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The Key to Good Psychotherapy

There always has been a large gap between the way competent psychodynamic therapists conduct therapy in their real world practices and the way their conduct is formally depicted in the professional literature and at professional meetings. This gap was empirically demonstrated in the two-decade-long Menninger Foundation Psychotherapy Research Project (Wallerstein, 1989) and across theoretical models (Goldfried et al., 1998). What is most neglected in the formal conceptualizations of therapists' activities is their crucial reliance on common sense about living a satisfying and meaningful life, particularly in terms of interpersonal relationships. For competent and expert therapists, this common sense is refined over the years, through a multitude of personal and professional experiences. Another neglected characteristic of the conduct of good therapists is their technical flexibility—that is, their ability to respond constructively to the circumstances they face at the moment. A final essential characteristic of the competent therapist, often neglected in formal discussions, is good interpersonal skills; fortunately, this characteristic is receiving more appropriate acknowledgment, at least by some (Norcross, 2002). The most promising students in graduate therapy training programs arrive with a foundation comprised of these characteristics. All too often, however, our training methods then bury this foundation under a pile of knowledge about personality, psychopathology, and rules about how to conduct therapy that are either too vague to provide useful guidance or too rigid. For

extended periods of time students are completely preoccupied by the theories and facts they are expected to learn.

Therapists who turn out to be competent or expert manage to develop a way of doing therapy, to some extent, *in spite of* their training. They recover their buried common sense and flexibility, which allows them to use their inherent interpersonal skills. At that point these characteristics have been refined by the acquisition of extensive clinical knowledge and accumulating clinical experience. Unfortunately, not all therapists move in this direction. They either lacked the characteristics or, for whatever reasons, have been unable to recover them, at least in the practice of psychotherapy.

The purpose of this book is to reduce the extent to which these essential characteristics get buried during training and to accelerate their recovery, when needed. It aims to accomplish these goals by reducing the gap between the way competent therapists actually think and act while they are conducting psychotherapy and the way their thoughts and actions are formally depicted. For students who already have learned basic psychodynamic therapy concepts and principles, this book is meant to serve as a guide on how to apply these concepts and principles practically and in a time-limited format. Practicing therapists may find this book to be a useful aid in fully recovering and using their common sense, technical flexibility, and interpersonal skills in their practice of therapy.

This depiction of how to conduct psychotherapy is based on over 30 years of psychotherapy practice and training and over 20 years of involvement in treatment and training research. The clinical theory used as a conceptual framework for discussing treatment is an integration of psychodynamic–interpersonal and cognitive aspects (discussed in Chapter 2). The treatment model also represents what has been called “assimilative integration” (Lazarus & Messer, 1991; Messer, 1992), which refers to reliance on a predominant theoretical framework, within which principles and techniques from other treatment models are incorporated.

My strategy for minimizing the gap between how good therapists actually think and act and how I depict their performances is to avoid, or at least minimize, the use of clinical language to describe therapist performances. Although useful for dealing with clinical issues, the languages of clinical theories are ill suited for the job of adequately depicting the mental processes and actions associated with a complex skillful performance, such as that of conducting psychotherapy (Binder, 1993, 1999). As a more effective alternative, I rely on a theoretical framework

and language from the cognitive sciences, as noted in the Preface. I employ a conceptual framework for understanding the generic skills that appear to underlie all domain-specific performances (Chi, Glaser, & Farr, 1988; Feltovich, Ford, & Hoffman, 1997; Schon, 1983). My approach is to focus on generic skills that appear to underlie and support the effective implementation of techniques associated with clinical theories and theory-guided models of treatment, particularly those of a dynamic–interpersonal model. Most people have acquired these generic skills, to some degree, because they are required for successfully managing the challenges of living, including managing interpersonal relations. These skills include recognizing recurrent interpersonal patterns, the disciplined use of curiosity, common sense, and self-reflection. The process of learning theory-guided therapy principles and techniques *should* allow trainees to preserve their relevant generic skills and facilitate the use of these skills to guide the implementation of techniques.

With sufficient practice, the novice therapist can develop into a practitioner who can implement treatment models in a competent manner. Master therapists, in contrast, are capable of transcending the technical parameters dictated by treatment models. They are able to *improvise*, which means they are able to further therapeutic progress by whatever creative means necessary, given the circumstances—which are often unforeseen. The ability to improvise is one of the essential features that characterizes experts, be they psychotherapists, physicians, professional actors, musicians, professional athletes, or representatives of any other performance domain. Throughout this book, I maintain a focus on what I consider to be therapeutically relevant generic skills as well as the general clinical skills derived from them. Mastery of these generic and general clinical skills is required to become a competent, and eventually an expert, therapist.

ASSUMPTIONS ABOUT EMPIRICALLY SUPPORTED TREATMENTS AND TREATMENT MANUALS

The idea that the foundation of competent and expert psychotherapy practice consists of the flexible deployment of various skills, culminating in technical improvisation, diverges from the view prevalent among health care policymakers. The pressure to reduce health care costs has motivated the various stakeholders in the health care system to develop strategies for delivering care more efficiently and, hopefully, ef-

fectively. The prevalent view is that efficiency can be maximized, as well as effectiveness, by precisely determining the disorder or problem and addressing it with a treatment or technical protocol that has been empirically found to resolve the disorder or problem with maximum efficiency and effectiveness.¹ This view is most vigorously promoted by managed care organizations, which can increase their profits by reducing the expenditure of health care funds. Consequently, these organizations are constantly seeking practice guidelines that will increase at least the efficiency of health care treatments. The medical field has responded with various sorts of “evidenced-based” practice guidelines. In the mental health field, the American Psychiatric Association responded with treatment guidelines for several disorders and mental illnesses (e.g., unipolar depression, bipolar disorder, eating disorders, substance abuse (American Psychiatric Association, 1994). Organized psychology, through the American Psychological Association, responded to the psychiatrists’ actions with its own Division 12 Task Force on the Promotion and Dissemination of Psychological Procedures, which published—and continues to publish—a growing list of approved psychotherapeutic treatments for specifically designated categories of “disorders” (Chambless & Ollendick, 2001). These “empirically supported” treatments have produced positive outcomes under controlled research conditions across several studies and therefore are considered superior to treatments that have not been put to this kind of test.

