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Psychotherapy Supervision in the 21st Century

Some Pressing Needs and Impressing Possibilities

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As a professional and educational service, psychotherapy supervision looms large in importance. Yet if psychotherapy supervision is to most viably advance in the century ahead, a number of pressing measurement, research, and training/practice needs cry out to be better addressed. Ten such needs are identified by drawing on recent major research reviews and other substantive supervision publications. The author concludes that better addressing these needs would expand and fortify the empirical base of psychotherapy supervision and also enhance its training and practice base.

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Psychotherapy supervision has long been regarded as a key means by which therapist trainees learn to become effective psychotherapists.[1–7] Psychotherapy supervision typically is an integral part of all mental health preparation programs, be they in psychiatry, clinical or counseling psychology, or psychiatric nursing.[8] Surveys suggest that many mental health professionals provide psychotherapy supervision services and devote a fair portion of their professional time to doing so.[9]

Over the last two decades, much growth and evolution has occurred in the theory, research, and practice of psychotherapy supervision.[10] Such growth and evolution, for example, can be seen in the rise of developmental models about supervisors and supervisees,[11–16] an increase in research into varied aspects of the supervisory experience,[17–19] and efforts to concretize and render ever more specific and meaningful the supervisory encounter.[20,21] That growth and evolution is good, reflecting progress in a much valued and, in some respects, much underrated professional activity: clinical supervision.

With such advances noted, what can or should be expected of psychotherapy supervision as we move into the 21st century? What needs must be better addressed if

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psychotherapy supervision is to most fruitfully advance as a professional service? What possibilities, if explored more vigorously, could help psychotherapy supervision further advance and emerge with a more solid empirical and practical base? This review, although not exhaustive, will attempt to identify some of the important needs and possibilities that merit more pressing attention from supervision theorists, researchers, and practitioners alike in the years ahead.

In the last decade, a number of substantive supervision research reviews, articles, chapters, and books emerged, and many of these converged with regard to important needs and possibilities in psychotherapy supervision. Ten key needs and possibilities culled from the recent literature are accented here.

NEEDS AND POSSIBILITIES FOR PSYCHOTHERAPY SUPERVISION

1. ***The need for valid, reliable supervision measures.*** Research is only as good as the measurement tools and procedures that are used for assessment and evaluation. In recent years, several supervision publications have emphasized one point vigorously: more valid, reliable, supervision-specific measures are needed to advance research efforts.[1,17,18,22–24] Many measures now in existence—for example, the Supervisory Levels Questionnaire–Revised[25] or the Supervisory Working Alliance Inventory[26]—have been criticized for not having sufficient psychometric soundness. In some cases, sample sizes have been too small, a measure's scales have not been orthogonal, or the most appropriate statistical procedure has not been used in data analysis.[17] This is not to say that progress has not occurred here; it clearly has. (See, for example, the Role Conflict and Role Ambiguity Inventory,[27] the substantially revised short form of the Barrett-Lennard Relationship Inventory,[28] and the Psychotherapy Supervisory Inventory.[29]) Still, some of the primary problems that plague supervision research are these: 1) too many supervision measures have been borrowed from psychotherapy research and have not necessarily been developed with the supervisory endeavor in mind, and 2) too many supervision measures have been "one-time wonders," created for the study at hand and never used again. Lambert and Ogles,[18] in their review on the effectiveness of psychotherapy training and supervision, had the following to say on this point:

> The field is still characterized by a plethora of homemade devices that are used only once and discarded. In addition, few researchers bother to publish reliability or validity data on their scales. . . . Advances in knowledge can be expected to increase with advances in criterion measurement. Research in this area is highly recommended and promises to affect theory as well as practice. (p. 441)

Thus, one of the most pressing needs for psychotherapy supervision in the next century remains the development and establishment of reliable, valid criterion measures to guide supervision research.

2. ***The need to research supervision outcome.*** Research that examines the effects of psychotherapy supervision on patient improvement or lack of improvement has been minimal. In the past 5 years alone, three major reviews[18,19,30] have arrived at that conclusion. Some modest, indirect support for a training/supervision–therapy outcome link can be found,[31] but more than a modest, indirect link needs to be established between the two. As Stein and Lambert[32] put it: "Given the enormous national investment of physical and human resources in graduate programs, it is quite remarkable that more compelling evidence is not available that demonstrates that graduate training directly relates to enhanced therapy outcome" (p. 194).

Increasing research attention has been brought to bear on the subject of psychotherapy outcome over the last generation; that

attention has borne much fruit, yielding new insights into the workings of psychotherapy and providing a more solid empirical foundation for its practice.[33] That same sort of attention must now be brought to bear on psychotherapy supervision outcome research. Thus, a most pressing need for the next century remains as follows: establishing a strong, direct link between supervision and therapy outcome—and, assuming that is found, establishing what in supervision enhances patient outcome and how that is done.

Establishing such a link, however, may be easier said than done. Wampold and Holloway[34] have provided a useful discussion on this issue, proposing a causal model of supervision outcome phenomena. In discussing the different elements of their model, they make a most interesting point: "Connection between supervision process and distal outcomes [e.g., patient change] will need to be established by studies focusing on various pieces of the mediated causal process . . . rather than by trying to establish relations among distal elements" (p. 23). If their suggestion is followed, establishing a supervision–therapy outcome link may be more easily accomplished.

3. ***The need for more rigor in supervision research.*** Advances in supervision research have occurred over the last two decades,[9,35] but the need for more rigor in future experimental efforts remains paramount. In the past couple of years, two major research reviews by Ellis and Ladany et al.[17,36] have emphasized the importance of this need as never before. Because of the significance of those two reviews, they deserve special attention from supervision researchers and theorists. In the first review,[36] 144 research studies of clinical supervision appearing from 1981 to 1993 were evaluated with regard to methodology (e.g., threats to validity) and statistical variables (e.g., inflated Type I error). In their second review,[17] Ellis and Ladany sought to replicate and extend what they had done earlier "by performing a more circumscribed methodological review" (p. 450). Their findings and conclusions are both sobering and startling:

> 91% of the investigators did not attempt to control systematically Type I or Type II error rates. The majority of the investigations of supervision were simultaneously unlikely to detect true effects and very likely to find spurious significant results.[36] (p. 43)

> Three threats to construct validity were consistently found: monomethod bias (79%), confounding of the construct with limited levels of the construct (69%), and inadequate preoperational explication of the constructs (69%).[36] (p. 41)

> Studies were found to have inconsequential hypotheses (83%), ambiguous hypotheses (80%), and diffuse statistical hypotheses and tests (99%).[36] (p. 41)

> More than 70% of the studies reviewed used ex post facto designs, and hypothesis validity was severely compromised in nearly every study.[36] (p. 44)

> The overall quality of [clinical supervision] research during the past 15 years was substandard. This cannot be taken lightly. . . . Few conclusions were justifiable given the lack of replicated results and the conceptual and methodological problems besetting the studies.[17] (p. 492)

> Readers should approach the empirical [supervision] literature with skepticism.[17] (p. 496)

As those statements make clear, matters of research design and experimental control have been key problems in supervision research over the last 15 years. Ellis and Ladany make a number of useful recommendations to which supervision researchers should attend in order to best deal with those problems—for example, formulate unambiguous hypotheses; perform *a priori* statistical power analyses; incorporate manipulation-treatment checks; and

test assumptions underlying statistical procedures. They even present a detailed description of a "good" supervision study. Their study and set of recommendations provide a useful blueprint to guide supervision research, and, as they emphasize, their words have some relevance for both qualitative and quantitative research investigations. (See Worthen and McNeill[37] for a recent example of a well-conducted, rigorous qualitative study.)

Again, those two reviews, because of their comprehensiveness, thoroughness, and painstaking attention to detail, represent significant contributions to the supervision literature. Calls for more rigor in supervision research are not new.[38] But it becomes clear that those calls have yet to be heeded. Supervision research since 1980 generally has not been sufficiently rigorous; if it is to be most informed and informative, then one of the most pressing empirical needs confronting us now is to infuse future experimental efforts with the proper rigor.

4. ***The need for the development of supervision manuals.*** Psychotherapy treatment manuals have increasingly emerged as viable means to research psychotherapy outcome and train therapists in particular theory-specific skills. Indeed, over a decade ago, Luborsky and DeRubeis[39] referred to the treatment manual as a "small revolution" in psychotherapy. Since then, treatment manuals have only become more plentiful, and their promise has been recognized by many.[18,40–45]

Although treatment manuals are not without drawbacks, they still have served a useful purpose in advancing the field of psychotherapy. Unfortunately, comparable manuals for training supervisors have been slow to develop. Only one, published a couple of years ago, exists.[46] That is a beginning, but 10 times that many psychotherapy treatment manuals existed 10 years ago.[33] Because such manualized attention in supervision is lacking, the field's advancement has been delayed.

A good supervision manual could be useful in at least three ways: 1) in defining and concretizing the supervision experience, thereby rendering it more researchable; 2) in facilitating the training of supervisors in particular supervision skills; and 3) in facilitating the training of supervisors in therapy-specific supervision approaches, such as cognitive approaches. Thus, such manuals can have ready benefit for supervision training and practice as well as research. The development of manuals to train supervisors must receive more serious attention from the supervision community, and that clearly is a pressing need that has yet to be reckoned with.

5. ***The need for a multi-method, multi-rater, behavioral, longitudinal focus in supervision research.*** As constructive critique of supervision research has continued to mount, two problematic patterns have begun to emerge: 1) in many studies, investigators inquire only about the perceptions of either supervisor, supervisee, or both; and 2) many if not most studies are cross-sectional in nature.

Before a need is identified here, it must first be said that the field requires further cross-sectional studies, and the study of supervisor and supervisee perceptions of supervision must continue. But a nice complement to such studies, as many reviews and commentaries appearing over the past decade have emphasized,[16,18,19,23,47–49] would be these:

a. A greater focus on the behavior of supervision, examining what actually happens in supervision, what supervisors and supervisees actually do, what actual changes occur in supervisee performance, and what actual changes occur in patient outcome.
b. The use of multiple indices to measure supervision process and outcome.
c. The use of multiple raters to provide data about the supervisory experience.
d. Longitudinal studies of psychotherapy supervision, allowing investigators to examine the process of growth and development of therapist trainees over time.

With observable behavioral data, a number of viable targets could be identified for

study—for instance, changes in supervisee planning and conceptualization, in-session cognitions, and intentions.[16] From a developmental, longitudinal perspective, it would be interesting to study how trainees' in-session cognitions or intentions might change over the course of a year's supervision with the same supervisor; that type of work thus far has not been done. As for using multiple indices for measurement, several can be readily identified: rating scales, questionnaires, patient outcome data, process measures.[23] Those all can be viable means for researching supervision and avoiding the monomethod threat. Multiple raters could include supervisor, supervisee, and patient, as well as trained observers who evaluate audiotaped or videotaped sessions.[16,23]

Multiple indices and raters of process and outcome allow for a fuller, more comprehensive picture of the supervisory endeavor to emerge. A longitudinal focus would bring a valuable perspective to the dismantling and understanding of the supervisory experience across time; such a focus is absent in the supervision literature, which is all the more surprising when one considers how popular a developmental view of supervision has become since 1980.[47,50] Thus, these are clear, compelling needs that must be better addressed in the years ahead.

6. ***The need for follow-up and replication studies.*** In two recent major research reviews,[17,18] one very prominent problem was identified: the supervision research literature is characterized by a lack of follow-up and replication studies. As Lambert and Ogles[18] noted: "Few follow-up studies have been reported in the literature, and even when included as part of the research design, follow-up studies are marred by uncontrolled variables" (p. 427). To that, Ellis and Ladany[17] added the following: "Without replications, there is no way of establishing the veracity of theories or previous findings. That is, to help rule out rival explanations (i.e., to ascertain whether a particular pattern of results was due to Type I or Type II errors, or other rival explanations), the results over several replications or replication and extension studies need to be virtually identical to those of the original study" (p. 493). In their review of 104 clinical supervision studies,[17] Ellis and Ladany found only four replication or replication-extension investigations.

It is surprising to see that so little has been done with regard to follow-up, replication, or replication-extension. The need for such work is self-evident and poses a real challenge that supervision researchers would do well to address sooner rather than later.

7. ***The need to study moderating variables.*** What variables moderate the supervision process? That question was raised in a well-done empirical study conducted almost 10 years ago by Tracey et al.[51] They investigated the effects of supervision content (e.g., noncrisis versus crisis client), and supervisee reactance level (e.g., low versus high) on the supervision process itself. Up to that point, much theory and research had supported the idea that beginning supervisees need more structure whereas more advanced supervisees need less. Tracey et al. challenged that, hypothesizing that both supervision content and supervisee reactance level would affect desire for structure; their hypotheses were supported. When presented with a suicidal patient, both beginning and advanced supervisees wanted a more structured supervision approach. When presented with a noncrisis patient, highly reactant advanced supervisees opted for more unstructured supervision; beginning and low-reactant advanced supervisees did not. Because of its significance, this study by Tracey et al. has been often cited in the supervision literature since its publication.

But what can be drawn from that study with regard to psychotherapy supervision research in the 21st century? Need remains for important moderating variables to be better incorporated into supervision research. As yet, that has not been done to any substantive degree. How do such variables as level of ego development, conceptual level, and dispositional affect (e.g., negative affectivity) affect supervisees' ability to use supervision and

perform effectively in therapy?[16] How does a variable such as self-criticality affect supervisors in their growth as supervisors and in their ability to perform effectively in supervision?[52] Those are viable research questions, viable moderating variables, that, thus far, have been only minimally studied or not studied at all. That must change. By better incorporating certain moderating variables into supervision research, a more informed perspective about supervisee needs can be gained and a more informed perspective can be brought to bear on supervision practice.

8. ***The need to study diversity in supervision.*** Appreciation of diversity and respect for gender, ethnicity, and lifestyle differences has emerged as a major force in the United States. With that has come increasing attention to how diversity affects psychotherapy, and some definite advances have been made in regard to psychotherapy research, theory, and training and diversity issues.[33] But the effects of diversity in supervision have been minimally investigated.

Neufeldt et al.,[19] in their recent review of research on supervisor variables, indicated that 1) no research on how supervisor gender affects either therapist behavior or patient outcome has been conducted, and 2) only one study about supervisor ethnicity and its training affects has been conducted. Ellis and Ladany,[17] in considering supervisee and client variables in supervision, reported on seven studies of supervisee–supervisor gender matching, finding all to be flawed in some significant way, and concluding that "inferences pertaining to gender effects in supervision seem inappropriate" (p. 469). They found only three studies about supervisee ethnicity. Stoltenberg and McNeill,[22] in summarizing needs in developmental supervision research, asserted the following: "Although issues of gender, multicultural, and gay and lesbian supervision have been discussed in the literature . . . few empirical investigations have been conducted to examine their interaction with developmental models" (pp. 198–199). When comparing these comments and conclusions with those made in earlier reviews,[23,38,48] one finds that not much has changed in the last 10 to 15 years.

The foregoing leads to one simple but inescapable conclusion: incorporation of matters of diversity—gender, ethnicity, and lifestyle—into clinical supervision research is sorely needed. As Lopez asserts, "Culture matters . . . in clinical supervision"[53] (p. 586); the same could be said for gender and lifestyle.[22,23,54] But research that informs us *how* they matter is missing.

9. ***The need for training in how to supervise.*** Another pressing need for psychotherapy supervision is for a meeting to take place between logic and practice with regard to supervision training. Logic suggests that training in how to supervise would be beneficial for would-be supervisors. Yet in practice, the norm is that those providing supervision services have received minimal to no training in how to provide supervision.[1,24] I have previously commented on this situation as follows[35]:

> Something does not compute. We would never dream of turning [unsupervised] untrained therapists loose on needy patients, so why would we turn untrained supervisors loose on those untrained therapists who help those needy patients? Just as becoming a therapist is a labor-intensive endeavor for which training and supervision are needed, so too can the same be said about becoming a supervisor. (p. 604)

That opinion is not unique; many others have also emphasized the importance of and need for supervision training.[1,24,55] Such training has the potential to better prepare supervisors, render them more skilled from the outset, enable them to handle supervisory problems and issues more effectively, better facilitate the growth and development of the therapist trainees they supervise, and better facilitate the growth and development of the patients their trainees treat. Thus, it is imperative that logic and practice meet, in such a way that training in the art and science of psycho-

therapy supervision is made more available to would-be supervisors and is considered a necessity, not a dispensable luxury.

10. ***The need for psychotherapy supervision standards.*** In the last few years, mention has been made of the need to establish standards for the education and practice of psychotherapy supervision. Rodenhauser[56] notes that the date of the last set of American Psychiatric Association standards for supervisors was 1957. In an earlier publication, he asserted the importance of "attention, at the level of a national organization such as the American Association of Directors of Psychiatric Residency Training, to the need for instructional models and standards for training psychotherapy supervisors"[55] (p. 88). The American Psychological Association Division of Psychotherapy last addressed any such standards in 1971.[57] Thus, it has been at least a generation since the subject of psychotherapy supervisor standards has received any attention at all. Yet the potential value of supervisor standards seems clear: they can provide a consensual guide to what critical areas must be addressed in psychotherapy supervision training and the basic standards of behavior to which psychotherapy supervisors must adhere in practice.

If supervisor standards were important enough to define in 1957 and 1971, they are no less important now. Other professional groups recently have seen fit to establish such standards, and their efforts merit study.[58–61] At a minimum, it could be beneficial to reexamine those earlier APA efforts and update them as needed. Standards are by no means a cure-all for the ills that beset us, but they are one means of bringing some specificity and concreteness to the education of psychotherapy supervisors and the practice of psychotherapy supervision. Specificity and concreteness are now lacking, and the need for that to be corrected is pressing.

CONCLUSION

The role of psychotherapy supervision is critical to the process of educating and "making" psychotherapists. Supervision has a long, rich history, is well within the tradition of apprenticeship training, and is central to what we as teachers and educators do. Because of the central, critical place of psychotherapy supervision in psychotherapy education, the salience of these 10 needs becomes all the more clear.

Some of the needs identified here will be far more difficult to address than others. For example, recent methodological discussions make it clear that supervision is a complex process that is difficult to research.[34] Still, if supervision is to most fruitfully advance, is to ever have a solid empirical foundation, then efforts must be made not only to research it but to research it well—attending to such matters as rigor, reliable and valid measurement, replication and extension, and diversity in those efforts. Furthermore, if the training/practice base of supervision is to be best strengthened, then attention must be given to developing supervision standards and to training supervisors in how to supervise. The 10 needs identified here are indeed pressing—calling for substantive, immediate attention. If these needs are better addressed, it will open up some impressive possibilities for psychotherapy supervision in the next century. Working to realize those possibilities is the charge now before us.

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Guided Imagery Treatment to Promote Self-Soothing in Bulimia Nervosa

A Theoretical Rationale

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Bulimia nervosa (BN) has been described as involving impairment in affect regulation and in self-soothing. Such a conceptualization suggests the need to design treatments that specifically target these problems in order to assist individuals with BN in comforting themselves. A model of guided imagery therapy suggests that imagery therapy has multiple levels of action and can assist these individuals in the regulation of affect by providing an external source of soothing and also by enhancing self-soothing. The authors illustrate the model with a case example and report the results of a study in a clinical sample of BN.

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Bulimia nervosa (BN) is characterized by a loss of control over eating, in the form of bingeing episodes and extreme attempts to control body shape and weight. It entails a set of attitudes frequently described as a morbid fear of becoming fat, or concerns regarding weight and shape that unduly influence the evaluation of the self. Since the description of BN in 1979,[1] a number of treatment approaches have demonstrated efficacy, at least in the short term.[2–4] However, the treatments shown to be helpful often address only the conceptual or cognitive and behavioral aspects of the disorder, and, moreover, a significant number of patients do not respond to current treatments.[5–8] The difficulty that BN patients have with affect regulation, feelings of emptiness, and the experience of extreme aloneness is often less amenable to standard treatments.

The theoretical literature has suggested that at least a subgroup of individuals with BN may have difficulty in modulating affects or in self-soothing.[9–12] This conceptualization suggests the need to design treatments that specif-

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ically target the problem of affect regulation and that help these patients comfort themselves. In this article we review the literature on self-soothing and propose a conceptual model of guided imagery therapy to address the difficulty of affect regulation.

THE CAPACITY FOR SELF-SOOTHING

The ability to manage or regulate tension (affect) has been referred to in the psychodynamic literature as the capacity for self-soothing.[13–15] This capacity is believed to develop through the internalization of earlier soothing or comforting experiences. Later, as children mature, they are able to soothe themselves with fantasies, images, and memories of interaction. In this regard, Winnicott[16] described the notions of "good-enough mothering" and the "holding environment" and emphasized the empathic bond between mother and child; he also outlined the broad limits of what might be "good enough." He introduced the term *transitional phenomena*, referring to various soothing experiences and behaviors such as the infant's repetitive babbling sounds and the holding of a soft blanket against the skin. It is believed that the infant, at the stage of recognition memory, is able to keep in his awareness the soothing of the mother through the holding and feeling of a familiar object that is reminiscent of her touch. With the development of "evocative memory," the infant develops the ability to produce a mental image of the object (mother) in her absence.

The internalization of earlier soothing experiences allows the progressive separation of the child from the mother and becomes crucial in the development of the capacity to be alone. The child is able to leave the mother's bosom when he can find something of her nurturance in the external world. Therefore, the child no longer depends fully on the presence of actual people for comfort. The child is able to soothe himself with fantasies, images, and memories of earlier interactions with objects that resonate with the soothing maternal presence. This capacity, referred to as the ability for "transitional relatedness," has been defined as "the person's unique experience of an object whether animate or inanimate, tangible or intangible in a reliable soothing manner based on the object's association or symbolic connection with an abiding mainly maternal primary process presence" (Horton,[13] p. 35).

Although there is general agreement among professionals that very young children usually make healthy use of growth-facilitating soothers, the existence of soothing (solacing) methods at later stages of development has yet to be sufficiently researched.[13] Soothers in early childhood or transitional objects, exemplified by the blanket, stuffed animal, and favorite tune, are normally replaced by increasingly subtle and complex vehicles for growth and solace through a lifelong series of progressive psychological transformations.[13] As Horton[13] notes, "Maturation is accompanied by increasing sensitiveness to the qualities of potential solacing objects" (p. 129).

