their blind spots meeting the patient's, and the discipline of supervision exists in large part to catch exactly this. The defences are thus not a catalogue to memorise but a lens for the whole of the work that follows, and they lead directly to the next question: where the settlement and its enforcements were first drawn up, in the earliest relationships, and how those relationships persist inside.

Going deeper: the maturity gradient and the order of interpretation.

Defences repay study as a developmental gradient, and the empirical tradition that followed cohorts across adult lifetimes found the gradient predictive of health, work and relationships to a degree few psychological variables match. At the immature end sit the defences that distort reality heavily or export conflict into other people: denial, projection, acting out, splitting. In the middle, the neurotic defences that manage conflict at the cost of restriction: repression, reaction formation, displacement, intellectualisation. At the mature end, the defences that transform rather than refuse: sublimation, which puts the forbidden energy to civilised work; humour, which lets truth be spoken sideways; altruism, which converts one's own need into care for it in others; and conscious suppression, the deliberate, revisable postponement of what cannot be dealt with today. Maturity here is not moral rank but transformational efficiency: how much reality the operation preserves, and at what cost to the person and their

relationships. Under sufficient load everyone slides down their own gradient, which is why exhausted clinicians project and grieving adults deny; state, not only character, chooses the defence.

Clinically, the gradient orders the work. With immature defences the first task is often strengthening rather than uncovering: a person holding themselves together by splitting needs containment and stability before any interpretation of the split. With neurotic defences the classical sequence applies, and it is among the tradition's most practical rules: interpret the defence before the impulse, and the anxiety before both. The patient is shown, first and sympathetically, what they habitually do ('something seems to happen to your anger; by the time it reaches words it has become an apology'); then what the doing protects against ('as if anger here would cost you the relationship'); and only then, often much later, what is being protected ('the anger itself, which seems to have been waiting a long time'). Interpret the impulse first and the defence hardens against you, for good reason: it was built precisely to keep that door shut, and a stranger rattling the handle proves the door is needed.

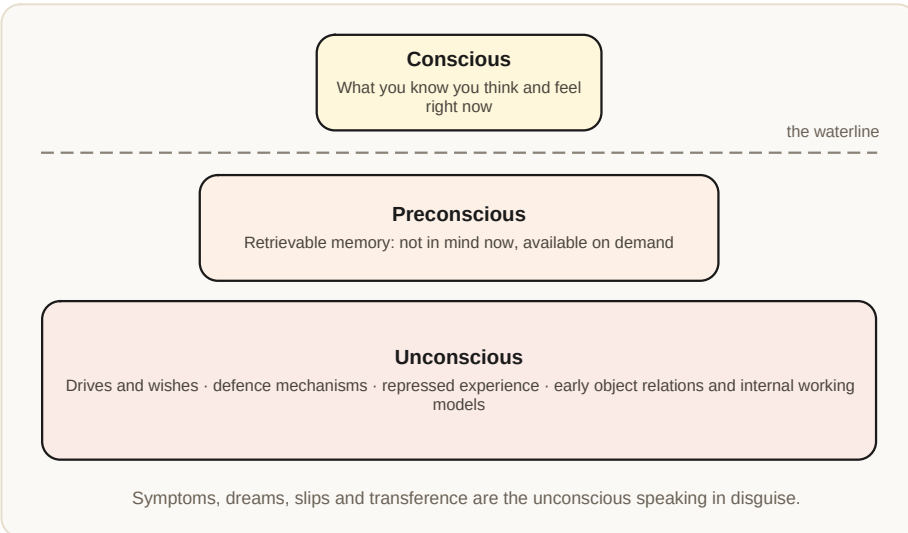


FIGURE 2.1 The topographical model: the mind as an iceberg

Freud's topographical model pictures awareness as the tip of an iceberg: a narrow band of conscious experience above the waterline, and beneath it the far larger mass the person does not see. The preconscious holds what can be recalled at will; the unconscious, widest of all, holds drives, defences and early relational templates that shape behaviour from below.

Points worth keeping

- Mature and immature defences
- Repression, denial, projection
- Reaction formation and displacement
- Recognising defences clinically

PRACTICE TASK

Identify two defences you have seen recently and their function.