Training of Therapists

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7. Capacity for accurate empathy, genuineness, and warmth (Rogers, 1957)

8. Ability to create an interpersonal context (therapeutic alliance) that supports mutual learning and growth

9. Absence of therapist characteristics and behaviors that could interfere with both the creation of a constructive therapeutic alliance and the optimal application of the prescribed interventions.

In the 1980s research on psychotherapy efficacy has developed and

promoted the use of manuals to help therapists to acquire competence in a particular treatment approach (Dobson & Shaw, 1988; Rounsaville, O'Malley, Foley, & Weissman, 1988; Strupp & Binder, 1985). Manual-guided training differs from standard psychotherapy training programs by providing detailed instructions on the use of prescribed techniques. Furthermore, the manuals were developed to describe treatment approaches for specific diagnostic groups (Beck, Rush, Shaw, & Emery, 1979; Klerman, Weissman, Rounsaville, & Chevron, 1984; Kernberg et al., 1989; Luborsky, 1984; Strupp & Binder, 1985).

The aim of manual-guided training is not to teach fundamental psychotherapy principles and skills but to shape and reinforce in experienced

therapists those skills that are part of the experimental treatment approach and new skills, attitudes, and behaviors unique to the new method of intervention. Thus, in most efficacy treatment trials only experienced psychotherapists have been selected for training and after relatively brief training, they achieved high levels of competence (Rounsaville et al., 1988; Shaw & Dobson, 1988). Most of the manual-guided training programs have the following format:

1. Review of the manual and relative theoretical papers
2. One or more didactic seminars to discuss and illustrate key treatment strategies
3. Supervision of one or more training cases followed by assessment of therapist competence.

Of all of the training ingredients special emphasis is placed on supervision, which most often includes observation of videotaped trainee treatment sessions.

The success of any psychotherapy training program is judged according to specific competency criteria:

1. Are therapist's attitudes, behaviors, and interventions faithful to the specified treatment?
2. Is an adequate level of skill acquisition maintained for the duration

of the treatment?

3. To what extent are skill application and relationship development optimally integrated?

4. Are high levels of competency in the treatment model related to outcome?

All four questions have been addressed with positive results. Rounsaville et al. (1988), and Shaw and Dobson (1988) found that experienced therapists achieved competency readily, developed supportive relationships with their patients, and maintained a constructive working stance for the duration of the treatment. Two studies also support the correlation between adherence to manual-guided interventions and outcome. Luborsky and colleagues (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985) found that therapists who were more faithful to the manuals achieved better results. O'Malley et al. (1988) showed that high competency ratings of Interpersonal Psychotherapy (IPT) trained therapists were predictive of greater patient improvement. Rounsaville et al. (1988) showed similar post-training findings but caution that high adherence to a psychodynamically based therapy such as IPT may simply characterize inherently good therapists.

Although study findings demonstrate the feasibility of using manual-guided training programs for achieving competency, the relationship between

specific active ingredients (techniques) of a treatment model and achieved patient outcomes is unknown. Might relationship factors such as accurate empathy, unconditional acceptance, and warmth contribute as much to positive outcomes as skillful application of technique? The manuals developed to date do not provide the opportunity for answering this question because emphasis has been placed on technique acquisition. Even though required therapist attitudes and general behaviors are described, instructions for acquiring the ideal interpersonal therapeutic stance are not well developed. Not surprisingly, in the NIMH Treatment of Depression Collaborative Research Program (Elkin, Parloff, Hadley, & Autry, 1985) experienced therapists who had demonstrated high levels of competence in their clinical work prior to training were readily trained to high levels of competency in the experimental treatments and achieved the best outcomes. Did these therapists have the “right stuff" prior to being trained? Does the "right stuff" include a healthy dose of personal qualities that contribute positively to the interpersonal dimension of any form of psychotherapy?

Interpersonal Group Psychotherapy Training Format

The training program for the IGP therapists shares the aims of other efficacy treatment programs. Effective training programs are essential for clinical research whose task is to demonstrate posttreatment outcome effectiveness. Sorting out the differences between training and treatment

seminars.