Typical intermediate objects include imaginary companions, tunes, fairy tales, poetry, religious figures, prayers, works of art, mentors, the church, spouses, lovers, and friends. It is the relationship with these objects that protects an individual from aloneness and fear and serves to propel an individual to the next stage of finding the highest good in self and others.[13,17] This developmental process may result in considerable refinement to higher-order object relations as experienced in "oceanic," "near-death," and "creative" experiences.[13,16]

For individuals who lack the capacity for self-soothing, a particularly vulnerable time exists when they are alone, because the chief function of self-soothing has been linked to the development of the capacity to be alone.[12,13,18–21] During these times the individual is left to his own resources for self-comforting and the maintenance of a calm state. An impairment in this self-function may be indicated when emotional arousal of panic or fear is experienced, resulting in behaviors such as bingeing or addictive behaviors coming into

play as a response to the experienced discomfort and inner pain.[22,23]

EMPIRICAL LITERATURE

Conceptualizations of early development related to self-soothing have been used to understand addictive behaviors,[13,24,25] BN,[9–11,26] anorexia nervosa,[27,28] obesity,[29] and borderline personality disorder (BPD).[14,18,22,30–32] Researchers have found that eating-disorder patients have difficulties identifying, verbally expressing, and regulating all forms of physical tension.[27,33–36] The literature has identified a primitive inability among these patients to verbalize emotion, despite being articulate in other areas.[27] This difficulty leads these patients to a state that is "incommunicable" at times and experienced as an "extreme state of tension," while at other times it is characterized by feelings of emptiness that they cannot soothe.[26,37] Researchers and theorists have suggested that binge eating and vomiting, as well as drug or alcohol abuse, represent an attempt to artificially modulate negative affect and, in a sense, to numb the pain.[8,26,27] Bruch[27] linked the sense of loneliness, the feeling of not being listened to or understood, and the pervasive sense of emptiness to eating binges. A preoccupation with food and bingeing and purging behaviors can be thought of as filling a need to relieve pain, and the individual may rely on these behaviors for this function. The psychological pain becomes a physical one, and emotional experience is concretized.[38]

Individuals with eating disorders have been described as maintaining strong efforts directed at avoiding any arising tension; this pattern can lead to a self-organization of extreme compliance and self-control, best exemplified by Winnicott's term *false self*.[16] The false self consists of an outer self that provides an appearance of compliance and high levels of functioning, control, and self-esteem; this false self serves to protect the inner self from being revealed. This way of being in the world can result in feelings of deadness, numbness, and emptiness and a state characterized as being devoid of feeling and spontaneity.

Few studies have been conducted to systematically investigate these phenomena in adult clinical populations. A recent study by Richman and Sokolove[30] investigated the borderline experience of extreme aloneness, suggesting an incapacity for self-soothing. Adler[22] expanded on the "empty, desperate" aloneness experienced by borderline patients, emphasizing that these patients cannot rely on their own internal resources to hold and soothe themselves when faced with separations, and consequently they experience the panic of total aloneness and abandonment.

Generally, studies thus far have focused on patients with BPD and have found that these individuals use more maladaptive soothing behaviors[39,40] and have fewer transitional objects, or show rigid or maladaptive use of their transitional objects throughout their development.[39,41] Studies investigating clinical populations have found an association between psychopathology and an incapacity for self-soothing (Gunderson et al., 1985[41]; R. Jampel et al., unpublished, 1983).

There have been no previous investigations to study the self-soothing capacity of BN patients. In clinical populations of BN, behaviors such as binge/purge episodes, theft, wrist-slashing, substance abuse, and sexual activity are common.[42–44] In addition, a distinct subgroup of "multi-impulsive" bulimics (those who display more than one impulsive symptom) has been identified and associated with poorer prognosis and the diagnostic overlap with BPD.[45] There is some empirical evidence to suggest that individuals with eating disorders have difficulty identifying, verbally expressing, and regulating forms of physical tension, including hunger and emotional states.[27,33,46] The construct of alexithymia, defined as an inability to identify and express emotions and to distinguish between emotional states and physical sensation, has been described among eating-disordered patients.[47,48] It has been suggested that this ego deficit has significant effects on the early relationship of self to body.[26] It is not clear how

this develops. Bruch[27] identified a group of patients who believed that they had been physically or emotionally "insulted." She believed that they were particularly vulnerable to eating disorders. Recent community and clinical studies have demonstrated a significant number of women with eating disorders who have been sexually abused.[49,50]

IMPLICATIONS FOR TREATMENT

Treatment approaches stemming from an object relations framework have focused on the roles of empathy and the holding environment as they relate to people with deficits in the capacity for self-comforting.[13,15,19] These approaches propose that therapeutic work occurs in the transference relationship and that patients are provided with a new opportunity for the internalization of self-regulatory structures that had failed to develop in early life. The repeated working-through of disruptions and events in therapy leads to a greater capacity to sustain empathic failures in relationships. Interpretations offered by the therapist assist in providing meaning and coherence, as well as practice in naming affective experiences.

Psychodynamic theorists have emphasized the value of interpretation, but others have cautioned against it. Winnicott[16,51] noted that therapist interpretation may pose a danger in that it may serve to repeat experiences such as intrusiveness or lack of validation in early caregiving. He suggested that any accurate interpretation for which the patient is not ready can reach the innermost self and evoke the most primitive defenses. The most valuable interpretation has been described as one that is "felt" and "created" by the patient.[27,51]

> For effective treatment, it is decisive that a patient experience himself as an active participant in the therapeutic process. If there are things to be uncovered and interpreted, it is important that the patient makes the discovery on his own and has a chance to say it first. The therapist has the privilege of agreeing or disagreeing if it appears relevant. Such a patient needs help and encouragement in becoming aware of impulses, thoughts and feelings that originate within himself. (Bruch,[27] p. 338)

Bruch believed that this approach promoted the development of patients' untapped resources such as autonomy, initiative, and self-responsibility and would lead to a feeling of aliveness as to what is going on within themselves.

More recently, self-psychological treatment approaches have highlighted the role of validation of subjective experience. This role involves assisting the patient in establishing an attitude of interest in, and a feeling of acceptance of, her own emotional life.[11,18,46] These authors propose that such an approach strengthens tolerance of affect and the growth and development of functional capacities to assist in regulating affects and impulses, resulting in a sense of mastery and enhanced self-esteem.

Adler and Buie[18] suggest that individuals who lack sustained mental representations of others are prone to the experience of recurrent fears and panicky reactions—particularly around the notion that the therapist does not exist in the intervals between therapeutic sessions. These authors emphasize the importance of a sense of continuity and stability within the relationship to allow for the internalization of more stable soothing representations. For example, in the treatment of BPD, telephone contact with the patient "at the time of emergencies" between therapy sessions is a means of providing concerned attention and fulfills the patient's need to evoke soothing object representations that can offset the fear of being alone.[18] Other techniques that may be useful for delaying interpersonal contacts include encouraging reading or other distracting activities, tape-recorded therapy sessions, and encouraging increased social activities. Such activities help patients learn adaptive behavioral responses and lead to an

increase in the tolerance for affects.[18,52]

The literature on difficulty in affect regulation (self-soothing) and the inability to tolerate aloneness led us to the speculation that guided imagery as a therapy may facilitate the internalization of soothing experiences and the use of a therapist for self-soothing.

Guided imagery therapy provides an ideal opportunity to address the difficulty of affect regulation in BN for a number of reasons:

1. Guided imagery occurs within the context of a therapeutic relationship, thereby facilitating the role of empathy and the development of a holding environment.
2. The efficacy of guided imagery for enhancing the relaxation response and a calm affective state has been well documented.[52–55]
3. Guided imagery provided by the therapist can act as an "external" source of soothing and comfort, and it therefore can assist individuals in managing painful affective states. The use of audiocassette tapes, written scripts, or recalled imagery exercises used in a therapeutic session provides a portable "transitional object" that can be used between therapeutic sessions. The imagery provided by a therapist (such as the therapist's taped voice) facilitates the connection between the patient and the therapist and may promote a "therapist presence" outside of therapy.
4. The specific words and phrases of imagery are tailored within the context of the illness and therefore can incorporate image descriptions that are relevant for soothing.
5. Imagery is the language of the inner self. It produces personal images and metaphorical themes and provides an active and "playful" approach that engages the individual in working with her imagination and in contemplating meaning in the experience. The subtle, nonintrusive symbolic character of imagery is less apt to trigger defenses or resistance, and it frequently evokes revelations. As Hutchinson[56] notes, "A single image can symbolize or arouse an entire constellation of meanings, which can then be explored" (p. 158).
6. Increased awareness and self-reflection during guided imagery facilitate the experience, and the identification, of emotions and themes that can be validated.
7. Self-experience is enhanced through various modes of expression of the imagery, including verbal and written forms and drawings.

A GUIDED IMAGERY TREATMENT APPROACH

Guided imagery has been used in a variety of clinical areas, and empirical studies have supported its wide-ranging applications. Imagery has been extensively used as a therapy in oncology, particularly in symptom and stress management,[55,57–59] and more actively as a healing imagery focusing on the cancer.[58,60,61] A few well-controlled studies suggested significant improvement in performance by the use of mental rehearsal,[62–66] in the promotion of weight loss,[67] for body-image disturbance,[56,68] and in the production of physiological changes such as changes in cellular immune function[69] and alterations in skin temperature.[70,71] The use of guided imagery in the promotion of the relaxation response is well documented,[72,73] and relaxation imagery remains a frequently used treatment, either alone or with subsequent imagery exercises.[74,75]

Imagery has been used in psychotherapy as a method for eliciting insight and feelings associated with past experiences.[76–79] A few studies have made use of imagery as a treatment for depression.[80–86] These studies provide evidence that various types of directed imagery, either alone or in combination with other cognitive-behavioral approaches, can reduce both self-report and behavioral indices of depression.

No controlled study has investigated the use of guided imagery in BN patients. However, bulimia patients have been found to be significantly more hypnotizable than patients with anorexia nervosa and normal age-

matched populations, and a trend was found for purging subgroups of anorexic patients.[87–90]

There are few controlled trials of hypnotherapy in eating disorders. However, a number of case reports and anecdotal evidence suggest its usefulness as a component of a multidimensional treatment program.[90–92] A variety of approaches in using hypnosis/imagery have been presented. For example, its use as a relaxation/calming technique has been suggested (using nature imagery or progressive muscle relaxation).[93,94] Other suggestions in the literature include exercises geared toward increasing awareness of bodily sensations at mealtimes,[90,95,96] age-regression techniques aimed at identifying precipitating events of the eating disorder,[52,97] ego-state therapy,[52] imagery to correct body image distortions,[56,94,97,98] ego-strengthening hypnotic suggestions,[51,99,100] cognitive restructuring,[52] and future-oriented age-progressive hypnosis involving imagining future goals or life without an eating disorder and associated personal changes.[96,97] The therapist, therefore, has a large variety of exercises/suggestions from which to draw in tailoring a hypnotherapeutic/imagery treatment program for any given patient.

Despite the variety of hypnotic/imagery suggestions offered, a number of common elements are apparent, including the following: 1) the identification of the need to decrease arousal and promote comfort, 2) the recommendation to incorporate audiocassette-taped exercises (made by the therapist or patient) for practice outside of therapy, and 3) the identification of use of metaphors or symbols as a useful way to explore personal issues (particularly where difficulties with self-expression impede therapeutic progress).[52,90,93,94,96,99] In addition, it has been suggested that these types of therapies enhance the development of the therapeutic alliance.[94]

In summary, most of the evidence on the use of hypnotherapy, relaxation, or imagery in eating disorders is anecdotal and presents the described technique as one part of a multicomponent approach to treatment. Few details are therefore available about the specific mechanisms involved.

In the literature on imagery, studies report greater success with the use of images that are characterized by close approximation to real-life situations in that the person actually "feels" the image (experiencing the sensations as if actually performing the task in the imagery).[53] Imagery exercises practiced through the use of audiocassettes were found to be effective and superior to self-directed practice by newly trained subjects.[101]

A Model of Guided Imagery Treatment to Enhance Self-Soothing

We have developed a conceptual model of guided imagery therapy that is relevant for the treatment of an impairment in self-soothing. Although we recognize the multidimensional nature of BN, we have chosen to focus our model on the role of self-soothing, for two primary reasons: 1) treatments geared to affect regulation as a feature of the illness have not been extensively developed and tested in BN, and 2) the literature on imagery, hypnosis, and relaxation has demonstrated that such techniques can decrease arousal and therefore suggests their relevance to helping these individuals build skill in managing affect.

The proposed guided imagery treatment approach is conceptualized as having "layers" of active ingredients, with the view that each added layer deepens the effect (Figure 1).

Reading the model from left to right suggests each individual layer promotes a psychological-soothing state. Reading downward indicates the additive and simultaneous nature of the layers in facilitating psychological soothing. It is not necessary to incorporate all of the layers in order to achieve a soothing experience; in fact, working with one or two levels can achieve significant results. For example, an unknown soothing voice suggesting comforting images can result in the experience of a calm state (as attested by the numerous audio-

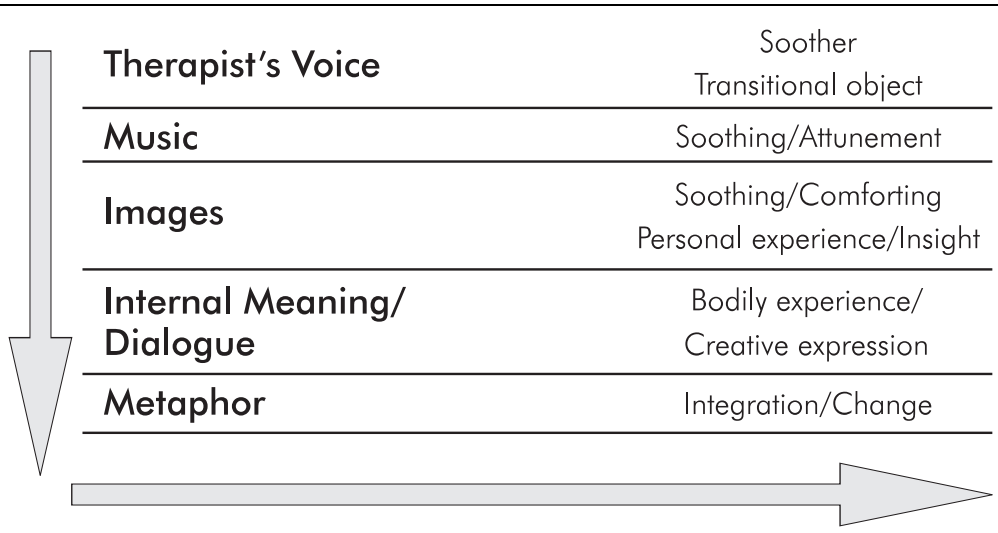
cassette relaxation/imagery tapes that are commercially available). However, the addition of a familiar therapist's voice significantly enhances the effect, and the imagery tape or exercise may function as a transitional object. Similarly, the further addition of soothing music (the therapeutic effects of which are well documented[54,102]) can complement the other components, such as voice and images, in promoting a calm state.

The specific words and phrases used in guided imagery exercises are generally designed within the context of the illness. Within a self-soothing model, one would use image descriptions that are relevant for soothing and ego strengthening. The soothing imagery provided by the therapist's voice can become internalized for self-soothing during vulnerable times, and therefore it can act as a transitional object outside of therapy. Individuals are encouraged to practice imagery between sessions (either with scripts or audiocassette tapes). This practice assists the individual in becoming familiar with the technique and enhances personal responsibility and self-efficacy in regulating emotional states. The guided imagery can promote the development of internalized representations (e.g., of the therapist) that may provide a future and potentially permanent capacity for self-soothing.

Two types of imagery can be incorporated in imagery exercises: directive, in which the image is specifically described ("imagine a meadow"), and nondirective, in which less specific description allows for the formation of more personalized and spontaneous imagery ("imagine some natural environment"; "find some special place"). Some individuals experience ambivalence or difficulty with a nondirective suggestion and prefer the more direct approach. It is important to note that directive imagery is also personal, as demonstrated by having different individuals describe the "meadow" experienced in their imaginations.

Difficulties with the technique or the imagery are explored during therapeutic sessions. Individuals who have difficulty with imagining a nondirective exercise can be encouraged to try a more directive imagery approach. Those who have experienced painful emotions through the experience are encouraged to express their feelings. They can be introduced to alternative, more soothing exercises, encouraged to build in greater safety in their imagery—or, if they are willing, they can be encouraged to contemplate and work with the evoked images (for example, through

FIGURE 1. Guided imagery therapy model.



dialogue with the imagery: "Is there anything you would like to say or do with the image?").

Images used during the early stages of treatment should suggest an inner atmosphere of safety, so as to establish a secure environment and raise interest in the identification of emotions and themes that will occur through the more challenging self-exploration exercises. Imagery themes that may enhance safety include soothing environments (outdoor water and meadow scenes, warmth of the sun, a golden light, familiar places where the individual has felt safe), the construction of a protective structure, or the inclusion of a trusted individual. The imagination is embedded in bodily experience, and therefore each image is accompanied by physical and emotional sensations.[103,104] During the imagery therapy, personal images occur spontaneously and bring forth reactions. Feelings of fear, surprise, and recognition of earlier experiences are among the reactions that may occur. During or after the imagery exercise, the individual is encouraged to identify and comment on her bodily experience. The individual's attention is directed by asking questions about these reactions: "How do you feel here?" and "When you observe this image, what feelings come forward?" The therapist assists in exploring any arising themes or changes in affective states that occur.

According to this model, personal insight is promoted through soothing exercises in a relaxed state. A relaxed state is viewed as a necessary condition for self-reflection. The process of self-reflection occurs at the individual's level of readiness. It is important for the therapist to allow the individual to comment on self-experience through several sessions, rather than make interpretations. Personal imagery will be linked to experience, and frequently individuals are able to find their own meaning in the images.

This process is congruent with Bruch's[27] therapeutic approach, which focused on self-experience and discovery. Imagery therapy is ideal in this regard. The imagery exercises produce personal images within the individual's private imagination. These images range from the concrete, such as objects or persons, to the more abstract, such as a color or metaphor. The therapist guides the individual to concentrate and observe the experienced personal images as they are forming, and this promotes a feeling of being active and creative in the therapeutic process. Such an approach results in a kind of "playful" engagement between the therapist and the individual as she imagines and awaits the images and emotions that emerge during a given exercise. This aspect of guided imagery incorporates the elements of self-discovery and spontaneity that Bruch[27] and Winnicott[51] emphasized as being particularly important in the treatment of these individuals. The role of creative activities has been linked to feelings of vitality and a sense of being alive, feelings that appear to be lacking in the lives of many with BN.

Personal imagery is frequently abstract, having metaphorical themes. At times, a profound sense of surprise or discovery is experienced with emerging images and themes. A particular image or metaphor may have significant meaning for an individual—by being linked to an earlier memory or experience, for example, or providing insight into some behavioral pattern or emotion, or shedding light on an important goal. The individual is encouraged to "play" with personal imagery, verbally engage with the images, rehearse behaviors or interactions, and express any corresponding feelings. Self-expression is encouraged in oral and written forms and, if the individual is willing, through more creative modes such as drawings of the images. These multiple forms of expression promote communication and reflection of the imagery experience at cognitive and bodily levels. Encouraging drawings or written expression provides the opportunity to observe and inspect aspects of the imagery and assists in identifying emotional reactions and personal insights.

Discussing an issue or feeling through a metaphor can be experienced as less threatening because the metaphor or image is viewed in this model as providing permission and

safety for the expression of feeling. At times, the individual may be unaware of what is being revealed and gradually come to identify some key insight. Further deepening of the process occurs when the identification of an important metaphor is linked to some symbol. Once a symbol is identified it can carry with it special meaning, and the therapist explores with the individual methods of integrating new discoveries into daily living. The individual is encouraged to bring this symbol into her life in some way. Some individuals may choose to incorporate a real object that serves to remind them of an important discovery, a goal, or a new skill that is being developed, while others may choose a color or a symbol in nature to represent some important theme in their imagery. This symbolic form of expression can be viewed as providing a space in the real world where meaning can be represented and stored. The symbol, in a sense, provides a type of bridge between the individual's internal world and physical reality. Once based in reality, the symbol can be used as a reminder of progress, personal strengths, and possibilities for the future. This symbolic representation promotes the integration of new meaning and insight into experience.

GUIDED IMAGERY EXERCISES

We have included six major imagery exercises that can be used for soothing and that promote self-exploration of the individual's inner experience (recognizing that there are other possible themes that can be used). The two early exercises familiarize the patient with guided imagery, focus on the relaxation response, and promote increased awareness of inner feelings. As the individual becomes familiar with imagery and gains a sense of mastery with the technique, progress can be made to the more challenging self-exploration imagery exercises (exercises 3–6). We have chosen here to provide the script for the first exercise, with a brief description of the images and goals of the other five.

Six Imagery Exercises

1. *"Creation of an Inner Sanctuary":* This exercise has been used in the literature to have the individual create a special internal place for relaxation and becoming aware of feelings.[105]
2. *"Exploration of a Meadow":* This exercise consists of directive imagery and has the individual explore a meadow.[106] Its functions include promoting the use of all senses during imagery, enhancing a relaxation response, and demonstrating to the individual his ability in doing imagery.
3. *"Creating a Mask":* This exercise has the individual imagine discovering a box full of creative supplies and making a special mask. It helps introduce the individual to a self-exploration exercise and at the same time involves participation in a creative act.
4. *"Color of Self":* This exercise involves having the individual draw herself as a color or combination of colors, called a colorform. The individual is asked to imagine the colorform on paper and to experiment with a variety of colors of paint, including a special jar called the "color of aliveness." The individual is encouraged to experiment with the colors and to note what she observes. This exercise is designed to be soothing and to continue with the self-exploration in a creative and playful manner and frequently addresses body image issues.
5. *"Theater Scene":* This exercise has the individual imagine being in a theater and observing his "colorform" in an interaction (past, current, or future) of his choice. Its goal is to continue the self-exploration to the realm of interpersonal relationships.
6. *"Design of a Personal Quilt":* This exercise has the individual imagine making a personal quilt through a medium of choice and to observe the pattern that is developing. The exercise is designed to be soothing, to continue with self-exploration, and to promote themes of continued growth

and change. The exercise is viewed as creative, and we have found it to be useful near the end of therapy to promote an internalized feeling of continued development and growth, thereby facilitating termination.

Example of Imagery Exercise: "Creation of An Inner Sanctuary"

This is an exercise through which I will guide you. Just follow my voice and the script, but remember that you have control over the exercise. Even if you are experiencing a build-up of your emotions and feelings, you can use this exercise to help you feel relaxed . . . and safe and to help you to gain control and to manage the feelings that you are experiencing. So, just follow my voice and allow the images to come. Try to acknowledge and recognize your feelings as they come forward and know that you can learn to manage these feelings . . . to understand them . . . and you can feel more relaxed . . . and more in control . . . and some release from these emotions. . . . Remember, it will be within your ability to follow these instructions. . . . Just feel my voice and allow your senses and imagination to follow the voice. . . . You can feel safe during the exercise . . . and although you may be feeling some difficulty or pain . . . you will soon feel more relaxed and in control. Feel free to use all of your senses. . . . Feel the images. . . . Imagine yourself experiencing these images. . . .

We're going to begin by focusing on your bodily feelings. Make yourself comfortable. . . Close your eyes and allow your body to feel loose and comfortable. Take a deep breath . . . slowly . . . a deep breath. Concentrate on your breathing as you count silently to yourself. Inhale, "In . . . one . . . two. . . . Out . . . one . . . two . . . [repeated several times]. Feel yourself relax as you breathe. . . . Breathe out slowly . . . . Concentrate on your breathing . . . slowly and deeply . . . breathing deeply. . . . Feel the air going into your lungs . . . out of your lungs. As you breathe out, notice that you begin to feel more and more relaxed. Tension is draining from your body. Let the painful feelings go. . . . Go from your body. . . . They will go . . . and soon you will feel more in control . . . and more at ease. . . . Continue breathing slowly. Continue in . . . and out. . . . Breathing slowly. . . . Continue to listen to my voice.

