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Short-Term Psychodynamic Psychotherapy (STPP) for a Severely Performance Anxious Musician: A Case Report

Dianna T Kenny*

University of Sydney, New South Wales, Australia

Abstract

Most people experience performance anxiety (PA) at some time in a range of diverse endeavours. However, for those in careers related to the performing arts (music, theatre and dance), public speaking, or sport, it can be a career-limiting or career-ending experience. Little attention has been paid to performance anxiety, empirically, diagnostically, or therapeutically. This paper contributes to the theory proposed by Kenny that the underlying psychopathology of severe performance anxiety is an attachment rupture in early life that is unresponsive to cognitive behavioural therapies. Accordingly, a short-term psychodynamic psychotherapy (STPP) whose therapeutic focus is the resolution of attachment ruptures was undertaken with a young female musician who was in danger of failing her final year at a prestigious music school because she could no longer perform without breaking down. This paper describes the application of the triangle of conflict and the triangle of time/person in the resolution of the attachment ruptures of the three key attachment figures in the life of this young musician. This paper represents only the second detailed case report on the treatment of debilitating music performance anxiety using STPP. Given the successful outcome of both case reports, further investigation of this therapeutic approach for severe performance anxiety is warranted.

Keywords: Short-term dynamic psychotherapy; Attachment theory; Triangles of person and conflict; Performance anxiety; Music performance

Introduction: The Extent of the Problem

Performance anxiety is a very common source of psychological distress. Most people have experienced it at some time in any one of a range of diverse endeavours that include test-taking, mathematics, and sexual performance. However, for those in the performing arts (music, theatre and dance), public speaking, or sport, it can be a career-limiting or career-ending experience. Prior to 1994, performance anxiety was not included in the classificatory systems of psychological or psychiatric disorders. In the DSM-IV [1] and DSM-IV-TR [2] performance anxiety is briefly discussed in a section on differential diagnosis in social phobia.

Performance anxiety, stage fright, and shyness in social situations that involve unfamiliar people (a potentially hostile audience) are common and should not be diagnosed as Social Phobia unless the anxiety or avoidance leads to clinically significant impairment or marked distress. Children commonly exhibit social anxiety, particularly when interacting with unfamiliar adults. A diagnosis of Social Phobia should not be made in children unless the social anxiety is also evident in peer settings and persists for at least 6 months [2].

DSM 5 [3] gives a similar short shrift to performance anxiety; it is again tucked away in Social Anxiety Disorder (Social Phobia) 300.323 where it is given only as a specifier - Social Anxiety Disorder – Performance only "if the fear is restricted to speaking or performing in public" (p. 203). The specifier states:

Individuals with the performance only type of social anxiety disorder have performance fears that are typically most impairing in their professional lives…Performance fears may manifest in work, school or academic settings in which regular public presentations are required. Individuals with performance only social anxiety disorder do not fear or avoid non-performance situations (p. 203).

It is disappointing that such scant attention has been given to a condition that affects approximately one quarter of the population at least once over their lifetime. In the *National Comorbidity Survey Replication* (NCS-R) [4] comprising a nationally representative survey of 9,282 people over 18 years, 24% respondents identified at least one lifetime social fear, the most common of which was public speaking (21.2%) and speaking up in a class or meeting situation (19.5%). People who reported more individual fears showed greater severity of the condition and more social and occupational impairment than those describing fewer fears. There was a strong relationship between the number of fears reported and earlier age of onset. Those reporting more than five fears had earlier onset, between early childhood and mid-adolescence, compared with those with fewer fears who showed later onset, typically in their mid-20s.

Comorbidity was very common, with two-thirds of those suffering between one and four social fears qualifying for at least one other diagnosis. The comorbidity rates increased with the greater number of social fears; there was a 90% comorbidity rate in those who reported more than 11 social fears [4]. Shared vulnerability factors such as low positive affect may account for the high comorbidity between social anxiety and mood disorders [5]. People with lifetime social phobia are three times more likely to have a major depressive disorder and dysthymia (chronically depressed mood) and were six times more likely to have bipolar disorder [6]. Based on a number of NCS studies, Kessler concluded; "The combination of high prevalence, early onset, chronicity, impairment, risk of secondary co-morbidity, and low probability of treatment makes social phobia an important disorder from a public health perspective" (p. 565).

***Corresponding author:** Dianna T Kenny, Professor of Psychology, University of Sydney, Parramatta and City Rds, Sydney, NSW 2006, Australia, Tel: 61291140711/612425358275; E-mail: dianna.kenny@sydney.edu.au

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The lack of a clear definition of performance anxiety and the failure to make explicit the criteria that distinguish performance anxiety from other anxiety disorders, including its close relatives, specific social phobia and social anxiety disorder is a theoretical impediment to the field that compromises identification of those who need treatment and hinders the development of appropriate treatments. In view of the prevailing unsatisfactory definitions of (music) performance anxiety, Kenny [7] offered an evidence-based definition, as follows:

Music performance anxiety is the experience of marked and persistent anxious apprehension related to musical performance that has arisen through underlying biological and/or psychological vulnerabilities and/or specific anxiety conditioning experiences. It is manifested through combinations of affective, cognitive, somatic and behavioral symptoms. It may occur in a range of performance settings, but is usually more severe in settings involving high ego investment, evaluative threat (audience) and fear of failure. It may be focal (i.e., focused only on music performance), or occur comorbidly with other anxiety disorders, in particular social phobia. It affects musicians across the lifespan and is at least partially independent of years of training, practice and level of musical accomplishment. It may or may not impair the quality of the musical performance [7].

