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The Vanderbilt Approach to Time-Limited Dynamic Psychotherapy

Handbook of Short-Term Dynamic Psychotherapy

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Contents

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ORIGINS AND DEVELOPMENT

Several important developments have influenced our approach to Time-Limited Dynamic Psychotherapy (TLDP) and have in turn contributed to advances in research and practice. The first, and most important, relates to the growing role of research, that is, the recognized need for disciplined scientific study of the phenomena and processes in our domain (Strupp & Bergin, 1969; Bergin & Strupp, 1972). The Vanderbilt Psychotherapy Research Team has been committed to this objective since the early seventies; the research efforts of one of us (Hans Strupp) date back to the early 1950s. As in all scientific endeavor, the key to our research is specificity: to study psychotherapeutic phenomena and processes, one must define and, if possible, quantify them; global descriptions will not suffice.

The second impetus for the development of TLDP derived from the Vanderbilt I study (see the section on empirical support), which highlighted the neglected (or underestimated) issue of the management of hostility in the therapeutic relationship. This finding constituted a major reason for focusing TLDP on the patient-therapist relationship and the study of countertransference reactions, both of which may be regarded as the *Leitmotif* of the Vanderbilt research group.

We wish to note the influence of societal pressures, exemplified by demands from insurance companies and governmental agencies for specification of the treatments they are being asked to underwrite. Related to this issue are the qualifications of practitioners of a particular form of psychotherapy. For purposes of licensing and other forms of legislation, it is essential to develop criteria by which one may judge whether a practitioner meets specific standards of competence. The appearance of treatment manuals in our time, including that for TLDP, may be viewed as part of the clinical investigators' response to demands for greater specificity.

TLDP has continued to form the basis for our systematic studies of the psychotherapeutic process and its outcomes. However, we believe that we have gone beyond codifying a traditional form of therapeutic practice. Instead we have endeavored to integrate our understanding of psychoanalytic psychotherapy as it has evolved over the years and to present a contemporary model of that treatment modality. The model is intended as a blueprint of psychoanalytic psychotherapy that is broadly applicable irrespective of time limits.

Our research has called forceful attention to the overriding importance of the dyadic *interactions* between patient and therapist over the course of therapy, with special emphasis on the early phases. Thus, our approach forms part of a movement toward a greater integration of classical and

interpersonal psychoanalytic theory and technique—in short, nothing less than a reconceptualization of transference and countertransference phenomena in interactional terms.

From a historical perspective, the forward-looking ideas of Franz Alexander and Thomas French (1946) have greatly influenced our thinking, as have the writings of specialists in time-limited dynamic psychotherapy (such as Malan, 1963, 1976a, 1976b; Sifneos, 1972, 1979; Davanloo, 1978, 1980; Mann, 1973; and Mann & Goldman, 1982). From a theoretical perspective we have profited greatly from the incisive contributions of Gill (1979, 1982), Klein (1976), Peterfreund (1983), Schafer (1976, 1983), Levenson (1972, 1982), and Epstein and Finer (1979). In developing TLDP, we have tried to stay close to clinical and observational data and to avoid as much as possible higher level inferences and complex theoretical constructions that have no apparent consequences for therapeutic activity. This has been a distinctive feature of our approach. Although techniques are crucial to the practice of psychotherapy, they are inextricably embedded in the interpersonal context of the relationship between patient and therapist. Beyond explicating this context, TLDP is designed to contribute to the training of thinking clinicians who view their profession as a disciplined activity evolving from clinical experience and scientific evidence.

SELECTION OF PATIENTS

While the theoretical foundation for TLDP is psychoanalytic, personality development and malfunctioning are viewed from interpersonal and object relations perspectives. The task in TLDP is to identify and examine certain themes from a person's internal object relations repertoire that are not responsive to current interpersonal realities and, therefore, may maladaptively influence that person's experiences and behavior in a variety of interpersonal settings (particularly with significant others). These themes take the form of maladaptive interpersonal patterns that press for enactment in current interpersonal relationships, including that with the therapist. Therefore, the therapeutic process involves (1) creating optimal (safe) conditions for the enactment of the patient's maladaptive interpersonal patterns; (2) allowing the patterns to be enacted within limits; (3) helping the patient to see what he or she is doing while doing it; and (4) encouraging the patient to identify and question the assumptions underlying maladaptive patterns. In this effort, TLDP relies primarily on examining transactions between patient and therapist as they occur.

This process presupposes that the patient's internal object relations and associated interpersonal patterns are sufficiently developed to be characterized by (1) coherent and identifiable interpersonal themes, (2) appreciation of the distinction between oneself and others, and (3) a capacity for concern and integrity in human relationships. Conversely, patients for whom TLDP would not be beneficial include those who are currently in a

disorganized psychotic state and those whose affective experiences and object relationships are chronically incoherent, diffuse, and disorganized (Giovacchini, 1989). There are also patients whose modes of relating manifest identifiable patterns but who see no value in examining interpersonal relationships (or the therapeutic relationship) or who do not value honesty and integrity in human relationships.

The object relations capacities sought in potential TLDP patients may be detected across a broad range of formal diagnostic syndromes. Therefore, neither a presenting symptom picture nor the diagnosis of a specific personality disorder will itself justify exclusion from this form of treatment. It should be apparent that in most cases we do not advocate specific treatments for specific symptom pictures or personality disorders. We posit that for the range of patients previously defined, attention to correcting maladaptive interpersonal patterns will reduce psychopathology in whatever form it takes.

Since emphasis in TLDP rests on interpersonal concerns, it is important to elicit information on the extent to which the patient is able to recognize and discuss subjective experiences in interactions with significant others. Once forms of psychopathology that would contraindicate TLDP are ruled out, the attempt is made to formulate a salient maladaptive interpersonal pattern, identify life areas most affected by this pattern, and construct a general

picture of the patient's interpersonal history of significant relationships. Most important is evidence of maladaptive functioning manifested in the immediacy of the therapeutic relationship. Then, in descending order, priority is given to functioning in current relationships outside of therapy and to recollections of past relationships extending back to childhood.

