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Short-Term Supportive-Expressive Psychoanalytic Psychotherapy

Handbook of Short-Term Dynamic Psychotherapy

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ORIGINS AND DEVELOPMENT

Dynamic psychotherapy is the oldest, the best known, and the most widely practiced of the many forms of psychotherapy. Its techniques gradually evolved into the two treatment forms used today: classical psychoanalysis and psychoanalytic psychotherapy. Dynamic psychotherapy, which is our simpler term for psychoanalytic psychotherapy, has itself developed two formats: open-ended and time-limited.

This chapter is specifically devoted to a review of the techniques of the time-limited, manual-guided, dynamic supportive-expressive (SE) psychotherapy described in Luborsky (1984). The chapter does even more: it offers a set of principles and techniques that are ordered in their importance for this therapy.

A brief note is needed at this point to explain the terms *supportive* and *expressive*, even though they will be more fully explained later in the chapter. *Supportive* refers to the techniques aimed at directly maintaining the patient's level of functioning; *expressive* refers to the techniques aimed at facilitating the patient's expressions about problems and conflicts and their understanding.

The ideas about how to conduct this form of psychotherapy found their way into the manual from conventional psychodynamic sources. It should be obvious already that the manual was never intended to offer a new psychotherapeutic system, but rather to capture the essence of the technical system inherent in the writings of those who were among the accepted propounders of the method. By far the most influential source was Freud's six papers on technique: 1911/1958b, 1912/1958a, 1912/1958e, 1913/ 1958d, 1914/1958f, and 1915/1958c. But some of the other writers who based themselves on Freud also had an impact on the manual: Bibring (1954), Fenichel (1941), Luborsky and Schimek (1964), Menninger and Holzman (1973), and Stone (1951).

The essential substance of the system is derived from the above writers as summarized by Lester Luborsky and David Mark. Lester Luborsky's clinical experiences came from the apprentice training at the Menninger Foundation; much of the training there was in supportive-expressive psychotherapy, which was the main form of psychotherapy in addition to classical psychoanalysis. In his thirteen years there, he changed supervisors annually, gaining the benefit of a range of points of view. He also learned about dynamic psychotherapies from his nine years of psychoanalytic training and from his six years as head of the termination evaluation team in the Menninger Foundation Psychotherapy Research Project (Kernberg et al., 1972; Wallerstein, 1986). David Mark's experience has also been with

training, practice, and research in dynamic SE psychotherapy; some of it has been in collaborative projects with Lester Luborsky.

The ideas for the format of the manual also evolved over time. The evolution was helped along because the manual was used daily in the teaching of dynamic psychotherapy in the Department of Psychiatry at the University of Pennsylvania. Beginning around 1970, the manual was only in the form of a Socratic conversation—questions and answers of the kind that were typical in the supervision for dynamic psychotherapy. The current manual format for dynamic SE psychotherapy took shape in 1976 and was eventually further formalized in Luborsky (1984). This format had the three essential components of a clinical manual that would be suitable for research (Luborsky & DeRubeis, 1984): a set of the most accepted principles of the technique, examples of each of the principles that make unmistakable what is intended, and a set of scales for each of the main techniques so that independent judges can estimate the degree to which any sample of therapy conforms to the manual. This manual format for dynamic SE psychotherapy obviously has filled a widespread need in both practice and research. In the years since its publication, it has been translated into German, Italian, Japanese, Portuguese, and French.

In 1978, a more continuous immersion in a time-limited (twenty-four-session) version of the manual began through experiences in the

orchestration of a supervision group of therapists who were treating heroin-addicted patients for the Woody et al. (1983) project. Starting in 1987, an even briefer (sixteen-session) version was constructed for the treatment of patients with *DSM III-R* diagnosis of major depression. The experiences in these studies have contributed to the creation of two special adaptations of the SE manual for time-limited psychotherapy: one for drug dependence (Luborsky, Woody, Hole, & Velleco, 1977) and another for major depression (Luborsky et al., 1987).

SELECTION OF PATIENTS

Because research has not yet provided tested conclusions about which patients are most suitable for any of the psychotherapies, including shortterm supportive-expressive psychotherapy, we must rely on the considerable clinical experience from its applications and especially from the ongoing supervision groups using time-limited dynamic SE therapy. The experience has shown that this form of psychotherapy is suitable for many kinds of patients. The breadth of usefulness of dynamic SE psychotherapy for patients with different degrees of psychiatric severity is largely based on the individually determined mix of its supportive and expressive components for each patient. For instance, more supportiveness is to be given to the sicker patients along with only sparing and cautious use of expressive techniques. But we also recommend screening out most patients who are psychotic or

borderline, as well as patients who find it extremely difficult to tolerate becoming dependent and then separating, when this difficulty is shown in an inclination to suicide.

There is one research-based recommendation about patients who should be excluded: those diagnosed as antisocial personality (Woody, McLellan, Luborsky, & O'Brien, 1985). This finding was based on the time-limited treatment of *DSM III*-diagnosed, drug-dependent patients. The patients in this *DSM III* category appear to be the only ones who are almost completely unresponsive to psychotherapy. Yet even for this group there are mitigating conditions derived from the presence of dual diagnoses: for example, when the antisocial personality diagnosis is accompanied by depression (Woody, McLellan, Luborsky, & O'Brien, 1985), or when there are signs that a helping alliance can be formed and therefore that the prognosis with psychotherapy is somewhat improved (Gerstley et al., 1990).