The Nature of Music Performance Anxiety

Following more than 10 years of research into performance anxiety [8-13] and clinical presentations of musicians seeking therapy, Kenny challenged the prevailing view that music performance anxiety (MPA) is a unidimensional construct occurring on a continuum of severity from career stress at the low end to stage fright at the high end. She argued that MPA is better understood as a typology comprising three subtypes to account for qualitative differences in presentation as well as variations in severity. The three subtypes are: (i) MPA as a focal anxiety, where there is no generalized social anxiety, depression or panic and the anxiety is specifically focused on an objectively highly stressful performance such as an audition or solo recital; (ii) MPA comorbid with other anxiety disorders, in particular social anxiety disorder; and (iii) MPA with panic and depression. Many of this latter group are reliant on medications comprising anxiolytics, beta blockers and/or anti-depressants, with some also reporting the use of alcohol and marihuana to manage their performance anxiety [14]. An underlying, unresolved attachment disorder was proposed as the central psychodynamic feature of this presentation [8,10,12].

There are different levels of severity within each MPA subtype. The theoretical model underpinning this typology is that MPA represents an intersection between an individual's developmental history, which may be more or less disturbed – mildly, or not at all, in the case of focal anxiety and more severely in the third subtype - and the specific psychosocial conditions of musicianship - talent, achievement of technical mastery, preparedness, performance demands, exposure, competitiveness, and so on. Accordingly, MPA will have some of the general characteristics of other psychological disorders, in particular, the anxiety disorders, which are shared by non-musicians, and some that are specific to MPA and other performing artists such as dancers, actors, and athletes. This conceptualization of performance anxiety awaits further empirical examination.

Aim

The aim of this paper is to contribute to a better representation and understanding of the third proposed subtype of MPA that I observe in my clinical practice, which constitutes the most debilitating form of the condition and to report on the efficacy of short-term psychodynamic psychotherapy (STPP). In view of the hypothesis that an underlying attachment disorder is associated with severe MPA, this paper reports on the process of resolution of the attachment ruptures with significant caregivers and the impact of this resolution on the capacity to perform.

Method

Participant

The musician, Penelope, aged 22, was an advanced tertiary student in her final year at a prestigious music school in Australia. Penelope self-referred for urgent treatment as she had been unable to perform in public for several months. Failure to complete her final recital would result in non-award of her degree. In addition, final year students are expected to apply through audition for employment, and she had been unable to attend these auditions, even though she had indicated her intention to do so. She was fearful that her future as a professional musician was bleak.

Penelope began playing piano at five years of age. She commenced violin at seven years and singing at 12 years. She was awarded a music performance diploma with distinction in violin at 13 years, a milestone not generally achieved before the age of 18 years. However, she chose classical singing as her major for her Bachelor of Music degree. She stated that MPA "has been a prominent issue since as far back as I can remember and has prevented me from truly enjoying the one pursuit I consider a means of refuge in my life. Such anxiety has begun to affect the outlook I have on other areas in my life."

Treatment modality

Short-term dynamic psychotherapy (STPP) is an umbrella term that incorporates a group of therapies that share common goals and processes. Examples include Experiential Dynamic Therapy, Affect Phobia Therapy and intensive short-term dynamic psychotherapy (ISTDP) [15]. The theoretical rationale for STPPs is founded on psychoanalytic theory [16], object relations theory [17-19], and attachment theory [20,21]. ISTDP has manualized the principal tenets of STPP into a formalized treatment process that involves inquiry, pressure, diagnosis based on the degree of resistance observed and the degree of fragility in the character structure, challenge, clarification, "unlocking the unconscious", recapitulation and consolidation [22].

The common goals of STPPs are to restructure the defences, regulate anxiety and facilitate the awareness and expression of affect. There is a growing evidence base for the efficacy of STPP for the treatment of a range of psychiatric conditions [23,24], including panic disorder [25]. ISTDP has been the most researched form and there is now research supporting the efficacy of this approach [22,26]. The common procedural features include a more or less explicit focus on early attachment ruptures (as opposed to a focus on the anxiety symptoms in CBT), active therapist involvement (as opposed to the non-intrusiveness of analysts), and the explicit use of the transference (i.e., directing attention to the patient's feelings towards the therapist). The importance of the therapeutic alliance is stressed because this enables the patient to cooperate with treatment, collaborate with the therapist, and face painful feelings.

Maintenance of a therapeutic focus (as opposed to the free association of psychoanalysis) is of central importance. This is achieved through the use of the Triangle of Conflict [impulse/feeling, anxiety and defence; [27] and the Triangle of Person/Time – (parents/past-P), here-and-now (therapist-T), and current relationships (Other-O)] [28,29]. Figure 1 presents a schematic representation of how the triangles guide

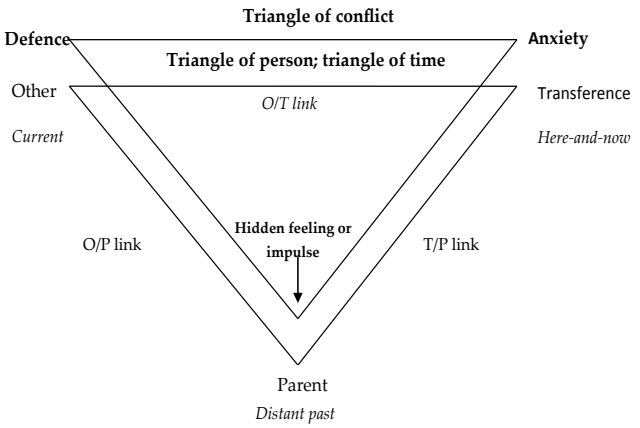

Figure 1: Triangles of conflict, person and time and the links between them that are made in psychotherapy [8,27-29]. T/P link=therapist/parent link; O/P link=other/parent link; O/T link=other/therapist link. Triangle of conflict rotates over the triangle of person, e.g. anxiety, defence and hidden impulse can appear in the transference, the other and parent.

the therapeutic process. Keeping these triangles in mind, the therapist interprets the patient's reactions and behavior according to the linkages in these triangles. Three linkages are interpretable for each apex of the triangle of conflict (anxiety, defence and hidden impulse/feeling). These are the other (current relationship, i.e., other-therapist link (O/T); therapist-parent link (T/P) and other/parent link (O/P). For a detailed explanation, see Kenny [8]. There has been insufficient attention paid in the literature with respect to working therapeutically with the triangles. One of the aims of this paper is to more fully elucidate and illustrate this process.