Now, continue to focus on relaxing, and I am going to describe some images. Just follow my voice. Continue to breathe slowly and deeply . . . and allow the images to soothe your feelings. By continuing to breathe slowly and deeply . . . you will allow any tension that you are experiencing to flow from your body . . . to leave your body. [Further breathing instructions repeated.]

Now, you are beginning to feel more relaxed and in control. . . . Continue to close your eyes and just follow my voice and the images that I describe. . . . Imagine yourself in some beautiful natural environment. . . . It can be any comforting place that appeals to you . . . in a meadow . . . on a mountain . . . in a forest . . . or beside a lake or an ocean. It may be some special place where you have been before . . . where you felt warm and safe . . . and where you felt the beauty and strength of its atmosphere. If you find difficulty in relating to a place where you have been before . . . imagine and create a beautiful, serene, and peaceful place. . . . It may be another planet if you like . . . or a place that you recall from a novel . . . or a place in your imagination. . . . The special place is one of your choice . . . any place that appeals to you . . . one that you would like to return to . . . perhaps one that you have created in your own imagination . . . that would have this special, wonderful atmosphere. . . . Wherever it is . . . it should feel comfortable, pleasant, and peaceful to you.

Feel this environment around you. Use all of your senses . . . the beauty of it that you see . . . the quiet and pleasant rhythmic sounds of the environment. . . . Feel the warmth on your skin . . . the breeze feels so warm and gentle. . . . Notice the smells in this environment. . . . It feels familiar to you. . . . Your senses are open to all of the atmosphere's textures, smells, sounds . . . .and warmth. . . . Explore your en-

vironment, noticing all of its details. . . . This is your special place . . . and notice the feelings and impressions that you are beginning to experience.

Now, continue exploring your surroundings . . . and do anything that you would like to do to make it your special place and comfortable for you. . . . If you would like to build some type of shelter or house . . . begin to imagine its structure. . . . Or perhaps you would like to surround the whole area with a golden light of protection and safety. . . . Create and arrange things that are there for your convenience . . . and enjoyment . . . in order to establish it as your special place.

Create a kind of sanctuary . . . one that is only yours . . . so that when you need to visit this sanctuary you can at will. . . . Every time that you return you will feel these warm feelings. . . . These feelings of safety . . . and increased understanding . . . and peace. . . . You can come here to explore yourself. . . . To find this calmness and to experience and enjoy it. . . . When you need to get away . . . from moments of tension. . . .

This can be your inner sanctuary. . . . It's very personal . . . and you can explore your feelings . . . and your thoughts and come here to recognize your feelings . . . and understand why you are experiencing these feelings. . . . Allow the calmness here to help you . . . to feel safe . . . to come in touch with your feelings . . . and to learn new things about yourself and your feelings. . . .

This calmness will always be in your personal place. . . . It will be soothing and familiar, and it can be reached when you need to feel comforted. You can return at any time to this special place by closing your eyes and desiring to be there. You will come to recognize and always feel these comforting feelings and in a sense your imagination can become a trusting friend that will help you to return to this place . . . when you need to . . . just by closing your eyes . . . or by following my voice on the tape.

Sense this personal inner sanctuary as a healing and relaxing place. . . . It belongs only to you. . . . You are the only one who knows about this place . . . and you do not have to share it with anyone if you don't want to. . . . This place will become more and more familiar to you as you visit it repeatedly, over time . . . and it will become more and more easy for you to recall this place as you continue to visit it when you are feeling frightened . . . or tense . . . or angry . . . for any reason. . . . You can even visit it any time you want to feel that comfort . . . and trust . . . or when you wish to explore your own inner feelings . . . and thoughts . . . It is always open . . . any time . . . at night . . . or during the day. . . . This place is to help you to explore . . . to heal . . . and to feel more in control and in touch with your experience of your mind and your body.

You may want to make changes and additions to your sanctuary . . . from time to time . . . and you are free to add things to it . . . but it will always remain peaceful . . . and tranquil . . . and you will always feel safe here. . . . It is comforting and has a soothing atmosphere. . . .

Now, you may stay within your inner sanctuary as long as you wish. . . . And when you are ready to leave . . . just count backwards slowly from five . . . to . . . one . . . and you can leave . . . by focusing again on your breathing and bodily feelings. . . . Notice how relaxed you feel. . . . The tension that you felt before has left and you feel more in control . . . and more calm . . . and you feel more positive . . . and trustworthy . . . that you can be in touch with your inner self . . . and feelings. . . . You feel much more relaxed. . . . [Repeat of breathing exercises to end of exercise.]

Case Example

"Helen" is a 23-year-old woman, living with her boyfriend and attending university. She has a history of anorexia nervosa, which developed at age 15 following a move with her parents to Denmark from Canada. At the age of 19 and after reaching her "goal weight" of 108 pounds (she is 5 feet 4 inches tall), which followed an intensive treatment program, she began engaging in binge eating and self-induced vomiting on a regular basis. By the age of 23, she had returned to Canada

and was able to eat regular meals daily and had somewhat accepted her body weight; however, she had been unable to stop binge/purge episodes (reporting 3 to 6 episodes weekly), which prompted her to seek treatment.

Helen was introduced to imagery through individual outpatient psychotherapy in a randomized trial of guided imagery. In this trial, imagery was the focal psychotherapeutic technique, with no concurrent therapy other than self-monitoring of eating symptoms. The therapist conducted the "inner sanctuary" exercise during an early session. Helen's visualized "place" where she felt comfort was a "stone house" that she imagined being located in Denmark. When asked to explore what was so special about this place, Helen eloquently described feeling "safe," "peaceful," and "protected" and in some way even "more secure." She was encouraged to practice this first scenario, daily, particularly around her bingeing and purging behaviors. Following her first week of therapy, she reported using the taped exercise on several occasions, and was able to discontinue 3 episodes of bingeing by listening to the taped version of the inner sanctuary exercise. During her sessions, she was encouraged to explore in detail her experiences in Denmark and the image of the stone house (which became a central theme during her sessions).

Her history revealed that her parents had moved from Canada to Denmark when Helen was 14, following her completion of primary school. Helen recalled feeling "popular," "confident," having "numerous friends" (including a boyfriend), participating in athletics, excelling at school, and being healthy in Canada. After her arrival in Denmark she found herself having difficulty making friends. She felt uncomfortable in a foreign country and began to strongly resent her parents for taking her away. She found solace only in skating and became competitive in the sport, participating in little else. It was at this time that she began to severely restrict her food intake, developing anorexia nervosa. She also relayed feelings of fear in relation to dating male colleagues, particularly around her feelings of sexuality, as she perceived the students in Denmark to be permissive and "more mature." She became so ill that she was hospitalized at that time, despite being successful in her competitive skating. It was several years later (after Helen returned with her family to Canada and following her treatment for anorexia) and while she was attending university that she sought treatment for her bingeing/purging. At that time she continued to have conflictual feelings and anger toward her parents, and when beginning the imagery therapy she described intense negative feelings around her past experiences in Denmark.

Helen was encouraged to explore "the stone house" that presented itself consistently through many of the exercises described above (for example, during the meadow scene, and again when "making her mask," she was in the stone house). The therapist pointed out that the stone house appeared to be a refuge and a place of calming (according to Helen's verbalization on her imagery), and yet it was in an environment that she associated with strong and intense negative feelings. Helen, too, made this observation and was encouraged over time to explore in detail what it was about the stone house that was so meaningful for her and contributed to her feeling so secure. She described the house as not being particularly familiar to her (there are many in Denmark), but as being "strong," "old," "natural," and "very real"; as not being "brightly colored" or "perfect," but as having "depth" and a comforting solitude.

As Helen progressed in therapy and expressed her feelings about her imagery through her drawings of images and verbally during therapeutic discussions, it became evident to her that she saw herself as "not measuring up to others," feeling inadequate, and wondered how her boyfriend could care for her. When alone at home prior to his return in the evening, she would experience strong urges to binge and purge. However, over time it became clearer through her descriptions of the house that she admired the qualities of the "stone building" in contrast to personal qualities she described as being "superficial" and uncomfortable for her. Her innermost yearnings seemed to be for self-qualities that she described in terms of the house; for example, she revealed that her chief goal was to engage in academics and produce "meaningful" and "worthwhile" work that would be of enduring quality. However, she felt she could never "permit" herself to engage in courses that she desired, such as philosophy or historical literature. She believed that her family and friends did not see that she had such qualities within her. In addition, despite having participated in athletics and "the glamour of performing," she felt unfulfilled by these accomplishments and had never experienced a sense of

esteem (despite many hours of preparation toward achieving goals in her skating).

As the imagery therapy progressed, Helen was encouraged to visualize the "stone building" regularly in a sensory way and to explore her attachment to this image and its meaning for her. Her personal imagery became a vehicle through which she could disclose (metaphorically at first) her innermost feelings, express her pain associated with being in Denmark and her feelings toward her parents. Over time she was able to grasp something more positive from her time there, rather than to view it as "wasted and painful years of her life." After her 6 weeks of imagery therapy, she was able to describe her experiences in Denmark as possibly contributing to the development of personal qualities such as "strength," "endurance," and "substance" that she was beginning to sense she possessed as she explored her imagery. The therapist encouraged her to remain in touch with these qualities ("to really feel them") and to allow them to fully develop. She was encouraged to nurture the qualities that she valued and to share them with others over time as she felt comfortable. She also came to recognize the house and its special qualities as representing her and her personal experience in Denmark—and, interestingly, as being separate from the experience of her parents. This was an important self-discovery for her to make, given that she felt so "cheated" and "controlled" in being taken from a comforting safe environment to an unknown country, contrary to her wishes to remain in Canada.

By the end of the 6 weeks, Helen had only occasional binge/purge episodes (1 or 2 every few weeks) and reported a greater sense of control. She also reported an increase in her mood level and a renewed life interest. She continued to utilize the imagery for self-comforting in connection with her exams and her eating urges, and she shared her personal experiences with her imagery with her boyfriend. She had also discussed her feelings more openly during a visit to her parents.

This case example is useful in highlighting the elements in the imagery model as well as demonstrating the patient's acceptance of the imagery therapy as a comforting device and participatory experience. Helen took an active role, the imagery was "personal," and through focusing on her specific images during the therapeutic sessions (and in her journal) she came to the conclusion that the stone house represented some aspect within her that was hidden from others and kept private. Perhaps because it was her own personally evoked image (rather than one suggested by the therapist), it became particularly meaningful and solacing for her, and she repeatedly called upon it for comforting and to inspect its meaning. The therapist acted to guide the patient to explore the imagery, and as themes emerged asked the patient to inspect them and to describe any associated feelings or interpretations. This procedure is similar to Bruch's[27] "fact-finding" approach, which she believes to be crucial for promoting self-discovery and autonomy.

Helen, through her imagery, was able to further understand from a new perspective her development of an eating disorder and to learn about personal issues that may be contributing to her need to binge/purge, despite having normalized eating and feeling fairly comfortable with her body weight. She frequently had commented on the fact that she had gone through previous treatments and addressed other issues (such as her weight), and yet, could not understand her lack of control at times over her eating and self-induced vomiting. Helen received the guided imagery without any concurrent therapies (other than maintaining self-monitoring of her eating symptoms as part of her personal journal). However, the therapist refrained from making comments/recommendations on her eating and kept a focus on her experienced imagery, suggesting that her insights and behavioral changes appeared to have occurred as a result of the imagery therapy.

GUIDED IMAGERY RANDOMIZED TRIAL

The guided imagery model described above has been applied in a recent study described elsewhere.[107] A randomized controlled trial compared patients receiving 6 weeks of indi-

vidual guided imagery therapy (with self-monitoring of symptoms) with a control group of untreated BN patients (which controlled for therapist contact and self-monitoring of symptoms). Fifty participants who met DSM-III-R criteria for BN completed the study. Scores on measures of eating disorder symptoms, psychological functioning, and self-reports associated with the experience of guided imagery therapy were obtained. The guided imagery treatment had substantial effects on the reduction of bingeing and purging episodes; the imagery group had a mean reduction of binges of 74% ($P < 0.0001$) and of vomiting of 73% ($P < 0.0001$). The imagery treatment also demonstrated improvement on measures of attitudes concerning eating, dieting, and body weight in comparison to the control group. In addition, the guided imagery group demonstrated improvement on psychological measures of aloneness ($P < 0.05$) and the ability of self-comforting ($P < 0.001$). Evidence from this preliminary study suggests that guided imagery is an effective treatment for BN, at least in the short term, and promotes psychological soothing.

SUMMARY

In summary, BN has been linked to a difficulty in the ability to modulate affects or in self-soothing. This conceptualization suggests the need to design treatments that specifically target the problem of affect regulation and that assist these individuals in comforting themselves. A model of guided imagery therapy has been described that can be used to provide an external source of soothing and to enhance self-soothing. The model suggests that imagery therapy has multiple levels of action that can assist these individuals in the regulation of affect. A case report and preliminary evidence from a randomized trial have demonstrated its effectiveness in improving eating disorder symptomatology and in promoting self-comforting at least in the short term, possibly by providing patients with a transitional object.

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A Match Made in Heaven?

A Pilot Study of Patient–Therapist Match

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The authors report on a study of patient–therapist match in 50 psychodynamic psychotherapy dyads. Sixty-six percent of patients and therapists agreed about the quality of the match, with 58% of patients and 56% of therapists reporting that the match was positive. Positive match correlated with positive patient and therapist assessments about the progress and process of therapy, but not with perceived similarity of personal characteristics. Patients' and therapists' perceptions about their similarities and differences from one another did not correlate. This study suggests it is both possible and important to gather data from both patient and therapist when studying match.

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The recognition that psychotherapy is a two-person system naturally created interest in the complex and multifaceted relationship between patient and therapist. The term *patient–therapist match* attempts to capture an important dimension of that relationship. The concept of match originated in the developmental perspective of "goodness of fit" between mother and child. Baby watchers believe that there is a strong correlation between goodness of fit and successful progression through the phases of separation and individuation and the process of identity formation. Conversely, problems in psychological development can arise when the fit is discordant. The concept of fit assumes that a child's intrapsychic development results from a highly interactive interpersonal relationship, as opposed to the child's passively absorbing the mother's influence.

As the psychotherapeutic relationship was reconceptualized as a two- rather than a one-person system, the concept of "goodness of fit" was adapted to the psychotherapeutic relationship and renamed patient–therapist match. As

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Kantrowitz[1] notes, "The similarities and differences between analyst and patient have an impact on whether the analyst can or cannot resonate with the patient, just as the similarities and differences between parent and child affect the synchrony between them" (p. 295).

Match is considered to be a "reality" that creates a context that significantly influences the subsequent development of all other dimensions of the therapeutic process. Often an idea of a fantasied match serves as the basis for the referral of a patient to a particular therapist. Thus, match is an autonomous reality that stands apart from the therapeutic process; however, it influences the development of other patient–therapist interactions considered critical to the therapeutic process (therapeutic alliance, transference, countertransference). If match is seminal in the development of key elements of the therapeutic process, this naturally leads to the hypothesis that "good" patient–therapist match correlates with therapeutic benefit. This hypothesis parallels the developmentalists' belief that goodness of fit between mother and child is necessary for healthy psychological development.

Although psychotherapists consider match to be distinct from such entities as therapeutic alliance, transference, and countertransference, the boundaries between these concepts are far from clear. In fact, although match is a concept that intuitively resonates for most psychodynamic clinicians, like many fundamental psychodynamic terms it has no consensual definition. If a core concept of psychodynamic metapsychology has no definition, clinical discussions that use the term are compromised.

While clinicians have been discussing patient–therapist match in conceptual terms, psychotherapy researchers have focused on gathering descriptive information. However, these studies have focused exclusively on match as it relates to the initial process of choosing a therapist rather than examining the evolution of match longitudinally. In a study by Alexander and colleagues,[2] patients were given the opportunity to choose between two therapists and selected the one they felt would be more helpful and whom they "liked" more. However, the study was not able to explicate the reasons that a patient liked a particular therapist, and it was unclear how liking the therapist related to the concept of being well matched.

Hollander-Goldfein and co-workers[3] studied 97 patients who were given the option to choose among three therapists. They chose the therapist whom they believed to be the most competent and the most understanding and who demonstrated qualities that they wished to emulate. Neither demographic variables nor the patient's perception of similar personality characteristics significantly influenced the choice of therapist. An intriguing finding in this study was a significant correlation between the therapist rating the patient as likable and the patient subsequently choosing that therapist.

Grunebaum[4] interviewed 23 psychotherapists to determine what they considered most important when choosing their own therapists. Most of the subjects had had more than one experience with psychotherapy. Characteristics such as warmth, supportiveness, and a nonjudgmental attitude were frequently cited, but the most important characteristic was the level of therapist activity in the session; therapists wanted therapists who would be active, who were "talkers," and there was a clear aversion to the inactive, "blank screen" approach.

In a study looking for predictors of outcome, a cognitive match between patient and therapist (as assessed by the Interpersonal Discrimination Test) was associated with decreased dropout in the first 2 weeks of therapy.[5] Furthermore, patient–therapist pairs that were cognitively matched appeared to have a faster rate of improvement in the first 12 weeks of therapy as assessed by the Global Assessment Scale. However, at 24 weeks cognitive match scores did not predict outcome.

Nelson and Stake[6] studied the correlation between patient and therapist perceptions of the therapy relationship and personal qualities.

Although some match between patient and therapist scores in "thinking-feeling" and "judging-perceiving" dimensions correlated with the patient's perception of a positive therapeutic relationship, once again the most powerful predictor of both patient and therapist mutual satisfaction was a high degree of therapist activity.

In a study of patient–therapist match in a sample of psychoanalytic training cases, Kantrowitz and colleagues[7,8] reported that patient–therapist match significantly influenced outcome in 13 of 21 cases. However, as Kantrowitz herself notes, this study is limited by several methodological problems, including small sample size, retrospective evaluation of match and outcome, and the concept of match being assessed only from the analyst's perspective, not the patient's. Perhaps the most important methodological problem was that Kantrowitz did not offer a definition of match.

In fact, a frequent problem with studies of patient–therapist match has been the lack of an *a priori* definition of what match is and—just as important—what it is not. For example, Kantrowitz says:

> Match . . . covers a broader field of phenomena in which countertransference is included as one of many types of match. The individual history, characteristics, attitudes, and values of each analyst and patient predispose them respectively to certain countertransference and transference reactions. Match, however, also can refer to observable styles, attitudes and personal characteristics which are rooted in residual and unanalyzed conflicts, shared or triggered in any patient–analyst pair.[7] (p. 895)

Such a broad definition fails to distinguish match from other phenomena such as transference, countertransference, and character armor. Thus, when two clinicians or researchers are talking about match they may use the same word, but they are unlikely to mean the same thing.

In this article we report a study in which patient–therapist dyads who were engaged in twice-weekly psychodynamic psychotherapy for an average duration of 1 year simultaneously reported perceptions of each other, the psychotherapeutic process, and the state of the match. The goal of this study was to assess the following questions:

1. Do patient and therapist agree about the quality of match?
2. Does positive match correlate with other variables?
3. Do patient and therapist respond similarly to questions about perceived similarities and differences?

METHODS

All psychiatric residents at the New York State Psychiatric Institute/Columbia Presbyterian Medical Center were asked to participate in this study, which involved completing a self-report questionnaire. If the resident agreed to participate, he or she presented the study to psychotherapy patients in open-ended, twice-weekly psychodynamic psychotherapy and asked whether they would agree to be contacted by one of the investigators (A.D.). Patients and therapists were both informed that neither party would see the other's answers to the questionnaire. If the patient agreed to participate, patient and therapist simultaneously completed the questionnaire. Patient and therapist questionnaires were answered anonymously, but patient–therapist pairs were identified by a code for the purposes of data analysis.

Patients participating in the study are predominantly Columbia University undergraduate and graduate students referred by the student health service for long-term psychodynamic psychotherapy. Treatment at this clinic is free of charge. Patients meet twice weekly with therapists who are supervised by the faculty of the Columbia Center for Psychoanalytic Training and Research.

After the study was explained in detail, all

participants signed written informed consent. This study was approved by the New York State Psychiatric Institute Internal Review Board.

The questionnaire elicited information in three areas:

1. Demographic variables.
2. Attitudes toward the therapy and the therapist (or patient).
3. Perceptions of similarities and differences between therapist and patient in terms of characterological traits such as humor and cognitive style.

Statistical Methods

Patient–therapist match was evaluated in terms of three questions:

1. Do patient and therapist agree about the quality of match?
2. Does positive match correlate with other variables?
3. Do patient and therapist respond similarly to questions about perceived similarities and differences?

Patient and therapist responses were compared by using Pearson's chi-square test of independence and Spearman's rho correlation. Logistic regression was applied when the predictive variable was continuous (e.g., age and duration of therapy). The spirit of the data analysis was exploratory. As such, no corrections for multiple comparisons were applied, and all patient and therapist responses were assumed to be independent, ignoring the fact that the same therapist might be treating up to 3 different patients. Significant relationships are reported by using an alpha level of $P < 0.05$.

RESULTS

Ninety-one percent (50/55) of patients and 94% (31/33) of therapists responded to the survey. Seventeen therapists were treating 1 patient, 9 therapists were treating 2 patients, and 5 therapists were treating 3 patients. The mean duration of therapy at the time of the study (± SD) was 11.6 ± 8 months.

Demographics

Mean patient age was 27.4 ± 5.6 years (range 19–41 years). Mean therapist age was 33.2 ± 3.1 years (range 27–40 years). Sixty percent (30/50) of patients and 61% (19/31) of therapists were female. The gender matches of therapist and patient were F/F in 21 cases, M/M in 10, F/M in 10, and M/F in 9. More than 85% of both patients and therapists were Caucasian. Eighty-one percent of patients had a college degree. Both patient and therapist reports of religious background were evenly distributed among Protestant, Catholic, Jewish, and none.

Do Patient and Therapist Agree About the Quality of Match?

Match was rated on a five-point scale ranging from "bad" to "excellent." No patient or therapist rated the match as "bad." In order to create cells of sufficient size for the purposes of data analysis, the categories were collapsed into positive ("good" or "excellent") or negative ("problematic" or "good enough"). Patients and therapists concurred about the quality of the match 66% of the time (Pearson $\chi^2 = 7.2$, $P = 0.007$; Table 1). In the 33 patient–therapist dyads who agreed on the rating of match, 20 pairs agreed that there was a positive match and 13 pairs reported a negative match. It is of interest that 58% of patients and 56% of therapists considered the match to be positive.

Does Positive Match Correlate With Other Variables?

Patient and therapist report of a positive match correlated positively with affirmative responses to the questions "Do you feel the ther-

apy is progressing?" and "Do you share a sense of how to proceed?", and with a rating of a high level of therapist activity during sessions. The robustness of these correlations was stronger for the patient group than for the therapist group.

Interestingly, female therapist gender correlated with patient, but not therapist, rating of positive match ($P = 0.025$). This finding is accounted for by the fact that 5 of 6 patients who rated the match as "problematic" had male therapists, while 6 of 6 patients who rated the match as "excellent" had female therapists. The 6 patients who rated the match as "problematic" included 3 males and 3 females, and the 6 who rated the match as "excellent" included 4 females and 2 males (Table 2).