Didactic Seminars

Session I: Introduction to IGP

Prior to the first session, the therapists are given two papers to read: Dawson's (1988) description of relationship management psychotherapy from which IGP was adapted, and an outline of the key assumptions of IGP:

1. Importance of the relational meanings of within-group transactions versus the content of what is transacted

2. Importance of therapists' subjective reactions for understanding group member interactions

3. Expectation of therapeutic derailment or error and general strategies for correcting errors and for maintaining or regaining positive therapeutic attitude (including the role of supervision)

4. Significant differences between IGP interventions and interpretive, dynamic group psychotherapy.

In the first didactic seminar the distributed materials are discussed and the therapists are asked to raise questions about the assumptions underlying the IGP model of treatment. The effects of the IG? approach on the manifest behaviors of borderline patients, which most therapists have observed in

Patient: I spent another night in the hospital last night.

Therapist: Did you?

Patient: Mm hmm.

Therapist: Is that something you want to talk about?

Patient: I refused to be admitted.

Therapist: Oh?

Patient: I don't want to be in the hospital. I'm tired of being in the hospital. It never helped. Over the years I've got nothing out of therapy and kept quitting. I had a therapist before. I'll be perfectly honest with you, I don't know what the hell he did for 2 years, but it sure as hell wasn't anything that lasted.

Therapist: This therapy may not offer you anything more.

Patient: There has to be a better way of living for me. I hate myself. All I do is turn all my feelings inside. I just get too afraid to say anything. It's just easier to keep it inside. 1 don't know how to get angry.

Therapist: It's hard to know how to get angry.

Patient: I'm just angry that everyone is trying to control my life, angry about what my mother did to me when I was growing up. I can't tell her that. I'm just angry all the time because it's the whole world's fault that I'm fucked up, and I know it's not.

Therapist: That's a difficult position to be in.

From these transcribed segments of actual sessions with borderline patients the trainee therapists begin to appreciate the differences between

the more confrontational, interpretive approach in Dialogue I and the more tentative, affirming, reflective approach in Dialogue II. Focus is placed on observing the patients' responses to the therapists' interventions in each segment. In Dialogue I, the patient persists in defending her position, disregarding the therapist's attempts at understanding and explaining the patient's anger about failed treatments. They remain "stuck" in the transaction. In Dialogue II, the patient's responses to the therapist's interventions reveal her fears of losing control over her anger and her despair that anything will ever change, even with therapy. The therapist does not try to convince her otherwise but affirms her perceptions of reality.

A number of contrasting segments are provided for analysis and discussion. In this manner the therapists gradually begin to grasp the overall approach of IGP and can see the aims and outcomes of the interventions. They also become aware of the fact that none of the IGP interventions are unique or unknown to them; rather, certain interventions that were included in their general repertoire of therapeutic behaviors are now extracted and identified as appropriate responses to the observed within-session meanings of the patient-therapist interactions

Session II: IGP Technique

In the second training session, categories of therapist actions that

adhere to the IGP treatment model are distinguished from actions that deviate from the model. To assist in this task, a list of interventions and their operational definitions are given to the therapists. Interventions that best represent the model are discussed and illustrated from transcripts of therapeutic dialogue. Interventions that are more likely to represent therapeutic error are also identified. The intervention list includes the following key strategies:

Note. All therapist statements are phrased in a tentative format. The option to respond is left to the patient.

Explanatory statements. An explanation about an observation, thought, or feeling is provided. That is, a new construction is offered, a new way of observing behavior, thoughts, or feelings.

Exploratory information-gaining statements. Information is asked for. Included here are empathic statements that are viewed as exploratory hypotheses about how the patient is feeling.

Questions. Statements that question the patient's observations.

One-sided commentary. Statements that reflect on one side of an issue. *Two-sided commentary.* Statements that reflect on two (or more) sides of an issue.