GOALS OF TREATMENT

The primary therapeutic goal of TLDP is to foster positive changes in interpersonal functioning. We believe that such changes will have beneficial effects on more circumscribed symptoms, such as affect and mood problems. In TLDP interpersonal problems are conceptualized in a specific format, which we have termed the Cyclical Maladaptive Pattern (CMP). Other short-term treatment approaches employ different constructs that serve functions similar to the CMP (for example, Luborsky, 1984; Davanloo, 1980; Malan, 1976a). The CMP is used as a heuristic that helps therapists to generate, recognize, and organize psychotherapeutically relevant information. It is not an absolute or final formulation of the problem, but rather it is used throughout the course of treatment as a tool for keeping the therapist focused on a remediable problem.

The CMP is a working model (Peterfreund, 1983) of a central or salient pattern of interpersonal roles in which patients unconsciously cast

themselves; the complementary roles in which they cast others; and the maladaptive interaction sequences, self-defeating expectations, negative selfappraisals, and unpleasant affects that result.

This model is built upon an abstract format that aids in the construction of the model. The format of the CMP specifies four categories of information:

1. *Acts of self.* Included are both private and public actions (such as feeling affectionate as well as displaying affection). Acts of self vary in the degree to which they are accessible to awareness.

2. *Expectations about others' reactions.* These are imagined reactions of others to one's own actions. Such expectations may be conscious, preconscious, or unconscious.

3. *Acts of others toward self*. These are observed acts of others that are viewed as occurring in specific relation to the acts of self. Typically, under the influence of a maladaptive pattern one tends to misconstrue the interpersonal meanings of the other's actions in a way that confirms one's wished for or feared expectations.

4. *Acts of self toward self* (*introject*). This category of actions refers to how one treats oneself (for example, self-controlling, self-punishing). These actions should be articulated in specific relation to the other elements of the format.

The CMP should ideally encompass a pattern of interpersonal

transactions that is both historically significant and also a source of current difficulty. Although currently enacted patterns are of primary importance, the specific nature of these patterns may be ambiguous. Historical knowledge aids therapeutic understanding by providing a context in which confusing meanings of present events may be more easily interpreted. Typically, no single event can be characterized as the "presentation" of a focus (CMP) to the patient. It is better to understand the process as one of introducing the patient to the primary importance of interpersonal issues and then collaboratively arriving at a shared view of what appears to be the most salient and meaningful maladaptive interpersonal pattern currently troubling the patient. The goal of treatment is to ameliorate this pattern.

THEORY OF CHANGE

TLDP is based on psychoanalytic conceptions and their extensions and reformulations by contemporary theorists (see Sandler, 1976; Schlesinger, 1982; Gill, 1982). Accordingly, we assume that therapeutic change is produced by an interplay of intrapsychic and interpersonal activities and that no particular therapeutic event is uniformly the most mutative. We also appreciate that all dynamic conceptions of therapeutic change are hypothetical (indeed, the primary goal of the Vanderbilt studies has always been empirically to explain the therapeutic processes associated with change). Consequently, we have chosen interpersonal conceptions of

therapeutic change as our primary framework because of their relevance and utility for moment-to-moment clinical work. Our primary allegiance is thus to an interpersonal perspective that is anchored in the theories of Harry Stack Sullivan, other members of the neo-Freudian school (Karen Horney, Erik Erikson, and Edgar Levenson), and the contributions of modern interpersonal theorists (Anchin & Kiesler, 1982).

In our view, psychotherapy is basically a set of interpersonal transactions. It is a process that may become therapeutic because of the patient's unwitting tendency to cast the therapist in the role of a significant other and to enact with him or her maladaptive patterns of behavior rooted in unconscious conflicts. Through participant observation the therapist provides a new model for identification. He or she does so, in part, by limiting the kinds of attitudes and behavior (such as hostile, controlling) that the patient's maladaptive behavior tends to provoke. The therapist also attempts to grasp latent meanings in the patient's interpersonal behavior and communicates this understanding to the patient, thereby helping the patient to assimilate aspects of his or her experience that were hitherto unrecognized or disowned (repressed). To this end, the patient's experiences with significant others in his or her current and past life represent important sources of information that aid the therapist's understanding; however, they are secondary to the contemporary transactions between patient and therapist.

The foregoing implies that the patient's self-identity and interpersonal behavior are important functions of learning experiences during his or her formative years. Because of early deprivations, traumatic experiences, and the like, the patient is unable to gain sufficient gratification from his or her contemporary interactions with others and lacks adequate resources (or denies their existence) to mold his or her environment in accordance with his or her legitimate wishes and needs. The patient has unrealistic expectations of himself or herself and others, and frequently feels stymied. Patterns of dealing with changing life circumstances are rigid, and although their maladaptive character may be perceived, he or she feels unable to change them.

Essentially, the therapist uses the relationship with the patient as the primary medium for bringing about change. What the patient learns in psychotherapy, what conduces to therapeutic change, is acquired primarily in and through the dynamics of the therapeutic relationship. Identifying the recollected childhood origins of current psychological conflict and the unconscious fantasies and feelings associated with the continued influence of these early experiences probably make an important contribution to therapeutic change. However, in TLDP the most important change process is considered to be the recognition of patterns of interactions with others that continuously reinforce maladaptive attitudes and feelings about oneself and others (these attitudes and feelings are the object-relational manifestation of

intrapsychic conflict). The sooner this recognition can be associated with the actual enactment of a maladaptive pattern, the greater is the potential for altering it. This is why identifying the influence of maladaptive patterns on the patient-therapist relationship is the primary strategy in TLDP.