The rating of positive match by either patient or therapist was not significantly correlated with a perceived similarity of personal characteristics such as cognitive style, sense of humor, political values, personality style, or hierarchy of personal values.

TABLE 1. Do patient and therapist agree about quality of match?

Therapist's Rating of Match	Patient's Rating of Match		
	Negative	Positive	Total
Negative	13	7	20
Positive	8	20	28
Total	21	27	48

Note: Pearson $\chi^2 = 7.2$, $P = 0.007$.

Do Patient and Therapist Respond Similarly to Questions About Perceived Similarities and Differences?

Patients and therapists responded similarly and positively more than 90% of the time to five questions:

1. Does the therapist like the patient?
2. Does the patient like the therapist?
3. Does the patient feel accepted and respected by the therapist?
4. Do therapist and patient agree on the kinds of changes the patient would like to make in therapy?
5. Do patient and therapist feel they are working together?

Responses to these questions were so strongly correlated with each other that these questions do not appear to assess distinct domains.

In seven questions, patients and therapists were asked to rate whether they perceived themselves as similar or different in personal characteristics, including:

1. Sense of humor.
2. Political values.
3. Personal values.
4. Cognitive style.
5. Personal style.
6. Sense of discipline.
7. Level of activity versus passivity.

TABLE 2. Does positive match correlate with other variables?

Question and Respondent	χ^2	Probability	Correlation
Therapy progressing?			
Patient response	9.6	0.001	0.45
Therapist response	6.5	0.01	0.36
Shared sense of procedure?			
Patient response	7.6	0.006	0.40
Therapist response	5.0	0.026	0.32
Therapist active?			
Patient response	10.9	0.001	0.48
Therapist response	4.0	0.05	0.28
Therapist gender			
Patient response	9.4	0.025	0.35

In one question, "political values," the number of responses was too small to allow for meaningful analysis. In the other six characteristics, there was no significant correlation between patient and therapist rating; that is, patient and therapist did not agree as to whether they are similar or different.

DISCUSSION

Perhaps the most important result of this study was to demonstrate that it is feasible to collect data from both members of the patient–therapist dyad. Indeed, the results of this study indicate that it is not only possible but necessary to do so. In 33% of patient–therapist pairs, the rating of sense of match was discordant; that is, there was disagreement regarding whether the match was positive or negative. In addition, in the entire sample, patients and therapists did not give similar answers to the majority of questions other than match. Not surprisingly, patients and therapists do not perceive things the same way. To talk about match in the psychotherapy dyad with input from only half of the pair is like attempting to do couples therapy with only one person.

A rating of positive match correlated with positive responses to questions that assess therapeutic alliance, therapeutic process, and outcome. In addition, positive match was strongly correlated with a high level of therapist activity. This finding replicates the work of Grunebaum[4] and Nelson and Stake[6] and suggests that therapist activity is important in establishing a sense of match and of therapeutic alliance.

In contrast, match was not associated with a perception of shared personal characteristics. If a patient is engaged in treatment, the match is positive regardless of whether the patient and therapist perceive each other as similar. A "therapeutic" match, which is most likely really the therapeutic alliance, is not dependent on patient and therapist personality concordance.

Our findings must be interpreted in light of the fact that mean duration of treatment at the time of assessment of match was almost 1 year. Because we do not have longitudinal data on the evolution of match, we cannot exclude the possibility that in the early stages of treatment, perceived similarity of personal characteristics is correlated with a perception of match, or perceived differences with a bad or problematic match. In the latter circumstance, patients may well have dropped out early and therefore not been included in this study. However, it is striking that therapy continued among the 58% of patient–therapist pairs in which at least one participant rated the match as negative—and despite the fact that 43% of patients rated the match as negative. Although longitudinal studies of match are clearly needed, our data seem to suggest that the concept of match does not add to our understanding of the therapeutic relationship or process, at least in the midphase of long-term treatment.

If the concept of match is ever to be useful, the term needs to be defined, its assessment operationalized, and the phenomenon studied longitudinally and with data collected from both members of the patient–therapist dyad. Only in this way can we answer the question of whether the patient–therapist match is indeed a match made in heaven or a partnership created by the therapeutic process itself.

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Early Identification of Treatment Failures in Short-Term Psychotherapy

An Assessment of Therapeutic Alliance and Interpersonal Behavior

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*Early sessions of patients categorized as dropouts (*n *= 25), good outcome (*n *= 28), and poor outcome (*n *= 20) completers of a 40-session protocol of short-term psychotherapy were compared to determine predictive validity of in-session measures of therapeutic alliance and interpersonal behavior (Working Alliance Inventory, Session Evaluation Questionnaire, and Interpersonal Adjective Scale). A number of significant differences were found among the three groups: both patients and therapists in the dropout group rated the relationship as more problematic than those in the good outcome group, and patients in the dropout group also rated the relationship as more problematic than those in the poor outcome group, while therapists' ratings did not distinguish dropouts from poor outcome. Differences between good and poor outcome groups were nonsignificant. These findings have clinical significance, particularly in early identification of patients at risk for treatment failure.*

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Research on the therapeutic alliance has consistently confirmed the centrality of the alliance construct and its predictive value in the overall outcome of therapy, as well as in the ongoing process of therapy. Bordin,[1] in one of his last works, emphasized that the repair and working-through of strains or ruptures in the alliance is crucial to the process of change. While this is certainly not news to our colleagues in analytic circles, who have been writing about and working clinically with transference, defense, and alliance phenomena for many years, Bordin's transtheoretical language has enabled psychotherapy researchers to begin testing these multifaceted concepts empirically.

EXISTING RESEARCH

Gradually, focus has been shifting toward the study of therapeutic misalliance and the dimensions that predict problematic patient–therapist relationships and poor overall out-

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come. Such studies have been pursued as a means to more fully understand mechanisms of the change process. However, process studies often compare alliance and interpersonal behavior between good and poor outcome cases but do not include subjects who have prematurely terminated. As Bordin[2] has suggested, severe alliance ruptures could result in premature and unilateral termination by the patient. Therefore, it could be expected that premature termination cases would be characterized by more extreme ruptures and generally more problematic alliances than would cases resulting in poor overall outcome. Dropout conditions may provide an additional context within which to identify and study features of problematic therapeutic relationships. At a more practical level, the high rates of patient attrition from brief psychotherapy—which average about 47% and range as high as 67%[3,4]—suggest that a substantial proportion of people seeking outpatient treatment are probably not receiving adequate care. Attrition rates have been found to be comparatively higher in patients diagnosed with personality disorders.[5]

Problems in Conducting Research

One reason why dropouts are often not included in psychotherapy process research studies may be the variability within this subsample and, hence, inconsistencies in how dropouts are identified. Failed treatments have been defined in the psychotherapy literature in a multitude of different ways, and this lack of consensus has likely contributed to conflicting and confusing research findings. In fact, the defining criteria are least reliable and valid for those patients who terminate therapy prematurely—as compared with patients who complete treatment protocols and have their outcome status defined by pre- and post-therapy ratings of symptoms and personality change.

Frayn[6] has conceptualized two general categories of dropouts. He found that 50% of patients who dropped out of therapy did so within the first month; the rest of the premature terminators remained in therapy for a longer period of time but ultimately failed to complete the full course of treatment. Frayn observed that an early versus late pattern of attrition was also evident in the NIMH collaborative depression project,[7] in which 44% of the premature terminators left therapy within the first month. He believes that the "early terminators" dropped out of therapy within the first month because of lack of motivation and the presence of a "powerful . . . negative transference . . . before a significant therapeutic alliance is available" (p. 258). Later dropouts, he hypothesized, are a more heterogeneous group who leave treatment for a variety of conflictual and environmental reasons. These percentages of early dropouts are consistent with rates reported by Garfield and Bergin,[8] who noted that 50% of dropouts left therapy prior to session eight.

Wierzbicki and Pekarik[3] conducted a meta-analysis on studies of premature termination, summarizing studies from January 1974 to June 1990, and found that dropout rates differed significantly as a function of the distinct definition used by each of the authors. In general, the criteria used to define dropout fell into three conceptually distinct categories: 1) termination by failure to attend a scheduled session, 2) therapist's judgment that termination was premature, and 3) low number of sessions attended. Without a reliable and valid definition of dropout, this sample remains a relatively heterogeneous one. For instance, a patient who accepts an unexpected job offer in another city early on in the treatment may have been completely satisfied with the therapy, but would be defined as prematurely terminating because of the small number of sessions completed. As Silverman and Beech[9] found, subjects who terminated therapy prematurely often benefited from just a few sessions and should not be considered treatment failures based on the number of sessions attended or the disagreement of the clinician. Moreover, although the therapist's judgment

may be one of the most valid methods of defining premature termination, it is also the least reliable, since therapists differ widely in the criteria they use for making such an assessment.[10–12]

Besides inadequate definition, a second reason for the paucity of empirical studies including dropout samples may have to do with the difficulty in collecting data from these subjects. Patients who feel they are not receiving satisfactory treatment and are considering early termination may be less inclined to spend time completing self-report inventories for the benefit of the study. In support of this supposition, "missing data" was found to be a better predictor than a number of self-report indices in a pilot study that looked at the early identification of treatment failures in brief psychotherapy.[13] Lack of overall outcome data may be a factor in the emphasis on pretreatment variables (such as demographic and descriptive data) in the literature on dropouts. (In contrast, an "intention-to-treat" model[14] applied to psychotherapy research assumes early attrition and incorporates more frequent assessments into the procedure, so that regardless of where in the treatment protocol a patient withdraws, comparative data are available and the patient can be included in endpoint analyses. Measures collected after each session also allow for ongoing assessment of therapeutic process.)

In terms of pretreatment variables significantly associated with patient dropout, findings seem to most consistently demonstrate an inverse, albeit weak, relationship between dropout and socioeconomic status.[15,16] Wierzbicki and Pekarik's meta-analysis[3] confirmed this statistically. These authors also found that there was a significantly increased risk for dropout among minority patients and those with low levels of education. Although a few patient demographic variables have been reliably demonstrated to predict dropout, overall their clinical utility is rather limited. These global indices do not tell us much about the mitigating factors influencing the relationship between patient and therapist, how each of them thinks about the relationship, and specifically what is going wrong between them. As a number of researchers have now demonstrated empirically,[17–19] the types of interpersonal dynamics and processes that develop in the relationship between a particular patient and therapist will depend on their unique interaction.

Validity Studies

Research examining the validity of in-session alliance or process variables within dropout samples represents a small body of literature to date, and those studies that have been conducted present mixed and inconclusive results. Some studies have found that patient ratings of a variety of alliance measures at pretreatment[20] or early in treatment[21–23] significantly predicted dropout, whereas another showed no relationship between patient or therapist ratings of alliance after the first session and premature termination.[24] In contrast to their earlier findings, Tryon and Kane[25] found that therapist ratings of alliance were predictive of termination type, but patient ratings were not. The results of these dropout studies are inconsistent with the general finding that patients' assessment of the alliance, as compared with ratings by therapists and third-party observers, is the best predictor of overall outcome.[26] As mentioned above, the weak or contrasting findings in this literature may be the result of the different methods by which subjects were categorized into outcome conditions. As Wierzbicki and Pekarik[3] have recommended, careful operationalization of criteria for defining premature termination is required.

Alliance Rupture Studies

An additional body of theoretical and empirical work that has addressed the issue of problematic therapeutic relationships is the alliance rupture literature. A number of researchers have been focusing simultaneously on the elaboration of aspects of alliance strains or ruptures, approaching the phenomenon from a variety of empirical vantage points.

Initial studies were completed by Lansford and Bordin,[27] Lansford,[28] and Foreman and Marmar[17] identifying poor-alliance cases and describing the components of repair and related improvements. The work of Safran and his colleagues has involved detailed qualitative and quantitative analysis of interpersonal-experiential therapy sessions, describing distinct rupture types and the processes by which these breaches in the alliance are resolved with the therapist.[29–31] Rhodes et al.[32] have assessed subjects' retrospective reports of moments when they felt misunderstood by their therapists and how these events were either resolved or not. Interestingly, these different methodologies studied across different types of treatment have resulted in similar, although not identical, resolution models, providing some validation for the construct.

One of the methodological hurdles within this literature has been the definition and operationalization of the alliance rupture itself. Because different patient–therapist dyads play out subtly distinctive interpersonal dances, which also vary greatly in terms of intensity, their components have proven difficult to generalize and therefore to study in traditional, large-sample research designs. Two studies conducted at the Vanderbilt Project[18,19] identified cohorts of therapists who treated both good (high-change) and poor (low-change) outcome dyads and compared them with respect to interpersonal process variables as measured by the Structural Analysis of Social Behavior.[33,34] Overall, results demonstrated a significantly greater degree of hostile interpersonal interactions between patient and therapist in the poor outcome cases. A pattern of more frequent complex communications (defined as a speech utterance conveying more than one interpersonal message) was found in the poor outcome cases, although this finding was not statistically significant because of the small sample size. In the second study,[19] which examined seven therapists, each with a good and a poor outcome case, it was found that hostile therapist introjects were linked to hostile interpersonal behavior and were characteristic of poor outcome dyads. It was demonstrated that "the same therapist, using similar techniques with similar patients, nonetheless might exhibit markedly different interpersonal behaviors in low-change cases as compared to high-change cases"[18] (p. 30). These studies by Henry and colleagues[18,19] demonstrate the validity of ratings of the early therapeutic relationship in predicting differential treatment outcome, and they identify additional components of problematic alliances.

Process/Outcome Studies

To our knowledge, only two previously published studies of brief psychotherapy[35,36] have examined interpersonal process across the continuum of outcome possibilities: in other words, comparing dropout, poor outcome, and good outcome cases within the same design.

As part of the Vanderbilt I study, Hartley and Strupp[35] examined therapeutic alliance in a sample of male college students in a 25-session protocol. The subjects were divided into high outcome, low outcome, and premature termination groups depending on their status at the end of treatment. High or low outcome was determined by a composite score that included patient, therapist, and observer ratings of pre- and post-treatment assessment measures. Premature termination was defined as the completion of no more than five therapy sessions. These authors were not able to statistically predict premature termination on the basis of observer ratings of alliance; however, they noticed different patterns of alliance development among the three conditions. Specifically, the mean alliance scores for the dropout group increased in later sessions compared with the two completed-treatment groups, which showed a decrease in mean ratings. The dropout patients were observed "to be slightly less involved in the therapy,"[35] (p. 31) which may have served to increase the therapist's level of engagement in the process and accounted for the increase in the mean alliance rating for this condition. Hartley and

Strupp note that the small sample of 6 dropout subjects may have accounted for the nonsignificant findings, as well as confounding "external" reasons why subjects terminated therapy prematurely.

The second study[36] was part of the Vanderbilt II project, which examined therapist effectiveness before, during, and after psychodynamic training. Najavits and Strupp[36] included patient "length of stay" in treatment as an outcome variable, in addition to a composite index of patient symptom change. This study looked at a much larger sample of outpatient psychotherapy subjects (80 patients and 16 therapists) and found that 25% of the correlations between length of stay and in-session ratings of therapist behavior were significant, compared with only 6% of the correlations between outcome (the composite index) and therapist in-session behavior. The authors also found that therapists defined as "more effective" demonstrated more positive behaviors in session, such as warmth, understanding, and helping, and showed fewer negative behaviors, such as belittling, ignoring, and attacking, compared with the "less effective" group. Furthermore, more effective therapists had no patients terminate prematurely (defined here as dropping out prior to session 16), whereas a minimum of 2 of the 5 patients of the less effective therapists prematurely terminated. Thus, therapist in-session behavior was demonstrated to be a significant factor in predicting which patients prematurely dropped out of treatment.

The purpose of the current study was to examine the predictive validity of a number of early, in-session indices of therapeutic alliance and interpersonal behavior in a sample comparing two distinct types of treatment failure conditions (premature termination and poor outcome) and a good outcome condition. In order to clarify the contradictory existing research findings regarding prediction of premature termination from in-session process variables, we attempted to create a more homogeneous and valid treatment sample by employing a more detailed and specific definition of premature termination than has previously been used in the research literature. We hypothesized that with this improved definition, the dropout cases would demonstrate significantly poorer therapeutic alliance scores and significantly more problematic interpersonal behavior patterns than the poor outcome cases, which in turn would demonstrate more problematic alliances than the good outcome cases. We also asked whether patients and therapists would differ with respect to the *sensitivity* and *type* of in-session measures of alliance and interpersonal behavior that might predict overall outcome.

METHODS

Subjects

Seventy-three patients (43 women; 59%) from the Brief Psychotherapy Research Project, Beth Israel Medical Center, participated as subjects in this study. Their mean age was 40.71 years (SD = 9.36), most had obtained at least a college degree (68; 93%), most were white (66; 90%), and a majority of the patients were either single or divorced (54; 74%). After an initial intake interview, patients were randomly assigned to a therapist for 40 sessions of dynamic, cognitive-behavioral, supportive, or interpersonal-experiential treatment (see Therapists and Treatments section below).

In accordance with the project's inclusion criteria, patients were between the ages of 18 and 65 and described evidence of at least one close personal relationship. Exclusion criteria included evidence of current substance abuse; use of psychotropic medication (such as neuroleptics, antidepressants, or lithium) within the past year; a significant Axis III medical diagnosis; history of recurring psychotic or manic episodes; and history of suicidal, violent, or destructive impulse-control problems. Patients provided informed consent to the research protocol.

Diagnoses were formulated by the research team based on information collected from the Structured Clinical Interview for

DSM-III-R–I and II (SCID I[37] and SCID II[38]). Patient DSM-III-R[39] diagnoses for the sample were as follows: on Axis I, approximately two-thirds of the sample received a primary depression-related diagnosis (45; 62%), 18 (25%) received an anxiety-related diagnosis, 9 (12%) reported interpersonal problems, and 1 (1%) received an eating disorder diagnosis. Axis II diagnoses were categorized by cluster type, with the majority of subjects receiving either a cluster C diagnosis (27; 37%) or personality disorder not otherwise specified (NOS) with cluster C features (31; 42%). Three patients (4%) received a cluster A diagnosis, and 1 (1%) received a cluster B diagnosis. Eleven patients (15%) presented with no Axis II pathology.

The sample of 73 patients was divided into three groups: 1) dropout ($n = 25$), 2) completed treatment with good outcome ($n = 28$), or 3) completed treatment with poor outcome ($n = 20$). Dropouts were selected if they 1) voluntarily ended therapy within the first third of the protocol and had completed at least four sessions; 2) reported dissatisfaction with some aspect of the treatment and/or therapist and did not terminate exclusively as a result of factors beyond what is typically considered within the therapeutic frame (e.g., moved out of state because of a new job); and 3) had their therapist's acknowledgment of a problematic relationship. The 25 dropouts selected for this group completed a mean of 8.36 sessions (SD = 3.11).

Patients and therapists reported any problems or dissatisfactions with the treatment in response to an open-ended item on the Post-Session Questionnaire[40] (PSQ). Patient and therapist versions of the PSQ are included in Appendix A and are described in the Process Measures subsection below.

Within the time frame of this study (spanning approximately 3 years), 10 patients who terminated within the first third of treatment did not meet these criteria. The additional 10 dropout patients did not meet criteria for the following reasons: 1 felt much better after nine sessions and terminated because he had solved his presenting problem; 6 dropped out after only one session (1 reported this was due to "scheduling problems," and the other 5 did not state reasons); and 3 reported having to terminate because they moved out of state. The method used to classify patients as either good or poor outcome is described in the Pre- and Post-treatment Assessment subsection below.

A comparison of patient demographic information among the three treatment groups (Table 1) was conducted by using Fisher exact tests (FI) or analyses of variance. Five variables were tested: age, race, marital status, gender, and education level. There were no significant differences on any of these variables, although a trend was noted toward a greater proportion of women in the dropout group and a greater proportion of men in the poor outcome group (FI = 5.94, df = 2, $P = 0.051$).

Other analyses using the Fisher exact test showed no significant differences on DSM-III-R Axis I and II diagnostic categories across the three groups. On Axis I, the frequency of primary diagnostic categories was as follows: *good outcome:* depression, 16; anxiety, 10; V codes, 2; *poor outcome:* depression, 12; anxiety, 5; V codes, 2; eating disorder, 1; *dropout:* depression, 17; anxiety, 3; V codes, 5 (FI = 7.22, df = 6, $P = 0.30$). Subjects' primary Axis II diagnoses were as follows: *good outcome:* cluster C, 15; NOS, 9; none, 4; *poor outcome:* cluster A, 3; cluster C, 5; NOS, 10; none, 2; *dropout:* cluster B, 1; cluster C, 7; NOS, 12; none, 5 (FI = 9.03, df = 6, $P = 0.17$).

Therapists and Treatments

Forty-seven therapists (25 women, 22 men) participated in this study. There were 19 M.D.s, 12 Ph.D.s, and 17 master's-level therapists, with a mean (± SD) of 7.51 ± 8.10 years of clinical experience. The therapists' mean age was 38.01 ± 8.20 years. Overall, the average number of patients per therapist was 1.55 (range 1–5), with no more than 4 patients seen by a single therapist within any outcome group. All therapists were white, and most were married.

Differences in therapist demographic variables were not tested among the three patient

TABLE 1. Patient descriptive information compared among the three outcome groups, using the Fisher exact test (FI) or analysis of variance (*F*)

Variable	Outcome Group: Good ($n = 28$)	Poor ($n = 20$)	Dropout ($n = 25$)	df	FI or *F*
Age (mean ± SD)	40.79 ± 9.59	39.55 ± 8.81	41.80 ± 9.69	2,72	0.32
Race					
White	24	18	24		
Minority (Hispanic or Asian)	4	2	1	2	1.60
Marital status					
Single	13	12	17		
Married	10	5	4		
Divorced/separated	5	3	4	4	3.17
Gender					
Female	16	8	19		
Male	12	12	6	2	5.95*
Education					
High school	3	0	2		
College	15	13	15		
Graduate school	10	7	8	4	2.27

*$P = 0.051$.

outcome groups because of the random occurrence of therapist overlap. In other words, a number of therapists (12; 26%) treated patients who fell within more than one outcome category. As a way to understand any effect of training on outcome, dyads were divided according to training status, with a therapist's first two treatment cases in a modality defined by the research project as training cases (regardless of years of experience). Therapists met weekly for group supervision and didactic seminars, with an additional weekly individual supervision provided for training cases. In fact, no significant difference was found among outcome groups with respect to therapists' brief psychotherapy training status. The number of training cases per condition was as follows: good outcome, 9/19; poor outcome, 4/16; dropout, 9/16 (FI = 1.43, df = 2, $P = 0.49$).

As mentioned under Subjects above, patients were randomly assigned to one of five manual-based, 40-session therapies. The treatments included two types of dynamic,[41,42] cognitive-behavioral,[43] supportive,[44] and interpersonal-experiential[45] psychotherapy. All therapy sessions were videotaped.

Pre- and Post-treatment Assessment

Patients completed the Symptom Checklist-90–Revised[46] (SCL-90-R), and the 127-item version of the Inventory of Interpersonal Problems[47] (IIP-127) at pre- and post-treatment. The overall mean score of the SCL-90-R was used as a measure of general psychiatric symptomatology. For the IIP-127, the overall mean score was used to reflect the severity of interpersonal dysfunction. Both of these measures have demonstrated adequate psychometric properties and are commonly used in psychotherapy research.