Reiteration. Statements that paraphrase what has been said, general commentary that encourages more dialogue, or Rogerian-type (1957) repetition of the last phrase.

Confirming. Statements that agree with or confirm the patient's viewpoint.

Reflecting Doubt or Confusion. Statements that reveal the therapist's lack of knowledge or understanding.

During the second training session transcripts of a variety of therapeutic dialogues with borderline patients are used to illustrate both "on-model" and "off-model" interventions. There is considerable discussion about judging the effects of any intervention. The therapists are encouraged to observe patient responses and determine whether the process is maintained in a balanced fashion or whether polarization is the outcome. Two dialogues used in the training follow. One illustrates what we identify as a "negative down spiral," and the other illustrates a "balanced working" dialogue.

Negative Down Spiral

Patient: I'm a rotten mother. My husband's a single parent half the time. The rest of the time he's trying to cope with me. End up with a profession that I hate. End up stuck in it. Too afraid to do anything about it.

Therapist: Except that you're taking this part-time course at the university.

Patient: That. Nothing will ever come of that. Nothing ever comes of anything I do.

Therapist: Well, I hear you saying that's what will come of this therapy. But one of the things I'm well aware of is that despite what you're saying now, you did complete four years of university and that you have accomplished things in your life.

Patient: It just feels hopeless. I just want to crawl inside myself. I don't sleep. I feel lethargic, and I just totally withdraw—don't want to see anybody, and I don't want to talk to anybody.

Therapist: So it sounds like you need people but only if it's with the right dose. If it's too much it's overwhelming. If it's too little it's frightening.

Patient: It's just that when I'm depressed people are telling me what to do. "You shouldn't feel this, and you shouldn't feel that," and what am I supposed to say, "right, I shouldn't feel it"? What am I supposed to do—just turn it off? I shouldn't be thinking of my mother anymore. I should have put it away. My relationship with her affected every other relationship I ever had.

Therapist: I guess there are a lot of feelings about your mother that haven't been worked through. You can't let go until the feelings tied up with her are gone.

With the exception of the last intervention, all of the therapist's statements are "off-model." The therapist initially attempts to meet the patient's despairing statements with encouraging comments, but these are rebuffed by the patient. Then, the interpretation that explains to the patient her reactions to needing people leads to a response that telling her how she should or should not feel doesn't help. The last therapist response is partially on-model in that it shows empathic understanding; however, the second half of the statement tends to repeat the "instructive" quality of the earlier

interpretation.

The trainee therapists are asked to consider the "message" that the patient wishes to convey to the therapist. They learn that in the IGP model of treatment the process, rather than the content, of the dialogue is emphasized. Regardless of which patient is speaking, they are to detect which wish, which demand is being expected of the therapist. In the dialogue the patient seems to be expecting the therapist to be as fed up with her as she is with herself; the therapist, like the patient, will reject her angry, depressed, incompetent self. In order to avoid confirmation of the patient's worst fears, the therapists are asked to generate "on-model" responses to the patient's dialogue. In this example, "on- model" responses would be "no response" (that is, leave the patient to develop her own theme), brief reiterations such as "You feel stuck," or brief empathic statements such as "Sounds like you are feeling pretty awful about a lot of things." These therapist statements are intended to convey two things:

1. The patient's message has been heard.
2. The therapists can tolerate the patient's frustration, anger, and disappointment with herself, with the therapists, and with others.

In the context of the group these therapist behaviors demonstrate that both the therapists and the group as a collective body can tolerate and

manage interpersonal transactions that are painful, do not lead to rejection, and for which there are no immediate answers.

Balanced Working Dialogue

Patient 1: We don't get any feedback from you people. We discuss things and find that we have a lot in common, but you're supposed to be our main source.

Patient 2: Information and teaching?

Patient 3: That's why I'm here. I'm here to learn—none of us know what we are doing.

Patient 1: Could you two tell us what your roles are?

Patient 4: I agree with some of what you are saying—other things I'm not so sure about. I find that we are struggling with things, and the response we get is "well it's hard to know" or "maybe it will, maybe it won't." You know like it's so . . .