In other words, therapeutic learning is experiential learning. The patient changes as he or she lives through affectively painful and ingrained interpersonal scenarios and as the therapeutic relationship gives rise to outcomes different from those expected, anticipated, feared, and sometimes hoped for. To promote these changes, the therapist, first, assiduously avoids prolonged engagement in activities that have the effect of perpetuating the conflicts that have resulted in the patient's interpersonal difficulties, and, second, actively promotes more satisfying experiences associated with productively collaborating in the solution of interpersonal problems.

With respect to the first, the therapist remains constantly attentive to the patient's unconscious attempts to elicit reciprocal behavior that meets the patient's wish for or expectation of domination, control, manipulation, exploitation, punishment, criticism, and the like. Such unwitting invitations may take the form of subtle seductions, requests for advice, special attention, extra hours, and many other maneuvers to which the therapist must be alert. The only way to avoid completely the impact of the patient's transference pressures would be for the therapist to erect barriers against any empathic

involvement with the patient. A more therapeutic stance is to maintain a "free floating responsiveness" (Sandler & Sandler, 1978) to the patient's attempts to draw the therapist into a particular scenario. A therapist who cautiously goes along with the patient, while remaining alert to his or her own reactions, can obtain invaluable information about the nature of the self-and object-representational components of the patient's relationship predispositions.

With respect to the second, the patient must come to experience the therapist as a reliable and trustworthy ally who is in the patient's corner, and who, in a fundamental sense, has the patient's best interest at heart. To that end, the patient must become convinced that the therapist has something worthwhile to offer, that he or she has a genuine commitment to the patient as a person rather than a case, and that the therapeutic experience is manifestly helpful. These are the essential ingredients of a good therapeutic alliance, the prime moving force in all forms of psychodynamic psychotherapy. Conversely, unless these conditions are met early in therapy, a good outcome—certainly in time-limited psychotherapy—is seriously in question (Strupp, 1980).

If the therapist successfully fosters this process, the patient's salient CMP will be viewed with increasing clarity. The patient will gain a greater ability to question the previously accepted assumptions about his or her self-image and about the attitudes and intentions of others that lend the CMP its

persistent influence. In turn, as the patient gains confidence in the beneficial effects of collaboratively examining maladaptive patterns, he or she is better able to confront emotions and fantasies associated with these patterns. The result is progressively more freedom to modify conflictual attitudes and behavior in the direction of more adaptive and flexible responses to changing circumstances and realistic opportunities for satisfying interpersonal needs. These changes typically are associated with improved overall functioning.

TECHNIQUE

The TLDP Process and Technical Goals

The basic working assumption in TLDP is that the patient will immediately enact a cyclical maladaptive pattern in the therapeutic relationship. In other words, the patient's behavior will be influenced by an amalgam of preexisting and long-established negative expectations of others, including of the therapist. Furthermore, he or she unconsciously seeks to induce the therapist to conform to the interpersonal scenarios dictated by those expectations. Thus, the overarching goal of technique in TLDP is the systematic and thorough examination of the patient's maladaptive action patterns and their effects on the interaction of the two participants. In common psychoanalytic terminology, the TLDP therapist's technical approach emphasizes the analysis of transference and countertransference in

the here and now.

Guidelines for Understanding the Patient's Conflicts

The TLDP therapist seeks to identify the presence of a prepotent, conflictual interpersonal theme and organizes his or her observations within the framework of a CMP. Furthermore, the therapist is particularly attentive to indications of transference and countertransference reactions. Although in the psychoanalytic theory of therapy the examination of transference is given a central role, our clinical and supervisory experiences have convinced us that transference analysis is frequently not well understood and is greatly underutilized in general practice.

Consonant with our view of the therapeutic relationship as an interactive dyadic system, we posit that conflict persists in the form of transference experience and behavior because circular interpersonal patterns confirm the patient's mistrustful expectations of others. Accordingly, the patient's transference experience and behavior are not simply representations of the past superimposed upon the therapist as "distorted" images. Rather, the patient has certain preexisting sets or fixed expectations with which he or she interprets the meanings of interpersonal events. The therapist proceeds on the working assumption that these plausible (from the patient's point of view) interpretations are always in response to something

actually occurring (conscious or unconscious attitudes and behaviors of the therapist; or aspects of the therapeutic arrangements, such as office fixtures, fees, appointment times, and so forth). In other words, the patient's transference experience does not distort some consensual reality, but rather is based on rigid proclivities to interpret events in a certain way without the flexibility to consider alternatives (Gill, 1979, 1982; Hoffman, 1983). Furthermore, having turned to the therapist for help and being unconsciously prepared to relate to him or her as a significant other, the patient becomes exquisitely sensitive to everything that transpires in the evolving relationship. It follows that any clinical data, whether generated in the form of references to people and events outside the therapeutic relationship, the patient's mood and dreams, or the emotional climate of the interviews, must be viewed as "disguised allusions" to the transference (Gill, 1979, 1982). Whatever else they may represent, such data should always be scrutinized for what they might reveal about the patient's experience of the therapeutic relationship.

In TLDP, countertransference is defined as encompassing two types of reactions: first, therapist actions and reactions (including attitudes and behavior as well as thoughts, feelings, and fantasies) that are predictably evoked by behavior of the patient that is part of the enactment of a maladaptive pattern (transference); and, second, reactions of the therapist that express unresolved personal issues.[1] From this perspective

transference and countertransference are ineluctably intertwined. Countertransference in TLDP terms may be described as a form of interpersonal empathy, in which the therapist, for a time and to a limited degree, is recruited to enact roles assigned to him or her by the patient's preconceived CMP. The therapist's empathy, however, encompasses more than an understanding of the patient's inner world—it can expand to include the first-hand experience of participating in that world as it is translated into interpersonal behavior. Thus, at the center of the therapeutic process in TLDP is the therapist's ability to become immersed in the patient's modes of relatedness and to "work his way out" (Gill & Muslin, 1976; Levenson, 1982).