Those patients who completed the 40-session protocol were classified as having either good or poor treatment outcome based on reliable change (RC) scores,[48] calculated from IIP-127 and SCL-90-R scores obtained pre- and post-treatment. These measures provided an independent classification of treatment outcome. The means and standard deviations of the two self-report indices at intake assessment for the 1) dropout, 2) poor outcome, and 3) good outcome groups, respectively, were as follows: for the IIP-127, 1) 1.04 ± 0.47, 2) 1.49 ± 0.72, 3) 1.26 ± 0.43; and for

the SCL-90-R, 1) 0.87 ± 0.51, 2) 0.96 ± 0.56, 3) 1.03 ± 0.50. A multivariate analysis of variance (MANOVA) indicated no significant difference among them ($F = 2.16$, df = 2,70, $P = 0.12$).

The RC index is a statistical approach that was used to evaluate the extent to which individual patients demonstrated change over the course of treatment. It is a method of assessing outcome that incorporates the predictive power of large-sample data with ideographic precision. Jacobson and Truax[48] identify two types of reliable clinical change based on a statistical differentiation between "recovery" (RC > 1.96) and "improvement" (change in the expected direction, but RC < 1.96). In order to increase power, cases defined as either recovered or improved in this study were classified as having good outcome. However, we used a more rigorous definition of improvement, where an RC score of > 0.5 (half a standard deviation) but < 1.96 was required. Therefore, cases were classified as poor outcome if they demonstrated change in the negative direction or if their improvement was minimal (RC $<$ 0.5). Each patient's RC index was computed by comparing the difference in scores on each instrument from pre- to post-treatment, relative to the standard error of difference (S_{DIFF}) between the two scores:

$$\mathrm{RC} = \frac{X_2 - X_1}{S_{DIFF}}$$

The S_{DIFF} was computed from the standard error of measurement (SE) derived from another, comparable sample of patients. The SE was derived from a sample of 118 patients who had completed the 40-session psychotherapy protocol and had participated in other research studies. These patients did not complete the PSQ and were therefore not included as subjects in the present study.

The RC scores from the SCL-90-R and the IIP-127 were averaged to derive a composite index. Using this method, 28 patients were classified as having good outcome and 20 as having poor outcome.

Process Measures

After each therapy session, patients and therapists independently completed equivalent versions of a post-session questionnaire[40] (PSQ; Appendix A). This questionnaire was made up of a number of different scales measuring aspects of the therapeutic alliance and interpersonal complementarity, including the Bond, Goal, and Task dimensions of the 12-item Working Alliance Inventory[49] (WAI-12; Part C on the PSQ), derived from Horvath and Greenberg's original 36-item scale;[50] Depth and Smoothness indices of the Session Evaluation Questionnaire[51] (SEQ; Part D on the PSQ); and Friendliness and Hostility subscales of the Interpersonal Adjective Scale, short form[52,53] (IAS-S; Part E on the PSQ), developed from Wiggins and colleagues' revised scale.[54] Although the IAS-S has a total of 16 items, only the patient's ratings of the therapist and the therapist's ratings of the patient were used in this study. (Patients' and therapists' ratings of themselves were not included.) The scales included in this research study were selected because they had been found to be the most predictive of ultimate outcome in pilot studies with a similar patient sample.[13,55]

On the basis of this previous research, and the high rate of missing data reported above, patients were closely monitored as to their questionnaire return rate. Prepaid envelopes were provided for patients to mail in completed forms if they were unable to stay and fill them out immediately after their sessions (they were instructed to complete the form as soon after the session as possible), and they were contacted by mail or telephone to inquire about any missing questionnaires. Also, the PSQ was described to patients at the beginning of treatment as a forum for their reactions to the therapist and the therapy program. They were encouraged to be open in their feedback and were reminded that the therapists did not have access to their PSQ responses.

A total of eight process variables, each rated by patients and therapists after every session, were included in the analyses. In order

to examine and compare the nature of the therapeutic relationship across the three treatment groups, we identified a window of six early sessions. For the dropout group, mean PSQ scores from the six sessions prior to the last meeting were calculated (for instance, if the patient dropped out at session 9, scores were collapsed across sessions 4 through 9). As a comparison, the window in the good and poor outcome groups was defined as sessions 3 through 8, for three reasons: 1) the average last session in the dropout group was session 8 (which is also consistent with the existing literature in this area, described earlier); 2) it seemed to make clinical sense to give the relationship a few sessions to become established; and 3) it also seemed reasonable to give the patients some experience with the PSQ before collecting data. There is some empirical evidence for this last point: Marziali[56] found that alliance ratings collected after the first therapy session of a time-limited protocol were less predictive of overall outcome than ratings taken a few sessions later in treatment (after session 5). There were 4 patients in the dropout group who terminated prior to session 8 (2 completed the minimum of four sessions, 1 terminated after session 5, and 1 terminated after session 6). For these cases, the unavailable sessions were treated as missing data.

RESULTS

Discriminant Validity of the Self-Report Measures

A MANOVA comparing the three treatment groups (dropout, good outcome, and poor outcome) was conducted with the eight relationship variables (WAI-12: Bond, Goal, Task, Total; IAS-S: Friendliness, Hostility; and SEQ: Depth, Smoothness), for each set of patient and therapist self-report ratings (reported in Tables 2 and 3, respectively).

Patient Ratings: Overall, there was a significant difference in ratings of alliance and interpersonal behavior from the patient's perspective among the three outcome groups ($F = 11.29$, df = 2,68, $P < 0.001$). Specific contrasts indicated that the dropout group was significantly differentiated from both the good outcome group ($F = 21.48$, df = 1,68, $P < 0.001$) and the poor outcome group ($F = 10.53$, df = 1,68, $P < 0.01$). However, there was no difference between good and poor outcome groups.

Univariate tests (Table 2) demonstrated that each of the WAI-12 Bond, Goal, Task, and Total scores were significantly different among the three outcome groups, with dropout patients consistently rating the lowest alliance scores, poor outcome patients rating moderate scores, and good outcome patients rating the highest scores. On the IAS-S, patients' ratings of Therapist Friendliness were also significantly different among the groups, with therapists in the dropout dyads being rated as the least friendly, therapists in the poor outcome dyads rated as moderately friendly, and therapists in the good outcome cases having the highest levels of patient-rated friendliness. Patients' ratings of Therapist Hostility did not distinguish outcome groups. Finally, it was found that the Depth factor of the SEQ differentiated the three outcome groups, with good outcome patients reporting the highest Depth scores across sessions, and dropout patients the lowest scores. The Smoothness factor was not significantly different among the groups.

Therapist Ratings: Similar to the analysis of patient-rated variables, there was a significant overall difference of alliance and interpersonal behavior measures among the three outcome groups from the therapist perspective ($F = 6.76$, df = 2,70, $P < 0.01$). Specific contrasts also demonstrated a significant difference between the good outcome and dropout groups ($F = 13.49$, df = 1,70, $P < 0.001$) and no difference between good and poor outcome groups. The difference between dropout and poor outcome groups did not quite reach significance ($F = 2.12$, df = 1,70, $P < 0.10$).

As with the patient ratings, univariate analyses (Table 3) indicated that each of the three WAI-12 factor scores and the Total score

were significantly different among the three outcome groups: Bond, Goal, and Task factors and Total score. Mean scores for the three groups fell in the expected direction, similar to the patient scores. The pattern of results from analyses of therapists' ratings on the IAS-S and the SEQ factors were reversed to those found with patients' ratings. Specifically, therapists' rating of Patient Friendliness was not significant, whereas Patient Hostility was: patients in the dropout dyads were rated by therapists as being the most hostile, patients in the poor outcome dyads as being moderately hostile, and those in the good outcome condition as being least hostile. With the SEQ, the Smoothness factor distinguished among the three outcome groups, with the good outcome group showing the greatest degree of Smoothness and the dropout group the least. There was no significant difference on the Depth factor.

TABLE 2. Multivariate analysis of variance comparing patient self-report Post-Session Questionnaire variable scores (mean ± SD) among good and poor outcome completers and dropouts

Measure	Outcome Group			Univariate
	Good ($n = 28$)	Poor ($n = 20$)	Dropout ($n = 25$)	F (df = 2,68)
WAI-12				
Total	5.21 ± 0.69	4.98 ± 0.80	4.27 ± 0.85	9.97***
Bond	5.44 ± 0.79	5.10 ± 0.80	4.42 ± 0.86	10.13***
Goal	5.09 ± 0.80	5.04 ± 0.88	4.29 ± 0.94	6.19**
Task	5.10 ± 0.71	4.80 ± 1.08	4.00 ± 1.08	8.88***
IAS-S: Therapist				
Friendliness	11.00 ± 1.63	10.77 ± 1.74	9.41 ± 2.15	5.20**
Hostility	3.06 ± 1.11	3.44 ± 1.37	3.58 ± 1.57	1.04
SEQ				
Smoothness	4.16 ± 0.96	3.95 ± 0.49	4.30 ± 1.06	0.81
Depth	5.26 ± 0.80	4.95 ± 0.70	4.61 ± 0.96	3.83*

Note: WAI-12 = Working Alliance Inventory;[49] IAS-S = Interpersonal Adjective Scale;[53] SEQ = Session Evaluation Questionnaire.[51]
*$P < 0.05$; **$P < 0.01$; ***$P < 0.001$.

TABLE 3. Multivariate analysis of variance comparing therapist self-report Post-Session Questionnaire variable scores (mean ± SD) among good and poor outcome completers and dropouts

Measure	Outcome Group				Univariate
	Good ($n = 28$)	Poor (n = 20)	Dropout ($n = 25$)	df	F
WAI-12					
Total	4.89 ± 0.58	4.59 ± 0.80	4.01 ± 0.96	2,70	8.46***
Bond	4.91 ± 0.62	4.56 ± 0.87	4.06 ± 0.94	2,70	7.33***
Goal	4.96 ± 0.60	4.69 ± 0.82	4.10 ± 0.97	2,70	7.81***
Task	4.80 ± 0.61	4.53 ± 0.95	3.85 ± 1.10	2,70	7.68***
IAS-S: Patient					
Friendliness	9.22 ± 1.55	8.38 ± 1.72	8.24 ± 2.18	2,70	2.24
Hostility	4.64 ± 1.65	5.19 ± 1.43	5.79 ± 1.95	2,70	3.05*
SEQ					
Smoothness	4.18 ± 0.45	4.00 ± 0.57	3.71 ± 0.48	2,70	5.98**
Depth	4.85 ± 0.49	4.76 ± 0.65	4.47 ± 0.73	2,47	2.67

Note: WAI-12 = Working Alliance Inventory;[49] IAS-S= Interpersonal Adjective Scale;[53] SEQ = Session Evaluation Questionnaire.[51]
*$P < 0.05$; **$P < 0.01$; ***$P < 0.001$.

Post Hoc Analysis

Given the near-significant finding of a gender difference among the outcome groups, a post hoc MANOVA was conducted comparing the eight process variables between male and female patients. There was no significant difference overall.

DISCUSSION

The results of this study indicate that a number of alliance and interpersonal behavior variables measured from patient and therapist perspectives were predictive of treatment outcome and may be useful in the early identification of patients at risk for dropout or poor outcome. The variables that significantly discriminated the three outcome groups in this study included the Total and factor scores of the WAI-12 (rated from both patient and therapist perspectives); the IAS-S (therapist ratings of Patient Hostility and patient ratings of Therapist Friendliness); and the SEQ (therapist-rated Smoothness and patient-rated Depth). Overall, patient ratings significantly distinguished the dropout and good outcome groups and the dropout and poor outcome groups, but they did not discriminate the good from the poor outcome group. In comparison, therapists' ratings distinguished the extreme groups (the dropouts from the good outcome cases), but ratings of poor outcome subjects were not significantly different from those of either of the other two groups. This type of session-by-session monitoring of specific alliance and interpersonal patterns in time-limited psychotherapy—the so-called nonspecific factors of therapy—was demonstrated to be a predictive link to the overall evaluation of treatment progress and may be particularly crucial in the early phase of therapy when the foundation of the therapeutic relationship is being established.

As expected, the therapeutic alliance scores (on WAI-12) of the dropout group were significantly worse than those of the good outcome group, with poor outcome cases falling in between the two. This was consistent for both therapist and patient ratings, although patients' ratings were demonstrated to be more sensitive in discriminating dropout from both good and poor outcome cases. These general findings are consistent with the literature, which has shown the patients' assessments of alliance early in treatment to generally be the best predictors of outcome.[26]

Results of this current research suggest the case may not simply be that patients are better subjects for rating the therapeutic relationship than therapists, but that patients and therapists pay attention to different aspects of the treatment process. For example, with the IAS-S and SEQ, opposite factors were found to significantly discriminate the outcome groups: for therapists, the Patient Hostility and Smoothness scores discriminated groups; for patients, the Therapist Friendliness and Depth scores were significant. The IAS-S ratings fell in the expected direction, consistent with alliance scores, with the most hostile patients and less friendly therapists found in the dropout group. More specifically, therapists rated patients in the dropout group as being significantly more hostile than good outcome patients, and the poor outcome group scores fell somewhere in the middle. Patients, in contrast, rated the therapists in the good outcome group as significantly friendlier than therapists in the dropout group, with poor outcome scores on this variable falling in between. The items of the Friendliness and Hostility subscales, although typically conceptualized as poles of a single "affiliation" axis, are written as separate items on the questionnaire and, in fact, seem to be pulling for distinctive phenomena occurring between patients and therapists: high Friendliness is not equivalent to low Hostility, and vice versa.

A similar pattern of opposite variables being statistically significant from patient and therapist perspectives was found with the SEQ, where patient ratings of Depth were significantly different among outcome groups (the good outcome group had the highest scores and the dropout group had the lowest),

compared with therapist ratings of Smoothness, which distinguished the groups (the good outcome group had the highest ratings, the dropout group the lowest). In other words, patients appear to value sessions that have greater Depth (sessions of good outcome cases were rated as "deep," "valuable," "full," "special"), and therapists place more importance on Smoothness, valuing sessions that are less rough (sessions of good outcome cases were defined as "smooth," "easy," and "pleasant"). One possible reason why the Smoothness dimension was predictive for therapists may have something to do with the format of supervision: therapists show their videotaped sessions to their colleagues in the weekly group supervision conferences, which have a strong evaluative component, emphasizing adherence to manuals. Therapists may be focused on producing sessions that clearly and coherently demonstrate the treatment model (Smoothness) and on fitting the material into their agenda rather than responding more spontaneously to what the patient brings into the room each week. These results may be an artifact of conducting short-term, manualized psychotherapies. Additionally, it would be interesting to compare therapist and patient ratings on the PSQ between sessions that are taped and sessions that are not taped to see whether this type of supervision had an effect.

With respect to patient demographic information, two findings contradicted those of previous studies in the dropout literature: 1) the significantly higher number of minority patients in the good outcome group and 2) the finding of no difference with respect to educational status among groups. This sample comprised a highly educated, mostly white group of patients, and the restricted range of these two variables likely affected the results. Including the interaction of demographic categories (all minority patients in this study were highly educated) or weighted variables (education may be more important than racial status) in future research of this kind may produce more meaningful items for comparison among outcome groups. With a much larger and more varied sample, interactions of demographic and diagnostic variables could be tested for effect size and statistical significance.

The nearly significant difference in gender across outcome groups was an unexpected result. In this sample, women were more likely to have either good overall outcome or to drop out of therapy, whereas men were more likely to remain in dyads with either good or poor overall outcome. This result is consistent with some theoretical literatures indicating that females are generally more "object related" than males and may therefore be more attuned to relational cues.[57,58] The women in the present study may have been more sensitive in assessing the quality of the interpersonal match and less likely to remain in a treatment that would result in poor overall outcome, while the men tended to see the therapy through to completion regardless of the quality of the relationship. In a post hoc comparison, no significant differences were found between alliance and interpersonal behavior ratings of men and women in this study, suggesting that it was not the quality of alliance per se but rather its subjective meaning that may have accounted for the skewed distribution of genders across outcome groups. Although the sample size of the present study limits additional comparisons, such as matching patients and therapists by gender, this finding indicates an area for further research.

The next step in the validation of this method will, of course, have to be its application to a new treatment sample. At present, the findings may serve as a preliminary step toward the early, systematic identification of psychotherapy patients who present as being at risk for treatment failure. It is hoped that this type of ongoing assessment of treatment process will help to inform therapists regarding specific intervention choices and ultimately improve the quality of treatment provided.

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APPENDIX A. Patient and Therapist Post-Session Questionnaire (PSQ)

BRIEF PSYCHOTHERAPY RESEARCH PROJECT
BETH ISRAEL MEDICAL CENTER, NEW YORK, NY 10003

PATIENT POST-SESSION QUESTIONNAIRE

Complete immediately after session. Please answer all questions.

Your number_____Your therapist's initials_____Session number_____Date of session_____

PART A

1. Please rate how helpful or hindering to you this session was overall by circling the appropriate number below.

1	2	3	4	5	6	7	8	9
Extremely hindering				Neutral			Extremely helpful	

2. Please rate to what extent you feel that the problems you had at the beginning of therapy are resolved.

1	2	3	4	5	6	7	8	9
Not at all				Moderately			Completely	

PART B

1. Did you experience any problem or tension in your relationship with your therapist during the session? Yes No
2. If so, about where in the session did this problem begin? Beginning Middle End
3. Please rate the highest degree of tension you felt during the session as a result of this problem.

1	2	3	4	5
Low		Moderate		High

4. Please describe the problem:

5. To what extent was this problem addressed in this session?

1	2	3	4	5
Not at all		Somewhat		Very much

6. To what degree do you feel this problem was resolved by the end of the session?

1	2	3	4	5
Not at all		Moderately		Completely

PART C: The following items reflect your working relationship with your therapist based on your most recent session. Please rate each item by circling the appropriate number in terms of how you felt about this session.

	Never			Sometimes			Always
1. My therapist and I agreed about the things I need to do in therapy to help improve my situation.	1	2	3	4	5	6	7
2. What we are doing in therapy gave me new ways of looking at my problem.	1	2	3	4	5	6	7
3. I believed that my therapist likes me.	1	2	3	4	5	6	7
4. My therapist did not understand what I am trying to accomplish in therapy.	1	2	3	4	5	6	7
5. I was confident in my therapist's ability to help me.	1	2	3	4	5	6	7
6. My therapist and I worked towards mutually agreed-upon goals.	1	2	3	4	5	6	7

APPENDIX A. Patient and Therapist Post-Session Questionnaire (PSQ) *(continued)*

BRIEF PSYCHOTHERAPY RESEARCH PROJECT
BETH ISRAEL MEDICAL CENTER, NEW YORK, NY 10003

PATIENT POST-SESSION QUESTIONNAIRE

	Never			Sometimes			Always
7. I felt that my therapist appreciates me.	1	2	3	4	5	6	7
8. We agreed on what is important for me to work on.	1	2	3	4	5	6	7
9. My therapist and I seemed to trust one another.	1	2	3	4	5	6	7
10. My therapist and I seemed to have different ideas on what my problems are.	1	2	3	4	5	6	7
11. We had a good understanding of the kind of changes that would be good for me.	1	2	3	4	5	6	7
12. I believed the way we were working with my problem was correct.	1	2	3	4	5	6	7

PART D: Please circle the appropriate number to show how you feel about this session. **This session was:**

Bad	1	2	3	4	5	6	7	Good
Safe	1	2	3	4	5	6	7	Dangerous
Difficult	1	2	3	4	5	6	7	Easy
Valuable	1	2	3	4	5	6	7	Worthless
Shallow	1	2	3	4	5	6	7	Deep
Relaxed	1	2	3	4	5	6	7	Tense
Unpleasant	1	2	3	4	5	6	7	Pleasant
Full	1	2	3	4	5	6	7	Empty
Weak	1	2	3	4	5	6	7	Powerful
Special	1	2	3	4	5	6	7	Ordinary
Rough	1	2	3	4	5	6	7	Smooth
Comfortable	1	2	3	4	5	6	7	Uncomfortable

PART E: Please rate how well each of the following sets of four adjectives, taken all together, describes **YOUR THERAPIST** in the session just completed.

	Not at all						**Very much**
ASSERTIVE–FORCEFUL–PERSISTENT–INDUSTRIOUS	1	2	3	4	5	6	7
TRICKY–BOASTFUL–CONCEITED–CRAFTY	1	2	3	4	5	6	7
UNSOCIABLE–INTROVERTED–DISTANT–SHY	1	2	3	4	5	6	7
MEEK–INCONSISTENT–UNPRODUCTIVE–UNAUTHORITATIVE	1	2	3	4	5	6	7
UNDECEPTIVE–UNARGUMENTATIVE–NONEGOTISTICAL–UNDEVIOUS	1	2	3	4	5	6	7
KIND–TENDER–FORGIVING–COOPERATIVE	1	2	3	4	5	6	7
COLDHEARTED–IMPOLITE–UNSYMPATHETIC–UNCORDIAL	1	2	3	4	5	6	7
FRIENDLY–OUTGOING–CHEERFUL–APPROACHABLE	1	2	3	4	5	6	7

(continued)

APPENDIX A. Patient and Therapist Post-Session Questionnaire (PSQ) *(continued)*

PSYCHOTHERAPY RESEARCH PROJECT
BETH ISRAEL MEDICAL CENTER, NEW YORK, NY 10003

THERAPIST POST-SESSION QUESTIONNAIRE

Complete immediately after session. Please answer all questions.

Your patient's initials_____Your initials_____Session number_____Date of session_____

PART A

1. Please rate how helpful or hindering to your patient this session was overall by circling the appropriate number below.

   1 2 3 4 5 6 7 8 9
   Extremely hindering — Neutral — Extremely helpful

2. Please rate to what extent your patient's presenting problems are resolved.

   1 2 3 4 5 6 7 8 9
   Not at all — Moderately — Completely

PART B

1. Did you experience any problem or tension in your relationship with your patient during the session? Yes No
2. If so, about where in the session did this problem begin? Beginning Middle End
3. Please rate the highest degree of tension you felt during the session as a result of this problem

   1 2 3 4 5
   Low — Moderate — High

4. Please describe the problem:

5. To what extent was this problem addressed in this session?

   1 2 3 4 5
   Not at all — Somewhat — Very much

6. To what degree do you feel this problem was resolved by the end of the session?

   1 2 3 4 5
   Not at all — Moderately — Completely

PART C: The following items reflect your working relationship with your patient based on your most recent session. Please rate each item by circling the appropriate number in terms of how you felt about this session.