Patient 3: Patronizing?

Patient 4: Well, wishy-washy.

Patient 2: I've found with other counselors I would talk for a while, they would be thinking of things, and they would ask a question or come out with something really astounding—it gave me a different perspective. I already know the things I tell you people; I'm looking to being led into having more insight into myself.

Patient 4: Yeah. We are not expecting answers, the answers have to come from us —when I went to a counselor she told me that I talked in circles. She would stop me and ask questions.

Patient 2: It might be an idea if we came up with a topic—like something that a lot of people have in common; we could talk about how we've dealt with it in the past. Now we kind of go blindly into things—direction would be nice.

Therapist A: I hear some of you saying more direction would be helpful and other saying the answers have to come from you—waiting and letting it come out of yourselves. You know there are really no experts here.

Patient 5: I've been in another group [AA] with no leader—people get help from the feedback from each other.

Patient 4: But we are all agreeing about needing direction.

Patient 2: Yeah, I agree.

Therapist B: It would be nice to think that somebody did have the answers. I wish I did. And it would be kind of nice to know which direction to take to find answers. It's hard to feel that sometimes things are just unclear.

Patient 3: Well if we come up with an answer, great, that's terrific. I'm glad that we can do that. But we miss it—obviously we've missed a few answers in our lives or we wouldn't be here.

In this dialogue the group members' message to the therapists is quite clear; the therapists are incompetent, provide no leadership, and have no answers. However, despite agreement within the group that the therapists are "wishy washy," the patients maintain in their dialogue with one another, a relatively balanced process; on the one hand they challenge the therapists, and on the other hand they talk about having to find answers within themselves, to choose topics, and the benefits of gaining feedback from one another. Therapist A's response simply reflects back the balance, that is, the

wish for direction versus the answers coming from the group members. By adding that "there are no experts here" the therapist attempts to address more directly the patients' wishes for rescue by competent therapists. The therapists avoid falling prey to rescue strategies because then each patient could confirm a sense of self as incompetent and helpless. When two patients try to return to the wish for "direction," therapist B confirms again that the therapists do not have the answers and adds empathically how hard it is to be "unclear." The next patient statement states more clearly than any other the pain and sadness of having lived a life "missing a few answers."

Trainee therapists readily identify their own impulses to show their competence, to say "something really astounding." Initially, they have difficulty identifying with Therapist A who communicates that the therapists are no more competent than the patients ("there are no experts here") and can accept more readily the position taken by Therapist B who acknowledges the shared wish to have answers but voices empathic understanding about the discomfort experienced when things are not clear. During this part of the training, trainee therapists discover that their previous clinical knowledge and experiences are applicable to understanding the meanings of the group process. What differs are the intervention strategies. All of the therapists trained in the trial were well versed in the principles and techniques of psychoanalytic psychotherapy; thus they were accustomed to using the techniques of interpretation, confrontation, clarification, and so on.

understood. The Ogden (1979) and Wachtel (1980) papers are presented as an integrated framework for conceptualizing the process through which therapeutic error occurs and is managed. Also emphasized is the reciprocal nature of the constructs discussed—how projective identification, assimilation, and accommodation can be applied ta understanding the therapists' participation in the commission of and recovery from therapeutic error. (Essentially, the material of chapter 6 is presented for discussion in the didactic seminars and supervision sessions.)

Session IV: Integration of Conceptual and Strategic Principles

This session is used to review and reinforce the conceptual and clinical principles covered in the first three training seminars. This is done in the context of anticipating the therapists' experiences with their first IG ? group. A list of possible group events is distributed and discussed in terms of their management. Because the therapists have had previous experience as group therapists, many of their questions have to do with the task of integrating group-focused techniques into IGP strategies.

Because many borderline patients are at high risk for engaging impulsively in self-harming behaviors, trainee therapists are particularly concerned with managing these behaviors in the group. Typical "acting-out" behaviors are discussed, with suicidal acts and self-mutilation topping the list.

