DYNAMIC THERAPIES FOR PSYCHIATRIC DISORDERS

Supportive-Expressive Dynamic *Psychotherapy* for Treatment of *Opiate Drug* Dependence

Lester Luborsky George E. Woody
Anita V. Hole Anthony Velleco

Supportive-Expressive Dynamic Psychotherapy for Treatment of Opiate Drug Dependence

Lester Luborsky, George E. Woody, Anita V. Hole, and Anthony Velleco

e-Book 2015 International Psychotherapy Institute

From *Dynamic Therapies for Psychiatric Disorders (Axis I)* edited by Jacques P. Barber & Paul Crits-Christoph

Table of Contents

Supportive-Expressive Dynamic Psychotherapy for Treatment of Opiate Drug Dependence

Lester Luborsky, George E. Woody, Anita V. Hole, and Anthony Velleco

HISTORY AND DEVELOPMENT

This manual is a guide for psychotherapists engaged in supportive-expressive (SE) dynamic psychotherapy with people who suffer from heroin dependence and are simultaneously being treated with methadone. The manual is an adaptation of a general manual (Luborsky, 1984) that was first formally used early in 1976 in the training of therapists at the Department of Psychiatry of the University of Pennsylvania. It has been gradually shaped to meet the needs of drug-dependent patients by adaptations based on both clinical and research experiences.

The backing to do studies using this manual first came from the National Institute on Drug Abuse (NIDA) to determine the contribution of psychotherapy to the benefits from the usual treatments for heroin-dependent patients. The initial group of researchers included A. Thomas McLellan, George Woody, Lester Luborsky, and Charles O'Brien.

From the beginning of the training in the use of this manual, a special training format was developed (Luborsky, 1993a; 1993b). Groups of therapists worked for yearly periods with Lester Luborsky, who has served as the group orchestrator (since 1992 Lynne Siqueland has been co-orchestrator).[1] The first studies of the method were part of the Veterans Administration (VA) Drug Dependence Treatment Program at the Philadelphia VA Medical Center, directed first by Charles O'Brien and later by George Woody. From 1987 to 1990, the patient groups also included clients from three community clinics in Philadelphia, including the Parkside Clinic, the Jefferson Clinic, and the Alcohol and Mental Health Association (Woody, McLellan, Luborsky, & O'Brien, 1994).

The principles in this manual have a long background in clinical practice. Starting about 1940, Freud's recommendations for psychoanalysis (1912, 1913) were adapted into the SE psychoanalytic psychotherapy used at the Menninger Foundation by Knight (1949), Gill (1951), and others, including Ekstein and Wallerstein (1958) in their system for training psychotherapists. Our manualization of the SE dynamic psychotherapy system is not intended as a new method but only as a formalization of the widely used existing methods of dynamic psychotherapy. As its name implies, the essence of the method is the use of techniques for establishing a supportive relationship and for encouraging patients to express and understand their relationship patterns and the conflicts within them as they

appear in interaction with the therapist and others.

INCLUSION/EXCLUSION CRITERIA

The primary inclusion criterion is the presence of a *DSM-III-R* substance abuse disorder primarily for opioid dependence (APA, 1987, 304.00). Other diagnoses involving other substance abuse disorders can be evident, but the opioid diagnosis should be primary. The method of diagnosis used in the original study was a structured interview and application of the Schedule for Affective Disorders and Schizophrenia (SADS), leading to a *DSM* diagnosis as well as a Research Diagnostic Criteria (RDC) diagnosis. Patients were screened to exclude those with serious medical, legal, or personal problems that would prevent them from continuing to take part in or profit from the treatment. Patients with signs of organic impairment or inability to read were excluded. Patients assessed with antisocial personality were nevertheless included in the studies, although experience suggests that many of those with antisocial personality do poorly (Woody, McLellan, Luborsky, & O'Brien, 1985). Currently, the *DSM-IV* (APA, 1994, pp. 249-250) diagnosis of opioid substance abuse disorder and the Structural Clinical Interview for DSM (SCID) interview are used.

DYNAMIC ISSUES IN PATIENTS WITH OPIOID DEPENDENCE

Psychoanalysts and psychodynamically oriented psychotherapists have a long history of concern with conceptualizing the nature of addiction, as shown, for example, by Fenichel (1945). The outstanding dynamic issue is the involvement in taking the drug. Following are a few of Fenichel's (1945) conclusions: The addict is thought to come to use the effect of the drug for satisfaction of other needs. The need is so strong as to overwhelm other interests. It is therefore not just the chemical effect of the drug but the nature of the personality that is significant. Interests other than those having to do with getting the drug diminish or disappear. Addicts are amenable to psychoanalytic treatment, but they offer special technical problems. It is best to treat the patient after withdrawal of the drug, but it is not to be expected that withdrawal will be consistent; drug taking will increase with increased resistance. In general, the more recent the addiction, the better the prognosis.

Some of Fenichel's conclusions about addiction are still part of the explanatory framework used today, and some of that framework is further specified in the present manual. Still applicable is the concept of the attachment to the substance and its rewarding properties at the expense of other interests, especially in relation to people and also often in relation to work. Personality patterns vary considerably, but addicts have a strong tendency to concentrate their interests on the satisfactions from the drug itself rather than from people. This observation, in fact, has become part of the definition of addiction.

TREATMENT GOALS

Goal setting takes place primarily in the early sessions but extends throughout the treatment as the patient comes to settle on the goals. For all of these patients, one common treatment goal will be to control the opiate use without increasing their use of other substances. Another more general goal for most patients will be to improve psychological and occupational functioning. Some patients will have the goals of decreasing certain symptoms or getting along better with others. The selection of the main goals should also take into account what seems achievable.

One of the functions of setting goals early in treatment in SE dynamic psychotherapy is to keep the treatment focused on the main goals and to make it clear to both patient and therapist toward what ends the treatment efforts will be directed and the time span allotted for achieving the goals. In this type of treatment, taking a relaxed attitude toward time is an unaffordable luxury. Goals are not only important at the beginning and end but also throughout the treatment. They provide markers of progress, or the lack of it. Goals achieved during the course of treatment are likely to be correlated with "internal markers" that, as observed by Schlesinger (1977), signal the change, thus making it possible to recognize treatment phases. These phases and subphases allow the patient and therapist to have a sense of completion and accomplishment along the way. In addition, setting

reasonable goals is especially important for those patients for whom the treatment may be seen as an opportunity for goal-less dependence. Reasonable goal setting acts as a modulating brake on such regressive developments.

THEORY OF CHANGE

What is unique about SE dynamic psychotherapy as compared with other psychotherapies is how it fosters expressiveness as a vehicle for acquiring self-understanding and its ability to vary the proportions of supportiveness and expressiveness as needed for each patient.