	Never			Sometimes			Always
1. My patient and I agreed about the things I need to do in therapy to help improve his/her situation.	1	2	3	4	5	6	7
2. My patient believed that what we are doing in therapy gave him/her new ways of looking at his/her problem.	1	2	3	4	5	6	7
3. My patient believed that I like him/her.	1	2	3	4	5	6	7
4. My patient believed that I did not understand what he/she is trying to accomplish in therapy.	1	2	3	4	5	6	7
5. My patient was confident in my ability to help him/her.	1	2	3	4	5	6	7
6. My patient and I worked towards mutually agreed-upon goals.	1	2	3	4	5	6	7
7. My patient felt appreciated by me.	1	2	3	4	5	6	7
8. We agreed on what is important for him/her to work on.	1	2	3	4	5	6	7

APPENDIX A. Patient and Therapist Post-Session Questionnaire (PSQ) *(continued)*

PSYCHOTHERAPY RESEARCH PROJECT
BETH ISRAEL MEDICAL CENTER, NEW YORK, NY 10003

THERAPIST POST-SESSION QUESTIONNAIRE

	Never			Sometimes			Always
9. My patient and I seemed to trust one another.	1	2	3	4	5	6	7
10. My patient and I seemed to have different ideas on what his/her problems are.	1	2	3	4	5	6	7
11. We have established a good understanding of the kind of changes that would be good for him/her.	1	2	3	4	5	6	7
12. My patient believed the way we were working with his/her problem was correct.	1	2	3	4	5	6	7

PART D: Please circle the appropriate number to show how you feel about this session. **This session was:**

Bad	1	2	3	4	5	6	7	Good
Safe	1	2	3	4	5	6	7	Dangerous
Difficult	1	2	3	4	5	6	7	Easy
Valuable	1	2	3	4	5	6	7	Worthless
Shallow	1	2	3	4	5	6	7	Deep
Relaxed	1	2	3	4	5	6	7	Tense
Unpleasant	1	2	3	4	5	6	7	Pleasant
Full	1	2	3	4	5	6	7	Empty
Weak	1	2	3	4	5	6	7	Powerful
Special	1	2	3	4	5	6	7	Ordinary
Rough	1	2	3	4	5	6	7	Smooth
Comfortable	1	2	3	4	5	6	7	Uncomfortable

PART E: Please rate how well each of the following sets of four adjectives, taken all together, describes **YOUR PATIENT** in the session just completed.

	Not at all						**Very much**
ASSERTIVE–FORCEFUL–PERSISTENT–INDUSTRIOUS	1	2	3	4	5	6	7
TRICKY–BOASTFUL–CONCEITED–CRAFTY	1	2	3	4	5	6	7
UNSOCIABLE–INTROVERTED–DISTANT–SHY	1	2	3	4	5	6	7
MEEK–INCONSISTENT–UNPRODUCTIVE–UNAUTHORITATIVE	1	2	3	4	5	6	7
UNDECEPTIVE–UNARGUMENTATIVE–NONEGOTISTICAL–UNDEVIOUS	1	2	3	4	5	6	7
KIND–TENDER–FORGIVING–COOPERATIVE	1	2	3	4	5	6	7
COLDHEARTED–IMPOLITE–UNSYMPATHETIC–UNCORDIAL	1	2	3	4	5	6	7
FRIENDLY–OUTGOING–CHEERFUL–APPROACHABLE	1	2	3	4	5	6	7

What's in a Case Formulation?

Development and Use of a Content Coding Manual

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A case formulation content coding method is described and applied to the formulation section of 56 intake evaluations randomly selected from an outpatient psychiatric clinic. The coding manual showed good reliability (mean kappa = 0.86) across content and quality categories. Although 95% of the formulations included descriptive information, only 37% addressed hypothesized predisposing life events accounting for the individual's presenting problems, and 16% included a precipitating stressor. Only 43% inferred a psychological mechanism, 2% inferred a biological mechanism, and 2% mentioned sociocultural factors. Formulations were more descriptive than inferential, more simple than complex, and moderately precise in use of language. In sum, clinicians used the formulation primarily to summarize descriptive information rather than to integrate it into a hypothesis about the causes, precipitants, and maintaining influences of an individual's problems.

(The Journal of Psychotherapy Practice and Research 1998; 7:144–153)

Psychotherapists appear to agree that case formulation skills are fundamental to providing effective treatment,[1–3] particularly for difficult-to-treat patients with comorbid mental disorders.[4] Sperry et al.[3] reflect this agreement in noting that "the ability to conceptualize and write succinct case formulations is considered basic to daily clinical practice" (p. vii). Some argue that the advent of managed care and time-limited psychotherapy has heightened the importance of case formulation skills because psychotherapists are increasingly called on to work more efficiently and to justify the value and expense of their services.[2,3,5]

In light of the consensus that case formulation skills are important, it is striking that little research has addressed the formulation skills of clinicians. Research in this area would not only provide feedback to clinicians that could aid in training, but would also serve the goal of consumer protection by ensuring that a well-thought-out understanding of the patient has been attempted and an appropriate treatment plan developed. In our review of the literature, we found only two studies that directly addressed formulation skills and none in which these skills are directly assessed. Both studies

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suggest that clinicians may not feel that they are well trained in case formulation. Surveying a small sample of psychiatry program directors and senior psychiatry residents, Fleming and Patterson[6] found that fewer that half of the programs provided guidelines for case formulation, and most respondents agreed strongly that standardized, biopsychosocially based guidelines for case formulation were needed. In an earlier survey, Ben-Aron and McCormick[7] found that 60% of psychiatry chairs and program directors believed that case formulation was important but was inadequately stressed in training.

These respondents' views are echoed by numerous writers about psychotherapy. Sperry et al.[3] recently described case formulation as a poorly defined and undertaught clinical skill. Similarly, Perry et al.[8] lament that among psychotherapy supervisors, "a comprehensive psychodynamic formulation is seldom offered and almost never incorporated into the written record" (p. 543).

One reason that case formulation skills have not been more studied may be a lack of consensus as to what a case formulation should contain and what its structure and goals should be. For example, in 1966 Seitz[9] found that a group of psychoanalysts showed little agreement in the structure and content of formulations they constructed using the same clinical material. This explanation has less currency today, however, because several systematic methods for constructing case formulations have been developed in recent years. These case formulation construction methods have been developed within several psychotherapy orientations, including psychodynamic,[10–14] cognitive-behavioral,[15] interpersonal,[16] behavioral,[17,18] and blends of orientations.[19,20] Most share three features:

1. They emphasize levels of inference that can readily be supported by a patient's statements in therapy.
2. The information they contain is based largely on clinical judgment rather than patient self-report.
3. The case formulation is compartmentalized into preset components that are addressed individually in the formulation process and then assembled into a comprehensive formulation.

A number of newer psychodynamic case formulation methods have good reliability and validity, according to Barber and Crits-Christoph's[21] review of them. Separate components of Luborsky's Core Conflictual Relationship Theme (CCRT) method, for example, had a mean weighted kappa coefficient in the range of 0.61 to 0.70. Similarly, Curtis et al.[22] report intraclass correlation coefficients ranging from 0.78 to 0.90 for components of their Plan Diagnosis Method.

Validity studies have focused on how well adherence to a case formulation predicts psychotherapy process and outcome. Crits-Christoph et al.[23] showed that the accuracy of therapist interventions, as defined by adherence to reliably constructed CCRTs, correlated positively with residual gain in psychological adjustment in a group of 43 patients undergoing psychodynamic psychotherapy. Similarly, researchers at the Mount Zion Psychotherapy Group demonstrated that formulation-consistent interventions are associated with a deeper level of experiencing in patients, as compared with interventions that do not adhere to a formulation.[24,25] A review of the behavioral and cognitive-behavioral literature by Persons and Tompkins[15] showed more equivocal findings as to the association between individualized case formulations and treatment outcome.

Although encouraging, these developments in case formulation research should be viewed in the light of certain limitations.

1. The evidence for interrater reliability in many of the studies was based on relatively small samples.
2. Most of the studies were done by developers of the methods, which may have introduced subtle biases in favor of higher reliability.

3. The content of a case formulation appears to be greatly dependent on its guiding theory. Collins and Messer[26] showed that two psychotherapy research teams using the same case formulation method, but guided by different theoretical orientations (Joseph Weiss's cognitive-analytic theory[27,28] and Fairbairnian object relations theory), independently constructed formulations that were highly reliable as measured within each research team but widely divergent in content when cross-team comparisons were made.
4. There is evidence that therapist adherence to an initial formulation in brief dynamic therapy may predict a good outcome only for individuals with interpersonal relationships that are of relatively good quality, and may predict a poor outcome for individuals with low-quality interpersonal relationships.[29] McWilliams[2] and Eells[30] discuss other caveats about case formulation.

Although the case formulation construction methods mentioned above have not led to a consensus on what the content, structure, and goals of a case formulation should be, and regardless of their limitations, they do provide guidelines that can facilitate the evaluation of case formulations.

The purpose of this study is to extend our knowledge of how clinicians use their case formulation skills in daily practice. We first present a multitheoretical system we developed to evaluate the content of written case formulations. The system was guided by the case formulation construction methods just described. Second, we demonstrate the application of the system to a set of case formulations as they appeared in intake evaluations at an outpatient mental health services clinic.

THE CFCCM

The primary purpose of the Case Formulation Content Coding Method (CFCCM) is to provide a tool for reliably and comprehensively categorizing the information that a clinician uses in conceptualizing a patient. Provisions are also included for rating the quality of the formulation. The CFCCM was initially designed to provide a means for coding and comparing the "Case Formulation" and "Treatment Goals and Plan" sections that are usually part of intake evaluations, but it can also be applied to audio-recorded case formulations, narrative case formulations specifically constructed for research purposes, or similar materials.

In constructing the CFCCM we assumed that the primary function of a case formulation is to integrate rather than summarize descriptive information about the patient. We broadly defined a case formulation as a hypothesis about the causes, precipitants, and maintaining influences of a person's psychological, interpersonal, and behavioral problems. The approach views a case formulation as a tool that can help organize complex and contradictory information about a person. Further, it can serve as a blueprint guiding treatment, as a marker for change, and as a structure facilitating the therapist's understanding of and empathy for the patient. This definition is consistent with the newer formulation models reviewed earlier, and it contrasts with the view of some that a formulation is primarily a summary of descriptive information.[31,32]

A major goal in developing the CFCCM was to make it applicable across several approaches to psychotherapy. Toward this end, we reviewed the case formulation construction methods mentioned earlier, as well as other writings on case formulation, and identified four broad categories of information that are contained in most methods:

1. Symptoms and problems.
2. Precipitating stressors or events.
3. Predisposing life events or stressors.
4. A mechanism that links the preceding categories together and offers an explanation of the precipitants and maintaining influences of the individual's problems.

Although these categories are consistent with a medical model for treating mental disorders,

they were chosen to be theoretically neutral and to provide a structure into which information generated within any theoretical perspective on formulation could be organized. We will first describe the content categories of the CFCCM, then discuss the quality ratings.

Content Categories of the CFCCM

Each content category is given one of three codes: absent, somewhat present, and clearly present. Each piece of information in the formulation is coded under only one category.

Symptoms and Problems: The first common factor is the identification of signs, symptoms, and other phenomena that may be important clinically. This category incorporates the patient's presenting symptoms and chief complaints as well as problems that may be apparent to the clinician, but not to the patient. As noted by Henry,[33] a patient's problems, which Henry defines as discrepancies between perceived and desired states of affairs, may not be readily apparent in the patient's initial self-presentation and thus could require skilled interviewing to reveal.

Precipitating Stressors: These are events that catalyze or exacerbate the person's current symptoms and problems. These events may be construed either as directly leading to the current problems or as increasing the severity of preexisting problems to a level of clinical significance. Examples: recent divorce or relationship breakup, physical injury, illness, loss of social support, and occupational setback.

Predisposing Life Events: These are traumatic events or stressors that have occurred in the person's past and that are assumed to have produced an increased vulnerability to developing symptoms. We separated these into three categories: early life (childhood and adolescence), past adulthood, and recent adulthood. We arbitrarily set a cutoff for recent adult stressors as within 2 years of the date the patient is currently being seen.

Inferred Mechanism: This factor, the most important, represents an attempt to link together and explain information in the preceding three categories. The inferred mechanism is the clinician's hypothesis of the cause of the person's current difficulties. There are three major categories under inferred mechanism: psychological, biological, and sociocultural. *Psychological* mechanisms may include a core conflict; a set of dysfunctional thoughts, beliefs, or schemas; skills or behavioral deficits; problematic aspects or traits of the self; problematic aspects of relatedness to others; defense mechanisms or coping style; and problems with affect regulation. *Biological* mechanisms refer to both genetic and acquired conditions that cause or contribute to the patient's problems. Examples include a genetic predisposition for depression, a depression associated with hypothyroidism, or a presumed constitutional predisposition toward anxiety. *Sociocultural* mechanisms are factors such as ethnicity, socioeconomic status, religious beliefs, degree of acculturation, and absence of social support. A separate mechanism was included for substance abuse or dependency, since it spans the other categories.

Other Content Categories: In addition to the four major categories just reviewed, the CFCCM includes content categories for positive treatment indicators such as strengths and adaptive skills; the clinician's treatment expectations; inferences as to the patient's overall level of adjustment; negative treatment indicators; and several categories of descriptive information such as past history of mental health care, developmental history, social or educational history, medical history, and mental status.

Quality Ratings in the CFCCM

In addition to examining the content categories listed above, the CFCCM includes quality ratings for the formulation as a whole, for each major subcategory (symptoms, predisposing life events, precipitating factors, and

mechanism), and for the complexity of the formulation, the degree of inference used, and the precision of language. (The latter three categories were adapted from Strupp.[34])

Complexity: This refers to the degree to which the formulation takes into account several facets of the person's current problems and integrates these facets into a meaningful account. This dimension was rated on a five-point scale (1 = simple, 5 = complex).

Degree of Inference: This is the extent to which the formulation goes beyond descriptive information offered by the patient. On a five-point scale (1 = descriptive, 5 = highly inferential), the formulation is rated low if it includes almost exclusively descriptive information, and it is given a higher rating as it contains increasingly more hypothetical considerations. In the development of the scale we were guided by Henry and colleagues'[35] distinction between observable phenomena about a patient and assumptions about that patient's "deep structure."

Precision of Language: This category refers to the extent to which the language used in the formulation appears tailored to a specific individual or is more generic in nature. This was rated on a five-point scale (1 = general, 5 = precise).

Aims of the Study

We conducted an exploratory investigation intended to

1. Gather initial reliability data on the CFCCM.
2. Examine whether the categories are sufficiently broad and inclusive.
3. Assess the comprehensiveness and quality of a set of representative written case formulations.

METHODS

Fifty-six intake reports at an inner-city outpatient psychiatry clinic were randomly selected from a pool of approximately 300, and their content was analyzed by using the CFCCM. Two advanced clinical psychology graduate students performed the coding on the 56 selected intake reports after independently coding and achieving consensus on a set of practice intake reports.

The interviewers were 9 psychiatry residents, 4 social workers, and 1 psychiatric nurse. The intake reports were written as part of the interviewers' typical clinical duties. Six of the 14 identified their primary orientation to psychotherapy as psychodynamic, 3 as cognitive-behavioral, 2 as a blend of psychodynamic and existential, and 1 as a blend of psychodynamic, cognitive-behavioral, and humanistic. Two did not respond to a questionnaire addressing orientation.

Patients

The 56 patients were representative of those seen in the clinic. The mean age was 40.0 years (range 20–66), and most were women ($n = 37$; 66.1%). Forty-six (82.1%) were Caucasian, and 10 (17.9%) were African American. Eighteen (32.1%) were single, 17 (30.4%) were divorced, 11 (19.6%) were married, and the remainder were separated ($n = 6$; 10.7%), widowed ($n = 2$; 3.6%), or living with a significant other ($n = 2$; 3.6%). Most were high school educated (mean years of education = 11.4, range 4–16 years) but unemployed ($n = 31$, 55.4%). Fifteen (26.8%) were employed, 8 (14.3%) were on disability, and 2 (3.6%) were retired.

RESULTS

Reliability

The mean kappa coefficient[36] for both content and quality categories of the CFCCM was 0.86, with a range from 0.67 to 1.0. In computing reliability for the content categories, we

collapsed "somewhat present" and "clearly present" into one category, leaving "not present" and "present" as the categories evaluated. Table 1 summarizes the reliability coefficients for each content category. The mean kappa for these items was 0.88. Kappa coefficients for the quality ratings of the four common factors were 0.79, 0.88, 0.83, and 0.74, respectively, for symptoms/problems, precipitating stressors, predisposing life events, and inferred mechanisms. The kappa for the ratings of the overall quality of the formulation was 0.70. Complexity, degree of inference, and precision of language had kappas of 0.82, 0.67, and 0.77, respectively. Overall, these data indicate good reliability across the CFCCM categories.

Content Categories

Table 1 summarizes the numbers and percentages of case formulations in which each formulation element was judged as somewhat present or clearly present by both coders. Descriptive information was presented in 94.6% ($n = 53$) of the formulations. The descriptive categories most frequently mentioned were symptoms/problem list (67.9%; $n = 38$), identifying information (64.3%; $n = 36$), and past psychiatric history (41.1%; $n = 23$). Only 37.5% ($n = 21$) included a predisposing life event inferred as contributing to a patient's problems. Only about one-fifth (21.4%; $n = 12$) of the formulations contained references to childhood or adolescent events, 17.9% ($n = 10$) dealt with past adult events, and 3.6% ($n = 2$) referred to recent adult events. A precipitating stressor was considered in only 16.1% ($n = 9$) of the formulations. A minority inferred a mechanism as contributing to the individual's problems: 42.9% ($n = 24$) inferred a psychological mechanism, 1.8% ($n = 1$) inferred a biological mechanism, and 1.8% inferred a social or cultural mechanism. In addition, only 21.4% ($n = 12$) inferred a positive treatment indicator. In sum, the formulation section of the intake evaluations was dominated by descriptive information with a primary focus on symptoms and past psychiatric history.

Formulation Quality Categories

In addition to assessing whether each of the four "common factors" was present, it seemed important to measure the quality of its presentation. Therefore, we developed a five-point scale, with verbal anchors as follows: 1 = not present, 2 = rudimentary presentation, 3 = adequate presentation, 4 = good presentation, and 5 = excellent presentation. As shown in Table 2, ratings are predominantly in the "not present," "rudimentary," or "adequate" categories.

Consensus global ratings of the formulations appear in Table 3. As shown, 31 of the 56 formulations (55.4%) contained no presentation of a mechanism; 16 (28.6%) contained a mechanism that was described as rudimentary, with little attention given to how the mechanism is linked to symptoms, problems, precipitating stressors, or other predisposing life events. Only 3 formulations (5.4%) were rated as having adequate to strong mechanisms.

Complexity: The mean complexity rating on the scale of 1 (simple) to 5 (complex) was 2.05 (SD = 0.94), indicating that the formulations were rated as relatively simple, with little evidence of interweaving and integrating of different types of information.

Degree of Inference: The inference ratings indicate that the formulations contained primarily descriptive information and little inference. On the scale of 1 (descriptive) to 5 (highly inferential), mean inference ratings were 1.80 (SD = 0.77). Of the 56 formulations rated, 23 (41.1%) were consensually rated at the most descriptive end of the scale; 21 (37.5%) were rated "2"; and the remaining 12 (21.4%) were rated "3."

Precision of Language: The formulations were rated as moderately precise in terms of the language used. The mean precision rating was 2.57 (SD = 0.93) on the scale of 1 (general) to 5 (precise).

TABLE 1. Reliability and percentage present for formulation content elements ($n = 56$)

Formulation Element	Somewhat Present or Clearly Present (as seen by both coders)		
	Kappa	*n*	%
Four Common Factors			
1. Symptom and problem list	0.96	38	67.9
2. Predisposing life events, traumas, stressors inferred as explanatory			
a. Childhood or adolescence	0.95	12	21.4
b. Past adult	0.84	10	17.9
c. Recent adult	0.79	2	3.6
3. Precipitating stressors	0.77	9	16.1
4.1 Inferred mechanisms: psychological			
a. Problematic aspects of the self	0.87	8	14.3
b. Problematic aspects of relatedness to others	0.95	12	21.4
c. Dysfunctional thoughts and/or beliefs (not self or others)	–	2	3.6
d. Problematic traits	0.79	2	3.6
e. Affect regulation/disregulation	0.81	5	8.9
f. Defense mechanisms	1.00	1	1.8
g. Coping style	0.85	3	5.4
h. Skills or learning deficit	–	1	1.8
i. Absence of or poor social support	0.74	5	8.9
j. Psychosocial stress from physical illness or accident	1.00	2	3.6
4.2 Inferred mechanisms: biological			
a. Genetic influences	1.00	1	1.8
b. Acquired biological influences	1.00	1	1.8
4.3 Inferred mechanisms: sociocultural	1.00	1	1.8
4.4 Alcohol or substance abuse or dependence	0.79	2	3.6
Additional Formulation Categories			
5. Descriptive information			
a. Identifying information	0.92	36	64.3
b. Referral source	0.92	7	12.5
c. Appearance	–	0	0.0
d. Diagnosis	0.75	14	25.0
e. History of present condition	0.72	16	28.6
f. Past psychiatric history	0.86	23	41.1
g. Family psychiatric history	0.85	3	5.4
h. Past medical history	0.71	6	10.7
i. Family medical history	1.00	2	3.6
j. Developmental/social history	0.86	13	23.2
k. Mental status information	0.79	2	3.6
6. Global level of adjustment	0.79	2	3.6
7. Iatrogenic factors	1.00	2	3.6
8. Positive treatment indicators			
a. Strengths or adaptive skills	0.73	3	5.4
b. Positive motivation for treatment	0.85	7	12.5
c. Adaptive aspects of self	1.00	4	7.1
d. Adaptive perceptions/views of others	1.00	1	1.8
e. Adaptive wishes, hopes, or goals	1.00	2	3.6
f. Good psychosocial support	1.00	1	1.8
9. Treatment expectations			
a. Negative treatment indicators	0.85	7	12.5
b. Prognosis	0.87	8	14.3

TABLE 2. Quality ratings

Formulation Component	Not Present		Rudimentary		Adequate		Good		Excellent	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Symptoms, problems	18	32.1	17	30.4	19	33.9	2	3.6	0	0.0
Precipitating stressors	47	83.9	3	5.4	4	7.1	1	3.6	1	1.8
Predisposing life events	35	62.5	10	17.9	9	16.1	2	1.8	0	0.0
Inferred mechanism	31	55.3	18	32.1	5	8.9	2	3.6	0	0.0

DISCUSSION

This naturalistic study has a number of limitations. First, a written case formulation may not accurately or completely depict the therapist's understanding of the patient. Second, despite the consensus that case formulation skills are important, little is known about the relationship between case formulation skill and treatment efficacy. A poorly written case formulation may not predict poor psychotherapy outcome. Further, the effectiveness of therapists with good case formulation skills may be due to skills other than those related to case formulation. Third, the case formulations we evaluated were typically dictated after a single intake session with the patient. This may not have provided enough time for an adequate database to be collected. Fourth, the clinicians may not have used the case formulation skills that they have. In that sense, the study is better viewed as an investigation of representative written case formulations rather than as a clinician's best possible work.