The main therapeutic focus in this treatment for severe MPA is the resolution of attachment ruptures, not resolution of the presenting symptoms of performance anxiety. Therapies that focus only on the symptoms of anxiety in severe performance anxiety are rarely effective or enduring. It has been my experience clinically that the more debilitating symptoms of performance anxiety spontaneously resolve if the early trauma and its associated painful affect are accessed, expressed and understood (i.e., processed) [10,12]. However, particular attention is directed to the role of anxiety, which is viewed either as a response to an external threat or an internal, emotional conflict. In situations where a legitimate external threat exists, anxiety is an adaptive response that prepares the individual to deal with the threat as effectively as possible. In performance anxiety, this would pertain to issues like repertoire choice and suitability, practice routines, task mastery, self-care, performance preparation, and other practical matters. These issues may need to be considered in the treatment.

Internal emotional conflicts are created through ruptures in attachment relationships in the first eight years of life [30-32]. There are a wide range of events and situations that create attachment ruptures. These include, but are not limited to death of a parent, prolonged separation due to illness of child or parent, emotional neglect, emotional, physical or sexual abuse, or a more subtle but equally damaging chronic parental misattunement to, or lack of empathy with their child's emotional signals and needs. The age of the child at the time the rupture first occurs, and the frequency and duration of these experiences of rupture are prognostic of the severity of the attachment rupture and its associated affect, anxiety and defences recruited to manage the pain associated with the rupture [30]. The younger the child, the more frequently the events occur, and the longer the overall duration of the events or experiences, the more persistent and unrelieved the parental misattunement in the absence of other compensatory attachments [33], the more severe the attachment rupture [34-36].

The rupture in the attachment relationship causes emotional pain in the child and a retaliatory rage towards the parent(s) for causing the pain. However, because the child also loves his parent(s), he feels guilt about experiencing rage towards someone he loves. The rage, guilt about the rage, grief and craving for attachment and positive feelings are all repressed into symptoms and submerged under behaviors that enable the child to continue a relationship with his parent(s). This process eventually becomes a characteristic defensive system [37], variously called pathological accommodation [38] or fragile character structure [15,39,40]. Whenever the child is in a situation that has the potential for a rupture of attachment, the repressed rage, guilt about the rage, grief and pain from the initial attachment rupture is re-activated. Anxiety is experienced to block the feelings from entering conscious awareness and the defensive system is automatically triggered to keep the feelings repressed and to avoid or alter the emotionally triggering situation [41]. Over time, this pattern is automatically activated in any situation that has the potential to trigger the repressed feelings about the initial attachment rupture [42].

A psychoanalytic understanding of music performance anxiety takes as its starting point that the performance situation stirs conflicting unconscious desires, wishes and conflicts. The audience has a pivotal role in this process because of "the universal propensity of performers to experience an audience as though it were a person from childhood, real or imagined" [43]. As for all causes of anxiety, music performance anxiety in its severe form is multiply determined.

The anxiety associated with the internal emotional conflict and the defensive patterns used to avoid experiencing emotional pain become the psychological problems in the person's life. Anxiety can manifest in any of four ways, alone or in combination. The most adaptive manifestation of anxiety is tension in the striated muscles of the body [15]. Chronic striated muscle anxiety is associated with a number of physical problems including fibromyalgia, pain, spasm, hyperventilation and panic [44]. In a therapeutic context, striated muscle anxiety is an indication that the person has the capacity to consciously experience the repressed feelings from the attachment rupture(s). Other, more problematic manifestations of anxiety include smooth muscle anxiety that is somatized into the gut, leading to gastrointestinal symptoms including nausea, reflux, cramping and the urge to urinate and/or defecate. The striated muscles remain relaxed. Chronic smooth muscle anxiety is associated with hypertension, irritable bowel syndrome and migraine [45,46]. Anxiety may also manifest as cognitive perceptual disruption (CPD) which is experienced as tunnel vision, blurred vision, or ringing or buzzing in the ears, and feelings of depersonalization [40]. Physically, the person will appear relaxed as anxiety is not being expressed in the striated muscles, but will manifest confused thinking and not be "present" in the room. Chronic cognitive perceptual disruption is associated with neurological complaints, for which no medical cause can be found such as dizziness and fainting. In rare cases, anxiety may manifest as conversion [47].

In a therapeutic context, the experience of smooth muscle anxiety, cognitive perceptual disturbances or conversion indicates that a psychological restructuring process is required before the person is able to consciously experience the repressed feelings associated with their attachment rupture(s). In restructuring, the person is gradually exposed to increasing levels of anxiety, via graded exposure to their repressed feelings, and helped to develop and maintain a striated muscle anxiety

response [39]. Eventually, the patient is able to consciously experience the previously repressed feelings without unmanageable anxiety. This process is akin to systematic desensitization in CBT, although in CBT, the focus is on overt symptoms, not repressed feelings. Patients may experience only one of the four types of anxiety, or they may experience a shift from striated to smooth muscle or cognitive perceptual disruption as the repressed feelings move closer to conscious awareness.