Those who put their faith in the effectiveness of empirically supported therapies also tend to put their faith in the use of treatment manuals as the foundation for training therapists in the use of effective treatment methods. Treatment manuals were originally developed by psychotherapy research teams for the purpose of improving the internal validity of research studies by precisely explicating the technical principles, strategies, and tactics of a therapy model (e.g., Barlow & Cerny, 1988; Beck, Rush, Shaw, & Emery, 1979; Klerman, Weissman, Rounsaville, & Chevron, 1984; Luborsky, 1984; Strupp & Binder, 1984). Although these manuals usually originate as part of research protocols, increasingly they are being used as all-purpose texts for students and more experienced practitioners. In fact, their use is being promoted as a requirement for accreditation of clinical psychology training programs (Crits-Christoph, Frank, Chambless, Brody, & Karp, 1995). Treatment manuals have contributed to the formulation of a more precise language for describing and explaining technical strategies and interventions, and they are associated with increased thera-

pist adherence to the techniques prescribed in the models being taught (Binder, 1993).

The use of treatment manuals as an innovative method for enhancing psychotherapy training was greeted with tremendous optimism (Luborsky & De Rubeis, 1984; Strupp, Butler, & Rosser, 1988). Evidence does indicate that manuals are useful training tools for decreasing variance attributed to therapists in controlled studies—which was, after all, their original intent (Crits-Christoph & Mintz, 1991). After two decades of experience in using manuals in controlled studies of therapy process and outcome, however, this training innovation has not resulted in the large increment in therapist competence or effectiveness that was anticipated (Addis, 1997; Henry, Schacht, Strupp, Butler, & Binder, 1993; Lambert & Bergin, 1994; Miller & Binder, 2002). Treatment manuals usually are designed to guide the therapy of specific, circumscribed problems by applying specific techniques. A controlled research context oversimplifies the complexity and ambiguity of clinical problems encountered in actual practice. Therefore, if manuals have not made a significant impact on therapists' performances in controlled research settings, it is highly unlikely they will have a noticeable impact on real-world practitioners. Indeed, a decade after publishing his optimistic view of the potential of treatment manuals to enhance therapy research and training, Strupp (Strupp & Anderson, 1997) expressed concern about the "blind acceptance" of manuals as an effective means of improving therapist performance.

The fundamental presumption in the promotion of empirically supported treatments is that correctly chosen technical interventions are the primary determinant of therapeutic change and positive treatment outcome. Furthermore, treatment manuals are the best method of disseminating information about these correct techniques. Nevertheless, over two decades of manual-guided psychotherapy process and outcome research "have not produced support for more superior treatments or sets of techniques for specific disorders" (Lambert & Ogles, 2004, p. 167). Furthermore, "little evidence exists that efficacious treatments are readily transportable [from controlled research conditions to real-world practice]. Similarly, little evidence supports the notion that specific techniques make a substantial contribution to treatment effects" (Lambert & Ogles, 2004, p. 176).

Although there may be a host of reasons for these findings, I want to focus on two. First, practitioners working in real-world contexts are unlikely to limit themselves to specific treatment protocols designed

for isolated disorders, because most patients desire help for a mix of symptomatic, interpersonal, and environmental difficulties that defies the circumscribed diagnoses used to generate outcome criteria in controlled studies. Second, even in controlled treatment trials, where there is an attempt to standardize therapists' performances, there remains significant variability in competence and effectiveness across therapists and across patients for any given therapist (Beutler, 1997; Blatt, Sanislow, Zuroff, & Pilkonis, 1996; Garfield, 1997; Lambert & Okiishi, 1997, 1986). Luborsky and his colleagues (Luborsky, McClellan, Diguier, Woody, & Seligman, 1997) used an innovative research strategy that involved compiling data from sufficient numbers of therapists who have treated sufficient numbers of patients in research studies in order to use each therapist's caseload as the unit of measure. Accordingly, therapists' caseloads could be compared for relative treatment effectiveness. Significant differences in therapeutic effectiveness across therapists again were demonstrated, with some therapists identified as generally ineffective and others as generally effective. Even the most effective therapists, however, demonstrate noteworthy variability in effectiveness across patients, although they tended to be relatively more effective with difficult patients than were the less effective therapists (Najavits & Strupp, 1994). In sum, the argument can be made that what needs to be identified are not empirically supported treatments but empirically supported *psychotherapists* (Lambert & Ogles, 2004).

Regardless of the evidence, those who have advocated for the use of treatment manuals and empirically supported treatments have achieved a hegemony in public policy. How has this development come to pass? The turmoil around health care financing is one exacerbating factor. A more fundamental and enduring reason, however, is that the advocates embody a positivistic epistemology of clinical practice (both in the mental health and general medical fields) that has attained supreme influence with health care administrators—with the support of many researchers, educators, and practitioners. This philosophy of practice posits that "standards of care" associated with specific technical strategies and interventions should be developed for each disorder. These standards of care should be derived from the findings of treatment outcome research. It is presumed that deviations from these standards would produce inefficient and ineffective treatment (Elstein, 1997). Accordingly, the core of a training program should be a treatment manual and the program's primary aim should be students' consistent adherence to empirically supported techniques.

In the health sciences the striving to develop standards of quality care is salutary, as is the desire to use empirical evidence to guide development of these standards. Unfortunately, in the mental health field such efforts are often associated with the tacit attitude that psychotherapy involves no more than a dispensing or delivery of the proper set of techniques and can be accomplished by anyone following the right format. Accordingly, it has been reported that “most managed care companies . . . regard doctoral-level practitioners as overtrained and overqualified to spend most of their time performing psychotherapy” (Cummings & Sayama, 1995, p. 29). One position held by some mental health teachers/researchers is that psychotherapies that have been used in clinical trials “have been standardized and manualized, enabling any reasonably intelligent, well-motivated ‘generic therapist’ to administer them” (Detrie & McDonald, 1997, p. 203). Although this approach to practice has a scientific aura, it does not have a scientific foundation, as evidenced by the research cited above. Indeed, it justifies the warning about the “uniformity myth” made by the respected psychotherapy researcher Donald Kiesler (1966) to his colleagues years ago; namely, to avoid the assumption that all therapists of a given “school” practice alike. This myth, however, also can be applied to the assumption that all therapists trained with the same manual treat their patients with equal competence.