Clinical experience also shows that some kinds of patients require much longer therapy. Patients with personality disorders, for instance, may require longer treatment, especially when the personality disorder is added to an Axis I diagnosis (Reich & Green, in press). Instead of the usual short therapy in the range of sixteen to twenty-five sessions, they may require a year to two years. Because it is difficult to predict which patients will do well with which treatment length, a trial of short-term therapy can be given at times. Such

trials typically do no harm. If a brief trial is not sufficient, the longer term treatment can then be given.

The general manual applied in its time-limited version is suitable to guide the therapist in the treatment of a broad range of patients. But manuals tailored for specific diagnoses and personality types have been written. The oldest of these is the adaptation of the general manual for drug-dependent patients, mainly methadone-treated heroin addicts (Luborsky, Woody, Hole, & Velleco, 1977), which has had several editions. The manual is for time-limited treatment (twenty-four sessions in twenty-four weeks) and has these special emphases: (1) introducing the patient to psychotherapy and engaging the patient in it; (2) specifying the goals; (3) developing a therapeutic alliance and providing sufficient support; and (4) keeping the therapist abreast of the patient's illicit drug use and of the current level of methadone. An adaptation of this manual for cocaine abuse disorders is being developed (Mark, Crits-Christoph, & Luborsky, 1990).

Another version of the general manual was developed in 1987 for the time-limited (sixteen sessions in sixteen weeks) dynamic psychotherapy of *DSM III* major depression (Luborsky et al., 1987). The special adaptations of the general manual for time-limited therapy of major depression include: (1) selecting and maintaining an interpretative focus; (2) dealing with the special themes of depressed patients, especially suicidal ideation; and (3) dealing

with the time limit and the termination.

SELECTION OF GOALS OF TREATMENT

Starting within the very first sessions, goal setting is helpful in open-ended SE psychotherapy; it is crucial in time-limited SE psychotherapy.

The focus on goals tends to speed the therapeutic work by strengthening the impetus to change. The goals specify the patient's desired changes, so they help the patient to keep in sight the motive for continuing to come to treatment and for trying to change. As a further benefit the setting of goals, along with the time limit, may halt the patient's regressive tendencies, such as the propensity to feel unmanageably dependent.

The therapist may have learned about the patient's goals from the pretreatment evaluation, but certainly in the beginning sessions the therapist should "listen in order to establish what the patient's problems are and then let the patient try to cast these in terms of goals ordered in importance" (Luborsky, 1984, p. 61). The goals that are selected early in treatment usually remain the goals throughout the course of treatment, especially in time-limited psychotherapy.

If the patient does not state any problems in the form of goals in the first session, the therapist may say: "Tell me about the problems you wish to work

on." The discussions that follow result in an agreement with the patient about what the goals will be for the time-limited treatment. Although the therapist may contribute to the decision, the goals have to be ones that the patient experiences as his or her own. It helps the patient to feel understood and self-directed when the goals are expressed in the patient's own words. The therapist may help in clarifying the relative importance of each goal. The therapist may guide the choice even further only in those few instances when a decision is to be made about goals that are clearly beyond achieving within the limited period of the therapy.

In addition to the patient's direct statements about goals, the goals are often implicitly expressed in the patient's wishes in the narratives they tell about interactions with other people. The goals in these narratives can also be about a desired change in the expected responses from other people or in the responses of the self. The therapist may be assisted, therefore, by listening to the patient's narratives, by following the basic Core Conflictual Relationship Theme (CCRT) method (to be described) as it is applied clinically during the sessions, and by identifying the relationship themes that are most pervasive across the narratives.

In the case of Ms. A, the therapist offered a not uncommon kind of help in framing a patient's goals. In the first sessions the patient responded to the therapist's question about her goals by saying: "My problem is that I'm

unhappy." She explained: "I wish to work on finding a more suitable boyfriend than the ones I've had." The therapist continued to try to reframe the patient's goal more broadly. By the end of the second session, the therapist understood the patient's central relationship pattern in terms of her wishes to be taken care of by a man whom she saw as older and wiser. Ms. A had gone through a series of such relationships, and in each one she had become infuriated and eventually depressed. The therapist therefore said:

> Therapist: It sounds to me that you've been drawn to men who are older and who seem to be wiser and at first you are awed by them, then the relationship begins to wear on you and you feel suffocated and then depressed, seeing yourself as the eternal student. We've seen this with R, your boss, and with B and D, your two boyfriends. Working on this pattern would fit in with your goal to become less unhappy and less vulnerable to depression by dealing with these kinds of relationships that you have gotten into. Perhaps understanding this pattern and dealing with it would fit with your goals for our work.

THEORY OF CHANGE

What is presented here is an integration of the main curative factors as offered by representative authorities (as reviewed in Luborsky, 1984). These factors fall into two main classes of questions about the therapy: What changes? and How do the changes come about? Each of these classes of questions requires assessment of the three main curative factors: (1) the helping relationship established; (2) the self-understanding gained; and (3) the degree of internalization of the gains achieved.

Our summary of what changes specifies these factors: (1) the patient's increased sense of having a supportive ally in the struggle to overcome the repetitive self-defeating patterns of behaviors and thoughts; (2) the patient's increased understanding of the symptoms and the related Core Conflictual Relationship Theme (CCRT) problems containing major components of which the patient had been unaware. The understanding allows changes in the symptoms and greater mastery over the conflicts that lead to the symptoms (as these are expressed in the CCRT); (3) a more internalized control-mastery system in relation to the conflicts, so that the gains are maintained after the treatment ends.