SE dynamic psychotherapy has two main therapeutic components: support via the relationship (the supportive component), and information and insight via clarifications and interpretations (the expressive component). Of the two components, the support via the relationship appears to be the more therapeutically potent. That a relationship with another person who is seen as potentially helpful can be curative has been known through the centuries. The loss of such a relationship has also been known for its power to set off psychic and somatic illness (e.g., Schmale, 1958; Luborsky, in press). It should be no surprise, then, that the power of the relationship is recognized as a potent curative factor.

This recognition of the power of the relationship is not intended to

diminish the value of the interpretations provided by the therapist and by the patient. Interpretations have a value in their own right in providing understanding, and the search for understanding provides a meaningful agenda for the joint work in the sessions, but interpretations as a vehicle for achieving a good relationship probably have even greater value.

The therapist's tasks are: (1) to listen to what the patient is trying to say; (2) to attend during this listening to the understandings that will occur of the central relationship patterns and their connections with the patient's drug dependence and relationships; (3) to impart this information to the patient in the most readily assimilable ways; and (4) to accomplish these tasks knowing that the information imparted cannot be of much use without attending to the special needs of drug-dependent patients, especially the supportive conditions and good therapeutic alliance. In fact, the good relationship and alliance are furthered by the focus on understanding.

Personality change appears to be more difficult for many addicted patients than for nonaddicted patients. It is their attachment to the drug that makes for the greater difficulty. The consequences of using drugs impede attachments to people and involvement in work, as noted earlier.

TECHNIQUES

The methods in this manual derive from dynamic concepts. The main

concept is the importance of understanding the patient's wishes and their consequences (Klein, 1970). These wish-consequence sequences, although partly outside of the patient's awareness, can be understood by listening to the flow of what the patient says. After forming a helping relationship with the patient, the therapist, as well as the patient, can then use some of the understanding gained to help the patient both to deal with the drug dependence and to improve his or her general functioning.

Our experience with psychotherapy for heroin-dependent patients has been with treatments that also provide methadone. The methadone makes it possible for most patients to give up the search for illegal heroin and to concentrate on the psychotherapy.

Two main classes of psychotherapeutic techniques, supportiveness and expressiveness, are essential in SE dynamic therapy. The designation "supportive-expressive" or "expressive-supportive" has been used for many years at the Menninger Foundation for a similar form of treatment and was the subject of a long-term study in the Menninger Foundation Psychotherapy Research Project (Wallerstein, Robbins, Sargent, & Luborsky, 1956; Kernberg, Burstein, Coyne, Appelbaum, Horwitz, & Voth, 1972; Wallerstein, 1986).

The expressive component of the treatment refers to the techniques aimed at permitting patients to express themselves so as to facilitate

understanding. The focus is on two main goals: (1) finding the meanings of the drug dependence, particularly by understanding the stresses that precipitate and continue the drug taking, as well as the other symptoms; and (2) discerning the core relationship conflicts as expressed both inside and outside of treatment, especially in relation to the drug dependence. The expressive component, therefore, is much like what has been called in recent years a "focal psychotherapy," as described in Sifneos (1972), Malan (1976), and Mann (1973): the therapy focuses on one main problem. Each patient is provided with as much of the expressive component of the treatment as he or she can profitably use. This component will be greater for those persons who possess the requisite ego strength and anxiety tolerance, along with a capacity for reflection about their interpersonal relationships.

Psychoanalytically oriented psychotherapies are widely used by psychiatrists, psychologists, and social workers. For example, a recent survey of clinical psychologists (Norcross, Prochaska, & Farber, 1993) found that of the 481 practitioners listed in the American Psychological Association Division of Psychotherapy, taking primary and secondary orientation topics, fully 70% endorsed a form of psychoanalytic or psychodynamic orientation (Henry, Sims, & Spray, 1973, p. 272).

Representative overviews of techniques are Menninger and Holzman (1973), Bergmann and Hartman (1977), Mann (1973), Luborsky, Fabian, Hall,

Ticho, and Ticho (1958), Luborsky, (1984), and Miller, Luborsky, Barber, and Docherty (1993). The aims of our manual are to further specify the treatment's operations and to adapt the treatment to the needs of opiate drug-dependent patients. Specifying its operations requires surveying what has been written, selecting what is most central, and presenting it in a form that makes it immediately obvious what a therapist must do. We hope that such specification will make the therapist's learning task easier and ensure that therapists carry out the treatment in a uniform manner.

Summary of Special Adaptations for Drug-Dependent Patients

The form of psychotherapy described here, because of its application to opiate-dependent patients, has special emphases as compared with the general manual (Luborsky, 1984). The therapist attends to working out the conditions that reduce the drug taking and is aware of the dynamic issue of the patient's readiness to retreat into involvement with drugs rather than relationships. The therapist must spend extra time and energy introducing these patients to this psychotherapy and engaging them in it. In addition, goals must be formulated early and kept in sight.

The therapist must also be attentive to developing a therapeutic relationship and supporting the patient. With most drug-dependent patients, it is usually not possible to provide a mainly expressive psychotherapy because a strong supportive component is necessary for them to be able to

tolerate the expressive aspects. A supportive component is especially suitable for patients with character disorders and disruptive symptoms who have low anxiety tolerance and difficulties with being reflective. Supportive psychotherapy is designed to strengthen defenses as compared with its polar opposite, the analysis of defenses (Gill, 1951). The support is aimed at preventing regression, stabilizing the patient, and thus increasing his or her chances of benefiting from the expressive aspects of the treatment.

The therapist must also keep abreast of the patient's compliance in not taking nonprescribed drugs and staying on methadone (Woody, Stockdale, & Harris, 1993). Regular compliance information should come from the patient and from the drug counselor. Information about compliance will allow the therapist to explore the meaning of relapses into illicit drug taking or infractions of rules. A team approach with its pision of duties allows the SE dynamic therapist to keep out of the administration of rules—a valuable asset for maintaining a psychotherapeutic relationship.

Another difference in SE therapy with opiate-dependent patients concerns the methadone dose: it should be temporally separate from the sessions. Therapy can occur before or after the methadone dose is administered. However, therapists may want to have the session *before* because methadone usually is such a central part of the patient's life that the patient may temporarily lose interest in therapy immediately after the dose

has been received—especially those patients who are just starting the program and have not yet established a close relationship with the therapist. Yet preventing the patient from receiving methadone until the session has been completed may create negative feelings and hinder the development of a positive relationship.

Presentation of the Opportunity for Psychotherapy

Without special assistance, some of these patients are not likely to seek psychotherapy and, if given the opportunity, often would not take advantage of it. One reason is their inexperience with psychotherapy; many come from a low socioeconomic group. Strupp and Bloxom (1973) suggested that a role induction film may be helpful for these patients. Burstein's (1976) study concluded that it is not necessarily true that poor people lack the capacity for insight. The same view was expressed by Lorion (1974), who also provided suggestions for treatment. One of his main suggestions was to modify the therapists' attitudes in this regard in the course of training. Chappel (1973) and others have discussed how the negative attitudes of physicians can serve as barriers to effective treatment for substance abusers. It has taken many years to show that even some of those referred to as "intractable" addicts grow out of the addiction because of the help of peers and significant others (Valliant, 1973, 1983). SE dynamic psychotherapy is aimed at providing such "significant others."