There are times when it is extraordinarily difficult for the therapist to avoid enmeshment in the patient's scenarios. As we have stressed, patients are often impelled to force the occurrence of self-fulfilling prophecies by making the therapist a co-participant in their struggles. These pressures may be exceedingly subtle but they are vastly more pervasive than is commonly realized, particularly around the issue of hostility. The findings from our process/outcome studies (Vanderbilt I and II) have convinced us that even highly experienced therapists have great difficulty in therapeutically managing the hostility expressed by patients as well as their own reactive hostility. We have observed that even with extensive training to increase adherence to techniques for dealing with issues that arise in the patient-therapist relationship, therapists continue to be inconsistent in their

management of hostility. This is a serious problem for the delivery of effective treatment. There is evidence that regardless of how much "warmth," "friendliness," and "support" may be present, if expressions of hostility (direct or indirect) are not effectively handled, there will be repercussions on the development of a positive therapeutic alliance and on outcome (Henry, 1986; Henry & Strupp, 1989; Kiesler & Watkins, 1989).

In each therapeutic hour the TLDP therapist attempts to identify a recurrent theme that in one way or another is related to the defined TLDP focus. In TLDP, the most important facet of a theme in any interview is its interpersonal manifestation in the therapeutic relationship. In order for the therapist to identify the general form of the patient's relationship predisposition, he or she must maintain constant alertness and curiosity about the state of the therapeutic relationship. At the same time, while attempting to understand the current interpersonal transactions, the therapist attends to other aspects of the patient's communications. Thus, any area of his or her life the patient chooses to discuss should be jointly examined.

The therapist must always begin a session by entering the patient's internal world at whatever point admittance is given. Needless to say, much can be gained by clarifying and interpreting conflicts that are manifested in relationships outside of therapy. Simultaneously, however, the therapist

maintains a mental set aimed at applying what is learned about conflicts in other relationships to understanding the immediate state of the patient-therapist relationship. The translation is attempted when the therapist identifies a similarity between patterns of conflictual experience and behavior in other contexts and the transactions occurring in the therapeutic relationship.

Guidelines for Therapist Interventions

The TLDP therapist maintains with the patient a dialogue that is designed to help identify CMPs and to determine the affective meanings of these patterns. The paradigm guiding the therapist's interventions is as follows: first, the patient must act; then, with the therapist's help, he or she must step back and observe the action; finally, the meaning and purpose of the action must be explored. Typically, a patient spontaneously reports an interpersonal experience outside of therapy and his or her reactions associated with it. Patients clearly vary in the extent to which they can spontaneously report their interpersonal experiences. The TLDP therapist, through his or her interventions, seeks to obtain as detailed a picture as possible of the patient's interpersonal transactions and associated internal experiences. The CMP provides the format used to conceptualize these transactions. Five basic questions, based on that format, may serve as a guide to interventions:

1. How does the patient behave toward the other person, and what is the nature of his or her feelings toward the other?

2. What might be the patient's experience of the other's intentions, attitudes, or feelings toward him or her?

3. What might be the patient's emotional reactions to fantasies about and actions of the other?

4. How does the patient construe the relationship with the other, and how might his or her most recent reactions be a consequence of their previous interactions?

5. How does the patient's experience of the interactions and relationship with the other influence the manner in which the patient views and treats himself or herself?[2]

At the same time, the therapist endeavors to make optimal use of all opportunities for exploring and explicating the patient's experience in the therapeutic relationship. To aid this effort, the five guiding questions can be reframed by substituting the first person "me" for "the other." In this form, the questions can be posed directly about conditions in the therapeutic relationship as well as about implications for the relationship that can be detected in reports of interactions outside of therapy.

Although most analyses of interpersonal patterns will deal with relationships outside of therapy, whenever possible the line of inquiry should

return to examination of the therapeutic relationship, where the affective immediacy of the situation is most conducive to instilling in the patient an appreciation of affective and interpersonal patterns (Gill, 1982). As noted, the difficulty encountered by therapists in maintaining a consistent alertness to "disguised allusions to the transference" is often greatly underestimated (see Gill, 1979, 1982; and the authors' personal observations of supervisees and of experienced therapists participating in process/ outcome studies).

Our emphasis is on therapeutic learning based on systematic examination of the transactions between patient and therapist. Accordingly, interpretive connections to current and past outside relationships can be helpful in placing a particular transference enactment in broader perspective *after* the enactment has been carefully explored in the immediacy of the patient-therapist relationship and the patient has gained an appreciation of its impact on his or her experience and behavior. Forging such links serves three primary functions: (1) to strengthen the patient's capacity to achieve emotional distance from stereotyped predispositions, (2) to reinforce the patient's awareness of the patterns' profound effect on the current relationship with the therapist, and (3) to help the patient achieve an understanding of how such maladaptive patterns may have developed.

The TLDP emphasis on experiential learning through analysis of transactions in the patient-therapist relationship should be thought of as a

guiding strategy and as a mind-set that the therapist disciplines himself or herself to maintain. The actual extent to which transference interventions are used during any phase of treatment is determined by three factors: (1) the therapist's identification of material that can be understood as plausibly related to transference issues (Hoffman, 1983); (2) the patient's current receptiveness to examining his or her experiences of the patient-therapist relationship; and (3) the therapist's attentiveness to overt or disguised patient references to their relationship, as well as his or her attentiveness to countertransference reactions.

Preliminary findings from our latest process/outcome study indicate that the use of transference interventions per se is not tantamount to successful management of the therapeutic process, nor will it guarantee a positive outcome. Examination of transactions in the patient-therapist relationship represents use of a *type* of intervention. The utility of this intervention depends on the skill with which it is applied (Schaffer, 1982; Butler, Henry, & Strupp, 1989). Skill, in turn, is a function of such factors as how well the therapist times the intervention to coincide with the patient's readiness to address issues in their relationship, relevance of the content of the intervention to the patient's immediate concerns (Silberschatz, Curtis, & Nathans, 1989), and the extent to which the manner of intervening serves to minimize enactments of maladaptive patterns within the therapeutic relationship. The question of whether primary reliance on analysis of the

patient-therapist relationship, if skillfully conducted, will produce the most successful outcomes (at least with certain patients) awaits adequate empirical investigation.