The delivery-based view of psychotherapy is a specific case of a more general positivistic strategy that has had enormous influence on both scientific research paradigms and professional training. The social scientist Donald Schon (1983, 1987) has termed this strategy “technical rationality”: The basic principle is that problem solving is made rigorous by the application of scientific theory and technique to clearly defined problems with clearly defined goals. But Schon argues that many, if not most, practice situations are not so clear-cut, whatever the professional discipline. On the contrary, many practice situations are characterized by ill-defined problems; they are “indeterminate zones” of uncertainty, instability, uniqueness, and value conflict (Schon, 1983, 1987). What an apt characterization of the typical psychotherapy session! The patient typically evidences more complex problems than are targeted in treatment efficacy studies (Seligman, 1998). Furthermore, the interaction of a particular therapist and a particular patient creates interpersonal dynamics unique to that therapeutic dyad, resulting in context-dependent technical challenges for that therapist.

Competent performance in a context such as psychotherapy—where the problems to be addressed continuously shift their form, the

contextual meanings of actions continually change, and the therapist is immersed in an emotionally charged interpersonal relationship that must be effectively managed—requires more than the straightforward implementation of prescribed techniques. What *is* required are complex interpersonal skills deployed under the guidance of very sophisticated mental activities. The use of techniques associated with a particular model of treatment or with an eclectic strategy is not synonymous with competent (or expert) performance (Addis, 1997). Therapeutic techniques must be used with skill and within the containment of a positive patient–therapist relationship. Unfortunately, even clinical theorists who have recognized the multidimensional nature of therapist performance are influenced by the positivistic viewpoint, reflected in the optimistic expectation that treatment manuals eventually would evolve to a level of precision that would be sufficient to ensure skillful technical performance (Schaffer, 1982, 1983).

On the contrary, I propose that the skillful use of therapeutic techniques is ultimately based on an ability to *flexibly* adapt them to immediate contextual circumstances. All other forms of skill require this fundamental capacity. Whether choosing a surgeon for an operation or a mechanic to work on a car, the intention is to select an expert at the task, not merely someone who can “go by the book.” What differentiates an “expert” from a by-the-book person? Expertise transcends simple competence to reflect the most skillful level of performance. This performance level involves the ability to deal effectively with conditions of the moment, whether routine, unique, novel, unexpected, puzzling, or critical. In other words, it is the ability to *improvise* when necessary. Going by the book—or the manual—may suffice when conditions are routine, but real skill is needed when the unexpected occurs.

IMPROVISING: THE SUPREME THERAPIST SKILL

When “master” therapists representing different treatment models conduct therapy, they tend to act more like each other than like the less skillful adherents of their own models (Goldfried et al., 1998). Indeed, the highly competent representatives of a treatment model often do not conduct therapy in the technically straightforward manner that is portrayed in the training manuals of their treatments, even when they are the authors of those manuals. For example, after viewing a videotape of Aaron Beck conducting cognitive therapy, a student of Beck’s

expressed surprise at the discrepancy between the official manual version of how to conduct this form of treatment and the manner in which Beck actually dealt with a difficult therapeutic situation: "Apparently, the actual practice of CT was richer in its handling of the therapeutic relationship than the textbooks would have had us believe, even then" (Newman, 1998, p. 96). A related observation from a study of cognitive and interpersonal treatments of patients with unipolar depression was that therapists who deviated from the manual-prescribed approaches in a way that made sense, particularly with difficult patients, tended to be judged as more competent (O'Malley et al., 1988). Expert therapists perform therapy in a way that distinguishes them, even from those who are using the same treatment model. The primary distinctive characteristic of these expert therapists is that they improvise, particularly in difficult situations. The necessity of improvising grows out of the inherent structure of any complex, problematic situation.

The capacity to improvise is made possible, *on the one hand*, by the acquisition and mental organization of knowledge and skills that are relevant to specific performance domains. In other words, experts improvise, but only within their specific areas of expertise. On the other hand, there are certain types of knowledge organization and basic skills that cognitive scientists have found to be associated with all of the complex performance domains that they have empirically studied. The findings from the efforts of cognitive scientists to study the development of generic expertise can be applied to better understand the mental processes and performances of psychotherapists (Binder, 1999).

Novices in any complex performance domain first acquire what is called "declarative" knowledge. This form of knowledge consists of facts, theories, principles, and rules about a knowledge domain. For example, therapy treatment manuals facilitate the understanding of abstract theories and empirically based facts about psychotherapy by rendering this type of knowledge in the form of precise technical strategies and tactics. However, whether we are playing golf, playing a musical instrument, or doing psychotherapy, a complex set of skills cannot be developed by merely reading and talking about them and observing others performing them. Simply possessing declarative theories, principles, and rules does not automatically ensure that the performer knows when and how to implement this knowledge in real-world contexts where it should guide understanding and behavior. Without additional knowledge about the appropriate and timely use of declarative knowledge, this knowledge is not spontaneously ac-

cessed when needed in the context of real-world problems. It remains “inert” (Bransford, Franks, Vye, & Sherwood, 1989). To apply the concept of inert knowledge to the work of therapy is to recognize that although a therapist may be proficient in thinking about therapy, he or she may not be proficient at actually doing therapy. Competent performers, including psychotherapists, appear to have a kind of “tacit knowing,” an ostensibly ineffable sense of what to do within their performance domains (Polanyi, 1967; Sternberg & Horvath, 1999). Donald Schon (1983, 1987), a social scientist who has studied expertise in various knowledge domains, calls this tacit knowledge “knowing-in-action,” to highlight the masterful performer’s ability in many situations to apply his or her knowledge in spontaneous action, without deliberate thought.

Cognitive scientists refer to knowing-in-action as “procedural knowledge” and explain that this type of knowledge shapes how declarative knowledge is applied in real-world situations. In a professional context, procedural knowledge develops from the experience of applying theoretical concepts, principles, and technical prescriptions in actual psychotherapeutic contexts; it consists of the pairing of propositions and concrete experiences with action strategies and rules, as well as appraisals of the consequences. For example, when a patient complains that the therapist is unhelpful, the therapist, rather than taking it personally and becoming defensive, is immediately aware that expressions of disappointment in the therapist often reflect a transference pattern of more chronic and pervasive disappointment in others, which, if explored, often leads to therapeutic progress.