Preliminary Socialization

In the VA-Penn project (Woody et al., 1983), which first utilized this SE manual in research, patients are launched into the treatment after two introductory phases: (1) a formal introductory orientation, sometimes called "preliminary socialization," and (2) completion of a required initial three sessions of psychotherapy. The introduction to psychotherapy is accomplished by an adaptation of the Orne and Wender (1968) interview, which showed the significant advantage of preliminary socialization interviews conducted just before the patient is assigned to the psychotherapist. The interviewer explains to the patient how psychotherapy works, what the patient is to do, and what the therapist does.

The interviewer also explains that the initial three sessions of psychotherapy, over a three-week period, are to be used for getting acquainted with psychotherapy, and that completing the three sessions will give the patient the opportunity to continue the treatment for six months. This agreement constitutes an engagement criterion for acceptance into the treatment.

The Use of Unauthorized Drugs and Medications

The patient should be told at the outset to avoid unauthorized medications: "We hope that you will be able to stay on the methadone, perhaps even gradually reduce it, and not take unauthorized drugs or medications. If it happens that you do take anything unauthorized, it is to

your advantage to tell your therapist and your counselor. We find that telling your therapist makes it easier for you and the therapist to figure out the conditions under which that happens. And if you have just taken something, it is very important that it not be done close to the time of a therapy session. Therapy sessions work best when you are able to think clearly, both before and after therapy, and the taking of substances prevents thinking clearly."

The Role of the Clinic Director

The role of the clinic director can be vital for the effectiveness of the psychotherapy for addicted patients, as it was in the VA-Penn study. Effective management and encouragement of the staff doing the treatment serves as a morale builder. The director also sees that patients keep appointments (or that therapists and counselors see that their patients keep appointments) and reminds therapists and counselors to stay current about patients' abstinence from unauthorized medications and drugs. The director can be the person who asks the patients to participate in the project, and he or she can also be the person who carries out the preliminary socialization interview.

Techniques for Beginning Treatment

Freud (1913), in his famous analogy between psychotherapy and a chess game, considered that, as with a chess player, the therapist's opening and closing moves are clear but the intervening ones are based largely on skill and intuition. The opening moves, in the first session especially, should

include (1) listening to what the patient wants and using those desires to help set goals, and (2) explaining to the patient what the therapist does.

Explaining the Treatment

Besides reviewing the patient's goals, the therapist should also explain the process to the patient—what the patient will be doing and what the therapist will be doing. This explanation may take several sessions, and it may repeat some of what was in the preliminary socialization interview. From time to time the therapist should emphasize that what the patient and therapist do is actively find ways of coping with and mastering problems that will lead to making progress toward the goals.

Techniques for Fostering a Supportive Relationship

Developing a Helping Relationship

Usually the patient's experience of a helping relationship will develop as the therapist simply does the job (Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988). The patient will ordinarily recognize that the therapist is trying to do his or her job of helping, the patient will then feel helped, and a good working relationship will develop. One main requirement for the development of a therapeutic alliance—which is, of course, a large component of a good relationship—is that the therapist *feel* an alliance. Sometimes its presence is reflected in the use by patient and therapist of the word *we. A* supportive relationship leading to the development of an alliance can produce

significant benefits for the patient, as was shown in the Menninger Foundation Psychotherapy Research Project (Wallerstein, 1986) and in the Penn Psychotherapy Research Project (Luborsky et al., 1988).

One possible impediment for the therapist is a dislike of the patient, especially patients with character disorders. A suggestion for therapists by Dr. Jan Frank (personal communication, 1952) is sometimes very helpful: If you search, you can always find some aspect of a patient that you approve of and like; it is useful to make such a search and find that part. Understanding the psychological problems, especially those related to the addictive behavior, is also useful, as well as being aware of the common countertransference responses (Singer & Luborsky, 1977).

The therapist may also at times need to foster the development of a helping relationship by using these specific techniques (also described in Luborsky, 1984):

1. The therapist conveys a sense of wanting the patient to achieve his or her goals. ("When you started treatment, you picked as your goal [cutting down on drugs] [going back to school]. In the next weeks you and I are going to try to see to it that you get what you are aiming for.")

2. The therapist is alert to any improvement in the patient and lets the patient know that he or she is aware of such improvement. ("You mentioned that you're feeling less depressed since you

started treatment. We are making some progress.")

3. The therapist conveys that he or she understands, accepts, and respects the patient, as in this session with Mr. Lennon.

Therapist: So you've started to feel depressed in the last couple of weeks?

Patient: Yeah. The last two weeks now. It's really been a drag. I've just got to break out of it.

Therapist: Yeah. Well, I guess it started when you started working nights, for one thing.

Patient: Yeah. It throws my whole routine off.

Therapist: Uh-huh. And you haven't had much time for yourself, and your girlfriend.

Patient: Nobody. No time for nobody—I just want to take a couple days off [from work]. It's just too much, I'm telling you.

Therapist: Yeah, it is. It seems that everyone should have off some time.

4. The therapist makes comments that show that he or she feels a "we" bond with the patient, a sense of alliance with the patient in the joint struggle against what is impeding the patient.

5. The therapist conveys (when appropriate) that he or she accepts the patient's growing sense of being able to do what the therapist does in terms of using the basic tools of the treatment.

6. The therapist refers (as appropriate) to experiences that he or she and the patient have been through together, building up, as it were, a joint backlog of common experience.

7. It may be necessary to encourage some patients to express themselves, especially to speak about the areas in which they wish to be helped.

Bolstering Areas of Competence

A second technique for providing support is to find the patient's strengths, including his or her areas of competence and effective defenses, and then to support them (Gill, 1951). For example, if the patient is trying to get a job or to complete school, the therapist should recognize the patient's efforts and explore with the patient anything that might interfere with these endeavors.

In this further example from Mr. Lennon's therapy, the therapist is clearly supportive of the patient's goal of having a job.

> Patient: So I got a job in this pizza pie place starting next week.
>
> Therapist: Oh, you do?
>
> Patient: Yeah.
>
> Therapist: Oh, good! That starts on Monday?
>
> Patient: Tuesday.

Therapist: So—what do you think? Are you happy about getting it?

Patient: Yeah! It's something to keep me occupied.

Therapist: Congratulations! That's good. You've been looking around for work.

Patient: Yeah. It's something to keep me busy.

Here the therapist is recognizing and supporting the same patient's continued reliance on self-control.

Patient: It [methadone] wears off in the early part of the morning. I'd start to feel not myself. I'd say, "You're going to get it this afternoon. Don't worry about it. You know it's there."

Therapist: How did you do on the weekend [with methadone take-homes]? Did you wait until afternoon to take them?

Patient: Yeah, every day. I'd take my medicine every day at three o'clock in the afternoon. I got up in the morning and didn't think about it.

Therapist: A lot of self-control to do that.

Patient: That's what I'm basing my thing on: a lot of self-control.