CASE EXAMPLE

The following excerpt from a twenty-five session treatment illustrates some of the distinguishing technical features of TLDP. The therapy was conducted by one of us, Jeffrey Binder. The patient, Mr. A, was a man in his late thirties who sought treatment because of discomfort over insufficient emotional involvement with people. He was particularly distressed by the lack of intimate, pleasurable relationships with his wife and young child. In general, he felt that he did not fit in in most interpersonal settings and had a persistent feeling of depression. Mr. A came from an upper-middle-class family in which both parents were perfectionistic, critical, and emotionally constrained. As a teenager, Mr. A came into conflict with his parents by defying their expectations for his education. He married in his late teens; after ten years his wife precipitously divorced him. He drifted for a time before returning to school and remarrying. Subsequently, Mr. A had been vocationally successful (describing himself as a workaholic). The primary diagnosis was dysthymic disorder, but there were also features characteristic of an avoidant personality disorder.

In the first few sessions the major theme involved the patient's belief that he hid selfish feelings and motives, of which others would be critical. More generally, he was very self-critical and expected the same harshly critical attitude from others if he were to expose his emotional life. He believed that his blameworthy feelings and motives contributed to his feeling out of place in most interpersonal settings. He was easily angered by human imperfections and would occasionally explode angrily at his wife or child. The influence of this pattern of criticism and blame directed toward and expected from others was quickly identified in the patient-therapist relationship: Mr. A felt that the therapist was dissatisfied with the low fee (arranged as part of the patient's participation in our research program). At the same time, Mr. A was impatient with the therapist for not providing sufficient direction.

The following passages are excerpts from the seventh session. At the beginning, Mr. A questioned how he and the therapist should address each other. Having explored Mr. A's motives and feelings about this issue (that is, its direct reference to the therapeutic relationship and its relevance for revealing the enactment of a CMP), the therapist eventually acknowledged that he routinely used last names.

Patient: OK. Well, that's all right with me. My main goal is just to know something.

Therapist: Well, in the context of what you've been saying about the implications of names, what reaction do you have to that?

Patient: My reaction is that it seems somewhat appropriate, in that your approach is to me a fairly distanced approach, quite analytical.

Therapist: True.

Patient: So it seems to me that. . . I don't know if that's a gut reaction . . . but that's my first reaction is, well, that makes some sense to me. Seems to go along with the rest of what I know about . . .

Therapist: How do you feel about it?

Patient: I'm a little uncomfortable with it, in the same way that I'm uncomfortable with the whole approach a little bit, somehow I feel like I'm *(nervous laugh)* always squirming slightly. And I am somehow always wishing that I could break through that feeling of reserve that I get from you.

Therapist: Can you elaborate on both of those experiences? You're feeling like you're squirming and you're also wanting to break through what you see as my reserve.

During the preceding interchange, the therapist used questions to encourage the patient to explicate his experience of their interactions around the issue of how to address each other. The technical strategy was to maintain a balance between encouraging spontaneous communication (free association) and keeping the therapeutic work focused on constructing a CMP. The therapist detected signs of a conflict between the patient's desire for closeness to a man, dissatisfaction with its absence, and concern that the therapist might be offended by his feelings. The therapist also silently formed the hypothesis that this issue recapitulated an old relationship pattern between the patient and his father. However, in TLDP the goal is to aid the

patient in recognizing and appreciating the current existence of a CMP *before* links are made to childhood experiences.

As the session progressed, Mr. A continued gingerly to press the therapist to provide more guidance and to reveal his feelings about the patient. He admitted the desire to break through the therapist's "reserve" and to discover whether the therapist liked him. The therapist commented that Mr. A appeared to be increasingly sensitive about how the therapist felt about him and frustrated over having no clear indication. The therapist's encouragement to discuss these feelings resulted in Mr. A's voicing his first direct complaint: his goal of therapy was to learn how to relate to people, and if he did not have a comfortable relationship with his therapist, then therapy was failing. The patient went on to express concern over this "direct personal confrontation" with the therapist and continued to complain about not feeling closer to the therapist. This resulted in his "hanging back" and not sharing things.

> Therapist: Why do you think you're doing that? What do you think holds you back?
>
> Patient: Some kind of risk involved, and, I'm not wanting to make *(nervous laugh)* waves and feeling like, I would rather, to an extent, adjust to what your expectations are of the situation.
>
> Therapist: Why? Especially since you feel that you're dissatisfied with it.
>
> Patient: *(Chuckles)* Well, yes, I don't know. I mean all I can say is why would I be hanging back? It's because I feel like, like I said, with the thing with the

names, that maybe it would develop organically. Then I wouldn't have to make a plan. And somehow that would be easier, I wouldn't have to bring up something that's uncomfortable, uh, risk your displeasure or making you uncomfortable or whatever.

Therapist: If we pull together some of the observations, the experiences you've described in the past few minutes, maybe it would help us understand particularly what makes you hold back. You see me as reserved and you see yourself as holding back because you're not sure what that's about and you feel at risk and anxious about it. You're also reluctant, like you said, to make waves. If you say you're dissatisfied, you don't want to make waves, you don't want to make it personal. It's hard for you to admit that you're dissatisfied with me. And once you did, of course you said, "Well, it's not really you, it's me, too."

Patient: *(Chuckles.)*

Therapist: You're not going to put all the blame on me.

Patient: *(Chuckles.)*

Therapist: I wonder if you don't read something into my reserve. And that is, that I don't like you and that I don't want to be bothered by your feelings, particularly if you've got something to complain about or fuss about . . . any feelings, whether they are feelings of wanting to be closer to me or feelings of dissatisfaction, complaints, whatever. So that you feel you need to hold back, because otherwise I'll get mad or be offended, and our relationship will be ruined.