Although procedural knowledge tends to operate outside of the practitioner’s conscious deliberation, it tacitly contributes to his or her “working model” of a problem context. Bowlby (1969) first developed the construct of working model to explain how humans select, organize, and store information in the process of learning to adapt to, and cope with, their environments. The working model is a kind of cognitive map that focuses on those aspects of the immediate environment relevant to the pursuit of selected goals. Although the construct was originally intended to organize explanations about general human learning, it has productively been applied to the analysis of therapist mental functioning (Peterfreund, 1983). The therapist’s working model is composed of contributions from two sources. The first source is comprised of schemas. A schema is a knowledge structure that is stored in memory. It consists of conceptual information, composites of lived experiences, or a combination of both, in which discrete information is

integrated into a cohesive pattern by some common theme. For example, we all have schemas that shape our views of self in various situations and interacting with specific categories of people under specific circumstances. The second source is the immediate interpersonal context (Horowitz, 1998). The therapists' working models influence (1) their use of theoretical concepts in organizing clinical information and assigning meaning to it, (2) their integration of relevant clinical data from current and past experiences, (3) their construction of coherent thematic patterns or "stories," and (4) their anticipation of events.

There is no substitute for firsthand experiences as a prerequisite for developing an intimate working knowledge of a performance domain. Competence in conducting psychotherapy is characterized by facile access to procedural knowledge that is relevant to a large variety of therapeutic situations. Procedural knowledge expands and becomes increasingly "nonconscious" and automatic with practice (Dreyfus & Dreyfus, 1988; Glaser, 1989). If not encumbered by inept performance habits, practitioners become capable of responding to a set of current practice circumstances by recalling similarly patterned experiences from previous situations as well as automatically thinking of the best strategies or actions. Competent practitioners are usually capable of acting in a reasonable and effective manner in a given the situation, without a deliberate and laborious search for the best move (Glaser, 1989; Holyoak, 1991; Kihlstrom, 1987). Relatively routine situations can be effectively managed by the partially automatized application of procedures derived from theoretical principles and professional experience. For example, in response to a patient stating that he or she does not know what to talk about, the psychodynamic therapist using the principle of "psychic determination" encourages the patient to verbalize whatever spontaneously comes to mind. The interpersonal patterns associated with such situations can be matched with prior interpersonal patterns that the therapist has encountered in a relatively straightforward manner. This matching process can be accomplished with varying degrees of conscious awareness. The therapist's current working model can be constructed with minimal effort (Cohen, Freeman, & Wolf, 1996; Schon, 1983) because his or her mental processes and behavior are guided primarily by a knowing-in-action—ability that can be only roughly described in treatment manuals.

Frequently, routine therapeutic procedural knowledge is not sufficient to deal with the vagaries of therapeutic relationships. As discussed previously, the psychotherapeutic setting is an example of a context characterized by ill-defined problems in an environment of un-

certainty, instability, uniqueness, and potential value conflicts (Schon, 1983, 1987). For example, a very high percentage of people seeking psychotherapy has a mix of problems and problematic situations that makes it impossible to specify an isolated target for intervention. Furthermore, the particular characteristics that emerge within each unique patient–therapist relationship have a profound influence on the patient’s assignment of meanings to the therapist’s interventions—and, therefore, on the impact of these interventions.

Sometimes the most effective performance requires the capacity to switch strategies in order to make an appropriate response to a situation that contains unpredictability (Patel & Groen, 1991). This sort of adaptive flexibility is a component of the capacity to improvise as the therapeutic context continuously changes. Improvisation in any knowledge domain can be defined as the capacity to reshape understanding of the situation by reframing problems, adjusting strategies and tactics, and significantly departing from established procedures in response to novel or unexpected conditions. Because this capacity involves mental processes that occur rapidly and largely outside of awareness, it appears intuitive in nature and thus beyond the reasoning processes (Holyoak, 1991; Schon, 1983). However, improvisation appears to rely upon two identifiable sets of skills: (1) highly disciplined and automatized procedural knowledge, and (2) a highly refined self-regulatory ability that allows the person to reflect on, and adjust, his or her performance in the moment (Glaser, 1989; Schon, 1983, 1987). Whether it is a jazz musician creating an innovative riff, a golf professional shaping a difficult shot, or a cardiac surgeon performing a complex operation, improvising within the parameters of domain-relevant understandings and principles marks an expert performance.

The expert psychotherapist unwittingly has stored an enormous and largely tacit mental record of interpersonal patterns, psychological themes, therapeutic scenarios, and theoretical concepts, principles, and procedures, all organized around action–consequence sequences. Just about any interpersonal situation will activate conscious memories or at least a sense of (i.e., tacit memories) previously experienced situations or types of situations that are, to some degree, similar to the current one. These memories include previous actions that might be currently useful, and they contribute to the therapist’s current working model of the therapeutic situation. As previously discussed, the activation of this sort of procedural knowledge is a tacit process. In many therapeutic situations, however, conditions are ambiguous or have potentially conflicting interpersonal meanings. Consequently, finding

something familiar in the current situation is not straightforward and may even be quite difficult, because there is no obvious match with available mental records (Cohen et al., 1996; Schon, 1983, 1987). In such a predicament, the knowledge represented by these previous understandings and actions must be reshaped to fit the unique circumstances of the current situation. For example, the therapist senses that her patient unwittingly pushed away people with whom she would like to emotionally connect. However, the way in which the patient does this does not appear to correspond to any pattern of behavior that the therapist has seen in other patients. Nevertheless, the therapist is familiar with strategies for closely examining the patient's perceptions of her intentions that are likely to reveal the patient's unique maladaptive actions.