And it seems to be working. But like I said, it isn't easy.

Therapist: No, not at all.

Patient: You know it worked every day.

Therapist: So you really kept to your schedule.

Patient: Yeah. I kept to it well, very well. If I can do that, you know—

Expressive Techniques for Achieving Understanding

For a large part of the time that the therapist is engaged with the patient in a session, the therapist's attention should be on the task of listening to what the patient is communicating, evaluating it, and then deciding how to communicate his or her understanding. The process from the point of view of the therapist is an alternation of three phases: listening, understanding, and responding.

Phase 1: Listening

In this phase, attention is unreflective, or as Freud (1912/1958) named it, "evenly suspended attention," or sometimes "free-floating attention." It is just listening and not trying to fit the material to any particular conceptual model.

Phase 2: Understanding

The type of listening in Phase 1 is the best preliminary for the next phase, which is understanding. After listening, the therapist shifts to a more reflective, evaluative, understanding attitude as hunches and hypotheses develop (as shown by Spence, 1973).

In this phase, the therapist's primary goal is to find the main theme of the patient's most important symptoms (usually related to drug taking and vocational problems) and their interpersonal context.

Some patients are aware when they first come for treatment that

psychological conditions contribute to their drug taking. Mintz, O'Brien, Woody, and Beck (1979) reported that 43% of addicts studied at the start of the methadone maintenance program said they used narcotics for relief of inner tensions and worries. Similar results were found in other studies (Fejer & Smart, 1972; Hart, 1976). Two kinds of observations assist in understanding the meaning of the symptom: (1) noticing the immediate circumstances leading to the symptom, which might be the taking of the drug or just the temptation to take the drug, and (2) finding the core conflictual relationship theme (CCRT), whose conflicts might serve as preconditions for the recurrence of the symptoms.

Noticing the immediate circumstances leading to the symptom: When the drug taking or even the urge to take drugs is reported in the session, the therapist and the patient have a special opportunity to notice important conditions that led to the drug taking, as would be true for any symptom that appeared during the session, such as a momentary forgetting or a sudden increase in depression (as is described in Luborsky, 1970; in press). The appearance of a symptom when the therapist can observe the verbal and nonverbal context in which it is reported can be revealing. The report of a symptom that occurred in the past is a bit harder to understand than one that arises at the moment, but it is still likely to be enlightening. Two examples are given from the same patient, Mr. Lennon, in the same session.

1. The session starts with the patient coming in, smoking, and remarking, "Everybody in the waiting room was smoking, so I got the urge." This information should be used by the therapist to review with the patient one of the conditions that might be related to his drug taking, that is, a kind of contagion effect based on the environmental stimulation of others who are smoking (or taking drugs).

2. Another aspect of the context for drug taking is very clear in this session when the patient says, "I feel I'm so bad when I eat. I therefore try to control the impulse by not eating. Then it's like a dam bursting, and I overeat." The same sequence apparently occurs in taking drugs. An interesting confirmation of this formulation is provided when the patient says that after seeing the therapist, he feels better and he can go and have a sandwich—after he sees the therapist, he feels better about himself and therefore does not feel the urge to overeat, and he can comfortably accept the idea of modest eating.

Finding the core conflictual relationship theme associated with the symptom: The therapist gains understanding of the intra- and interpersonal context for the patient's symptoms by figuring out the core conflictual relationship theme. The CCRT contains within it the patient's central relationship problems (Luborsky, 1977; Luborsky & Crits-Christoph, 1990). The biggest tip-off to this theme is its prevalence in many different narratives of relationship episodes, about relationships both in the present and in the past. Because it also appears in the relationship with the therapist, the CCRT

can be referred to as a measure of the transference relationship.

One of the best ways for the therapist to gain experience in identifying the CCRT is to review some sessions in terms of the patient's accounts of interactions with people. Each time the patient describes an interaction with another person, the therapist should attend to three components of the account: (1) the patient's wishes, needs, or intentions ("I wish [or want] something from the person"), (2) responses from others ("I will be rejected"), and (3) responses of self ("I get upset"). This kind of analysis for a series of narratives about interactions with people provides the therapist with a sense of the most frequent wish-consequence combination, i.e., the core conflictual relationship theme.

Viewing the symptoms as attempts at problem solution: The drug taking and other symptoms can partly be understood as faulty and costly attempts at problem solution. Seeing the symptoms as problem-solution attempts and using such language with the patient is useful to both therapist and patient. One of the virtues of formulating the CCRT in terms of wish-consequence sequences is that it leads the patient and therapist to think in terms of faulty problem solutions. After grasping the wish-consequence theme and thinking of the consequence as a trial solution, further listening will then allow both therapist and patient to hear alternative solutions. It is usually best for the patient to come up with alternative solutions, but if they are not clearly

labeled as such by the patient, the therapist should do so. Theoretically, there are always many possible ways of coping; practically, it may be difficult to tell which solution is one the patient can and will try.

The triad of temporal spheres: As the therapist obtains a rounded picture of the main theme, it is valuable to understand how it appears in three spheres: (1) current relationships inside the treatment ("current-in"), (2) current relationships outside the treatment ("current-out"), and (3) past relationships. The therapist should stay alert to when the pattern of relationships with people includes the relationship with the therapist ("current-in"). Understanding the relationship with the therapist, both its transference and real components, is a valuable guide to the therapist, especially at times of special stress in the relationship. In fact, it is a good rule for this kind of therapy that when the patient is unusually upset, especially if that state began during one of the sessions, that the causes of the upset might be found in the relationship with the therapist.

It will help in evaluating and understanding the patient's problems to keep a sense of the past process of the treatment. As Holzman (1965) points out so well, the therapist tends to comprehend the process on the basis of three segments: (1) relationships within the present session, (2) relationships of the present session and the immediately prior one, and (3) relationships of these two and the longer course of a series of sessions. As a practical guide, it

is often helpful for the therapist to refresh his or her memory just before seeing the patient by looking over the themes of the last session or the series of sessions immediately prior (without letting this review distort proper listening to the session about to convene). Staying in tune with what has happened between patient and therapist in the immediate past is often useful. This attention to what has just gone before as well as what follows immediately thereafter offers a solid psychological basis for understanding the main theme or any recurrent behavior in psychotherapy. As Freud (1895/1955,1926/1959) pointed out, temporal continuity is a good basis for suspecting causal association. It is also an underlying premise in exploring the basis for symptom formation (i.e., Luborsky, 1970; Luborsky, Sackeim, & Christoph, 1979).

Phase 3: Responding

The following principles can guide the therapist's technical responses to the patient.

Response Principle Number 1. Congruence between the therapist's responses (i.e., interpretations) and the patient's main theme: The main principle is that the therapist's responses should be chosen for their congruence with some aspect of (1) the theme of the drug taking or other main symptoms, or (2) the core conflictual relationship theme. This wish-consequence theme characterizes the following example from Mr. Lennon:

The wish, need or intention: I want my efforts to be approved and recognized, not criticized for being deficient.