Patient: Uh, I think that's true. And I think that maybe I'm waiting for you to set the appropriate level of intimacy, so to speak. If you would complain about me, then I would feel free to complain about you. If your reserve wasn't there, then I feel like maybe I would be less reserved.

The therapist's interpretation was based on responses to the questions

he asked about the patient's immediate experiences in their relationship and the therapist's understanding of similar features in the patient's recollections of his relationship with his father. At this point in the session, however, the therapist refrained from making a transference-parent link because he did not have clear evidence that the patient appreciated the immediate influence of a recurrent maladaptive interpersonal pattern. They were still in the midst of clarifying what the patient felt to be an issue solely between them. Furthermore, this issue involved subtle hostility toward the therapist. It was important to bring this attitude to the surface, because the patient already indicated that it inhibited his openness with the therapist.

Soon Mr. A expressed an awareness of what had been his unquestioned assumption that the therapist neither liked nor wanted to be bothered by him. "[It] wouldn't be my intellectual conclusion, but I think it would be my emotional conclusion, and the one that I've been acting on." Once the patient began to question how he was interpreting the patient-therapist relationship, the therapist sought evidence of similar experiences in other relationships. However, Mr. A retreated to intellectualized rationales, which the therapist gently confronted. When the patient again expressed an awareness of the maladaptive nature of his characteristic mode of relating to others, the therapist encouraged a search for the sources of this interpersonal pattern.

Patient: My father would have to be that source.

Therapist: Can you elaborate?

Patient: I think both in his actions and his reactions, my father . . . in his actions, he does not usually go out of his way to tell you anything that he's uncomfortable with. On the contrary, he'll withdraw usually if he's uncomfortable. And in his reactions, if he senses that you are coming to him with something that you're uncomfortable with, he'll also withdraw. So I guess that I picked up from those behaviors that is the right way to behave, both because it's a good way to get along with him, and also because that's the way he behaves.

Therapist: I was wondering about that, too. It sounded a lot like the way you describe your father and the relationship with him. But I wonder if it could be put more personally and more relevant to how you experience your relationships and how you act. He is prototypic of the other person who doesn't want to be bothered by your feelings, whatever they are. And maybe doesn't even like you. What I mean by not even liking you, look, you're growing up, you're a little kid and here you have this imposing figure, your father. And you're bursting with all kinds of things that you want to say and tell, reactions you want from your father. And he doesn't seem to want to listen or give anything. What conclusion can you draw from that? The obvious conclusion is he doesn't want to be bothered with you, doesn't like you, you're not worth bothering with. And I'm suggesting it's more than just speculation, because look at what you experienced with me today: that I'm reserved and that must mean I don't want to be bothered by your feelings, and maybe I don't even like you.

The patient indicated that this reconstruction was meaningful and proceeded to describe his unsuccessful attempts to remember childhood experiences with his father.

Patient: And I just couldn't come up with anything. And yesterday I lay down and I took a nap. And I had a . . . it wasn't really a dream exactly, but I remembered my fifth-grade teacher, a man by the name of Mr. M. And in this, remembering, it was as if I was just crying and crying, remembering

> this guy, because he was such an opposite from what my father was. He seemed so human, so approachable, he seemed to take such a concern with me. I was just remembering him, remembering his face. And it was just as if I was crying and crying. I wasn't really crying, because I was really asleep. But when I woke up from that and remembered it, I realized that I had finally remembered something from my childhood that was really significant to me, namely this other man who really did seem to care about me, more than my father did.

In this interchange the patient had acknowledged a particular set of expectations regarding the attitude toward him of important persons in his life. This acknowledgment was a sign to the therapist that the patient was ready to look for sources of this attitude. With only a little encouragement, Mr. A drew a connection (that is, the patient initiated a transference-parent link) between his current expectations of others and his childhood relationship with his father. At this point the therapist took the opportunity to offer an empathic rationale (reconstructive interpretation) for the patient's coming to expect significant others to be uninterested or disapproving. The therapist, then, sought to reinforce the current validity and relevance of his interpretation by linking it to the components of the interpersonal pattern that they both had identified as being enacted between them earlier in the session. Evidence supporting the utility of the therapist's interventions came from the patient's revealing more personal information, namely his intense longing for a close relationship with a man.

Patient and therapist continued to explore these newly emerged

feelings of longing for a close relationship with a paternal figure and sadness over its absence. Mr. A observed that as he talked about these feelings they faded from his experience. The therapist focused attention on this reaction (a resistance) and emphasized the patient's active participation in his emotional disconnection from others. The patient was struck by this realization.

Therapist: As you're recalling [the semi-dream] now, does it stir up any feelings now?

Patient: Yeah, it, somewhat the same feeling of wishing that I could have a relationship like that and also be a person like that or just have that quality. I think in some ways he personifies to me what is lacking in my life.

Therapist: Is there any of the sadness right now?

Patient: Yeah, though just when I started describing it, I lost a bit of it, but if I think about it, if I just think about his face as I was imagining it, I can bring up that feeling. It's a feeling of longing and grieving that I have to go back to fifth grade to find that. And this sort of sense of empty years.

Therapist: You know, even as you're feeling some of it now, from the outside, you're very successful at keeping it well hidden inside.

Patient: I'm sorry. I am not being real successful in getting into it.

Therapist: As you said, even as you start talking about it, it fades. Which is kind of striking, because just as often, if not more typically, as you talk about feelings they become clearer. In the context of what we've been talking about today, I wonder if there's a part of you that feels that even as we're talking about assumptions about what you can share with other people you're still very much operating with them. As you begin to talk about feelings with me, there's a part of you that feels that you have to stifle them, that I don't want to be burdened with them.

Patient: I don't know if that is it or not, but I do know that this feels like it's a very deep thing. And it's very hard for me to stay in touch with it because of that. As you were talking, I started to get more in touch, and now as I start talking, I'm losing it again.