This reshaping process occurs with conscious recognition, to some degree, and is the product of the other set of generic skills that underlies expertise: the capacity for self-regulation of action. This capacity involves what cognitive scientists refer to as "metarecognition skills": knowledge of, and ability to regulate and modify, one's own mental states, processes, and behaviors (Cohen et al., 1996). The elementary form of metarecognition skill involves "*reflection-on-action*," either by pondering past action or by pausing in the midst of action. In the more advanced form of metarecognition skill, "*reflection-in-action*," deliberation occurs in the midst of action, without interrupting whatever is ongoing. Thinking leads to a reshaping of the performance while it is occurring (Schon, 1983, 1987). The ability to reflect-in-action requires a reshaping of the components of procedural knowledge during the process of comprehending and acting, as feedback from the situation calls for context-dependent adjustments. Self-modifications of a therapist's working model may involve revisions of the story associated with the patient's problems (in the direction of greater consistency and plausibility), or it may involve shifting strategies in order to overcome an obstacle in the patient-therapist working collaboration.

Peterfreund (1983), for example, described a "dialogue" between an operating working model and error-correcting feedback from the actual therapeutic situation. Referring to generic problem contexts, Schon (1983, 1987) described "reflective conversations" with a problem context, in which interventions reveal consequences, implications, and indicators of further actions. In the case of psychotherapy, the reflective conversation is figurative, referring to the problem context, and literal, referring to a collaborative dialogue with a patient. There can be two goals for such reflective conversations: (1) the construction of a

therapeutically useful story to describe and explain the patient's problems, and (2) determination of the best methods for keeping the inquiry going. The most proficient form of improvisation involves reflection-in-action, whereby working models are fine-tuned or radically modified during the conduct of a therapy session through a special sort of problem-framing and problem-solving dialogue with the patient. In other words, the therapist improvises through a reflective conversation with the problem context and with the patient (Schon, 1983).

THE RELATIONSHIP BETWEEN LENGTH OF THERAPY AND OUTCOME

Therapy is most effective if it is skillfully conducted, in large part, regardless of the specific techniques used. This book focuses on how to conduct dynamic-interpersonal therapy skillfully *and* in a time-limited manner. There is no evidence to indicate how much can be accomplished in a given span of time or number of sessions if therapy is conducted with consistent competence or expertise. Over the last decade, however, solid evidence has accumulated about what can be accomplished by a very broad spectrum of therapists and patients on a very wide variety of problems, given varying amounts of time. The major innovation in research methodology that has contributed to this evidence is the "dose-effect" strategy; that is, the measurement of progressive change in therapy across treatment sessions (Howard, Kopta, Krause, & Orlinsky, 1986). The major findings regarding the individual treatment of adults are:

1. Reduction in symptoms tends to occur most quickly, whereas characterological and interpersonal problems respond more slowly to treatment.
2. Improvement tends to be greatest in the early sessions of therapy.
3. The longer the therapy, the greater the improvement, but with diminishing returns over time.
4. Across all sorts of individual therapy, 50% of patients with significant dysfunction achieve meaningful clinical improvement by the 21st session, and 75% of these patients achieve meaningful clinical improvement with at least 50 sessions.

Furthermore, treatment gains tend to endure, regardless of the length of therapy (Lambert & Ogles, 2004).²

The evidence is clear: On the whole, you can significantly benefit half the people you see in a traditionally defined brief treatment format (20–25 sessions), but you can substantially increase the proportion of people who benefit from your treatment if you can extend it to at least twice the length of traditionally defined brief therapies (from a traditional psychoanalytic perspective, however, a year of weekly therapy is relatively brief). It is equally clear that managed care companies that put yearly reimbursement limits on less than 50 treatment sessions are adversely affecting a substantial proportion of patients. In particular, when arbitrary limits are placed on the duration of treatment, the most likely adverse effects will be an insufficient treatment of personality patterns (affecting general as well as interpersonal functioning). Therefore, although symptom reduction may be achieved, the person may remain vulnerable to recurrence of symptoms produced by continued malfunctioning or, at least, continued malfunctioning, with the detrimental effects it has on self, others, and society. This situation is analogous to treating a bacterial infection with an arbitrary dose of medication that is insufficient to wipe out the bacteria. Symptoms may be temporarily reduced but the infection remains. Such is the logic of externally imposed treatment-session limits that are not guided by reputable research.

As the Menninger Foundation Psychotherapy Research Project revealed, long-established doctrines about the conduct, mechanisms of change, and outcomes of psychodynamic psychotherapy can be proven wrong. For example, the Menninger researchers discovered that the therapists conducting long-term expressive psychoanalytic therapy and classical analysis provided many more “supportive” interventions than would have been expected, according to theory, and the outcomes of some of the “supportive” psychotherapies indicated as much or more enduring intrapsychic “structural” change than many of the classically conducted analyses (Wallerstein, 1989). The researchers’ concluded that there are a variety of ways of facilitating significant psychological change.

When comparable empirical comparisons of long-term psychodynamic therapy and brief psychodynamic therapy are conducted, the same unexpected outcomes are likely to be revealed. The major differences between long-term and brief psychodynamic therapies occur in the relative impact of different change processes. In both forms of therapy, (1) cognitive insight and other forms of cognitive learning (e.g.,

through psychoeducation) and (2) internalized corrective interpersonal (emotional) experiences play roles in facilitating psychological change. The impact of a long-term, intimate relationship and the deep human attachment that forms between patient and therapist may result in corrective interpersonal experiences playing a relatively larger role in long-term therapy. Furthermore, because transference-countertransference enactments are much more likely to develop a prominent role in the long-term therapeutic relationship, transference interpretation is typically used more extensively. On the other hand, in the relatively shorter encounters characteristic of brief psychodynamic, interventions that promote and explicitly teach insight and interpersonal skill development may play a relatively larger role. In addition, the work may focus largely on areas of the patient's life outside therapy. These issues are discussed in more detail in Chapters 5 and 6.

In line with this perspective on the similarities and differences between long-term and brief treatments, let us consider several misconceptions about the supposedly unique technical features of brief psychodynamic therapy.