The consequences (responses from self): I grow up, I get upset, I get angry, I take drugs, I keep trying in hopes of getting the recognition.

The therapist selected responses that fit this wish-consequence theme.

Patient: You don't get your true recognition because they think, once a junkie, always a junkie. And they always think you're trying to connive and trying to do something, you know. It's not what some person does, like, it's just what goes along with the whole character. They generalize that you are the same as them [other addicts], but you know, it's hard to generalize everyone in one category. Everybody isn't the same. But they do, you know. They give you the runaround a lot of times. "We'll see about this," "We'll see," "We'll see." I think, "Ah, man, the hell with it. Why should I even bother anymore?" But then I say to myself, "If I didn't bother—but there's always the chance that I'll get it [a take-home]." There's always that little chance, a hope, you know.

Therapist: Yeah.

Patient: It makes me strive. But it seems like I'm never getting it, you know. I get upset. I get very ... I start to get hostile. Therapist: Then you need to calm down, and then you feel like you want to take some drugs to calm down. So I guess the pattern, if we try to make it more general, is you feel that people don't give you what you deserve. They don't recognize your accomplishments. You meet them halfway, and they don't meet you halfway.

Patient: Right.

Therapist: And then what happens is that you start getting angry about it, and it makes you feel anxious, you said. And then you end up really craving drugs

even more, feeling like you really need something to calm down.

Patient: Yeah, right. And that turns into doing something.

Therapist: And then you get angry with yourself for having done something. And it gets into a real circular thing.

Patient: Really, yeah, really. And it ain't worth it, you know. 'Cause there's always that hope I'll get the other take-home (of methadone). One of these days it's gotta happen. But I feel like, what else do I gotta do for you [counselor]? You bring in your pay slips to show him you're working and so on, keep your urines clean. I've been doing all that. I don't know what else I have to do.

Therapist: So I guess when you start getting angry with one person, you end up angry with a lot of people.

Patient: Yeah, right.

Therapist: And you feel like, "I'm just going to go out and do something. I'm not going to come to therapy. I'm going to take drugs." You end up sort of hurting yourself....

Response Principle Number 2. Presenting the therapist's responses in a tactful style that encourages the patient to feel understood (as in the previous example with Mr. Lennon).

Response Principle Number 3. Noting signs of progress in understanding: The therapist should recognize signs of progress. Since many of the therapist's responses are guided by attention to the CCRT, even after a few sessions the CCRT will become clearer to both therapist and patient and the way toward achieving goals of self-understanding will be clear. The therapist

may then say to the patient at an appropriate time, "We begin to see the problem in your relationships, which you are trying to solve. It is ." Such a formulation provides a renewed focus; "We now see ..." also increases the sense of progress, and the use of "we" adds to the sense of alliance. Such a focus is especially important in short-term psychotherapies.

Response Principle Number 4. Limiting the extensiveness and complexity of the interpretations: In general, it is better not to make too long or too complex a statement all at once. It may be hard for the patient to take it all in, if the therapist presents too much. Furthermore, it is better to give the response piece by piece and be guided by the patient's response to each piece.

Response Principle Number 5. Timing the responses: It is usually good to listen for five or ten minutes at the beginning of the session before responding to get a sense of the patient's main message. Most of the therapist's responding should be given in the first 40 minutes of a 50-minute session, leaving the rest of the time for the patient to work over what has been said. Ordinarily, new material should not be introduced at the end since there may not be enough time for the patient and therapist to go over it sufficiently.

Response Principle Number 6. Patiently waiting to respond until understanding comes: From time to time the therapist should remember to

avoid the temptation to respond before knowing what he or she is responding to. The best way for the therapist to heed this self-counsel is to also remember that it is natural not to understand consistently. Understanding comes saltatorially and unpredictably, not consistently and gradually. There is no point, then, to the therapist responding just for the sake of responding, or to the therapist appearing to be understanding before he or she really is. After working together for a while, a parallel process in the patient will develop. The patient, too, will become more tolerant of delays in self-understanding.

Response Principle Number 7. *Overcoming countertransference:* It is very easy to get caught up in certain types of negative or counter-therapeutic responses to the patient. Such responses can be especially problematic in patients with impaired ego function, such as is often the case with opiate addicts.

The first such response could be called responding without sufficient reflection and understanding. This usually happens when the therapist becomes overly involved in the exchange with the patient and finds it difficult to get the necessary distance for reviewing, reflecting, and understanding.

The second kind could be called the contagion of mood—if the patient is depressed, the therapist becomes depressed; if the patient is happy, the

therapist becomes happy; and so on. The term "contagion" has been applied by Redl (1966) as a partial explanation for the transmission of affects.

The third form of counter-therapeutic response may be more common than has been supposed: The therapist responds in ways that fit into the patient's negative expectations and fears (described in Singer & Luborsky, 1977, as "negative fit"). For example, if the patient is communicating his great fear that people in his life dominate him and tell him what to do, the therapist may unwittingly begin to do just that. Of course, the therapist is more protected from falling into these counter-therapeutic responses if he or she observes a reasonable balance between listening involvement and reflective uninvolvement. Maintaining this balance, the therapist would become aware of the main theme of the patient's fears and expectations and therefore have greater protection against fitting into them.

Response Principle Number 8. Testing the "goodness" of a session: One test of a good session that has stood up well in practical applications can be called the "matching-of-messages test." In reviewing a session, the therapist reflects on the patient's main message, which often is the same as the main relationship theme. Then the therapist should review the session again and ask a similar question: What was my main response to the patient? A good session is one in which there is a reasonable match between the two messages—when the therapist let the patient know that he or she was aware

of the patient's message, or the therapist's response took into account a realization of what the patient's message was. The matching-of-messages test was first applied under the label "therapist responds effectively to the patient's main communication" in Auerbach and Luborsky (1968). Three judges working independently were able to estimate this quality with moderately good agreement (.65, $p < .01$). In that study, the judge was instructed first to specify the patient's main communications, then to specify the therapist's responses, and finally to compare them so as to determine whether the therapist had dealt with the patient's main communication in a reasonable and effective way.

Phase 1: Returning to Listening

The therapist returns again to an attentional mode that is essentially unreflective listening. It may be difficult to shift back to this mode, not just because it involves a shift from reflectiveness to involvement. It is hard at times to keep the balance between openness to what the patient is saying at the moment and reflective recall of the main themes the patient has expressed before. The optimal state entails a combination of knowing how to proceed with the treatment and keeping calm enough to do the task. Knowing how to proceed means knowing the principles outlined earlier. And knowing these certainly lowers the therapist's anxiety about the task and therefore allows him or her to listen and understand more accurately (cf. Spence & Lugo, 1972). The therapist being able to hold his or her anxiety in check has

much to do not only with experience—with having treated many patients—but also with patience. Understanding will come in time; if it is not here at the moment, it will come in a while.