How do the changes in each of the three areas come about, according to the theory? Each area has both a patient and a therapist curative component.

1. For achieving a helping relationship, the patient component is the patient's ability to experience the relationship with the therapist as helpful. The therapist's contribution in this area is complementary: it is the therapist's ability to facilitate the patient's experience of a helping relationship with the therapist. The therapist is assisted by certain structural components in dynamic SE psychotherapy, including the regularity of the sessions; the pretreatment agreement on number of sessions; the therapist's role in helping the patient achieve the goals; and the therapist's attitude of sympathetic understanding.

2. For improving self-understanding, a patient component is the patient's motivation for the expressive aspect of dynamic SE psychotherapy. The patient has an opportunity to reexperience with the therapist and with others the conflictual relationship problems in the here and now and so to gain more meaningful insight that can lead to greater freedom to change. Self-understanding is facilitated as the patient sees new editions of the old relationship problems repeatedly appearing in the relationship with the therapist and with others. As Freud (1914/1958f) noted, a patient will either remember or repeat the conflictual relationship problems in the relationship with the therapist. Remembering or repetition may serve as ways to find increased mastery of the problems (Mayman, 1978). The repetition may also serve as an opportunity to test the relationship with the therapist in relation to the patient's expectations (Weiss & Sampson, 1986).

   The therapist's contribution toward achieving understanding is aided by the ability to engage the patient in the process of achieving understanding. This is done by involving the patient in working through the successive editions of the relationship problems as these are expressed in the relationship with the therapist and with others. The transference relationship is the locus of much of the resistance to change.

3. For the third facet of the theory of change, incorporating the gains, the patient component is the patient's ability to hold on to the gains of treatment after its completion by internalization.

> Most patients are able to maintain the gains, although with some erosion over time (Atthowe, 1973). Internalization is a gradual process by which external interactions between the person and others are taken in and replaced by internal representations of these interactions. But retention takes more than internalization capacity; the gains have a surer chance of being retained when separations, especially termination, are worked through in terms of their meanings (Luborsky, 1984, pp. 172ff.). A common meaning of termination, for example, is that the absence of the therapist will mean the disappearance of the gains because the gains are dependent on the presence of the therapist.

Taking all of the curative factors together, it is difficult to decide on the relative power of the supportive versus expressive components in the patient's acquiring and retaining benefits from psychotherapy. So far, there appears to be more evidence for the power of the helping relationship factor than for the power of the expressive factor aimed at achieving understanding (Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988).

TECHNIQUES AND EXAMPLES

The techniques are aimed at helping the patient achieve his or her goals. The choice of these techniques always begins with the therapist's understanding of the patient. Although we describe the techniques in less detail than is found in the original manual (Luborsky, 1984), we order them

here in their relative importance in the time-limited mode, from most essential to helpful but not crucial. The techniques are listed under headings phrased as recommendations and are followed by explanations and examples.

Most of the examples were selected from the psychotherapies of patients treated at the Center for Dynamic Psychotherapy of the Department of Psychiatry at the University of Pennsylvania. The center specializes in treating patients with a *DSM III-R* diagnosis of major depression with a time-limited psychotherapy as guided by the general manual (Luborsky, 1984) and supplemented by a dedicated depression manual for dynamic supportive-expressive psychotherapy (Luborsky et al., 1987). As is typical in our center, three evaluations are made: initial, termination, and follow-up. An evaluation of one patient, Ms. Smyth, will be summarized briefly. We will then illustrate from Ms. Smyth's therapy the essentials of the Core Conflictual Relationship Theme method (Luborsky & Crits-Christoph, 1990), because many of the recommended techniques depend on the therapist's understanding of the transference by the use of this transference-related measure.

Initial Evaluation of Ms. Smyth

The pretreatment diagnostic evaluation by a SADS (Schedule for Affective Disorders and Schizophrenia) reference interview yielded a *DSM III* diagnosis of major depression plus dysthymia. At that time, Ms. Smyth was a

thirty-two-year-old single woman. She was a recovering alcoholic who had been abstinent for three years. She came for treatment for depression (with a moderately high Beck Depression Inventory score of 25), after having failed a job training program. The therapy began inauspiciously when she showed up half an hour late and said that she was unable to schedule a next appointment. The therapist's reaction was one of anger, which the therapist did not express but used to recognize what the patient was setting up in her. When the patient said she was afraid of "sabotaging" herself, the therapist did say she thought the patient was correct to be concerned. In the course of the early sessions, the patient and therapist agreed to work on the goal of learning to be able to turn away from negative relationships so as to avoid being sabotaged by them.

Termination Evaluation of Ms. Smyth

Ms. Smyth continued to have difficulty in keeping appointments. Nevertheless, she benefited remarkably well from therapy and surprised the therapist by how well she did: at termination, she was recovered (her Beck Depression Inventory score was 6). The therapist concluded in her termination evaluation: "I would not have thought someone with such severe depression and who already was making full use of self-help therapeutic groups [such as Alcoholics Anonymous] could have resolved her depression without the use of psychopharmacotherapy."

In the termination interview, Ms. Smyth stated that she was generally feeling "good," and "everything's a lot better." Shortly after beginning therapy, she had begun seeing a man with whom she was pleased. She had set up a stable living arrangement with a female roommate and was working regularly in a clerical job with which she was not pleased. She still complained of premenstrual symptoms—tension and headachy feeling. Recently her period was late; she was concerned about being pregnant, and believed she may have had a miscarriage. She generally seemed in dramatically less turmoil and was less pessimistic and much more confident and hopeful. She gave the impression that she could take care of herself; at the time of the initial evaluation she had had a desperate, disorganized quality.