MISCONCEPTIONS ABOUT BRIEF PSYCHODYNAMIC PSYCHOTHERAPY

Circumscribed Problem Focus and Goals

The formulation of circumscribed problems and goals is commonly cited to distinguish time-limited therapies from open-ended approaches. There is no evidence that traditional psychodynamic therapies have qualitatively different outcomes from time-limited dynamic therapies (Levenson, Butler, & Beitman, 1997), and there is strong evidence that even successful psychoanalyses do not result in complete problem resolution (Schlesinger & Robbins, 1983; Wallerstein, 1989). One implication is that problems and goals are circumscribed, to some extent, in all dynamic therapies, from psychoanalysis to time-limited dynamic treatments. Consequently, regardless of the length of treatment, the therapist should articulate a treatment focus and associated treatment goals in collaboration with the patient. The focusing process can be viewed as analogous to planning a trip with the aid of a map. Whether the ultimate destination is relatively close or far, the initial direction will be the same if both potential destinations are along the same route. The point is that there should be a planned direction for treatment regardless of its intended duration. With regard to treatment goals, when

more time is available, the goals may be more ambitious but still should be specified, to some extent. In a nutshell, time-unlimited therapy is *not* characterized by an *absence* of problem definition or specified goals; that would be poorly conducted therapy. Conversely, a consistent focus on salient problems and goals is characteristic of good therapy, regardless of length.

Time Limits and Time Management

A common assumption is that time-limited therapies are, in part, defined by special attention to the management of treatment time. The setting of time limits is presumed to motivate the participants to work faster, a form of “Parkinson’s Law” (Applebaum, 1975). There is as yet no solid empirical evidence to support this presumption however. Concrete arrangements for the specific length of a therapy—whether defined by number of sessions, calendar date, or by specific goals—are the relatively superficial manifestations of time management. The most expeditious management of time involves a set of attitudes about how therapeutic time should be spent and the implementation of these attitudes (Budman & Gurman, 1988; Strupp & Binder, 1984). Time should be used with maximum efficiency. In order to accomplish this objective, both therapist and patient must remain consistently focused on relevant issues, and the therapist must remain alert and actively involved in facilitating a productive working collaboration with the patient. This level of involvement should characterize a therapist’s participation, regardless of the anticipated length of the treatment. Any less effort on the therapist’s part would constitute inefficient work, and therefore poorly conducted therapy, regardless of the amount of time available.

Specific Selection Criteria

From Freud’s epoch to the 1960s, patients’ suitability for psychodynamic therapy was evaluated. In the past three decades, however, sensitivity to consumer rights has contributed to a shift in the language used with regard to treatment evaluation; the patient is now evaluated to determine if the *treatment* is suitable for him or her. Perhaps this shift was nothing more than an exercise in semantics. In any event, suitability criteria comprise some mixture of psychopathology severity and level of “ego functions”—the latter set of criteria often being unreliable because of the abstract nature of the construct. There is no empiri-

cal evidence that the vast majority of selection criteria involving patient characteristics are useful in predicting the outcome of treatment (Binder, Henry, & Strupp, 1987; Garfield, 1994). There is some evidence, however, that severity of psychopathology is a factor that can help predict rate of change (Howard et al., 1986; Kopta, Howard, Lowry, & Beutler, 1994) and that, at least in psychodynamic treatments, the effectiveness of specific therapeutic strategies is associated with the patient's maturity level of interpersonal relating (Piper, Joyce, McCallum, & Azim, 1993). Time-limited dynamic therapists have developed stringent lists of selection criteria that, essentially, include circumscribed problems, previous good adjustment, good communications skills, mature interpersonal relatedness, and high motivation (Koss & Shiang, 1994). In Chapter 3 I discuss the only patient characteristic that has shown any empirical promise as a useful predictor of the quality of therapeutic involvement; namely, the capacity for interpersonal relating. This criterion is relevant regardless of the anticipated length of treatment. In our current treatment context the primary aim of the diagnostic evaluation process is to plan intervention strategies rather than to decide whether or not treatment will be attempted. The empirical evidence has validated a suggestion made almost 20 years ago by the venerable clinician Lewis Wolberg (1980): Try all patients in time-limited therapy rather than attempting to figure out who is "suitable." Careful assessment for the purpose of treatment planning is characteristic of good therapy, regardless of length.

Therapist Activity

In the course of teaching psychotherapy and participating in process-outcome research, I have had the opportunity to listen to, or observe, the audiotaped or videotaped recordings of many therapists representing all levels of competence, in addition to reflecting on my own work. It is my conclusion that good therapists foster an active dialogue with their patients. The amount of therapist verbal activity may vary as a function of the particular type of therapy (e.g., psychoanalysis vs. brief dynamic treatment), but more likely it varies as a function of the therapist's particular work and interpersonal style. Nevertheless, the working therapeutic relationship is characterized by a dialogue rather than by a patient or therapist monologue. A competent therapist is able to deftly balance the discourse strategies of (1) facilitating candid patient communication, (2) directing the mutual exploration of the patient's salient content themes, and (3) balancing listening and interven-

tion modes. This type of therapeutic dialogue is a hallmark of well-conducted psychotherapy, regardless of length. Furthermore, most therapist effort is directed toward the covert mental activities involved in selecting, organizing, and making sense of clinical data, in planning what to do, and appraising the nature and consequences of the unfolding therapeutic dialogue. This mental activity, conducted in a systematic, disciplined manner, is also characteristic of good psychotherapy, regardless of length.

Need to Quickly Develop a Therapeutic Alliance

A positive therapeutic alliance is the factor that psychotherapy research has shown, above all others, to be most strongly and consistently associated with positive outcome (Henry, Strupp, Schacht, & Gaston, 1994; Martin, Garske, & Davis, 2000; Orlinsky, Grawe, & Parks, 1994; Horvath & Greenberg, 1994). The expeditious establishment of a positive alliance appears to be crucial for successful treatment, regardless of length. In other words, there is no reason to conclude that unlimited treatment time reduces the need to develop and maintain a therapeutic alliance. The relatively limited time available in brief treatment leaves little opportunity for developing an alliance or fixing a broken one. The implication is that greater available treatment time offers more latitude for alliance problems. Although this argument has some merit, it does not imply that the therapist conducting open-ended therapy can passively wait for an alliance to develop without working at it, or can fix alliance problems at his or her leisure. Effective therapeutic work cannot occur without a strong alliance, so fostering the development of a therapeutic alliance should be a high priority from the inception of treatment. Similarly, dealing with alliance problems is an urgent issue in treatment of any length, if one of the goals is to maximize the efficient use of therapeutic time. Nurturing a positive therapeutic alliance is not simply a matter of being a "good person," warm, empathic, and interested. As with all intimate relationships, the therapeutic alliance takes work and is more difficult than is often presumed. The effective management of alliance issues is indicative of well-conducted psychotherapy, regardless of length.