Techniques for Dealing with the Anticipation of the Ending of Treatment

Terminating Time-Limited Treatment

The supportive-expressive psychotherapy we have presented can be carried out in either of two main time structures: time-limited or open-ended. The VA-Penn project used time-limited psychotherapy. When the treatment is structured at the outset as time-limited and the patient is kept adequately informed and aware of this constraint, the patient will go through all the phases of a longer treatment in a more condensed fashion and will not experience the ending of treatment as an abrupt cutoff. In time-limited psychotherapy, because the patient and therapist know the time frame, much of what would be present in a longer treatment is present as well in the shorter treatment, that is, the treatment is still shaped by a clearly marked beginning, middle, and end. Furthermore, it is reassuring, although surprising, to realize that so far the research evidence does not show time-limited treatment to be less effective than time-unlimited treatment (e.g., Luborsky, Singer, & Luborsky, 1975).

Maintaining Awareness of Treatment Length

To minimize the special problems of dealing with termination for drug-

dependent and generally dependent patients, it is important to have the patient clearly aware from the start that the treatment is intended to last six months. Such a clear statement at the outset, referred to repeatedly thereafter, will make it easier for the patient to complete the treatment at the end of six months, to minimize the sense of rejection, and to maintain the gains. As in the VA-Penn project, the patient can also be reminded that not all treatment stops; only this psychotherapy stops, but he or she will continue with the drug counselor (Woody et al., 1983). When signs of the patient's reactions to impending termination are not evident spontaneously, the therapist should remind the patient of termination or find out whether the patient is responding to termination but not expressing it.

Dealing with Resurgence of Symptoms in Anticipation of Termination

Dealing adequately with the meaning of termination will usually have a good effect on solidifying the gains of the treatment. For example, the initial problems usually revive as termination approaches. If the therapist deals with this reappearance of the initial problems by considering it with the patient in terms of an anticipation of the meaning of ending, usually the problems subside and the patient is better able to reinstate the gains made earlier.

For example, Mr. Fergeson was a little difficult to engage during the first and second sessions but then was very pleased to participate and come to the sessions. He was always on time until about a month before termination,

when he found it very difficult to come. Then he stopped coming altogether, because, he said, he was so frustrated that he didn't get the money to start his vocational training. His absence may also have been based on disappointment about having to stop the treatment, or other kinds of disappointments. He had seemed during the treatment to be headed toward being able to accomplish things that he needed to do, but none of them came to pass. His dose of methadone was down to 10; two months before termination, he was expecting to soon be off the methadone. He was expecting to start school. He spoke about it being time to leave his mother's home. As termination approached, however, he became discouraged and spoke of falling back into his mother's care and back into drugs. Discussion of the meaning of the return of his symptoms just as the ending came helped reinstate his improvements.

This is an example of a not uncommon inclination to get discouraged about achieving the initial goals as termination looms. In this case, discussing the issue with the patient restored much of his motivation.

Recognizing Treatment Phases

All through the treatment, the therapist should be alert to the appearance of phases of the treatment as a function of the achievement of the goals, as Schlesinger (1977) has pointed out. Completing or even partially completing goals and starting new ones is of special value for the therapist and patient since, as we discussed earlier, doing so provides a sense of

completion and progress to the patient at a readily understandable level. Attention to completion of phases can also provide a brake on too much transference involvement or too much regression.

Continuing the Relationship After Termination

Many patients naturally are interested in knowing whether the therapist wants to be kept up to date on their progress after termination. The therapist may say, when this issue comes up, that he or she would welcome news of how things are going. To those patients who were part of the VA-Penn project, therapists said that news would also come to them from the patient's routine follow-ups. Such an exchange at the time of termination can understandably contribute to maintenance of the treatment gains.

Dealing with the Need for Further Treatment

If at termination new goals are raised, or if the old goals are not achievable in the time remaining and the patient wishes to continue treatment, the therapist should help with a referral to another therapist.

CASE EXAMPLE

At the start of therapy, Mr. Lennon was heavily addicted to heroin. He functioned poorly in work, in relationships, and in self-care. His grooming was almost absent. By the end of therapy, his heroin usage had almost

vanished and he had a regular job in an automotive store. He had his old girlfriend back, he took better care of himself, and his grooming and self-esteem were much improved.

This patient's psychotherapy showed a strong supportive component. The following discussion, however, focuses on the central relationship problems that were the object of the therapist's interpretations. The therapist used the following examples of his relationship episodes (REs), told in the session of July 8, 1981, to formulate the core conflictual relationship theme, which was the recurrent focus of the therapist's interpretations.

RE1: Friends. For many years I helped my "friends" by giving them food, shelter, drugs, and money. But when I asked for help from them, they disappeared. It's difficult now to find friends who aren't using some kind of drug or alcohol. Everyone wants to get high. I do not want to get involved in that scene.

RE2: Therapist. I'm trying to figure out how to get out of this rut. It feels like there's no way out of this bind. I'm tempted to drive to New York City to buy some heroin. I just wanted to escape reality somehow. I thought about buying dope while I was driving here [to see you]. If I wasn't coming here today for our appointment, I would have driven to New York City. *[At this point, the regular 60-minute session would have ended.]* However, I want to

talk for an additional time about anything else but drugs. I can't leave here feeling this way, or I'll go straight to New York. Please, let's talk until I feel more calm.

RE3: Girlfriend. I want to tell you about my relationship with my girlfriend and our planned marriage. We have dated since we were 15 years old, although she refused to continue dating after I returned from Vietnam [at age 23] addicted to heroin, but we kept in contact with each other and remained friends. Four months ago, we decided to continue the relationship we had 12 years ago. Very recently, we decided to marry. Using drugs would jeopardize these plans. *[After 30 minutes, Mr. Lennon said he felt much calmer and ready to return to work.]*

These three relationship episodes reveal the following CCRT:

Wish: I want to work hard to do something that would please someone else. I wish for a return in terms of approval, respect, and affection.

Response from other: I expect the other person will not give me what I wish for.

Response of self: I feel deprived and angry. (*Taking drugs lessens these feelings of deprivation and anger.)*

During the course of the session, the buildup of this conflictual theme was apparent, and Mr. Lennon's request for additional time was a test of the theme in relation to the therapist. By the end of the session, he did not feel deprived to such a degree that he had to use drugs. The threat to the relationship if he did use drugs also served as a deterrent. In his relationship with his girlfriend, he usually had a sense of security, an expectation that he would receive approval and affection. The same feelings were illustrated in his relationship with the therapist. Fie was able to risk asking for the extra time and was able to feel satisfied after receiving it. At the time, his craving for heroin was sufficiently reduced that he did not feel compelled to use the drug that day.

An even briefer excerpt from an earlier session shows that the therapist had repeatedly focused interpretatively on parts of this CCRT. This example is from the first third of the session of June 17,1981.

> Patient: I'm using a lot of things for motivation—diet and relaxation. You know, coming here motivates me every Wednesday.
>
> Therapist: Yes.
>
> Patient: You know, going to see Melody [relaxation trainer], going to see Nina [nurse-practitioner], going to see Lou [counselor]. You know, four days a week I see people. . . . And everything is going good.
>
> Therapist: So, the main thing is, you're using motivation and challenges from all different areas.