Therapist: So, as though you can't share it. And if that is what's happening, if as you begin to get closer to sharing these very personal feelings with me, you have got to stifle them. It is such a contrast to that dream where you so much want to be close and to share feelings with a man: the fifth-grade teacher, your father, me. You have the dream the day before we are going to meet again.

Patient: Un-huh.

Therapist: And that is what you . . . that is what you began with today.

Patient: Un-huh.

Therapist: There, by the way, is also something that I think would be important to look for in other relationships. The more you want to be closer to somebody, the more the feeling of it gets stifled . . . your wife, your child, other people.

Patient: All I can say is yeah. I know, I feel a bit dumbstruck, by the sort of strange, quirky nature (*nervous laugh*) of myself. I have been amazed during these two weeks that I can't remember anything about my relationship with my father as a child. And if I really try to think back to anything concrete, I can't really remember anything. And now if I'm trying to describe this experience or this feeling, I know that it's there, just like I know my father was there, I know I had a relationship with him.

Therapist: You know, I don't think . . . in the context of what we're talking about and how you experience the relationship with your father, it's not quirky or strange at all. It seems so reasonable that if you decided that your father did not want to be burdened with your feelings, with your needs for closeness, with your feelings whatever they were, and you obviously wanted to be approved of by him, loved by him, not be rejected by him. Then what else

could you do but the more you wanted to be closer, the more you wanted to share, the more you had to stifle it. Because you felt that is what he wanted. Just like, again, earlier today you said you were going to hold back and wait and see what I approve of, what I will sanction.

Patient: Right now, all I can seem to say is that I believe that. It makes sense to me that it's there. Right now, it just seems like quite a dilemma. I wish that I was a more natural person and that I wasn't struggling with this.

The patient had been helped to see and genuinely appreciate the chronic and pervasive influence on his relationships of a particular mode of relatedness. He had seen evidence of it in his current relationships (the unhappiness associated with it was his original reason for seeking treatment), in recollections of the childhood relationship with his father, and in its influence on his relationship to the therapist. Although all areas of the "triangle of insight" (Malan, 1976a) had been examined, the line of inquiry always returned to the enactment of the maladaptive pattern in the immediacy of the patient-therapist relationship. At this point in their work, all components of the CMP had received some attention:

1. Acts of self. The patient maintained a wary, emotionally aloof stance toward others; he felt emotionally disconnected but yearned for closeness.

2. Expectations of others. He expected other people to not want to be bothered with his feelings and to not like him.

3. Reactions of others. Other people tended to react to his emotional aloofness with reserve, which the patient interpreted as

proof that they did not want to be involved with him.

4. Acts of self toward self. The patient felt unappealing and uninteresting.

EMPIRICAL SUPPORT

Empirical support for the TLDP approach derives from a variety of sources, including accumulated research on patient, therapist, and interaction variables as well as the broad array of investigations concerned with therapeutic outcomes (Garfield & Bergin, 1986). More specifically, our research is based on the findings of two studies: Vanderbilt I, and Vanderbilt II, a major process and outcome study using the TLDP approach, for which data analysis is still in progress.

Vanderbilt I

Vanderbilt I (Strupp & Hadley, 1979) involved comparisons of a group of patients (male college students) treated by highly experienced therapists with a matched group treated by warm and empathic but untrained college professors. Major findings of central significance for the development of TLDP included the following.

Neither professional therapists nor college professors were notably effective in treating patients with longstanding maladaptive patterns of

relating characterized by pronounced hostility, pervasive mistrust, negativism, inflexibility, and antisocial tendencies. On the other hand, professional therapists were most effective with patients who had personality problems in combination with high motivation and an ability to form a good therapeutic relationship (working alliance) early in treatment (Strupp, 1980; Hartley & Strupp, 1983; Henry, Schacht, & Strupp, 1986). This is not meant to imply that professional therapists were most effective with the least disturbed patients. Rather, these therapists were particularly effective with patients whose personality resources and capacity for collaboration allowed them to take maximal advantage of the kind of relationship and traditional techniques proffered by the therapists. These findings are in general agreement with the literature (Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971), perhaps most notably with the results of the Menninger Project (Kernberg et al., 1972).

The quality of the therapeutic relationship, established early in the interaction, proved to be an important predictor of outcome. In particular, therapy tended to be successful if by the third session the patient felt accepted, understood, and liked by the therapist (Waterhouse, 1979). Conversely, premature termination or failure tended to result if these conditions were not met early in treatment. In addition, reasonably accurate predictions of process and outcome could be made from initial interviews, specifically in terms of judgments relating to the patient's motivation for

therapy (Keithly, Samples, & Strupp, 1980) and quality of interpersonal relationships (Moras, 1979). Stated differently, there was no evidence that an initially negative or highly ambivalent patient-therapist relationship was significantly modified in the course of the therapy under study. Furthermore, the patients' perceptions of the therapeutic relationship remained fairly stable throughout therapy and to the follow-up period.

There was no evidence that professional therapists adapted their therapeutic approach or techniques to the specific characteristics and needs of individual patients. Instead, the kind of relationship they offered and the techniques they employed were relatively invariant. Similarly, therapists did not tailor their techniques in specific ways to the resolution of specifically formulated therapeutic goals.

The quality of the therapeutic relationship appeared to depend heavily on the patient's ability to relate comfortably and productively to the therapist in the context of a traditional therapeutic framework. This capacity, in turn, seemed to be a function of the patient's personality resources and suitability for time-limited therapy. In short, there was compelling evidence that with therapists who maintained a relatively invariant stance toward patients the quality of the patient-therapist relationship was significantly, although not entirely, determined by patient variables.

Therapists, in general, had little success in confronting or resolving the markedly negative reactions characteristic of more difficult patients. Instead, they tended to react negatively and countertherapeutically to a patient's hostility, mistrust, inflexibility, and pervasive resistances, thereby perhaps reinforcing the patient's poor self-image and related difficulties. The result of such interactions tended to be negative attitudes on the part of the patient toward the therapist and therapy; premature termination; or a poor therapeutic outcome (no change or negative change).