Despite these considerations, this first study of case formulation skills in a naturalistic context showed that the CFCCM can be reliably scored and can measure an adequate range of information contained in a case formulation. The findings showed that the clinicians did not consistently use the formulation section to offer hypotheses about a patient's symptoms or to integrate previously presented descriptive information. Instead, they used the formulation primarily to summarize descriptive information. Our findings provide empirical support for surveys suggesting that case formulation is an insufficiently taught skill.[6,7]

TABLE 3. Consensus global ratings of formulation sections of intake evaluations ($N = 56$)

Rating Description	Formulations Receiving Rating	
	n	%
No presentation of a mechanism	31	55.4
Rudimentary mechanism and inadequate links to symptoms/problems, precipitating stressors, and/or more distant predisposing antecedent factors	16	28.6
Presentation of a mechanism tied at least to symptoms/problems	6	10.7
Adequate or strong mechanism tied to symptoms/problems, and either precipitating stressors or more distant predisposing antecedent factors	3	5.4
Strong mechanism clearly linked to symptoms, precipitating stressors, and predisposing antecedent factors	0	0.0

What are the implications of these findings? Three seem central:

1. There is a need for more training in formulation. The availability of newer, empirically supported case formulation models should facilitate this training.[37]
2. The relationship between case formulation and treatment outcome should be studied further. Designs for doing so have

been offered by Hayes et al.[38] and by Persons.[39] Such studies could help document the incremental validity of formulation: whether individualized formulations lead to better therapy processes and outcomes than do generic formulations or the absence of an explicit formulation. They could also advance our understanding of specific therapist skills that lead to positive treatment outcomes.

3. The relationship between formulation and treatment plans and goals deserves study. One hypothesis would be that a suitably comprehensive, complex, and objective formulation that "fits" the patient well facilitates better articulated and more attainable treatment plans and goals. Another would be that a good formulation helps the therapist anticipate and manage events that could hinder or prevent treatment success.

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Shame-Related States of Mind in Psychotherapy

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Current theory on self-conscious emotions emphasizes the importance of shame-related phenomena in psychopathology and psychotherapy. An appreciation of manifestations of shame in psychotherapy greatly deepens our ability to connect with and understand our patients' experience. The relative salience of the shame-prone patient's devalued-self or devaluing-other internalizations will have critical importance in the psychotherapy setting, guiding the types of interventions and stances that are most helpful. Knowledge of some predictable shame-related transactions involving envy, blaming, or overzealous probing can help the psychotherapist preempt mobilization of unnecessary levels of shame in treatment.

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In recent psychotherapy literature there has been a resurgence of interest in the emotion of shame. Much of this literature tends to be segregated within particular theoretical or research camps. This is unfortunate for clinicians, because a working knowledge of manifestations of shame and related defenses in the psychotherapy session invariably deepens understanding of our patients' experience and behavior. It is especially useful in work with angry, defensive, elusive patients who otherwise defy efforts to establish and maintain therapeutic alliance.

This article offers a review of some current theoretical and clinical material in order to update and sensitize psychotherapists in their work with shame-prone patients. Discussion and a clinical vignette detail the predictable clinical variation of shame-related states according to the relative salience of warded-off mental internalizations of a devalued self or a devaluing other. A brief discussion of subtypes of narcissistic personality further clarifies this bifurcation of intrapsychic structure in shame. Clinical strategies that allow the therapist to notice relevant state changes and intervene effectively with shame-prone patients are discussed. Finally, several shaming transactions often encountered in the psychotherapy setting are outlined so as to reduce our need to enact them with the patient.

States of mind are relatively coherent

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patterns of verbal and nonverbal expressions of ideas and emotions that can be reliably identified by observers.[1] The content, shifts, sequences, elaborations, and defensive maneuvers associated with these states are the raw material with which the patient communicates about and manifests a problem. Recurrent states of mind convey patterns of communication style accompanied by shifts in schematic views of self and other, generally associated with a predominant emotional experience. In the psychotherapy setting, repeated transitions from one state to another begin to reveal important patterns of feeling, perception, and interpersonal behavior.

When entering the prototypical shameful state of mind, the individual has a sense of an exposed, vulnerable, devalued self being scrutinized and found wanting in the eyes of a devaluing other. Acute shame may be experienced as a pang of secret discomfort associated with communication that explicitly or implicitly conveys themes of overall inferiority. For many patients with depressive disorders, shameful states involving globally degraded self-schemas may be central features in their psychopathology. Accompanying such states may be a sense of feeling filthy or unworthy, accompanied by urges to hide or disappear.

If manifested in the psychotherapy hour, such states of mind may appear as a profound but elusive sadness accompanied by rapid changes of topic or obscure statements that temporarily sever meaningful exploration of the issue. It will often be in these states, in which the patient experiences an implosion of self-esteem, that depressive phenomena are manifested. But the range of shame-related states is much broader.

Extremely shame-prone patients tend to suffer from persistent, oppressive appraisal processes in which all interactions (including those in the therapeutic context) are rigidly assessed in accord with the degree of perceived criticism, ridicule, judgment, or outright humiliation experienced. Like a computer application program, whether running conspicuously in the foreground or more quietly in the background at any given moment, these processes are never completely disengaged. They can be triggered into primary operation by any of a number of interpersonal events, or by internal processes such as memories, fantasies, and associations, or by reactions to internal states of arousal such as sexual excitement, rage, or exhibitionistic urges.

When phenomena are viewed consciously or unconsciously to be in substantial accordance with these appraisals, certain rigid, scripted behavioral complexes of defenses, cognitions, and emotional state transitions may emerge. For example, narcissistic patients may present signature states of mind in which shameful schemas about self and others are warded off in the form of grandiose, inflated self-regard experienced in the imagined presence of an admiring audience. This same narcissistic patient, when perceiving a lack of adequate attention or support from the psychotherapist, may experience other shame-related states, including fleeting episodes marked by painful feelings of emptiness or of being a despicable nothing.

Shame is also closely linked to volatile expressions of anger. There are shame-prone patients for whom bitter, resentful feelings of being unappreciated, insulted, mistreated, or humiliated contribute to hostile, hypervigilant states of mind. At the extremes of these presentations are narcissistic patients who readily react to perceived slights with "self-righteous rage"[2] and patients for whom shame is experienced or defended against in paranoid states in which others are seen as actively tormenting or accusing the self. For other patients, envious states or episodes of obsessive blaming of the self or others may be significantly related to defensive efforts to ward off entering into painful shame experiences. Finally, it is important to be aware that when working with patients who experience or ward off salient shame-related material, psychotherapists are apt to enter themselves into complementary states of mind in which shame-related themes predominate, providing important clues to the patient's problems.

GUILT VERSUS SHAME IN PSYCHOTHERAPY

In guilt, there is a concern about some action perceived to cause harm to another. This concern leads to regret over the guilty action and, usually, a motivation to make amends or apologize. The guilty self can be perceived as inordinately powerful because of its potential to harm others.[3] The goal in psychotherapy with a guilty patient might be to help the patient to feel less omnipotently responsible, to forgive herself for her actions, and to feel more deserving of happiness and less deserving of punishment. In shame, the person goes beyond evaluating a set of actions to making a negative evaluation of the entire self. There may be a corresponding urge to hide or to blame others. The shameful self is experienced as small, weak, and bad. The psychotherapy goals for a shame-prone patient might include helping the patient to feel whole, adequate, and essentially deserving to exist.

Patients frequently present complaining of remorseful, guilty states (e.g., "I don't know whether it's rational, but I blame myself for *X* and I feel *Y* about it and do *Z* as a result."). In this respect, guilt is both a vexation and a compelling topic. Talking about it may seem intuitively helpful to the patient, if only to the extent of confessing or getting it off one's chest so as not to confront it alone. On the other hand, a less likely presenting complaint would be: "I occasionally enter into shameful states of mind accompanied by fantasies of being filthy or even disappearing altogether. I so dread this state that I go to frantic lengths to avoid experiencing it." Even if someone were dimly aware of shame and defenses against it, it is unlikely that he would consciously enlist for therapy to analyze it, because by its very nature shame tends to be hidden.

Even a brief review of the phenomenology of shame reveals why this emotion has often been relegated to the margins of psychotherapy. The experience of shame includes states that have been described as "wordless."[4] There is imagery of scrutinizing or being the object of scrutiny. Shame is generally not experienced in well-modulated states of mind in which phenomena are clearly understood, experienced, or conveyed. Instead, shameful states are often characterized by subtle or covert discordances between verbal and nonverbal behavior. Attempts by the clinician to direct attention to such processes may be anxiously thwarted. Furthermore, object relations and ego integrity frequently suffer decompensation in acute shame. Along with this regression in defensive functioning comes a transient inability to think, upon entry into shameful states, that has been referred to as "cognitive shock."[5] Taken together, these phenomena do not augur well for the convenient exploration of shame in psychotherapy. The challenge will be to talk about something very difficult to notice or articulate, often while in a mental state that includes disruptive imagery, cognitive disorganization, and emotional dysregulation. Whereas the psychotherapy situation may inherently be a metaphor for confession in which guilt may be expressed and expiated, the sense of being exposed and vulnerable may actually lead to an intensification of shame-related issues accompanied by an avoidance of direct communication about them. In order to appreciate the importance of shame in mental phenomena, it is helpful to review some of the current thinking about shame and guilt.

TWO CURRENT VIEWS OF SHAME AND GUILT

Social/Cognitive Theorists

Social and cognitive psychologists[6] have been interested in the empirical study of "self-conscious" emotions such as pride, shame, guilt, and embarrassment. Research and thinking from this perspective view emotions as adaptive to human functioning and grounded in cognitive processes such as appraisals. Emotions can then be described in terms of social scripts comprising patterns of cognitions, affective experiences, motivations, and resulting functional behavior. This particular approach

views shame and guilt as different emotions. Guilt is seen as dysphoria or regret at an action that has harmed another. In this view, guilt is based in a tendency to empathic response, elicited by the perception of the suffering of others, that can be demonstrated as early as the second year of life.[7] Less important is the internalization of an unconscious fear of retaliation, which is so central to the psychoanalytic conceptualization of guilt.

Shame, on the other hand, is seen as related to a global and pervasive sense of the self as bad, defective, or deficient. Once mobilized, a state of shame brings a malignant focus on the self. Anticipation of such states can lead to avoidance or to striking out defensively at "accusers." According to this view, it is shame that is more harmful within the interpersonal realm. The emotion can trigger behavior that conflicts with shame's prosocial, adaptive functions (such as those that help an individual develop herself and her place in society) and can instead lead the person to cut empathic ties to others. On the other hand, guilt tends to motivate reparative, affiliative social scripts in which the guilty person reaches out to others in an effort to make amends. Guilt, although painful and unpleasant, is seen as less pathological than shame, and many of the dysfunctional attributions to guilt in the psychoanalytic literature are reinterpreted by these theorists so that the real culprit is shame, which has become fused with and misidentified as guilt.

Affect Theory

The work of Sylvan Tomkins[8,9] is influential with many modern affect theorists. Tomkins' work was in turn heavily influenced by Darwin's[10] observations about apparent hardwired emotional mechanisms in man and other animals. Tomkins specified nine innate affects, each associated with a relevant facial display. There are two positive affects (interest-excitement and enjoyment-joy), one neutral affect (surprise-startle), and six negative affects (fear-terror, distress-anguish, anger-rage, shame-humiliation, dis-smell, and disgust). Within this point of view, affects serve to direct attention to and amplify drives, producing motivation. The shame-humiliation axis is seen to have evolved as an auxiliary to the affect system.[5] Shame affect interrupts the interest or enjoyment amplifying a positive state, by producing loss of tonus in the neck, downcast and averted gaze, and blushing. Because they are evident in the infant (and across various animal species), affects are seen as separate from, although precursors to, adult emotions ("affect is biology; emotion is biography"). In the case of shame, the affect originates as a mechanism triggered by any meaning-free impediment to positive affect in the infant.

By adulthood, experience has become "coassembled" with shame affect so that any of eight types of triggering events (including loss in competition, sexual failure, betrayal, or the knowledge of secret, intimate information by others) is capable of initiating a shame experience. Nathanson[5] further specified a sequence in which, once the shame affect proper is triggered (including relevant physiological responses), there are scripted ways (the "compass of shame") in which people deal with the shameful emotions. In withdrawal, the person turns away from the triggering stimulus, by means ranging from embarrassment to pathological withdrawal and depression. The individual may accomplish avoidance of shame by calling attention to anything that brings pride or by engaging in avoidance behavior such as substance abuse. According to this view, much of narcissistic pathology can be seen as "an avoidance script for the management of shame experience"[5] (p. 19) In the attack-other mode, others may be put down in order to adjust the balance of power between self and other. In the attack-self mode, the person may deal with shame by demeaning himself in order to maintain ties to others. For affect theory, the emotions of shame and guilt (as well as emotions like shyness or discouragement) are variants of the shame affect but are experienced differently because of differing coassemblies of perceived causes and consequences. In the case

of guilt, for example, the shame affect has become coassembled with fear of reprisal or punishment.

SHAME-PRONENESS AND PSYCHOPATHOLOGY

Tangney et al.[11] used the Test of Self-Conscious Affect (TOSCA) to operationalize the construct of shame-proneness. The TOSCA is a scenario-based instrument that yields a state or situational measure of shame-proneness, encompassing characteristic affective, cognitive, and behavioral responses. Shame scores by college students on the TOSCA were significantly and positively correlated with all types of psychopathology as assessed on a variety of instruments. In particular, shame was positively correlated with the tendency to make internal, stable, and global attributions for negative events ("I did it, I always do it, and it affects everything") and was negatively associated with internal, stable, and global attributions for positive events. In this view, shame-proneness is associated with a depressogenic attributional style. On the other hand, guilt-proneness was only moderately related to psychopathology, and correlations were ascribable entirely to the shared variance between shame and guilt. This finding supported the authors' notion that shame is uniquely and particularly linked to psychopathological attributional styles in which the self is broadly devalued in connection with stressful events. Guilt per se ("shame-free guilt") is viewed as not only nonpathological, but actually quite adaptive.

In another study, Tangney and colleagues[12] found proneness to shame among college students was significantly positively correlated with indices of anger, hostility, irritability, resentment, suspiciousness, and paranoid ideation. They concluded that shame often results in feelings of anger and hostility combined with a tendency to project blame outward. Tangney[13] further emphasized the link between shame and anger by noting that shame-prone people are not only likely to experience more anger, but are more likely to manage their anger in maladaptive ways, such as acting out their particularly hostile intentions. In addition, shame-prone individuals believed that angry feelings were likely to result in negative or destructive long-term consequences. On the other hand, guilt was negatively or negligibly correlated with indices of anger and hostility. Guilt was further associated with a tendency to accept responsibility and a decreased tendency toward anger and hostility.

These findings support the clinical observation that recurrent states of mind in which shameful emotions predominate or in which patients go to maladaptive defensive lengths to ward off shame are very often at the heart of the psychopathology that brings them to treatment. Guilt and shame generally coexist. Guilt about actions may be more readily discussed, but it is shame-related states that uniquely involve negative or degraded holistic self-conceptualizations that lead to problems in functioning. A deeper understanding of these empirical findings emerges as we look at the characteristic mental internalizations that accompany states of shame.

INTRAPSYCHIC STRUCTURE IN SHAME-RELATED STATES

Shame-prone patients evidence one or more states in which there is simultaneous activation of internal mental representations or person schemas[14] corresponding to a scripted sequence in which a weak or devalued self is found to be wanting, deficient, or aberrant in the eyes of a devaluing other. For a particular patient, various states may be readily or recurrently entered, or they may be rigorously warded off at the expense of self-integration or adaptive interpersonal functioning. In either event, these states of mind are important because much psychopathology is manifested in them.

As Nathanson[15] points out, the "growing child accumulates and stores experience as an

image colored by the affect that accompanies it. This leads to the clustering of memories linked by their relationship to specific affects" (p. 32). In an adult shame-related state, the representations of devalued self and devaluing other, as internalized in mental experience, embody an accumulation of memories, conditioning events, fantasies, thoughts, beliefs, expectations, and other phenomena that have become fused with the shame affect. A person may have multiple shame-related states, and for each one the devalued-self or devaluing-other internalization may be more or less salient at a given time.

It is useful clinically to be aware of this bifurcation of mental internalizations because it helps us to notice the prevailing polarity of the patient's active internal shaming dialogue. The devalued self/devaluing other bifurcation also has profound implications for the psychotherapy process itself when defensive operations around either aspect of the shame experience become mobilized and projected onto or into the therapist (in projection and projective identification, respectively). In fact, projective defenses are so common in shame-prone populations that it is worthwhile to examine them in some detail.

In projection, the patient will falsely attribute disowned feelings, impulses, or thoughts to others. The process of projection thus holds a mirror to aspects of the self too ugly to directly own or confront. In projection proper, the recipient of the projection does not participate actively in the process. It is the patient's unconscious needs rather than any realistic qualities of the recipient that determine the relevant perception. Projection tends to be a silent process in which the recipient is often unaware that it is occurring. As a result, it is not uncommon for psychotherapists to be surprised when they learn about absurdly unrealistic projections made upon them by patients in the course of treatment.

In projective identification, on the other hand, partly split-off internal representations may be aggressively projected into another person, who in turn behaves in a manner consistent with the projected material; the disowned material as thus embodied in the behavior, feeling state, or attitude of another person remains available to the patient. In projective identification, rather than the recipient merely being seen in accord with unconscious needs of the projector, an additional incitement is enacted with the recipient in order to achieve an interpersonal outcome that is, to varying degrees, unconscious. Because projective identification is an interactive process, the psychotherapist who receives these contents will generally be aware on some level that a powerful transaction is occurring. Disowned material so projected may then become the subject of manipulation within the treatment as the patient attempts to control or modify these contents while keeping them at arm's length within the treatment relationship.

PROJECTIVE DEFENSES INVOLVING THE DEVALUED SELF

With projective identification of devalued self-schemas, the psychotherapist may be made to feel about herself as the patient feels about himself. By paying attention to shifts in her own self-evaluation, the therapist may become sensitive to ways in which she has become the spokesperson for aspects of the patient's malignant self-esteem. In his update on projective identification, for example, Goldstein[16] described a case in which a woman with "chronic feelings of inadequacy and low self-esteem" (an internalization of a devalued self frequently seen in shame-prone, depressed patients) projected her inadequacy into the therapist by systematically and unconsciously undermining and devaluing his efforts until the clinician began to doubt his own adequacy as a therapist. Feelings of weakness or deficiency are common countertransference reactions to work with patients whose shameful sense of enfeeblement is enacted projectively, causing the psychotherapist to contain a sense of inadequacy or badness.

In the case of projection proper, the thera-

pist may merely be seen by the patient in accord with perceptions consistent with a devalued self that he wards off from himself. In these cases, the patient may reveal contemptuous or devaluing attitudes toward the therapist that can profitably be tied in treatment to a disowned weak, bad, or defective self temporarily superimposed upon the psychotherapist. Because projection may be silent and rather subtle, it will be useful to be alert for hints of reactions by the patient that suggest the psychotherapist is seen as unable, incompetent, or of insufficient status to provide adequate help. When the therapist is able to tolerate these projections openly and without corresponding shameful retreat, this provides a powerful message to the patient that it is safe to bring forward and examine this internalization of a devalued, incompetent self.

PROJECTIVE DEFENSES INVOLVING THE DEVALUING OTHER

When the polarity of the treatment reveals a more salient emergence of the devaluing-other internalization, this may be a signal to slow down the treatment and to reestablish or deepen the alliance between patient and therapist. In the case of projective identification of this devaluing-other agency, the therapist may be caused to feel and behave toward the patient in accord with an internalized but partly warded-off critical, demeaning, or disapproving agency. Negative countertransference reactions with shame-prone patients often signal instances in which the therapist is pressured to accept a disapproving stance toward the patient. The psychotherapist will in this case function as a spokesperson for the patient's self-contempt. Understanding this function enables the psychotherapist to refrain from abandoning the supportive stance while reflecting and encouraging exploration of those self-critical attitudes that the patient generally turns toward himself.

When the devaluing-other contents are projected outright, the therapist may be seen by the patient as hostile or condemning, although the patient may not explicitly complain of this perception. Hints of these types of projections, in which the psychotherapist is seen to embody a criticizing agency that the patient wards off from himself, may be manifested in various distancing maneuvers or in wounded reactions to routine interventions. All other considerations being equal, supportive approaches are likely to be the most helpful to the patient when the specter of a devaluing other becomes prominent in the psychotherapy hour. A supportive stance is rooted in attitudes and behavior that convey to the patient that the psychotherapist accepts him and is on his side in the struggle to continue with painful work despite impulses to hide from or disavow what is being learned.

A brief case example illustrates some of the ways in which these aspects of shame are typically encountered clinically.

Case Example

Ms. A. is a single woman in her thirties who began psychotherapy in the aftermath of a breakup of a 5-year relationship with a boyfriend whom she described as narcissistic, immature, and unable to make a commitment to the relationship. Her internalization of a devalued, degraded self was the object of treatment in psychotherapy. She worked directly, and rather successfully, to free herself of pathogenic beliefs that she was fundamentally unlovable and unworthy of the love of any suitable man. Much of this change was accomplished by transference testing[17] in which she would ostensibly make the case that she was fundamentally unworthy and rationalize instances in which she had been mistreated. When the psychotherapist did not agree with her negative self-characterizations, the patient gained increased insight into her internalization of a devalued self and felt more freedom to act and feel as though adequate. Then she met a man in a bar who was sexually interested in her. She described him as a disreputable and sleazy individual who was lying to her and was also lying to his live-in girlfriend. At the same time, she portrayed him as someone who was attractive and the best option she had.

As she had some further dates with him, the psychotherapist began to warn her that this man was unworthy of her. Finally, Ms. A. confessed that she felt very anxious prior to the previous week's session because she feared the psychotherapist's increasing disapproval of her.

In this instance the therapist had been the recipient of the projective identification of Ms. A.'s partly warded-off disapproving, devaluing-other agency, to which the patient reacted anxiously when her dating activity with an unsuitable man did not meet with approval. During this period, there was a shift in her internal shaming dialogue as she began to feel safe enough with the therapist to begin to bring forth an internalized critical, disapproving agency through projective identification. In this state, the therapist was pressured to accept projections as a disapproving parent criticizing Ms. A.'s self-schematization as a desperate, inadequate woman. This helped the therapist to better understand (briefly become the spokesperson for) the patient's self-contempt, which was in part related to Ms. A.'s accumulated experience with her critical father. The psychotherapist remained supportive but still did not encourage the relationship, and she quickly broke it off. By termination of treatment she was seriously dating a supportive, stable man whom she later married.

SHAME IN NARCISSISTIC PERSONALITIES

Narcissistic personality disorders are seen to be linked to defenses against shame,[18] and so it is illustrative to apply this model to two subtypes of narcissistic personality disorder. Gabbard[19] has distinguished an arrogant, grandiose, interpersonally insulated subtype (oblivious subtype) from an oversensitive, easily hurt or ashamed subtype (hypervigilant subtype) within the spectrum of narcissistic personality disorder. It is important to emphasize that these subtypes specify endpoints on a theoretical spectrum and that people exhibiting either of these subtypes of the disorder are likely to display other shame-related states in which other internalizations and defenses predominate.