Patient: Right, right.

Therapist: And I guess you're saying, no matter how hard you work, sometimes you feel that you're supposed to be doing more, or never feel that people are saying, "Good work."

Patient: Yeah. I never see people accept me for what I do. It always seems like a downhill struggle.

Therapist: You always feel like you're fighting this image [of a drug user].

Patient: Yeah. And I've got to struggle better all the time.

More detailed instructions for scoring the CCRT and its use in clinical work can be found in Luborsky and Crits-Christoph (1990), and Luborsky (1993a) adds more on how to use the CCRT to maximize the benefits of psychotherapy.

TRAINING

Trainees should already have had several years of experience as dynamic psychotherapists. For this group, the special training in SE dynamic can usually be accomplished in a matter of a year or two. Supervision aided by this manual is a necessary combination. Learning to follow the manual's recommendations can be facilitated by applying the manual to patients and then rereading the parts of the manual that are relevant to the treatment. The concurrent supervision can be either inpidual or in a group led by an expert in SE dynamic psychotherapy. Also helpful is a special form of group

supervision in which each therapist has a chance to present and also a chance to help supervise the other presenters (as described in Luborsky, 1993a).

Whether the supervision is inpidual or group, it is absolutely essential that samples of the therapist's audio- or videotape recordings be scored for adherence. Assessing adherence ensures that the therapist is actually using the essential principles in the manual.

Dynamic Psychotherapy for Treatment of Opiate Drug Dependence

Our first study of psychosocial treatments with opiate addicts was started in 1977 at the Drug Dependence Treatment Unit of the Philadelphia VA Medical Center (Woody et al., 1983). Patients who were interested in the treatments and fit the criteria were offered random assignment to drug counseling alone or to drug counseling plus six months of either SE dynamic psychotherapy or cognitive-behavioral psychotherapy. Of the patients who met the criteria, 60% expressed interest, and 60% of these, or 110, actually completed the intake procedures and became engaged in the therapy. Engagement was defined as keeping three or more appointments within the first six weeks of treatment. All three treatment groups significantly improved, but patients receiving the two psychotherapies showed greater improvement and improvement in more areas than those receiving drug counseling alone; they also used less medication. In summary, opiate addicts were both interested in the professional psychotherapies and benefited from

them.

In the same study, there were no significant differences in the number of areas of benefit between SE dynamic psychotherapy and cognitive-behavioral psychotherapy. The gains evident at the 7-month follow-ups (one month after termination) were also evident at the 12-month follow-ups. The psychiatric severity at the start of treatment (measured either through the Addiction Severity Index [McLellan, Luborsky, Cacciola, Griffith, McGahan, & O'Brien, 1985] or through composites of standard psychological tests) was a significant predictor of outcome for all three treatments. Finally, the advantage of the two professional psychotherapies over counseling alone was best seen among the most psychiatrically ill patients.

The National Institute of Drug Abuse was interested in the cross-validation of these results in community clinics. We therefore did a cross-validation in three Philadelphia community clinics from about 1986 to 1990 (Woody, McLellan, Luborsky, & O'Brien, 1994). Because the two psychotherapies had shown mostly nonsignificant differences, we chose only the SE dynamic psychotherapy for this study, and because less time had been given in the original study to the drug counseling than to the psychotherapies, we used two separate drug counselors. The results still showed the advantages for the professional psychotherapy, but the advantages were reduced as compared with the original study. While at seven months the

advantage was slight, at 12 months the advantage had become larger. The finding of reduced differences between drug counseling and SE therapy at seven months was almost certainly attributable to it being harder to show advantages when the comparison was between SE psychotherapy versus *two* drug counseling treatments simultaneously.

REFERENCES

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: APA.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: APA.

Auerbach, A. H., & Luborsky, L. (1968). Accuracy of judgments of psychotherapy and the nature of the "good hour." In J. Shlien, H. F. Hunt, J. P. Matarazzo, & C. Savage (Eds.), *Research in psychotherapy* (Vol. 3, pp. 155-168). Washington, DC: American Psychological Association.

Bergmann, M., & Hartman, F. (Eds.). (1977). *The evolution of psychoanalytic technique.* New York: Basic Books.

Burstein, A. (1976). Psychotherapy for the poor. In J. L. Claghorn (Ed.), *Successful psychotherapy* (pp. 189-196). New York: Brunner/Mazel.

Chappel, J. N. (1973). Attitudinal barriers to involvement with drug abusers. *Journal of the American Medical Association,* 224,1011-1013.

Ekstein, R., & Wallerstein, R. (1958). *The teaching and learning of psychotherapy.* New York: Basic Books.

Fejer, D., & Smart, R. (1972). Drug use, anxiety and psychological problems among adolescents.

Ontario Psychologist, 4,10-21.

Fenichel, O. (1945). *The psychoanalytic theory of neurosis.* New York: Norton.

Freud, S. (1955). Studies on hysteria. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 2, pp. 3-305). London: Hogarth Press and the Institute of Psychoanalysis. (Original work published in 1895)

Freud, S. (1958). Recommendations to physicians practicing psychoanalysis. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 111-120). London: Hogarth Press and the Institute of Psychoanalysis. (Original work published 1912)

Freud, S. (1958). On beginning the treatment (further recommendations on the technique of psychoanalysis). In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 123-144). London: Hogarth Press and the Institute of Psychoanalysis. (Original work published 1913)

Freud, S. (1959). Inhibitions, symptoms and anxiety. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 20, pp. 87-174). London: Hogarth Press. (Original work published 1926)

Gill, M. M. (1951). Ego psychology and psychotherapy. *Psychoanalytic Quarterly,* 20, 60-71.

Hart, L. (1976). Attitudes toward drug use, therapeutic community (concept) resident versus methadone patients. *British Journal of Addictions,* 69, 375-379.

Henry, W., Sims, J., & Spray, S. (1973). *Public and private lives of psychotherapists.* San Francisco: Jossey-Bass.

Holzman, P. (1965). Process in the supervision of psychotherapy. *Bulletin of the Menninger Clinic,* 29,125-130.

Kernberg, O., Burstein, E., Coyne, L., Appelbaum, A., Horwitz, L., & Voth, H. (1972). Psychotherapy and psychoanalysis: Final report of the Menninger Foundation's Psychotherapy Research Project. *Bulletin of the Menninger Clinic,* 36,1-275.

Klein, G. (1970). *Perception, motives and personality.* New York: Knopf.

Knight, R. (1949). A critique of the present status of the psychotherapies. *Bulletin of the New York Academy of Medicine,* 25,100-114.

Lorion, R. P. (1974). Patient and therapist variables in the treatment of low-income patients. *Psychological Bulletin,* 81, 344-354.

Luborsky, L. (1970). New directions in research on neurotic and psychosomatic symptoms. *American Scientist,* 58, 661-668.