Six-Month Follow-up of Ms. Smyth

Ms. Smyth remained free of depression; her Beck Depression Inventory score was 9. She had been working full time, although still at the same kind of work. Ms. Smyth found out she was pregnant by the man with whom she had been involved. She planned to be married, but the man was waffling on commitment. The patient was angry, anxious, and worried about the situation, but felt she could handle whatever happened; she planned to have the baby. At the first news of pregnancy, she had developed a probable generalized anxiety disorder and had missed some work. She and her boyfriend had entered weekly couples' therapy at that time, and they

continued in it. She had also maintained involvement with Alcoholics Anonymous. She continued to live with the roommate and maintained contact with her own family and a few close friends. Although this had been a difficult time due to the pregnancy and the ambivalent boyfriend, she expressed a resolve that she would get by, whatever it might take. Even with these stressors, although initially frantic for a short while, she was now basically OK and was not on medication for depression or anxiety.

CCRT Evaluation of Ms. Smyth

To briefly explain the CCRT method, Ms. Smyth's narratives about relationship episodes from session 3 (in highly condensed form) are presented in figure 1. The method requires that the clinician find the components that are most common across the narratives. In each narrative the clinician attends especially to three components: the patient's wishes from the other person, the other person's actual or expected response, and how the patient responds. The CCRT reflects a sequence of the most frequent types of each of these three components; that is, the CCRT is the pattern that is most pervasive across the self-other relationship narratives. The CCRT is a general relationship pattern that recurrently becomes activated, although with variations, throughout the therapy and perhaps throughout life. In figure 1, Ms. Smyth's narratives about relationship episodes with each other person are presented in the small peripheral circles. The CCRT that is extracted from

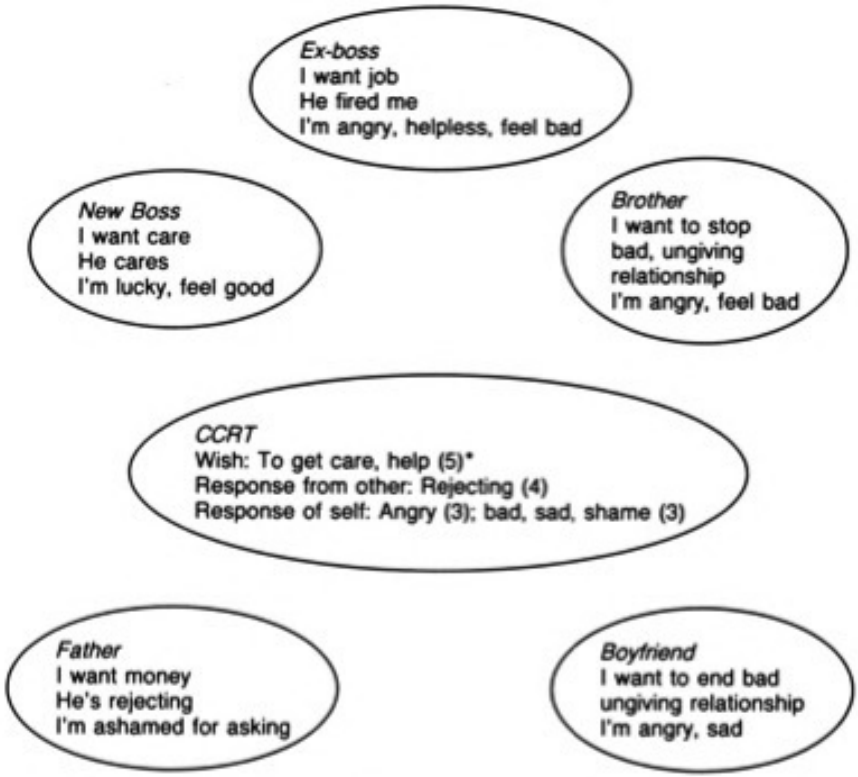
the five narratives is summarized in the core circle. The CCRT contains two versions of the same most pervasive wish, "to get care and help" and "to reject and oppose unhelpful relationships" (in all five narratives). The expected response from others is "are rejecting" (in four narratives) and the response from self is "to be angry" (three narratives) and "To feel bad, sad, or ashamed" (three narratives). The response of self includes the main presenting symptom, that is, depression.

A detailed explanation of the CCRT procedure is in Luborsky and Crits-Christoph (1990) along with evidence that Freud's twenty-two observations about the nature of his transference concept and the corresponding data from the CCRT are largely congruent. In everyday use, the CCRT method helps to guide the therapist in making transference formulations. One of the major advantages over unaided transference formulations is that clinicians can agree with each other through following its guidelines (Crits-Christoph et al., 1988).

The rest of this section lists the main techniques in dynamic SE psychotherapy. Each one is introduced as a recommendation, and each one is followed by an account of how to do it, with examples. Each recommendation ends with asterisks to show its order of importance from crucially important, *** to important, ** to helpful *.

Figure 1

Ms.Smyth, Session 3: Relationship Episodes and Core Conflictual Relationship Theme



*These parentheses give the number of relationship episodes in the five shown in which the component appears.