The therapists fear within-group contamination, that the self-destructive wishes of one patient might precipitate similar behaviors in other patients. Although the potential for contamination is always present in any group, the therapists learn to focus on the nature of the dialogue among patients when suicidal wishes or threats are raised in the group. If the patients maintain a balanced discussion about the management of the potential for self-harm (e.g., "Why'' You'd only lay a guilt trip on your family. Whom can you talk to?" etc.), then the therapists need not intervene. If, on the other hand, a number of patients begin to agree that the only way to stop the pain is to commit suicide, then the therapists intervene. The trainee therapists learn that in both dialogues the message is the same "rescue me/us": however, in the first transaction, the reciprocal roles taken by the patients play out both sides of the dilemma (hopelessness versus hopefulness); in the second transaction the balance is tipped to hopelessness, and the therapists' intervention provides empathic concern but avoids rescue. The therapists learn that part of the discussion of ever) group session is concerned with some form of self-harm; they also learn the importance of understanding the message that accompanies each communication.

Other difficult patient behaviors, such as repeated absences, unscheduled contacts, prolonging sessions, tardiness, silences, nonverbal communications, are discussed in the context of the "messages" conveyed to the therapists by each behavior. The therapists are encouraged to express

their anxieties and concerns as they anticipate managing behaviors that could result in patients leaving the group and ultimately in the disintegration of the group. In this regard they welcome the supervision phase of the training during which their first experiences with an IGP group can be observed and discussed.

Consultation

Assumptions

To be practiced effectively, IGP presumes a co-therapy model and consultation as an ongoing requirement for maintaining the specified therapeutic attitudes and techniques. Because borderline patients provoke in their therapists exaggerated responses that are difficult to contain, consultation provides support and direction for making neutral observations about the interpersonal meanings of group transactions. Traditionally, clinicians have assumed that well-trained, experienced, and highly skilled therapists are able to avoid therapeutic error or recover very rapidly when it occurs. Contrary to these beliefs, psychoanalytic training, a personal analysis, and the greatest amount of experience cannot protect therapists from strong negative reactions to borderline patients (Higgitt & Fonagy, 1992; Pines, 1990; Sandler, 1976). Therapists with even less training and experience are at greater risk of provoking negative therapeutic responses in their

borderline patients. Adler (1985) suggests that effective psychotherapeutic work with borderlines may be achieved only when ongoing consultation from a colleague is available.

In the IGP model of treatment, consultation advances the therapeutic work by acknowledging the fact that therapeutic errors or deviations from the recommended therapeutic attitudes are inevitable when treating borderline patients. For the IGP therapists the most important task is the recognition and management of their subjective reactions within the context of the treatment dialogue. When this is adequately managed, treatment progresses; when it is ignored or badly managed, treatment ruptures and eventual failed outcomes are the result.

Process

In IGP a collaborative model of consultation is used. The therapist trainees, like the consultant, are experienced therapists. They have much to contribute to the understanding of the group process and its management. What they most need is help in shifting from the use of techniques with which they are very familiar to the use of techniques that they initially experience as aimless and lacking in substance. Several strategies are used to support therapist learning:

1. All treatment sessions are observed by either the consultant or the

research assistant behind a one-way mirror.

2. Post-session consultations are held weekly for the first half of the scheduled 30 treatment sessions, then biweekly for the second half.

3. During the treatment sessions the therapists could leave the group to consult with the observer(s). The patients had given written consent to have the sessions audiotaped and observed. The structure of the consultations during the group sessions may have illustrated the balance between therapist competence and incompetence; that is, therapist incompetence was "witnessed" every time one of the therapists left the session for a behind-the-mirror consultation, although there was no way of confirming this hypothesis.