Luborsky, L. (1977). Measuring a pervasive psychic structure in psychotherapy: The core conflictual relationship theme. In N. Freedman (Ed.), *Communicative structures and psychic structures* (pp. 367-395). New York: Plenum Press.

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive (SE) treatment.* New York: Basic Books.

Luborsky, L. (1993a). How to maximize the curative factors in dynamic psychotherapy research. In N. Miller, L. Luborsky, J. P. Barber, & J. Docherty (Eds.), *Dynamic psychotherapy research: A handbook for clinical practice* (pp. 519-535). New York: Basic Books.

Luborsky, L. (1993b). Recommendations for training therapists based on manuals for psychotherapy research. *Psychotherapy,* 30, 578-580.

Luborsky, L. (1994). Therapeutic alliances as predictors of psychotherapy outcomes: Factors explaining the predictive success. In A. Horvath & L. Greenberg (Eds.), *The working alliance: Therapy, research and practice* (pp. 38-50). New York: Wiley.

Luborsky, L. (in press). *The symptom-context method: Solving and resolving symptoms in psychotherapy.* Washington, DC: APA Books.

Luborsky, L., & Crits-Christoph, P. (1990). *Understanding transference: The CCRT method.* New York: Basic Books.

Luborsky, L., Crits-Christoph, P., Mintz, J., & Auerbach, A. (1988). *Who will benefit from*

psychotherapy? Predicting therapeutic outcomes. New York: Basic Books.

Luborsky, L. B., Fabian, M., Hall, B. H., Ticho, E., & Ticho, G. (1958). Treatment variables. *Bulletin of the Menninger Clinic,* 22, 126-147. (Part of the *Menninger Bulletin* issue entitled *The Psychotherapy Research Project of the Menninger Foundation*)

Luborsky, L., Sackeim, H., & Christoph, P. (1979). The state conducive to momentary forgetting. In J. Kihlstrom & E. Evans (Eds.), *Functional disorders of memory* (pp. 325-353). Hillsdale, NJ: Lawrence Erlbaum Associates.

Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that "everybody has won and all must have prizes?" *Archives of General Psychiatry,* 32,995-1008.

Malan, D. (1976). *Towards the validation of a dynamic psychotherapy.* New York: Plenum Press.

Mann, J. (1973). *Time-limited psychotherapy.* Cambridge, MA: Harvard University Press.

McLellan, A. T., Luborsky, L., Cacciola, J., Griffith, J., McGahan, P., & O'Brien, C. (1985). *Guide to the Addiction Severity Index: Background, administration and field testing results* (Department of Health and Human Services Monograph Vol. 30). National Institute on Drug Abuse Treatment Research Report. Publication No. (ADM) 85-1419. Washington, DC: U.S. Government Printing Office.

Menninger, K., & Holzman, P. S. (1973). *The theory of psychoanalytic technique* (2nd ed.). New York: Basic Books.

Miller, N., Luborsky, L., Barber, J. P., & Docherty, J. (Eds.). (1993). *Psychodynamic treatment research: A handbook of clinical practice.* New York: Basic Books.

Mintz, J., O'Brien, C. P., Woody, G., & Beck, A. T. (1979). Depression in treated narcotic addicts, ex-addicts, non-addicts, and suicide attempters: Validation of a very brief depression scale. *American Journal of Drug and Alcohol Abuse,* 6(4), 385-396.

Norcross, J., Prochaska, J., & Farber, J. (1993). Psychologists conducting psychotherapy: New findings and historical comparisons on the psychotherapy pision membership.

Psychotherapy, 30, 692-697.

Orne, M., & Wender, P. (1968). Anticipatory socialization for psychotherapy: Method and rationale. *American Journal of Psychiatry,* 124, 88-98.

Redl, F. (1966). *When we deal with children.* New York: Free Press.

Schlesinger, H. (1977). The responsibility of the psychoanalyst for analytic and therapeutic change. *Bulletin of the Menninger Clinic,* 41, 202-206.

Schmale, A. (1958). Relationship of separation and depression to disease. *Psychosomatic Medicine,* 20, 259-277.

Sifneos, P. E. (1972). *Short-term psychotherapy and emotional crisis.* Cambridge, MA: Harvard University Press.

Singer, B., & Luborsky, L. (1977). Countertransference: A comparison of what is known from the clinical versus quantitative research. In A. Gurman & A. Razin (Eds.), *The therapist's contribution to effective psychotherapy: An empirical assessment* (pp. 431-148). New York: Pergamon.

Spence, D. P. (1973). Tracing a thought stream by computer. In B. B. Rubinstein (Ed.), *Psychoanalysis and contemporary science* (Vol. 2, pp. 188-201). New York: Macmillan.

Spence, D. P. & Lugo, M. (1972). The role of verbal cues in clinical listening. In R. Holt & E. Peterfreund (Eds.), *Psychoanalysis and contemporary science* (Vol. 1, pp. 109-131). New York: Macmillan.

Strupp, H., & Bloxom, A. (1973). Preparing lower-class patients for group psychotherapy: Development and evaluation of a role induction film. *Journal of Consulting and Clinical Psychology,* 41, 373-384.

Valliant, G. (1973). A 20-year follow-up of New York narcotic addicts. *Archives of General Psychiatry,* 29,237-241.

Valliant, G. (1983). *The natural history of alcoholism.* Cambridge, MA: Harvard University Press.

Wallerstein, R. (1986). *Forty-two lives in treatment: A study of psychoanalysis and psychotherapy.* New York: Guilford Press.

Wallerstein, R., Robbins, L., Sargent, H., & Luborsky, L. (1956). The psychotherapy research project of the Menninger Foundation: Rationale, method, and sample use. *Bulletin of the Menninger Clinic,* 20, 221-280.

Woody, G., Luborsky, L., McLellan, A. T., O'Brien, C., Beck, A. T., Blaine, J., Herman, I., & Hole, A. V. (1983). Psychotherapy for opiate addicts: Does it help? *Archives of General Psychiatry,* 40, 639-645.

Woody, G., McLellan, A. T., Luborsky, L., & O'Brien, C. (1985). Sociopathy and psychotherapy outcome. *Archives of General Psychiatry,* 42,1081-1086.

Woody, G., McLellan, A. T., Luborsky, L., & O'Brien, C. (1994, June). *The outcomes of psychosocial treatments for opiate addicts in three community clinics.* Paper given at the meeting of the North American Society for Psychotherapy Research, Santa Fe, NM.

Woody, G. E., Stockdale, D., & Harris, W. (1993). *Drug dependence treatment unit manual.* Unpublished manuscript.

Notes

1 The authors of the present version of the manual were part of the first such training group; those in successive training groups have also contributed ideas to successive editions, including A. Thomas McLellan, Anna Rose Childress, David Mark, Jeff Faude, Mike Montanero, Larry Hart, Sam Okpaku, Barbara Goldsmith, Andrew Cooper, Lorrie Helgie, Pam Bekir, and Morrie Olsen.