Helping Alliance

Be sensitive to allowing the patient to form a helping alliance. (***) This is the

most central supportive technique. It usually requires, as Freud (1913/1958d) advised, that the therapist merely refrain from doing anything to interfere with the development of rapport with the patient. Especially in the early part of the treatment, nothing more is needed than to listen sympathetically in order for an attachment and a positive component to the relationship to begin to form. Only with some patients, particularly those with high psychiatric severity, is anything more required in the form of fostering a helping relationship by the techniques of supportive psychotherapy (Luborsky, 1984).

Here is an example from Ms. Smyth's third session:

> Patient: Yeah, I mean, that's a big deal [to not drink for three years]. In alcoholics' eyes it is an anniversary.
>
> Therapist: You have been successful. It sounds to me that you have already been taking important steps for yourself.

Through this comment, the therapist is letting the patient know that she recognizes that the patient has been trying successfully to improve herself. The effect of such responses is to convey sympathetic understanding and in that way to allow the further growth of a helping alliance.

The CCRT for another patient, Ms. Waterman, included (1) a wish to be taken care of, (2) an expected response from others of not being taken care of, and indeed, of being condemned for having such a wish, and (3) a response

from self of guilt, feeling she is bad for having such a wish.

In session 3, after the therapist gave an interpretation about this main theme as she understood it, the following exchange ensued:

> Patient: I know I do that [feel guilty and then get depressed]. I don't know. I'm just so stupid.
>
> Therapist: It seems to me that you experienced this theme here again, condemning yourself with "I'm so stupid."

This therapist's response is a clear illustration that interpretations can have, and typically do have, both a supportive and an expressive impact. The therapist is conveying the view that it is possible for the patient to take an attitude of acceptance rather than of condemnation toward her feelings.

Central Relationship Patterns

Formulate and respond about the central relationship patterns. (***) This is clearly the most vital expressive technique. It begins early in the treatment, often with the therapist's formulation of the central relationship pattern by the Core Conflictual Relationship Theme method. The therapist should consider which aspects of the pattern are most conflictual and problematic for the patient and where the patient might be able to make changes. On the basis of this understanding, the therapist should recurrently respond with aspects of the CCRT as the focus of the therapy. Maintaining this focus aids the

working-through process and facilitates the development of the helping alliance. As we have noted earlier, an interpretative technique can not only convey understanding but also solidify the alliance.

Ms. Johnson, for example, is ambivalent about getting help. She has a strong need to present herself as having no difficulties. Her father looks up

to her for needing no help. But her mother infantilizes her—for example, buying her nightgowns that would be suitable for a child. In fact, she was at the time attending law school. In the third session she managed to tell the therapist what she had not been able to before: that she failed an exam for the second time and "it is a hidden hell in my life."

The patient's CCRT reflected this ambivalence; it was expressed in her conflict between wishes. One wish was to achieve spectacularly and without revealing any difficulty, while the other wish was to receive nurturance. It was of course difficult to receive nurturance when she did not indicate the need for it.

> Therapist: You want desperately to succeed in quite a big way. This would be difficult for anyone and anyone would want to be reassured in times of doubt. But you are unable to get this because you do not want to give any indication that you're having any difficulties.

At this point a comparison with other short-term psychotherapies is in order. The reliance on a focus and its maintenance happens to be generic to

short-term psychotherapies (Koss & Butcher, 1986). But the major locus of the differences among short-term therapies is in how the focus is chosen. In dynamic SE psychotherapy the focus relates to the patient's goals as these are expressed in the CCRT. This reliance on the CCRT means that the focus will differ from patient to patient because CCRTs differ from patient to patient. The evidence of such differences among patients is a benefit of the empirical grounding of the CCRT method. The patient-specific appropriateness of the focus is also likely to be experienced by patients as a sign that they have been understood. In contrast, some other types of short-term psychotherapies have a more uniform focus across different patients; this greater uniformity may be a product of overreliance on a uniformly applied theoretical basis and bias for choosing the focus. One example is Habib Davanloo's (1980) form of psychotherapy, in which the focus is likely to be on the patient's passivity as a way to deal with anger. That focus may well fit some patients but certainly is not likely to be uniformly appropriate for all patients.

Relationship Spheres

Attend and respond to each sphere of the relationship triad, including the one with the therapist. (***) This technique has much in common with the earlier one. The focus in the earlier one is on responding to the central relationship pattern; in this technique it is on responding to it in each relationship sphere (Luborsky, 1984). There is a special reason for responding in each sphere—it

improves the patient's learning about the existence of a general pattern to see it reappear in each sphere of this triad: current in-treatment relationships, current out-of-treatment relationships, and past relationships. The therapist should understand and then use the redundancy of the theme across the three spheres. Of the three spheres, attention to the in-treatment relationship with the therapist has the likelihood for the greatest potential for beneficial impact when carried out with tactful moderation. Particularly when the patient is unusually upset, the therapist should consider whether or not the stress is generated by the current in-treatment relationship and whether the source of the stress parallels out-of-treatment relationships and, possibly, past ones as well. With regard to past relationships, an important test of relevance is the appearance of the same patterns in both current in-treatment and current out-of-treatment relationships. The function of the therapist's pointing to such triads or dyads is to help the patient in recognizing the omnipresence of the central relationship pattern.

Take an example from Mr. Dean's treatment. At the end of the session he summed up by saying, "I'm getting a lot from you . . . but how can I be sure?" In the next session he described his relationship with his wife and her typical statement to him, "You can never say things that are positive about me or about things I've given you." The patient was reminded of what had happened in relation to his mother in the past and concluded that "she would not or could not give enough of what I needed and I must have felt deprived by her."