Rapid Assessment

Strupp and Binder (1984) suggested that any distinction between evaluation and intervention efforts was artificial in practice, even if a con-

ceptual distinction is made for teaching or research purposes. A productive therapeutic process involves, on the one hand, a therapeutic dialogue that seeks a deeper understanding of the patient throughout treatment, and, on the other hand, aims to provide some therapeutic benefit to the patient in each session. In describing the characteristics of competent problem solving across many professional domains, Schon (1987) offered this relevant aphorism: "The unique and uncertain situation comes to be understood through the attempt to change it, and changed through the attempt to understand it" (p. 132). An extension of this position is that assessment should be a high priority right from the beginning of any treatment, regardless of the anticipated length. An important component of assessment is the process of understanding the patient in order to guide and focus the type and content of interventions.

Attention to Termination Issues and Effective Management of the Process

It is commonly assumed that a distinguishing factor of time-limited therapies is the interpersonally tricky negotiation of the termination phase. Because time limits may put pressures on the patient and the therapist, it is assumed that termination will create extraordinary interpersonal stresses. Yet, the relatively brief duration of therapeutic relationships associated with time-limited treatments may, in fact, decrease the likelihood that parting will be especially difficult. The typically deeper attachments that develop in time-unlimited therapy may, on the whole, result in a greater likelihood of stress and conflict around termination. In short, there is no convincing reason or empirical evidence to presume that there are any special problems or technical strategies associated with termination issues that distinguish time-limited therapy from good psychotherapy, regardless of the length.

Therapist Optimism about What Can Be Accomplished

It has been claimed repeatedly that to be effective in using time-limited forms of therapy, the therapist must truly believe in this type of treatment (Budman & Gurman, 1988; Levenson et al., 1997). Although there is no empirical evidence to support this specific claim, common sense suggests that any effort is more likely to succeed if one has faith in the methods being used. Empirical evidence regarding the role of therapist attitudes and values in determining the fate of psychotherapy is

equivocal, partly because this factor is so entwined with patient contributions to any given therapeutic dyad (Beutler, Machado, & Neufeldt, 1994). Nevertheless, those authors who advocate for systematic training in time-limited therapies often presume that once the clinician (or student) develops faith in this approach, learning how to conduct time-limited forms of therapy will be a relatively uncomplicated process. There is no empirical evidence to support this presumption. Indeed, it appears that training therapists to conduct good therapy of any length is a daunting challenge that involves guiding and shaping the development of very complex interpersonal skills.

To summarize the main implications of this section, the major consequences of time constraints are (1) that therapeutic goals may have to be circumscribed, and (2) that the therapist may explicitly have to encourage the patient to learn certain skills for managing psychological and interpersonal problems after therapy ends. These two therapeutic strategies may be relatively more important with therapies of short duration, but specifying goals (which implies some amount of circumscription) and coaching the development of certain skills are a part of any good psychotherapy. Constraints on the amount of time available for psychotherapy do not always require the therapist to work harder, to be more skillful, or to use special techniques. Good therapy is hard work for both participants, regardless of the length. Conversely, poor therapist performance will not necessarily (perhaps not usually) be compensated by the availability of more time. If a physician prescribes an ineffective type or dose of medication for some medical disorder, an unlimited duration of time for this ineffective treatment to continue does not guarantee that this error will be recognized and corrected. It is perhaps just as likely that the patient will discontinue treatment, become demoralized by medicine and physicians, or become more seriously ill. A comparable sequence of events is likely to occur with poorly conducted time-unlimited psychotherapy. It might be a very good idea to discard totally terms such as *brief*, *short-term*, and *time-limited* when characterizing forms of psychotherapy and replace them with terms such as *time-effective* and *time-sensitive* (Budman & Gurman, 1988). These latter terms are based on the premises that (1) most therapies are of limited duration, (2) that it is impossible to predict what goals can be achieved in a given amount of time for any given therapeutic dyad, and (3) that the secret of effective brief therapy, in regard to the therapist's role, is to conduct the treatment skillfully. I continue to use terms such as *time-limited* in this book

because they are familiar, but unless stated otherwise, I am referring to the notion of *time-effective* treatment.

In sum, I do not believe that, aside from the brevity of the treatment, there is anything unique about the conduct, processes, or outcome of brief psychodynamic therapy in comparison to long-term psychodynamic therapy. *There are no specific techniques that hold the key to the practice of brief therapy. Instead, the most expeditious means to achieve efficient and effective therapeutic outcomes is to practice "good" psychotherapy, regardless of the anticipated or planned length.* In conducting brief therapy, it is especially important to identify a central issue or focus for the therapeutic work, articulate it precisely, and track it consistently within and across sessions. Conducting good psychotherapy, whether long term or brief, requires the exercise of several basic therapeutic competencies. Most of these competencies are composed of theory-guided technical strategies and tactics, although the aim of each competency is pantheoretical. In order for the therapist to improvise effectively, these competencies must be implemented with a sufficient level of skill. The competencies that I discuss were chosen partly on the basis of empirical evidence. Unfortunately, the scientific foundation of psychotherapy practice does not cover an area sufficiently wide to guide all facets of practice. It is necessary, therefore, to rely on clinical "wisdom," to some extent, which is composed, in part, of preferred theories and practices and an extensive collection of impressions and anecdotes. Drawing from these two sources of inspiration, I propose five clinical competencies that are associated with the practice of "good" dynamic-interpersonal psychotherapy.

1. *Competency in understanding personality functioning and therapeutic process.* Therapists must be able to apply (a) a clear model of personality functioning to their understanding of patients' worlds, and (b) a congruent model of therapeutic process to guide their interventions. This model of therapeutic process includes the roles of patient and therapist, how the process facilitates psychological change, and what aspects of the process may impede change. In time-limited dynamic-interpersonal psychotherapy, the process is broadly conceived of as a collaborative working relationship between patient and therapist that sometimes can be impeded by the enactment of the patient's maladaptive interpersonal patterns. These interpersonal patterns represent the expression of dysfunctional internal schemas (i.e., cognitive-affective knowledge structures) and may manifest in response to the therapist. In other words, although originating within the patient, maladaptive

interpersonal patterns may be influenced by, and in turn influence, the participation of the therapist. The enactment of interpersonal patterns that impede therapeutic change also provides a useful opportunity for understanding and acting upon the patient's problems. It is presumed that therapeutic change can be produced by several independent, or partially independent, mechanisms and processes, ranging from cognitive understanding to behavioral practice. In Chapter 2, I present models of personality functioning and therapeutic process and change that I think are a useful conceptual tools when conducting dynamic–interpersonal time-limited therapy.