In response to anxiety, defences are automatically activated. There are three main groups of defences [39]. Isolation of affect is the most adaptive defensive system. Patients are aware that they are experiencing a particular emotion, but they do not know how they are physically experiencing it. Instead of the physical experience of the emotion, patients with isolation of affect experience striated muscle anxiety. The second major defensive system comprises repressive defences [48]. Patients with repressive defences do not recognize that they are experiencing emotions. Instead feelings are repressed into the body. Repressive defences are linked to smooth muscle anxiety where feelings are internalized/somatized into, for example, nausea, irritable bowel syndrome, depression, headache or conversion symptoms. The third major system is the projective/regressive defensive system, which is associated with cognitive perceptual disruption [40]. Patients using this cluster of defences do not perceive that they are experiencing emotions, but rather perceive that another person is experiencing the patient's feelings. This most commonly occurs with anger, but any feeling can be projected, including hatred, envy and guilt. Typically, these patients manifest one or a combination of the following symptoms - weepiness (tears without feelings of grief), temper tantrums, explosive discharges of affect, confusion, self-harm, drug and alcohol misuse, dissociation, and projection of their feelings into others [40]. Each patient is carefully assessed with respect to the form of anxiety expression and the system of defence [15]. This gives important information to the clinician about how to proceed with therapy. Patients with much earlier and more severe attachment ruptures will be more fragile and will require a longer and slower-paced therapy [40].

The aim of therapy is to help the patient to abandon his/her defences to allow the previously repressed feelings into conscious awareness. The conscious experience of these repressed feelings triggers memories associated with early attachment ruptures, enabling these previously repressed memories and feelings to be resolved [48,49]. Much of the work is achieved through the transference, through which the murderous rage towards the original attachment figures may first be expressed. Once the patient accesses his/her rage, s/he will also experience the pain and grief at the loss of the attachment relationship.

In summary, STPP focuses on the experience of feelings in the here and now of the interaction (i.e., transference) between therapist and patient. In response, the patient begins to automatically manifest anxiety and defend against repressed feelings related to unprocessed emotions about early attachment ruptures from breaking through into conscious awareness through the transference. This enables the therapist to assess the anxiety patterns and defensive processes of the patient *in vivo*. If necessary, the patient is helped to restructure his/her anxiety pattern to striated muscle tension. The patient is encouraged to experience the feelings that are creating anxiety (if anxiety is in the transference), or to overcome the defences that are blocking the rise of anxiety and the transference feelings. This directs the resistance into the transference, paving the way for the eventual conscious experience of the transference feelings and the exploration of the unconscious.

This paper describes those sections of a 40 session therapy that specifically related to the resolution of the triangles of conflict, time and person for the patient's three significant attachment figures towards whom she experienced murderous rage, and how this resolution reduced her performance anxiety.

Assessment

Family history

Penelope is the elder of two daughters – her sister (Elissa) is 20 and studying business/law. This is an immigrant family. Mother is the sole bread winner who works as an ethnic welfare officer. Father has Bipolar Disorder and hasn't worked at all in the past 20 years. He is a failed musician who also suffered from extreme MPA; he started a university degree in his early adulthood that he never finished. He sits around smoking and playing his guitar all day when he is not sleeping, which is much of the time. His moods are labile and he is really a third child in the family. He has problems with alcohol abuse, during which times he becomes verbally abusive, particularly towards Penelope who provokes him. He lives the life of an invalid, relying on his wife to earn money and run the family.

Penelope's mother calls her husband a "lame dog" - she told Penelope that she does not regret marrying him because "my situation has made me strong". Penelope asked her mother why she did not leave him – and her reply was that she could not throw a lame dog onto the street. Penelope has expressed anger towards her father for failing her. She seems somewhat enmeshed with her mother and sister ("we always do everything together"), although recently she has expressed envy and anger towards her sister, who apparently knows her own mind and is pursuing her goal to become a lawyer. Penelope wanted to pursue an acting career but knows that this is not realistic. Her family is totally opposed to the idea.

Penelope had 10 sessions of cognitive behavior therapy in the year prior to this therapy and liked the structure and homework, but the effects were short-lived and she felt devastated by her failure to resolve her issues with this approach. She has expressed suicidal ideation on several occasions.

Trial therapy

The first three sessions were an assessment and trial therapy. The aim was to ascertain the nature of the defensive patterns, the degree of resistance, character structure, response to intervention, and suitability for the treatment modality. In the first session, Penelope presented as socially "polished" but it felt highly rehearsed, like a "false self" [37,38]. When asked what problems had brought her to therapy, she produced five pages of typed notes about herself that showed remarkable intellectual insight into her difficulties. She indicated that she viewed herself as an outsider, as defective and a failure, dependent on others and afraid of becoming independent.

Penelope worried that she would end up like her father, "a hopeless mental patient who had done nothing with his life." She said that music was her "main solace in life" and without it, she feels bereft. She entertained grandiose fantasies – "I wish to be great at what I do" - and strivings to be perfect, but with underlying depression and depletion that expressed itself as a lack of motivation, "I don't have a goal"; self-criticism, "I deserve strong criticism," "I did not realise how much I hate myself"; and failure of individuation, "My self-esteem is based on how people view me;" "I cannot tell who I really am." She felt humiliated by her "failures" - musically, interpersonally, and with respect to her body image. She perceived herself as overweight and ugly and was self-denigrating of her tendency to binge eat.

After an outpouring of self-loathing, Penelope remarked that she was scathing of self-affirmations. I hypothesized that there was probably a T/P link here, but waited to hear more. She told me that she would think very ill of me if I advised her to use them. She was impatient for answers and a solution and constantly asked for strategies and homework at the end of each session. I commented that she was feeling unsure about whether this therapy would help her, given her disappointment with her last therapy. She apologized for being "mean" and justified her impatience and uncertainty by saying that she was feeling quite desperate.

We identified the vicious cycle of high expectations, disappointment at perceived and actual failure, and the ferocious self-denigration that followed. She described herself as "a useless piece of carbon" and "wondered why I am even breathing." She could not accept that she had "any achievements worth anything in the scheme of things." She then launched into a panicked account of an impending assignment and how no-one would help her. I wondered out loud whether she felt that I was not helping her either, making an O/T link to bring the experiences of her current life into the transference. She acknowledged that she was left feeling abandoned at the end of sessions with no strategies to implement or homework to perform.