We came to view these results as having significant implications for research and clinical practice. The following conclusions, therefore, were systematically applied to our formulations of TLDP (Strupp & Binder, 1984) and formed the basis for the Vanderbilt II study.

Conclusion 1.

In order for psychotherapy to meet more adequately the needs of patients as well as society, it is essential to focus attention upon patients who have typically been rejected as suitable candidates for short-term psychotherapy and to explore systematically the extent to which such patients can be treated more effectively by a well-defined, time-limited approach.

Conclusion 2.

Psychological assessments must be sharpened to include (a) evaluations of the patient's character structure; (b) estimation of the quality of the patient's participation in time-limited psychotherapy in terms of the criteria that have been identified as important prognostic indicators; and (c) reformulation of patients' presenting complaints in terms of central issues or themes that lend themselves to focused therapeutic interventions. In order to effect more specific treatment planning, these determinations must become an integral part of the assessment process. Through this step, a closer link will be forged between diagnosis, formulation of therapeutic goals, techniques, and outcomes.

Conclusion 3.

In order to realize the full potential of short-term dynamic psychotherapy, therapists should receive specialized training, with particular emphasis on the following elements.

1. Techniques should be optimally geared to the achievement of reasonably specific therapeutic objectives identified early in the course of treatment. Crucial here is the definition of a central issue or maladaptive interpersonal theme (Schacht, Binder, & Strupp, 1984).

2. The therapeutic situation should be designed to meet the unique needs of the individual patient, as opposed to the tacit assumption that the patient conforms to the therapist's

notions of an "ideal" therapeutic framework. Techniques should be applied flexibly, sensitively, and in ways that are most meaningful to the patient.

3. Steps should be taken to foster a good therapeutic relationship (working alliance) from the beginning of therapy, thus enhancing the patient's active participation and creating a sense of collaboration and partnership.

4. Negative transference reactions should be actively confronted at the earliest possible time.

5. Concerted efforts should be made to help therapists deal with negative personal reactions, which are characteristically engendered by most patients manifesting hostility, anger, negativism, rigidity, and similar resistances.

6. Although time-limited psychotherapy poses particular challenges to all therapists (especially in its demands for greater activity and directiveness), they should resist the temptation to persuade the patient to accept a particular solution, impose their values, and in other respects diminish the patient's striving for freedom and autonomy.

7. Rather than viewing psychotherapy predominantly as a set of technical operations applied in a vacuum, therapists must be sensitive to the importance of the human elements in all therapeutic encounters. In other words, unless the therapist takes an interest in the patient as a person and succeeds in communicating this interest and commitment, psychotherapy becomes a caricature of a good human

relationship (the ultimate negative effect!).

8. Closely related to the foregoing, therapists should keep in mind that all good therapeutic experiences lead to incremental improvements in the patient's self-acceptance and self-respect; consequently, continual care must be taken to promote such experiences and to guard against interventions that might have opposite results.

Vanderbilt II

The Vanderbilt II study involved the systematic training of another group of experienced psychotherapists in the TLDP approach, in order to investigate the effects of this training on psychotherapeutic process and outcome. The preliminary analyses of Vanderbilt II data confirmed and extended our earlier results, as follows (Henry & Strupp, 1989).

Therapists can be trained to meet technical adherence criteria in a manual-guided training program in psychodynamic interpersonal psychotherapy (Butler, 1986). This result parallels similar findings by others (such as Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; Rounsaville, O'Malley, Foley, & Weissman, 1988).

TLDP training as conducted in the Vanderbilt II study can enhance treatment outcomes, but the relationship is far more complex than had previously been assumed, due to a number of mitigating factors that should

be addresed by further research leading to revised training efforts (Henry, 1987; Butler, Strupp, & Lane, 1987). A manual-guided therapy, taught using traditional training methods, did not result in "the therapist variable" actually being specified or controlled to the extent hoped for with the advent of the manual-guided approach to training and psychotherapy research.

When novices in a given approach apply technical interventions, they may do so in a forced, mechanical manner that may have deleterious effects on the therapeutic process despite meeting technical adherence criteria. Furthermore, less than skillful application of technical interventions may actually increase patient resistance and inhibitory processes (a result that is particularly problematic in time-limited therapy). We must consider the possibility that more specific and more focused therapeutic approaches may actually create some types of problems. Further research is necessary to better understand what happens when therapists attempt to apply techniques and to determine whether improved training can avert the observed problems.

The effects of training cannot be adequately understood without concurrent examination of personal qualities of the trainees, such as their own interpersonal histories. These qualities appear to interact with technical adherence, yielding complex process and outcome relationships (Butler, Henry, & Strupp, 1989).

Our central finding continues to be that experienced therapists often engage in countertherapeutic interpersonal processes with difficult patients, and traditional modes of instruction do not seem to rectify this problem, although they may have other benefits (Henry, 1986; Butler & Strupp, 1989). Put simply, the absence of poor process does not ensure good outcomes, but the presence of certain types of poor process is almost always linked to bad outcomes. This conclusion is consistent with an emerging body of empirical evidence pointing to the fact that even though dynamic approaches remain the principal theoretical approach to individual psychotherapy, interventions are often performed in ways that may not promote an optimal therapeutic process.

Further analyses of process-outcome links, with particular reference to in-session changes, are under way.

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Notes

[1] We assume that the stimulus for most countertransference reactions contains a mixture of contemporary interpersonal and intrapsychic sources. However, in the routine work of the TLDP therapist, the former source is always investigated first.

[2] We have observed that therapists tend to neglect detailed inquiry into the internal "relationships" (attitudes, thoughts, and feelings) that patients have with themselves. These internal relationships can be seen to mirror strikingly the maladaptive interpersonal patterns that are found in relationships with significant others (Benjamin, 1982; Sullivan, 1953).