In this example of relationship triads, it is the behavior in the present both in the treatment and out of the treatment that was most in need of interpretation because it had been hardest to see. The relationship pattern in the past by itself did not have the convincing power of the relationship patterns in the present, and the convincing power derived mainly from the parallels evident with the here and now. Through this process, the patient went on to recognize the parallels in the three spheres, and seeing the triad gave him a convincing view of the importance of the pattern.

Consider another therapist statement from the treatment of Ms. Johnson:

> Therapist: You wanted your father's love but you felt that he believed you to be a child who could do anything without any problems. He would not want to hear any problems. It's hard with telling such things now. And its hard telling *me* such things.

It is worth noting how difficult it is generally for the patient to express feelings about the relationship with the therapist. This observation is an old one. Freud (1914/1958e) noted how hard it is to express one's feelings to someone present as contrasted with someone not present. The same difficulty is often evident in the therapist's responses as well. Despite the obvious importance of paying attention to and using the experiences of the patient in relation to the therapist, therapists tend to be reluctant to use the current in-treatment relationship with the patient as much as it deserves to be used.

The Symptom in the Conflictual Pattern

Understand and respond about where the symptom fits into the pattern. (***) The symptom can be understood in the context of the CCRT as one of the responses of the self. The therapist's responses, therefore, should make clear from time to time the wishes and responses from others that are most conflictual and that are associated with the symptom, as Ms. Johnson's therapist did:

> Therapist: When you get so upset with trying to get caring responses and feeling you can't get them, you used to begin to lose hope, blame yourself, and end up depressed.

This therapist's response referred to the patient's wishes for care that were associated with frustrating and rejecting responses from others, in which she felt sabotaged, sad, and then symptomatic—depressed. The response in this example reflects the patient's CCRT derived from her narratives; it shows that this sequence is a pervasive one.

Separation

Attend to and respond to concerns about getting involved in the therapy and then separating. (***) Attention to attachment and separation is vital to the success of the treatment enterprise, in terms of both the gains achieved at termination and the long-term maintenance of the gains.

One helpful procedure is to give appropriate reminders about the treatment length. In time-limited therapy, the therapist must begin the therapy by reviewing its agreed-upon length; then, from time to time during the therapy, that expected length needs to be reaffirmed.

In the last half of the therapy, and even more in the last few sessions, the therapist needs to attend to the meanings of the termination. As we have noted previously, a frequent meaning involves a worry about whether the gains can be maintained without the continued presence of the therapist. At this time it is common to see a revival of the symptoms as a way of dealing with this meaning of termination. The paraphrased thoughts typically are the following: "If I don't see you the gains are lost because they depend on your presence; they are not part of me. They are part of you and what you do for me." When these thoughts are reviewed with the patient, the symptoms usually subside again and the gains are evident once more.

At the end of therapy, there is always some discussion of what kind of contact the patient could or should have with the therapist after termination. These contacts range from a telephone call or a letter telling the therapist how the patient is doing, to consideration of further treatment. If the symptoms remain, a reevaluation for further treatment may be necessary. A procedure that is helpful to many patients in the maintenance of the gains is to plan from the outset on a few follow-up sessions that involve a review and

reevaluation of the patient's status.

The Patient's Awareness

Responses should be timed in relation to the patient's awareness. (**) This is a standard technical principle. It is not difficult to apply because the therapist usually has an idea of what the patient knows and does not know. Although it is not useful to make interpretations that are too far out of the range of the patient's awareness, such interpretations do not usually do much damage. The therapist can just go on and try responses with less of a gap between the interpretation and the patient's awareness. To do this merely requires that the therapist relisten and get recentered on what the patient is again presenting.

Poor timing might also occur if the therapist feels an urgency to show understanding even before the therapist's understanding is sufficiently formed. The best advice the therapist can give to herself or himself is to be patient and listen; sufficient understanding will come. It is inevitable that there will be times in which understanding is lacking, but it is also to be expected that at unpredictable moments the understanding will come.

Testing the Therapist

Recognize the patient's need to test the relationship in transference terms (**)

The therapist should recognize that revivals of the transference relationship in the current relationship may be viewed as a test of the relationship with the therapist. Weiss, Sampson, and the Mount Zion Research Group (1986) point out the value of considering whether each expression of transference is the patient's need to determine the safety of bringing out an issue in the relationship, to test the therapist's response, to test whether the therapist will respond in the old expected terms. At these times, the therapist can be most helpful by (1) remaining neutral and not acting in the negative ways that the patient expects or is afraid of from other people and by (2) interpreting the testing aspect of the patient's behavior. Consider the following exchange from Mr. Quinn's therapy:

> Patient: I heard about the way you solved the staff problem. It was just common sense. But I get anxious saying that to you.
>
> Therapist: It may make you anxious because you are not sure this relationship can stand your expressing critical thoughts.

Framing Symptoms as Ways of Coping

Frame the symptoms as problem-solving or coping attempts. (**) The patient and therapist have something to gain from recognizing that the patient's symptoms are an attempt, although often a painful one, to cope with the patient's wishes and expected responses from others. For example, the patient is not just an anxious person. The anxiety may be a signal of feeling

incapable of succeeding (as in the example from Ms. Johnson). One of the values of thinking in terms of the patient's wishes and their consequences is that the patient can become less frightened of or less condemnatory of her or his symptoms. The symptoms can then be seen constructively, as signs of underlying conflicts (for example, Ms. Johnson, who, in spite of her pose of having no difficulties, could use recognition of her symptoms as a warning that she was getting into deep water). The patient can then think of new ways of managing and the conflicts may appear more controllable.