Following these three sessions, Penelope was judged to be suitable for STPP. She was articulate, motivated, and showed considerable psychological insight into her difficulties. Much of her anxiety was expressed through striated muscle tension and sighing respirations. There was no evidence of smooth muscle involvement or cognitive perceptual disruption, except for the report of a "globus[1]" when she tried to sing. She was able to acknowledge intense emotions, including murderous rage, towards significant attachment figures. Her defences comprised isolation of affect (intellectualization), turning anger in on herself, and tactical defences (cover smiles, practised social poise, breaking eye contact), suggesting that work could commence on mobilizing her feelings related to early attachment ruptures.

Music history and history of music performance anxiety

One of Penelope's earliest musical memories was as follows: At the age of six Penelope had to sing a duet with her sister in a concert. She broke down during the performance and ran from the stage crying, while her sister completed the performance alone. Although she has many musical accomplishments, including gaining her performance diploma at a young age, and wins at many eisteteddeodau, she regarded herself as a musical failure because she could no longer perform in front of an audience. This problem had become urgent as she was soon to graduate (if she could complete her final recital) and would then be seeking professional work through auditions, another situation that terrified her.

Penelope described her MPA as "demons" on her shoulder, who whispered destructive comments in her ear every time she tried to perform, such as "Why bother? You are going to botch this performance like all the others. You are a failure." She said that she tries to flick the demons off her shoulder but they "clawed and clung to her clothes and climbed right back" up onto her shoulder, all the while denigrating her and her incapacity to perform.

Penelope then said that the voices were so difficult to silence because she thought that they were speaking the truth – that she really was a failure, useless and without purpose. "How can you combat the truth?" she asked. I asked her whose faces she saw on the demons on her shoulder. Without hesitation, she said she saw her father's face and the faces of some of her music teachers who had had such high expectations and who had now expressed such disappointment in her. She had also felt pressured by her music teacher to give up her university studies and become a full time music teacher in her teacher's studio. This teacher, whom she described as a "second mother," had told her that she was not capable of finishing her university degree or competing in the cut throat world of the professional musician.

Penelope acknowledged feelings of rage towards these people but wondered how she would express it - whether it would be "word vomit" and not make any sense. I wondered whether she was concerned about what I might think of her if she vomited her meaningless words in my presence. She acknowledged that she had worried about this. Penelope also talked of her panic each time she was asked a question in her lectures and described this feeling as similar to her music performance anxiety as she walked on stage to perform.

Attachment relationships

Penelope recounted a recent experience in which she was trying to assemble a piece of furniture and her father just sat and smoked and watched as she struggled with the heavy pieces. She became enraged and shouted at him that he was not her father. Her mother remonstrated with her. "You need to have your antennas tuned when your father is having a bad day."

Penelope's rage towards her father was close to awareness but she defensively turned the anger in on herself, deriding herself for being defective and a failure, clearly attributions that belonged to her father. She was also angry that her mother was more interested in her father's feelings than hers and expected more of her than her father, who "is supposed to be an adult." I pointed out and clarified the system of defences Penelope used to defend against her hostile, angry feelings and the self-destructive consequences of such a system, how these characteristic patterns of interpersonal interaction were evident in the therapeutic dyad - her disappointment in me at the absence of a quick fix was barely concealed – but she would increase her self-critical comments when these negative transferential feelings threatened to erupt. This led to the interpretation of the T/P link.

In response to this focus to attend to her feelings, the defences she used and what the defences were helping her to avoid, Penelope disclosed an urge to self-harm and wished that she were dead. "I was standing on the railway platform watching the trains go by and I had an urge to just let myself fall onto the tracks." I suggested that Penelope would rather be dead than acknowledge her anger and disappointment in her parents. Focused attention on these feelings and encouragement of Penelope to take action against helplessness[2] by pointing out her detachment[3] in the transference (e.g. Penelope broke eye contact when feeling anxious, vulnerable, or suicidal, and laughed and became self-denigrating when connecting with painful feelings) and her use of the defences of rationalization (e.g. "I can't be angry with my father; he cannot help himself") and isolation of affect (e.g. "I have a job to do; I should just get up and do it") as strategies to avoid confronting her painful feelings towards her parents. I gradually increased the focus on the central issues, continually pointing out her defences, countering her rationalizations[4] and blocking irrelevant and distracting talk, including her frequent self-attacks.

[1] Globus, globus pharynges, globus sensation, globus hystericus refers to the sensation of having a "lump in one's throat" or persistent sensation of having phlegm, or some obstruction in the throat when there is none and physical causes have been eliminated (ICD-10, F45.8).

[2] Helplessness is a regressive defence triggered by excessive anxiety

[3] Detachment refers to emotional distancing as a defence against intimacy

[4] Rationalization is typically a tactical defence that finds intellectual explanations for problems devoid of affect

The challenge for Penelope was to acknowledge her hostility towards her father rather than avoiding, then rationalizing it and turning the hostile feelings onto herself. Penelope expressed her fear that she would end up like her father – "a lame dog," passive and a failure. I again made the link between her negative feelings towards me for not giving her a quick fix and the increase in her self-denigration when she became aware of hostile feelings towards me (e.g. "I feel like a waste of space. What am I even breathing for, taking up so much oxygen?"). I then made the T/P link with her father. In response, Penelope reported a major altercation in which her father accused her of being negative and wearing her anger and frustration on her face, and that he was sick of it. He had tried to throw her out of the car during one of their arguments.