In post-session consultations transcripts or audio tapes of the sessions were used to examine the process. The aim was to search for key "messages" communicated to the therapists and then appraise whether an intervention was required, whether interventions made responded :o the "message," and whether there were possible alternate interventions. The working stance in the consultation sessions was one of shared confusion, mutual support, and considerable doses of good humor. The humor helped alleviate the anxiety about working with a group of difficult patients using a method that requires the tolerance of confusion and the acceptance of negative subjective reactions while maintaining a genuine interest in each patient's painful life experiences.

therapists were less likely to be anxious or defensive about looking at what went wrong during a group session. They learned to observe patients' responses to their interventions. If an intervention was followed by patient dialogue that was balanced rather than polarized, then that intervention was judged to have facilitated the process. When, in contrast, a therapist intervention failed to help the patients to recover a balance or even reinforced polarization, the effects were readily observable in subsequent group member interactions. The role of the consultant was to support the therapists in their development of strategies for judging the efficacy of their work within and across the treatment sessions.

The general importance of consultation was also emphasized. Problems evoked by the patients (threats of self-harm, threats to terminate therapy, threats of losing control, etc.) and those evoked by the clinical institution (patients hospitalized or offered alternate treatments without consultation with the group therapists, etc.) are common occurrences, and consultation can be an effective tool for dealing with these. The ultimate aim of consultation is to avoid therapeutic error and thus maintain each patient in a constructive therapeutic environment.

Although the consultant's task is well understood by the treatment team, it is important to maintain an atmosphere of openness that allows the therapists also to examine the consultant's reactions to the group process and

to individual patient responses. As discussed in chapter 6, the consultant is also vulnerable to subjective reactions to patient input in the group. Thus, when a consultant fails to process her or his own exaggerated subjective responses, the supervision of the co-therapists can be skewed so that the potential for therapeutic derailments within the group are reinforced.

Evaluation of Training Reliability and Validity

A study was conducted to assess the effectiveness of the training program. The purpose of the study was to answer two questions:

1. Did the trained IGP therapists use more "on-model" than "off-model" interventions?

2. Did the IGP treatment model differ technically from the comparison treatment model (individual psychoanalytic psychotherapy)?

The data for the reliability study consisted of transcripts of two ear y and two mid-therapy sessions for the first and fifth groups treated with IGP during the trial. In order to demonstrate that the therapist interventions in the two treatments did in fact differ, the co-therapist interventions in the fifth IGP group were compared with interventions used by therapists with two patients treated with individual psychotherapy.

Three judges (social work graduate students) were trained to use a

coding system reliably. The coding system consisted of 14 categories of therapist interventions (see appendix, part I). It was expected that the IGP treatment would have fewer occurrences of interpretive statements delivered in a "certain" format than the individual treatment and that, overall, the IGP treatment interventions would be more frequently framed in a "tentative" format. These expectations were supported. In addition, the IGP therapists used "two-sided commentary" more frequently than the comparison treatment therapists.

The results of the study showed that the IGP therapists were able to alter their previous therapeutic stance and carry out the IGP model of treatment consistently. The IGP treatment model could also be distinguished on essential treatment interventions from individual psychoanalytic psychotherapy.

Summary

A unique factor in the training was the special emphasis placed on detecting and managing therapeutic derailments. Most other forms of psychotherapy presume that with sufficient training and clinical experience therapeutic error can be avoided and, if it occurs, that counterproductive aspects of countertransference are at work. The IGP treatment model was developed from the conviction that therapeutic errors are inevitable when

working with borderline patients and that the use of co-therapists and consultation provide the structure for recognizing errors more immediately when they occur and for developing strategies to mend disruptions to the therapeutic process.

The format used to train each pair of co-therapists was successful in ensuring consistent adherence to the prescribed treatment model. Over the course of training the therapists acquired expertise and became comfortable with the IGP strategies. They understood the rationale for selecting certain modes of intervention and rejecting others. During the treatment comparison trial, five pairs of co-therapists were trained successfully to use IGP. All independently reported that they much preferred being in a room with a co-therapist and a group of these patients than being alone with one borderline patient. They felt that when they used the IGP model of treatment their capacities for being empathically therapeutic were much more available to them; thus, there was more focus on liking their work with the patients, rather than dreading their contacts with them.