Countertransference

Reflect on your usual types of countertransference responses. (**) Even the most expert and experienced therapists are sometimes susceptible to countertransference responses. But in fact some therapists probably become less susceptible to expressing them, after repeated experiences, because they develop ways of reflecting on such responses. Also, they may recognize some of the countertransference responses sooner and therefore become able to overcome them sooner. One concrete way to recognize an incipient countertransference response is to notice the inclination to respond countertherapeutically to the patient. Such inclinations provide a good basis for understanding the patient because they can give the therapist an informative experience about what the patient is conveying and even how other people may often respond to the patient.

Mr. Patrick's therapist felt bored and inclined to reject the patient. After noticing this state, the therapist realized what the patient was doing to set up the state in him. The patient was presenting him with an impasse. The patient was testing him to see whether the therapist would accept him, but the condition for acceptance was that the therapist would do nothing that fit the category of acting like a therapist. The realization not only lessened the therapist's boredom, but also led to effective interpretations.

A common kind of countertransference is the inclination for the therapist to behave in ways that fit into the patient's expectations and fears about the ways others will respond—a kind of negative fit (Singer & Luborsky, 1977). A patient may, for example, communicate a fear that people will dominate; then the therapist may in fact become dominating. The therapist *may* then realize that, in fact, he or she has become dominating. The implication of this observation about such negative fit is that patients not only expect certain responses, but they may also stimulate those responses in others. The wise therapist knows that this may occur and is able to recognize it and use the stimulated enactment therapeutically. The prior knowledge of the patient's CCRT may serve to alert the therapist to what the patient expects and fears, which may make it easier for the therapist to anticipate how he or she might be inclined to react.

Timing Interventions

Interventions should be timed to suit the length of a session. (*) In a fifty-minute session, the first five or ten minutes are usually best for mostly listening in order to get a sense of the unfolding of the main issues that the patient is beginning to present. It is a good practice to keep the last five or ten minutes as a period for the patient to assimilate what has just been worked on rather than to present entirely new topics. If major new interventions are made in that period, there may not be enough time available for the patient and therapist to deal with their repercussions.

Limiting Interventions

Interventions should be limited in complexity and length. (*) In the service of the patient's ease of learning and understanding, it is good to avoid overcomplex and long-winded responses. When the patient is presented with too much all at once, he or she can become confused. Ordinarily, it is more effective to present complex material piece by piece so that it can be assimilated and the therapist can hear the patient's response to each piece.

Shifts in State

The patient 's shifts in mental state can be an opportunity for responses. (*) Marked shifts in the patient's state can provide an entree to an expanded understanding of the patient's dynamics. Many of these shifts are associated

with the development of a symptom. Studies of the immediate contexts in which symptoms appear have shown the special opportunities when such shifts occur. Two examples are sudden shifts in depth of depression (Luborsky, Singer, Hartke, Crits-Christoph, & Cohen, 1984) and shifts in terms of memory, such as momentary forgetting (Luborsky, Sackeim, & Christoph, 1979; Luborsky, 1988).

Mr. Quinn illustrates the point.

> Patient: I had a dream—I don't remember what it was. It wasn't anything remarkable, there was no sex involved in it. We were just talking or something like that so that just made me a little tight, I don't know why *(voice drops). (This is a shift point.)*
>
> Therapist: What made you tight?
>
> Patient: Talking about her.
>
> Therapist: Can you catch what it was?
>
> Patient: Just the thought of her, I guess. Oh, I know, I got it, it was that I said, well, a guy like me could be with her but you know a million times stronger. If it is me, then I'm not strong enough, that's what bothered me.
>
> Therapist: So it bothered you that you felt you were not strong enough and had lost a sense of control. Then it upset you and made you feel less worthwhile and then depressed.
>
> Patient: Yes.

The interpretation fits in with what was known about the CCRT for this

patient, which was the following: "I want to feel in control and competent and to show it. I can't; the other person has control. I don't; I blame myself; I get depressed."

Even communication sequences with only small shifts are worthy of being tracked. For example, for Mr. Dean, a frequent sequence was (in paraphrase): "What my wife did was good. . . . but if I tell her that, she'll spend too much." The sequence begins with an expression of positive feeling and appreciation which is quickly followed by the fearful state of feeling that he will be drained by her spending. When the therapist understands this sequence, the information may be useful for interventions.

Therapist's Accuracy

The match of patient s with therapist s messages is a measure of the adequacy of the therapist's responses. (*) A good test of the adequacy of the therapist's responses in a session is the degree of match between the essences of both the patient's and the therapist's messages. The patient's message can be found by reviewing the session to see to what extent the interpretations correspond with the patient's main communications (Auerbach & Luborsky, 1968). It has been shown (Crits-Christoph, Cooper, & Luborsky, 1988) that accuracy of the interpretations, in terms of their congruence with the CCRT, is significantly correlated with the outcome of the patient's therapy.

In concluding this section, we will comment briefly on the degree to which dynamic SE psychotherapy fits the usual characteristics of the short-term or brief psychotherapies listed by Mary Koss and James Butcher (1986). The characteristics dynamic SE psychotherapy shares with the other brief therapies include the following: it takes fewer than twenty-five sessions; the attempt is made to establish the therapeutic alliance quickly; its goals are limited to those within the main focus of the therapy; and the maintenance of the focus means that the therapist is a highly active participant.