Completion of the triangle of conflict with father

Davanloo [15] calls the process of working first with the anxiety, and then the defences to clear the way for accessing and experiencing the hidden impulses and feelings (rage, guilt about the rage, grief, attachment longing) that have arisen as a result of significant attachment ruptures in early life, the "unlocking of the unconscious". The hitherto unacknowledged and unexpressed murderous rage is accessed emotionally but must also be felt physically (i.e., in the body), as the extract from the therapy transcript below demonstrates. Guilt for these feelings of rage towards a parent follows and further defensive manoeuvres come into play to manage these.

In this session, Penelope had just returned to university from an inter-semester break. She launched into an account of her first week back at university. She had felt positive in the inter-semester break, had completed her readings and was motivated to do well. In the first tutorial, she was confronted with some students whom she thought had an easy life; they had rich parents, lots of opportunities, dressed expensively, and were smart and confident, attributes that she believed were absent in herself.

DK How do you feel about these students as you talk about them now?

P I feel intense hatred and jealousy towards them.

DK Where do you feel that in your body?

P [points to her head] There is a huge pressure in my head.

DK So you are struggling very hard to keep the lid on those feelings to prevent them from spilling out, exploding like a volcano?

We then discussed the specifics of her feelings and Penelope was able to identify that her real anger and hatred was for her father ("who spends 23-24 h in bed, only getting up to eat and smoke") who had deprived her of the life she could have had, like the students in her tutorial class (O/P link).

DK How do you feel about your father as you describe him lying in bed all day?

P I feel anger and frustration and even hatred

DK Where do you feel it in your body?

[Penelope made strong fists with her hands and started waving them about]

DK What would you like to do with those fists?

P I want to grab my father and shake him and tell him to wake up to himself

DK But your hands are in fists

P Maybe I want to do something worse

DK What would you like to do?

P I want to do a home invasion on him with three masked people who put him through some torture trials. If he survives all the trials, he gets to have mum and Elissa and me.

DK Who are the masked torturers?

P Me

DK You feel so angry with your father that you want to put him to the test through torture to see if he has qualified to be your father?

P [Laughs and looks away] I am so embarrassed about this. He is my father, after all

DK You are experiencing strong emotions of anger and disappointment with your father, yet you break eye contact, laugh and put distance between you and me so that we cannot deal effectively with the feelings that have come up in relation to your father.

I made the anxiety/defence link; Penelope became anxious when her hostile feelings towards her father were coming into awareness, so her defences were activated to prevent this from happening. We were then able to complete the triangle of conflict with respect to her father. I then made the link between her father's helplessness and failure and that part of him in her that is sabotaging her. She burst out spontaneously,

P I am going to make it. I will see it through and I will succeed

DK So are you not your father – neither the father who lies in bed all day nor the internal father who is helpless and irresponsible and who sabotages you.

Penelope was fascinated with how her feelings about the students in her tutorial were connected to her feelings about her father (O/P link) and in turn, her self-sabotage perpetuated by her internalized father. These experiences led to a significant deepening of rapport and strengthening of the unconscious therapeutic alliance. After this session Penelope reported a conversation with her father.

P: I told my father how I felt about the fact that he never tries to improve his life, get a job, help Mum or be a father to us. He burst into tears and said his life was over but that he wanted better for his daughters. I felt good that I told him how I felt and now I feel I do not have to be responsible for him feeling better. I know that I can't expect much of him and I am OK about that now.

Completion of triangle of conflict with mother

Over a series of sessions, Penelope described some experiences related to the apex of the triangle of conflict (i.e., hidden impulse or feeling). In the first of these, Penelope complained that she was feeling totally overwhelmed by her university course and couldn't cope. Uncharacteristically, she went to see her lecturer, who lent her a book with a summary of the lecture in it. Penelope did not feel comforted by the lecturer's facile assurances and said they felt like her mother's empty clichéd reassurances. I remembered her vehement aversion to positive affirmations in her first session and made the O/P link with respect to these.

Penelope reported that she had finally got some distance between herself and her father – that she had put him in the "angry box" and stopped worrying about what he was doing with his life (e.g. "He is a waste of space and oxygen"). She asked whether she had to do something similar with her mother. She promptly answered her own

question, saying that her mother needed to go into an "angry box" as well, because of the weight of all the expectations that her mother put on her, for constantly comparing her with her sister, for never offering meaningful emotional support instead of sprouting clichés about how everything would be fine.

Penelope then described two incidents with her mother. In the first, both Penelope and her father were having a bad time. Penelope approached her mother to complain about her life and to seek comfort from her. Her mother put her hands to her lips and said "Shhhh…" to Penelope, pointing to her father reclining listlessly on the couch. This incensed Penelope who called her mother "selfish" and stormed out of the room. I suggested that she felt particularly angry that her mother treats her father like a baby and does not expect anything from him, yet she is expected to behave like an adult and be considerate of her father even when she herself is in need of maternal care.

Penelope came in very distressed for her next session, having had yet another fruitless interchange with her family. The theme of this session was her recognition of her enmeshment with her family, such that they are "one tree with several branches, rather than four trees growing in proximity." She said that she had not realised how "machine-like and robotic" Elissa was, apparently having taken on her mother's persona of "do your work, face life without complaining, and don't rock the boat."

Penelope told her mother that she hated her and that she was no longer her child. She subsequently ignored the rest of the family because she was "sick of being blamed for everything that went wrong." I suggested that she was struggling to have an independent mind and separate existence from her family which her other family members found challenging. Penelope again addressed the issue of wanting to leave home, with her mother's words ringing in her ears – "If you leave home, I will not help you and you won't be welcomed back." This was understood as mother attempting to keep Penelope within the orbit of the family, where independent thought is punished. Penelope was afraid that she had been so protected from the world that she would not know how to live independently. She also had some legitimate concerns about having sufficient money to live independently, even though her need to leave home was growing more insistent.

P All my life as a child, my parents treated me as an adult; now that I am an adult, they want to treat me like a child.