2. *Competency in problem formulation and focusing.* A precise problem formulation that will serve as the focus of treatment interventions must be articulated as quickly as possible. This focus is initially incomplete and always subject to some modification and elaboration. It is a working plan of action that guides the content of the therapist's interventions. A descriptive diagnosis of psychopathology (currently represented by DSM-IV-TR categories), although ideally congruent with this formulation, is not designed to serve the same heuristic treatment function as an individually tailored formulation. In time-limited dynamic–interpersonal psychotherapy the problem formulation is conceptualized in terms of a “story” of recurrent maladaptive interpersonal patterns that reflects internal anachronistic, rigid, and dysfunctional mental working models. I discuss the assessment process and problem formulation model in Chapter 3.

3. *Competency in tracking a focus.* The problem focus serves as a guide for the content of the therapist's interventions. There is now a convincing body of empirical evidence indicating that therapist ability to track a problem focus consistently is associated with positive treatment outcome (Crits-Christoph, Cooper, & Luborsky, 1988; Messer, Tishby, & Spillman, 1992; Piper et al., 1993; Silberschatz, Fretter, & Curtis, 1986). Although there is no evidence that a precisely formulated problem focus, per se, directly contributes to a positive treatment outcome, common sense dictates that a more precisely formulated problem is easier to track. In any event, it is not known how consistently therapists can stay focused on the story content of a problem formulation, even when the precision of the formulation is enhanced by research procedures. The available evidence does not indicate that therapists do a satisfactory job of tracking a problem focus, although flaws in the research designs must be considered (Crits-Christoph et al., 1988). I discuss the tracking of a problem focus in Chapter 4.

4. *Competency in applying technical strategies and tactics flexibly and*

creatively. This competency addresses the style of the clinician's activities. The therapist must be able to operate *flexibly* within the framework of some model of therapeutic process and change. By this I mean that therapeutic strategy remains consistent with the model, even as specific interventions are determined both by their congruence with the technical strategy and by the immediate contextual demands (Beutler, 1997). The dynamic-interpersonal model of therapeutic process invites a technical strategy that promotes a particular sort of inquiry that has three broad aims: (a) progressively greater comprehension of the content, function, purposes, and history of salient maladaptive interpersonal patterns; (b) acquisition or enhancement of certain interpersonal problem-solving skills, and; (c) fostering of specific constructive interpersonal experiences. The disciplined implementation of a theory-driven technical strategy coupled with the flexible choice of specific interventions culminates in the quintessential therapeutic skill: the ability to *improvise* in response to unique therapeutic contexts. I discuss the flexible use of technical strategies and tactics to promote specific change processes in Chapters 5 and 6.

5. *Competency in relationship management*. The therapist must possess a set of skills that enables him or her effectively to manage vicissitudes in the interpersonal process that may occur during the course of a therapeutic relationship. The mutual involvement of patient and therapist assuredly constitutes a form of intimacy within the constraints of a professional arrangement. As with any intimate relationship, there are ups and down in the therapeutic dyad. The down periods can be quite tense. In addition, there is a significant potential challenge inherent in many therapeutic relationships. Anyone who genuinely requires psychotherapeutic intervention probably has significant difficulties in interpersonal relating, at least temporarily, regardless of symptoms. Furthermore, interpersonal difficulties usually involve hostility, which can often be very subtly expressed. The patient may convey hostility in a manner that pulls for a reciprocal reaction from the therapist—who is, after all, only human. The result is “negative process”; that is, patient-therapist interactions that are characterized by complimentary hostility, in which the provocative action of one party (i.e., the patient) has a high probability of evoking a reciprocal hostile reaction from the other party (i.e., the therapist) (Kiesler, 1996). Whether termed “negative transference and countertransference,” or “vicious circles” (Wachtel, 1993) or “cyclical maladaptive interpersonal patterns” (Strupp & Binder, 1984), I and others propose that negative process is a primary impediment to therapeutic change in all forms of

psychotherapy and is a widely underestimated factor in therapeutic relationships (Binder & Strupp, 1997a). Accordingly, therapists must develop a set of skills associated with identifying and effectively resolving episodes of negative process, if they arise. The core of these skills involves forms of self-monitoring within the flow of interpersonal process. The concept of negative process and the skills associated with managing it are discussed in Chapter 7.

The discussions in the chapters to follow include a description of each competency, clinical illustrations of it and the identification of specific therapeutic skills and underlying generic skills associated with each. In Chapter 8, Karishma Patel and I discuss the unique skills involved in terminating therapy. Chapter 9 addresses the topic of psychotherapy training and elucidates significant problems in training that have been identified as a consequence of research using manual-guided therapist training formats.

NOTES

1. This view is increasingly held by psychotherapy researchers (who depend on policymakers for research funds), teachers (who are pressured by accrediting organizations to promote only treatments or interventions that are empirically supported), and practitioners (who, for the most part, are feeling coerced into accepting this view in order to get reimbursed by third-party payers).
2. It should be kept in mind that the dose–effect data represent aggregate results reflecting the hypothetically average therapist. It is conceivable that the more skillfully you conduct therapy, the more efficient you can be. Whereas developing skill is a broad, ambitious goal, there is some empirical support for a specific, tangible way to improve therapeutic efficiency and effectiveness. Therapists who solicit feedback from their patients about the patients' responses to treatment sessions can potentially enhance outcomes and, at least, improve efficiency by reducing treatment failures or dropouts, particularly with difficult patients. Patient responses to treatment sessions—in the form of evaluations of symptoms, functioning, and the state of the therapeutic alliance—can be obtained from easy to administer self-report measures after each treatment session (Lambert, Whipple, et al., 2001; Lambert et al., 2002).