Finally, a caveat is in order for the use of these *or any* technical recommendations: do not overdo any of them just for the sake of adherence to the manual. These are general recommendations; they are to be applied to fit each patient. For example, do not make more interpretations of the current relationship with the therapist than are appropriate for the particular patient. The basis for the special caveat about this recommendation to interpret the relationship with the therapist has been that, *when it is used correctly,* it can be a good learning experience for the patient.

EMPIRICAL SUPPORT

There is a long history of research on dynamic SE psychotherapy, although only a modest amount is on its time-limited form (Miller, Luborsky, Barber, & Docherty, in press). One of the earliest investigations of dynamic

psychotherapy was the Penn Psychotherapy Study (1968-1973). The sample size was seventy-three, and the average length of the treatment was about forty-three sessions (Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988). The results showed that more than two-thirds of the patients benefited moderately or much. Although this study was done before the era of manuals, a small sample was reexamined and found to have used the central components of the later dynamic SE manual.

The VA-Penn Study, which began in 1978 (Woody et al., 1983) was the earliest major manual-guided comparative study of time-limited dynamic SE psychotherapy. The comparisons were among dynamic SE psychotherapy, cognitive-behavioral psychotherapy, and drug counseling for heroin-addicted patients on methadone. Both psychotherapies outperformed the drug counseling, but the two psychotherapies were not significantly different from each other in efficacy. In 1986, a larger cross-validation, now nearing completion (Woody et al., 1991), was begun in three different drug treatment centers where the comparison was between dynamic SE psychotherapy and drug counseling.

In a study by A. R. Childress (personal communication, May 1990) with cocaine-dependent patients, assignment was to one of four groups: (1) supportive-expressive (SE) plus a cue exposure component; (2) SE plus a control activity; (3) drug counseling plus cue exposure; (4) drug counseling

plus a control activity. The SE was provided three times a week during a two-week inpatient phase, followed by weekly sessions during an eight-week outpatient phase. Preliminary results indicate that patients in the first three groups have better retention and treatment outcome (using several measures of clinical status, including drug use) than does the fourth group. Even more interesting is the retention rate observed in group 1: at last analysis, this group attended almost 7 weeks (6.8) out of 8 possible outpatient weeks. Furthermore, the retention rate at 4 weeks after discharge from the inpatient phase was similar to the retention rate in the more intensive (thirty hours per week) day hospital (thirty-day) program. These results suggest that cocaine addicts can be engaged in SE psychotherapy, and that even weekly sessions (when preceded by a more intensive inpatient phase) can retain the majority of patients in the psychotherapy.

The most recent study of dynamic SE psychotherapy is still in progress; it uses the adaptation of the manual for major depression, and is aiming for a sample size of thirty-five (Luborsky et al., 1991). Preliminary inspection of the results shows that patients have benefited.

As part of the study of drug-dependent patients, we examined the adherence to the manual of each of the therapists (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985). We noticed that there were large differences in adherence; we then found that these differences in adherence

correlated with outcome of the treatment—the greater the adherence, the greater the benefit to the patient. We even found that there were differences in degree of adherence within each therapist's caseload, and that these differences also were related to outcome. That first observation about the relation of adherence and outcome was based on only a four-item adherence scale. Now Barber, Crits-Christoph, and Luborsky (1989) have made a new forty-five-item scale and have launched studies of its reliability and predictive validity. The new scale also makes the potentially valuable distinction between adherence and quality of the treatment.

Much more research is needed on the efficacy of dynamic SE psychotherapy and of dynamic psychotherapies in general (Miller, Luborsky, Barber, & Docherty, in press). The result of nonsignificant differences in Woody, McLellan, Luborsky, & O'Brien (1983) is typical of comparative psychotherapy studies of all kinds (Smith, Glass, & Miller, 1980); it is also typical for comparisons of dynamic versus other psychotherapies (Luborsky, in press). Of twenty comparisons, sixteen showed nonsignificant differences. This strong trend may be a reflection of the difficulty of any form of psychotherapy in showing superior performance to other psychotherapies or of limitations in designing assessment measures in outcome studies (Luborsky & Fiske, in press). Future work on dynamic SE therapy will focus more on specific manuals for applying the therapy to specific psychiatric disorders. Manuals have been started for personality disorders, generalized

anxiety disorder, chronic depression disorder, and cocaine abuse, so that we hope, in time, to come closer to the hoped-for knowledge of which treatment is best for which disorder.

It is not just efficacy of the dynamic psychotherapies that has been investigated: a progressively larger research investment has been devoted to studies of the theoretically relevant factors that influence efficacy. It may well be that the differences in performance of a therapy from one study to another has much to do with variations in their curative factors. Most of the main propositions of dynamic therapy, especially dynamic SE therapy, have already been examined by at least a few studies, as reviewed in Luborsky, Barber, and Crits-Christoph (1990) and in the two most recent books from the Penn Psychotherapy Project: Luborsky, Crits-Christoph, Mintz, & Auerbach (1988) and Luborsky and Crits-Christoph (1990). Significant predictive results have been found for these factors: psychiatric severity, the positive therapeutic alliance, and the accuracy of interpretation (Crits-Christoph, Cooper, & Luborsky, 1988). The predictive potential of two other factors is at the forefront of the current research agenda: self-understanding has achieved mixed results so far (Crits-Christoph & Luborsky, 1990), while internalization is already off to a good start and guided by promising instruments in a program by David Orlinsky and Jesse Geller (in press). We can look forward in a few years to a significant increase in our tested knowledge of how and how much these factors influence outcomes of dynamic SE psychotherapy.

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