DK You want to walk into your future with your adult self and your child self, hand-in-hand. You are now an adult who is able to take care of your child.

P Yes, yes, that is it. [Pointing to her throat] Now all this tension I was feeling in my throat is gone; it feels relaxed.

DK It is a relief to feel understood.

P [tears] Yes, it is. Thank you so much.

In the following week, Penelope exclaimed in great excitement that she had performed well and with enjoyment in a musical concert. Afterwards, she felt satisfied with her performance and did not engage in her usual post-performance rumination which inevitably ended in self-denigration. At the end of the session, she said, "I am not a waste of space. I have achieved a lot of things. I have survived the challenges of a family living with a member with a mental illness; I have managed financial hardship; I studied hard and got my diploma and then got entry into university. I have got to fourth year. I have done things. As well as all that, I was able to recognize that I wasn't doing well emotionally and that I needed help. I am proud of myself for doing that – recognizing my issues and finding help." She then said,

P I hope I don't come in next week in a big dip again.

DK We will deal with whatever you come in with next week together.

A few days after this session, Penelope rang me in a hysterical state asking for a phone consultation. Fortunately, I had time, and given the intensity of her distress, I agreed. She said that a distant relative had died and was buried today. The family asked her if she would sing at the funeral. She agreed to do a *cappella* duet with her sister. Penelope reported that it went well, she had not been overcome with panic and she and her sister were happy with their performance. When they left with their family to drive home, her mother attacked her viciously, saying that her performance was awful, that she could never step up when needed, and that she should forget about her music altogether. Penelope told her mother that she was happy with her performance and did not want to give up performing. A huge argument ensued between Penelope and her mother. Elissa sided with her mother, changing the focus to Penelope's "hysterics" rather than her mother's sadistic comments. Her father, as usual, laughed at Penelope's distress. The argument continued and Penelope screamed that her mother was a "dictator" and a "puppeteer" and her father was a "total failure." Penelope said that her mother always had to have things organized her way and was an oppressive martyr (e.g. "Look at what I do for all of you"). I suggested that her mother might need to make some adjustments in her relationship with Penelope who was now less dependent on her and went to her less often for solace now that she was feeling stronger in herself. I reminded Penelope that her mother called her father "a lame dog" and that perhaps she was good at caring for lame dogs but not for maturing adult children. I suggested that her father laughed because he could not cope with others' emotions, and that perhaps Elissa sided with her mother for the same reason. This all made sense to Penelope and she eventually calmed down.

In the following sessions, Penelope continued to struggle with the cataclysmic family conflict. She reported that her mother had spat in her face and told her that she did not want her in her house any longer. Penelope said, "In all the years and arguments my mother has ever had with my father, she has never spat in his face or told him to leave."

DK How did you feel about your mother spitting in your face?

P Very, very angry

DK How are you feeling that anger in your body? [Penelope points to her chest and her forehead].

DK What do you want to do to your mother right now?

P She was invading my personal space and I wanted to push her out of my face [makes a forceful pushing away gesture with her hands, palms facing outwards].

DK What happens then?

P She falls.

DK And then?

P I have some sort of weapon in my hand.

DK What is it?

P A large knife

DK What do you want to do with the knife?

P Cut her to pieces.

DK So, you have cut your mother to pieces and she is lying, lifeless, in a pool of blood on the floor. Looking at her lying there, what are your feelings towards your mother?

P I feel the most enormous sense of relief and freedom that I have cut the puppeteer's strings tying me to her. I can breathe.

Completion of triangle of conflict with sister

Over a number of sessions, Penelope discussed her complex relationship with her sister. Her initial early descriptions of her sister were idealized. "I do not know why I can't be more like Elissa. She has got her whole life figured out; she knows what she wants and she is working to make it happen. She never argues or raises her voice or makes a fuss. We grew up in the same family. Why are we so different?" According to Penelope, Elissa "had her act together", knew her goals, was disciplined, focused and unemotional and was sure to succeed, unlike herself, whom she described as having the opposite of these characteristics.

Penelope subsequently reported a "very serious fight" with her sister. It related to Elissa's condescension towards Penelope with respect to her frequent emotional outbursts, which Elissa viewed with barely concealed contempt. As Penelope was recalling the fight, she reported a growing constriction in her throat that she sometimes experienced during vocal performances. I asked her to focus on it and she said, "It makes me feel like I want to vomit." I commented that she might be referring to vomiting her feelings of rage and envy that she held onto so tightly but which were now demanding acknowledgement and expression. Penelope responded that her mother had told her that she was very jealous of Elissa when she was young. I replied that that was understandable because her mother had diverted a lot of attention from her to her fragile second child (and her mentally ill husband) and Penelope was expected to grow up quickly and fend for herself emotionally, which had left her with feelings of neediness and deprivation. We discussed how some chinks in her idealized perception of her sister were starting to show.

For the next few sessions, Penelope was focused on dealing with the impediments to her singing. She described her fear of a serious throat constriction (i.e., globus) every time she got up to sing in public. In one session, she reported a globus in her throat and throbbing in her temples. I suggested that these physical sensations represented suppressed feelings that she was "strangling" or preventing herself from expressing and that these feelings were literally getting stuck in her throat. I made the link between this restriction in her throat when she was becoming aware of her hostile feelings towards members of her family and how she felt on stage, when all the previous anguish, expectations and criticisms from her family were re-triggered by the evaluative performance setting.

I asked Penelope what she would say or feel if she allowed herself to express the "unexpressable." She painted a very vivid picture of herself as a little girl in a fancy dress on stage, black except for a spotlight on her. She makes a gesture with her hands to the audience which said "Please listen to me; pay attention, keep quiet and listen." I asked whether she was appealing to the audience like a little girl appealing to parents who are too distracted to pay her any attention or to understand her needs (O/P link).

Penelope then described a feeling of intense hatred for her sister whom she felt had received much more attention from her parents than she had. Penelope recalled Elissa standing in the doorway laughing at her while she became more and more distressed trying to explain herself to her mother on the day of the funeral, and who remained impervious to her pleas. At that moment, she realized that Elissa would turn on her and not care about her in the pursuit of her own goals.

P She has parts of both my mother and father in her – she is a goodie-goodie who thinks only of herself, who bosses like my mother and taunts like my father.

DK What do you want to do with Elissa?

P Rip out her vocal cords

DK You want to tear out her throat to stop the laughing

P Yes

DK How do you do that?

P I just lunge and grab her throat with my bare hands

DK What happens next?

P She has a look of disbelief on her face for one moment before she slumps on the floor next to my mother

DK Looking at Elissa on the floor, what are your feelings towards her?

P Well, she is not laughing now. She is not moving. I used to envy Elissa because she seemed to have her life together, her goals in place and strategies to achieve them. As I look at her now, I feel that I have freed myself of that envy because she does not understand herself or me. She would rather be a robot. My family has been deriding me for seeing a psychologist. My father hates psychologists and psychiatrists because he says they have done nothing for him, but I am so glad that I persisted because you have helped me to discover a life I can live.

In the following week, Penelope had two musical performances that she managed without panic and with considerable enjoyment. She said, "The lump in my throat reduced a lot because I think I expressed a lot of emotion last week. That constricted feeling that I get when I try to sing in public did not worry me this time so I was able to sing out for the first time in ages and become absorbed in the music."

Penelope then discussed her desire to leave home as soon as she could, state that she could do it; she could take care of herself. At the end of this session Penelope expressed the first genuinely felt joy I had observed in her; she laughed and clapped her hands, said she was feeling happy, and that she was confident that she could move into the future with renewed hope of pursuing a musical career.

Commentary and Discussion

Many patients, particularly young adults, are time and money poor. If they are university students, they spend many hours attending lectures and studying, often under conditions of financial strain. Many have casual jobs to pay the rent. When they seek psychological services, they expect a time-limited, once a week, affordable treatment. The short term dynamic psychotherapies fulfil these requirements.

STPPs have been criticized for falling into the errors of "therapist knows best," one-person psychology models, and that the triangles of conflict and person/time locate the problems as intrapsychic rather than relational [50]. I would argue that this position fundamentally misunderstands the central importance of the relational aspects of

working with the triangles and the therapeutic alliance in which the therapist and the patient team together to overcome the self-defeating defences and resistances that prevent change. ISTDP is the most prescriptive of this group of therapies; some patients may respond better to a less confrontational approach while working within the framework of the model. Indeed, some therapists also prefer to work with a gentler frame than ISTDP while adhering to its central tenets, as was the case in the therapy reported here.

The most interesting feature of the segments of this therapy presented in this paper is that while severe music performance anxiety was the ostensible reason for seeking treatment, the identified problem was, in fact, only one manifestation of the diverse psychopathology experienced by this young woman as a result of the ongoing emotional trauma caused by chronic parental misattunement and frank emotional abuse that she had suffered throughout her young life. Musicians presenting for urgent assistance with their music performance anxiety in circumstances in which they might not otherwise be able to perform, attend auditions, or complete requirements for their university degrees would, prima facie, provide a prominent focus for the therapeutic work. My clinical experience has demonstrated that too rigid a focus on the ostensible presenting problem may prove counter-productive and contribute to treatment failure. This was in all probability one reason for the failure of her CBT-based treatment. Although Penelope said that she enjoyed the sessions, the strategies and the homework, it had no effect on the underlying attachment ruptures responsible for her symptoms. Musicians spend many solitary hours practising between lessons, so the structure of CBT in which strategies and homework are planned during the session and then practised between sessions would have been familiar to Penelope, and therefore comforting in its familiarity. The collusive focus of CBT on the symptoms of performance anxiety served to keep the hidden impulses and feelings towards her parents and sister from reaching awareness.

The main symptom preventing Penelope from singing, the hysterical globus (i.e., psychosomatic throat restriction), resolved only after she was able to identify the strangulated feelings of rage and envy that were seeking expression but that were defensively kept at bay; they were literally stuck in her throat, the result of simultaneous competing impulses to express and repress. Penelope's presentation gradually changed over the course of the therapy from her "false self" to a more integrated "real" self. She no longer needed to play act because she was feeling freer to be herself, a self that could own her painful feelings and experience joy and confidence in her growing autonomy. However, this emergent autonomy was fraught with danger because her mother gave her the message at the funeral, "If you find your voice, I will hate and reject you." Perhaps there was a similar dynamic happening in the marital relationship. If her "lame dog" husband recovered or asserted himself, she would need to kick him to make him lame again. Penelope was angry with her father because he could not protect her from her mother's envious attacks. Her mother appeared to need a helpless husband and dependent daughter with whom she could be a "puppeteer" pulling all the strings in order to feel in control, to maintain her wall of defences against her own rage and envy.

Penelope's therapy dislodged this pathological family system; her mother felt threatened by her growing autonomy and worked hard to restore the status quo. The sadistic attack on her singing performance in the family car, in which there was no escape for Penelope was emblematic of the suffocating hold that her parents were attempting to reassert over their daughter. In a similar way to her parents' trapping her in the family car, Penelope had to consign her parents to "angry boxes," that is, to quarantine their influence on her as she struggled to achieve a separate mind. She has not yet achieved personhood but she has become closely acquainted with her depressed and deprived child whom she can now nurture rather than subjugate to the relentless attacks of the punitive internal and external parents in this pathological family.

In this paper, I have focused a spotlight on the importance of resolving attachment ruptures in musicians who are severely performance anxious. Although most of my work to date has been with musicians, I believe that the same dynamics would apply to other performance-based professions. This assertion awaits further empirical investigation, as does this form of therapy for this population.

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