Oblivious Subtype and the Devalued Self

Obviously, a grandiose "not-devalued" self, admired, envied, or appreciated ("not devalued") by a "not-devaluing" audience represents the converse of the prototypical shameful self/other schematization. In this apparent caricature of warding off, the self-schema of a large, powerful self exhibitionistically taking the center of attention nicely maps the antithesis of an internalization of a small, enfeebled self hiding from scrutiny in the generic shameful state. These patients spend considerable time in states disavowing an internalized devalued self. There may be projections in various states where the psychotherapist is made to feel or is seen in accordance with the devalued-self contents normally kept at arm's length. In these episodes, self-doubts induced in the psychotherapist may offer clues to devalued-self contents notably absent in the patient's typical presentation. Horowitz[2] has also described mixed states of mind in narcissistic personalities in which there is simultaneous activation of shame, anxiety, and anger related to defenses against degraded self-schemas. These confused, angry, disparaging states may offer opportunities to delve into fears the patient has about confronting aspects of an internalization of a self organized as defective or deficient. Extrapolation may often be required to deduce and explore the existence of these selfobjects in a way the patient can tolerate.

Gabbard[19] attributes to the oblivious narcissist a "heavily armored self," often only dimly aware of the psychotherapist's existence. Existing representations of others tend to be impoverished and distorted. They fail to include rich empathic fantasies about independent others who think, feel, and function in ways beyond mirroring the self. Transference interpretations, or interventions that rely on an ability to

consider hypothesized projections onto the psychotherapist, may be met with confusion or even resentment. As the designation implies, part of the goal in treatment with "oblivious" patients is to help them apprehend, elaborate, and enrich their internalized representations of other persons in the world who are reacting realistically to acts of the self.

Hypervigilant Subtype and the Devaluing Other

Whereas oblivious narcissists may primarily fend off devalued-self schemas, the hypervigilant patient manifests a preoccupation with devaluing-other internalizations and associated appraisals. Instead of adopting a grandiose stance, in which the shameful script is turned on its head, these patients are particularly obsessed with imagined hurtful scrutiny, overattending to sources of perceived criticism or slight. They tend to neutralize their sense of being shamefully evaluated by internalizing others as tormentors who unjustly devalue the self. The psychotherapy setting will therefore be replete with instances in which the psychotherapist is accused of having mistreated the patient in various ways.

Entrance into states in which other people are seen as unfairly demeaning the self (who only wants his due) may set the stage for ready escalation of anger or rage, with a capacity for loss of self-cohesion. As the anger escalates, defenses become more primitive. With deterioration of self-integration come more problems in living and more distortions in interpreting the behavior of self and other.

These patients need support but tend not to have well-developed internalizations of a supportive other person worthy of trust. The challenge is to forge a collaboration with the patient by promoting a supportive stance even when the patient aggressively projects disapproving contents into the psychotherapist. Some of the goals of treatment with these patients are to help them reduce their preoccupation with evaluation by others and to develop a less victimized identity.

FOCUSING ATTENTION ON SHAME-RELATED STATES

Inexperienced therapists may miss shameful states altogether, either by failing to notice subtle shameful phenomena,[20] by attributing what is actually shame to guilt (or vice versa), or by not having a clear idea of the distinction. Associated with entrance into shameful states of mind may be sudden defensive shifts of topic, along with facial features of lowering of eyelids, head turned down, and gaze averted. There may be signs of discomfort, including laughter, smiling, or psychomotor agitation. Speech may become suddenly inarticulate, vague, rapid, or evasive. Be alert for references to hiding or wanting to avoid or prematurely terminate psychotherapy. The patient may become emotionally unavailable or unable to discuss certain material openly. The presentation may either be overmodulated, with excessive control or restraint of expressive behavior; undermodulated, with undercontrolled, impulsive presentations; or a mixture of both (shimmering state).[21]

Shame may be experienced or warded off by the patient and manifested to the therapist in overmodulated states in which the patient seems relatively unable to articulate his experience of the process. On the other hand, in undermodulated states, in which the patient's expressions of ideas and emotions are dysregulated, the patient will describe or manifest abrupt, even explosive shifts of emotions, including anger, rage, or sudden self-righteous accusations that may surprise the psychotherapist in their intensity. Mixed or shimmering states of shame have competing elements of defensive distancing from the psychotherapist and signs of emotional turmoil.

With experience, shame-related states may be more easily discerned, but they are not necessarily best reviewed in real time, or even during the session in which they occur. Patients are able to understand, confront, and change their most debilitating pathogenic beliefs in a state of relative psychological safety and

emotional stability.[22] Thus, it is useful to get into the habit with such patients of carefully reviewing previous sessions for shamed reactions, and to try to accomplish these reviews when the patient appears controlled and emotionally shored up. The patient will often be better able to process these issues from the relative safety of a fresh new moment in which events are reviewed without the embarrassment of the current, active self having committed the "sins" being discussed or the current, active other (as embodied in the therapist) having committed the particular slight or cruelty involved. In this way the therapist will avoid overwhelming the patient by unnecessarily provoking shaming transactions in the treatment itself.

Common Shaming Transactions in Psychotherapy

Even the most tactful work with shame-prone patients nearly inevitably leads to certain predictable, scripted transactions in psychotherapy that mobilize shame on the part of patient or psychotherapist. The danger is that when these patterns intensify, there is the potential for escalation in which the psychotherapist unwittingly fuels further shameful behavior by unconsciously identifying with the patient's devalued-self or devaluing-other internalizations. If these patterns are prepared for, there is less likelihood of acting them out to a harmful degree. The following are some of these transactions.

Envious Transactions

In envy, the patient's attention shifts to an external object both idealized and degraded.[23] The object envied may be seen as immune to the relevant shameful quality in order to ward off a devalued self in the envier. There is also a hostile component to envy in which the other is taken down a peg in order to decrease the perceived distance between self and other. The psychotherapist working with shame-prone patients must be prepared to tolerate envy by the patient and to deal with projective identification in which there is pressure to envy the patient. It is common for these patients to brag about success, money, or sexual exploits in order to test whether the psychotherapist can tolerate feeling envious without attacking or retreating from the patient.

If envy is used primarily to ward off a sense of a devalued self, an idealizing identification may prevail. For example, a comment such as: "I wish I had your bright future as a doctor" may challenge the psychotherapist to tolerate being envied, as the patient reveals a despondent self. In this case, an interpretation like: "You worry about your future" may enable the patient to discuss feelings of hopelessness without feeling so vulnerable to exposure. On the other hand, a more hostile envy is expressed in the comment: "When you go home tonight to your nice house you will forget me, while I return to an empty house and struggle to get by." In this expression of envy, the patient also reveals a projection of an unavailable, devaluing other onto the psychotherapist. An interpretation such as: "You wonder whether it is safe to open up with me" might help the patient regain a collaborative sense of the treatment.

Blaming Transactions

Blaming may be seen as an attempt to fix or change the locus of "wrongness" and is often employed as a defense against shame. Externalization is a subtype of blaming in which agents external to the self, or out of its control, are held responsible for the perceived defect or error. If we look carefully at blaming transactions, we learn the nature of the wrongness and get clues as to why it is being projected or denied. For patients who engage in compulsive blaming, there are generally states of mind associated with self-blame (which correlate with depression) and those associated with blaming others (in which other-directed anger or rage may be present). These may alternate in pendulum fashion. Narcissistic patients may have states in which blaming is mixed and highly

fluid and related to vulnerabilities of the moment.[24]

Because the psychotherapy situation easily mobilizes feelings of inadequacy and perceived moral judgment, shame-prone patients often blame or feel blamed in regard to the issue of whether they are functioning satisfactorily in treatment. They may explicitly blame themselves for failing to improve, or they may blame the psychotherapist for their lack of improvement as a defense against a devalued self seen by the patient as so defective that it is beyond help. Often there is a countertransference urge on the part of the psychotherapist to turn the tables and restore blame to the patient for what is clearly the other's "fault."

For some patients, blaming may become particularly malicious, associated with escalation to rage. In these cases, it is helpful to incorporate some anger management techniques into the treatment to help the patient disengage early in the escalation cycle; if the patient is allowed to escalate without sufficient limits, there will ultimately be more consequences to be ashamed about. One goal of psychotherapy with these types of patients is to help them appropriately localize responsibility without resorting to blaming.

Overzealous Helping Transactions

The shame-prone patient is vulnerable to feeling deflated in the course of delving too rapidly into various aspects of experience. Horowitz[2] has urged "tactful slowness" in the process of enabling narcissistic patients to apprehend painful discordances between grandiose perceptions and reality. Psychotherapists are used to paying attention to the patient's reactions in order to gauge and adjust the pace of psychotherapy. This is also true, of course, in the case of shame-prone patients, but it is complicated by the subtlety of some shame-related reactions. Undermodulated reactions, including anger or other obvious signs of dysphoria, will sometimes clearly emerge upon requests for more information or attempts by the psychotherapist to home in on a particular issue. For example, when attempting to direct a narcissistic patient's attention to a particular significant pattern of interpersonal dysfunction, the psychotherapist might be angrily accused of failing to give the patient credit for his accomplishments but always focusing on his deficits. A series of such reactions guides the therapist to slow down and work more incrementally on enabling the patient to feel supported while exploring smaller, less painful components of dysfunctional cognitions, feelings, or behavior.

Overmodulated states of shame may be more difficult to discern because the patient may avoid clear communication about them. Optimal pacing with these patients requires good working knowledge about shame and its manifestations, along with a habit of routinely exploring various shameful reactions (both implicit and explicit) within the treatment. For example, patients who have experienced severe psychological trauma and those with addiction problems are particularly prone to manifest shame in the form of indirect or subtle tests of their safety in the treatment setting.[25]

SUMMARY AND CONCLUSIONS

As the study of emotion proceeds, clinicians benefit by inheriting more sophisticated techniques to uncover hidden aspects of emotional life. Affect theorists remind us that global psychiatric descriptors like "depression" and "dysphoria" unfairly aggregate at least six different families of negative moods, glossing over fine nuances of interplay among affect, cognition, memory, imagery, and defense that we encounter clinically. With increased awareness of patterns of emotional state transitions comes the ability to notice and clarify for a shame-prone patient, for example, ways in which a hurt, stubborn, childlike self resentfully licking its wounds repetitively gives way to an angry critic ready to blame the psychotherapist for its own failures. Interpretation of this sequence might cement alliance, leading to deeper exploration of a defective, painfully

exposed self always lurking in the background of each interpersonal interaction.

Cognitive and social psychology research reminds us that the distinction between shame and guilt has been blurred; the two emotions have very different implications for adaptive functions as well as for psychopathology and psychotherapy. Knowledge of this distinction leads to a keener ability to observe and make useful interventions that accurately underscore the patient's fundamental distress. Consider, for example, the not uncommon situation in which the psychotherapy focuses on self-conscious emotions stemming from a missed psychotherapy session. A guilt-focused interpretation such as "You feel you let me down by missing our last session" might, for a primarily shame-prone patient, appear to be an accusation of wrongdoing, provoking blame at the psychotherapist for blowing a minor inconvenience out of proportion ("making mountains out of molehills"). Conversely, a shame-focused interpretation like "You feel you are a terrible person for missing our last session" might mobilize pseudo-compliance in the primarily guilty patient, who might falsely agree to this premise so as not to disappoint the psychotherapist.

Paying attention to the relative salience of devalued-self or devaluing-other projections within the psychotherapy hour will help guide the clinician to appropriate interventive strategies. All other things being equal, delving into themes about degraded self-schemas may be better tolerated by the patient when the polarity of the treatment deals with the devalued-self aspects of shame. When devaluing-other aspects prevail, it may be a signal to adopt a more supportive, less probing stance. Preparing for the inevitable scripted transactions encountered with shame-prone patients will help prevent unnecessary levels of perceived shame by the patient and keep the psychotherapy setting safer to enable deeper work. Finally, it is important to remember that work with shame-prone patients results in frequent challenges to the psychotherapist's "grandiose professional self."[26] Shame-related sensitivities in the psychotherapist are easily mobilized in work with these patients, and when we have assessed our own particular narcissistic vulnerabilities we are in a better position to clarify projections that originate from the patient.

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A Group Cognitive-Behavioral and Process-Oriented Approach to Treating the Social Impairment and Negative Symptoms Associated With Chronic Mental Illness

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Major changes in health insurance have brought challenges in managed mental health care services to the forefront. Given slim capitation margins, brief treatment with proven efficacy has become the standard. These developments have significant ramifications for the treatment of chronic mental illnesses, which often require lifelong treatment. Efficacious short-term group treatment may help fill the gap between quality of care and the ideal economic allocation of mental health care services for people with chronic mental illnesses. The present treatment outcome study was designed to determine the extent to which Interactive-Behavioral Training (IBT)—a group psychotherapy model that actively combines cognitive-behavioral and group process techniques—can provide significant gains for people who suffer from chronic and debilitating social impairment and negative symptoms.

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Social impairment is widely believed to play a major role in the pathogenesis as well as the course of chronic mental illness.[1–3] Some researchers, for example, view social dysfunction as the "most debilitating and refractory aspect of psychopathology" for the chronically mentally ill.[4] Numerous investigations have also demonstrated clear overlaps in the expression of negative symptoms (such as diminished emotional range, insufficient social drive, social withdrawal, and poverty of speech) and those symptoms that are markers for social impairment.[4,5] Moreover, social skills deficits not only seem to persist over time, but also are more resistant to treatment when they are secondary to negative symptoms.[6,7]

Behavioral and cognitive-behavioral treatment (CBT) approaches to social skills training are used extensively in treating the social impairments found in people with severe mental illness.[4,6,8–12] Many studies appear to demonstrate that by learning social cue recognition, appropriate behavioral responses, and how to generate alternative solutions to interpersonal problems, the individual can develop significantly enhanced overall social compe-

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tence,[1,2,13] which is also assumed to provide positive long-term generalizable effects. However, treatment outcome studies reveal that enhancing specific cognitive-behavioral social skills components does not necessarily lead to enhanced interpersonal relationships outside of the treatment setting.[1,6,14,15] These studies have shown that for people diagnosed with schizophrenia, the treatment effects of current CBT models of social skills training are notably inconsistent with respect to generalization and impact on relapse rates.[16–19] For example, more recent findings by Penn and Mueser[17] show that while behavioral skills may be enhanced by social skills training, improvement in symptoms and community functioning are less prominent. Moreover, many investigators have found that cognition skills training has little effect on psychiatric relapse,[16,17,20] since between 35% and 50% of community service–connected people with a chronic mental illness relapse within a year and between 68% and 85% relapse within 5 years of a psychiatric hospitalization.[21–26]

A review of the literature also reveals that negative symptoms (estimated to affect between 30% and 60% of people with chronic mental illnesses[27]) significantly interfere with social learning and thus lead to further resistance to standard cognitive-behavioral social skills training.[7,28] Unsuccessful interpersonal interactions, poor coping skills, and high relapse rates reflect the adverse impact of negative symptomatology on social functioning and its relationship to social skills learning for the chronically mentally ill. Mueser et al.,[5] for example, found that negative symptoms were highly associated with poor social functioning and quality of life in chronically mentally ill populations. Although the presence of negative symptoms in schizophrenia and schizoaffective disorders is widely accepted as a significant barrier to pharmacological and psychological treatments,[6,7,27] current cognitive-behavioral social skills training models generally do not target actively the goal of negative symptom reduction.

It then seems likely that CBT social skills training outcomes are mixed in part because current models do not adequately examine how to motivate group members so that skills learned in training can be internalized and integrated into modifiable social models, which could then be used outside of the treatment environment. The abilities to internalize social skills, interpret instances of related knowledge, and integrate new information should lead to positive long-term generalizable improvement in overall social functioning and quality of life. The establishment of social skills training treatments that focus on the active facilitation of engaged relationships among group members should create viable models of social interactions while actively targeting negative symptom reduction. Many studies show that the facilitation of group process (through means such as altruism, group cohesiveness, self-disclosure, and instillation of hope) leads to enhanced interactions and engagement among group participants. Yalom[29] also found that for people with severe and persistent mental illnesses, emergence of group process factors was followed by long-term positive effects that improved overall social functioning. Although many CBT social skills training models do not actively explore how and to what extent group process factors should be fostered, an important modification of standard social skills training models may be the active inclusion of interpersonal group process strategies to facilitate motivation for learning and interpersonal connections between group members. This approach should, in practice, reduce negative symptomatology and significantly improve social skills acquisition.

The present study assesses the efficacy of Interactive-Behavioral Training (IBT),[30] an approach to social skills training with a combined focus on cognitive-behavioral techniques (such as instruction, modeling, and behavioral rehearsal) and group process strategies. The IBT format directly facilitates therapeutic group process and uses established cognitive-behavioral strategies. The blending of cognitive-behavioral and group process interventions is therefore postulated to increase motivation for learning, improve social skills

acquisition, and enhance overall social competence. It appears, then, that IBT should improve the effectiveness of current social skills training models, inasmuch as therapeutic group process itself reduces negative symptoms by increasing motivation for social learning. Through the use of cognitive-behavioral and interpersonal group process strategies, group members may learn to participate fully and to act as vehicles for social learning by serving as clarifiers of affect, reality testers, and interpersonal behavioral and problem-solving models. Thus, the combination of cognitive-behavioral and interpersonal group process strategies[29,31] may offer the most comprehensive and dynamic social skills treatment package. The application of cognitive-behavioral social skills techniques with group process strategies may then fill the current gap in outcome research between social skills and social competence.

Preliminary data[32] comparing the efficacy of IBT with standard social skills training[33] suggest that IBT training results in positive changes in psychiatric symptoms and social functioning. Clinical observations also provide encouragement for further examination of the IBT model. The following hypotheses were tested:

1. IBT will increase the overall social competence of people with chronic schizophrenia and schizoaffective disorders.
2. IBT will improve the negative symptoms that are often associated with poor treatment outcome for people diagnosed with schizophrenia or schizoaffective disorder.
3. IBT will facilitate the emergence of those therapeutic group process factors found to enhance social competence in people with chronic schizophrenia and schizoaffective disorders.

METHODS

Subjects

Subjects were recruited from the Long Island Jewish Medical Center/Hillside Division Ambulatory Outpatient Clinic and the Adult Continuing Day Treatment Program. These sites were selected because of their high utilization rate during the recovery process for those with severe and persistent mental illnesses.

All willing patients who met the DSM-IV[3] diagnostic criteria for a schizophrenia or schizoaffective disorder were screened and evaluated by a doctoral-level clinician and experienced diagnostician. Patients with medication noncompliance as a current and clinically significant problem or with a history of alcohol/substance abuse or dependence in the preceding year were excluded. Those with a history of moderate to severe neurological impairment or mental retardation as documented in medical records were excluded, as well as those who were significantly psychiatrically unstable as defined by scores of 5 (maximum score per item = 7) or more in any of the following Positive and Negative Syndrome Scale[34] domains: conceptual disorganization, hallucinatory behavior, or unusual thought content.

After being screened and giving informed consent, 40 patients (27 men and 13 women, mean age = 33.7 years, age range 19–61) were included in the study. Twenty patients were receiving outpatient treatment from the Adult Continuing Day Treatment Program, and 20 were enrolled in the Ambulatory Outpatient Clinic. The total sample ($N = 40$) included the following diagnostic categories: paranoid schizophrenia ($n = 24$), schizoaffective ($n = 12$), undifferentiated schizophrenia ($n = 3$), and catatonic schizophrenia ($n = 1$). Mean age of illness onset was 21.56 years (SD = 9.25, range 12–36 years), and total number of hospitalizations was 3.26 (SD = 2.56, range 0–10).

Assessment

Clinical rating scales were administered to measure changes in social functioning and negative symptomatology. Each participant was rated by the same trained single-blind rater (interrater reliability = 0.92) at each assess-

ment stage. The following instruments were administered to each participant at baseline and immediately following treatment:

The *Clinical Global Impressions (CGI) scales*[35] are widely used in schizophrenia research because of their ease of administration and their validity as a measure of global functioning. The CGI-S was used at baseline to clinically assess global illness severity. The CGI-I was used to assess global clinical improvement at posttest.

The *Quality of Life Scale (QLS)*[36] is an instrument for rating the schizophrenic deficit syndrome and was developed to evaluate major areas of functioning. It is widely used and has been shown to have adequate reliability and validity. This scale has several subscales: interpersonal relations (IR), instrumental role (IN), intrapsychic foundations (IF), and common objects and activities (COA). Overall, the QLS assesses interpersonal relations and social network, occupational functioning, and role functioning. The QLS was used to assess changes in the patient's quality of life experiences over the course of the study.

The *Modified Scale for the Assessment of Negative Symptoms (SANS)*[37] is a modified scale used in the assessment of negative symptoms for clinical trials. The scale assesses the severity and duration of negative symptoms with subscales assessing the severity of affective flattening or blunting (AF), alogia (AL), avolition-apathy (AA), and asociality (AS). The SANS was used to assess changes in negative symptoms from baseline to posttreatment.

The *Behavioral Assessment Task (BAT)*[38] is a four-part videotape of analogue scenarios that has been validated with schizophrenic populations. This assessment tool addresses the accuracy of social perception, the transformations or mental processes involved in social interactions, and the behavioral responses likely to occur. Based on standardization trials, this assessment tool has adequate psychometric properties and has been found to be effective in distinguishing groups with known differences in social skills.[38,39] The first two scenarios are comparable and were individually administered to all participants at baseline and posttraining. After presentation of each scenario, each participant was asked to respond to a set of nine questions regarding what she or he had viewed. Questions 1 through 4 assessed whether the participant encoded and received relevant details of the scenario. Questions 5 through 9 assessed the participant's ability to recognize that a problem existed, evaluated how problem recognition was executed, and assessed the participant's skills in defining and generating alternative solutions to the problem.

The *Global Assessment of Functioning Scale (GAF)*[3] is a 90-item scale used to assess overall psychosocial functioning and symptom level.

The *Brief Psychiatric Rating Scale (BPRS)*[40] is an 18-item scale used to assess current psychopathology including thought disorder, delusions, and hallucinations.

The *Positive and Negative Syndrome Scale for Schizophrenia (PANSS)*[34] is a 30-item, four-scale instrument that measures both positive and negative symptoms along with general illness severity. This instrument has been shown to have reliability as well as criterion-related and predictive validity. In the current study, the PANSS instrument was used as a screening tool to assess for the presence of positive symptoms.

Treatment

Following the baseline assessment phase, the 20 patients from each of the two sites were randomly assigned to a treatment group ($n = 10$) or a waitlist group ($n = 10$). Each of the two treatment groups followed a 16-session format, meeting for 50 minutes per session. Each group met twice per week and was led by two leaders. The group leader was required to have a minimum of 3 years' supervised IBT group trainer experience. The co-leader was a hospital clinical staff member with a minimum of 12 years of experience working with chronic mentally ill populations. Each session was videotaped,

using a camera positioned unobtrusively in the group training room.

Each IBT session[30] was divided into four stages. In the Orientation and Cognitive Networking stage, the leaders encouraged and facilitated social interactions among group members. For instance, the leader might make the following statement: "Ruth, your comments seem to suggest that you understand the issue John is raising. What might John be feeling about the issue?" This stage began as a 10- to 15-minute segment. However, with the emergence of group process factors (such as altruism and self-disclosure), this stage averaged 3 to 5 minutes by session 10.

During the Warm-up and Sharing phase, the second stage of the training model, there was a strong emphasis on self-disclosure. It was during this 15-minute phase that members were encouraged to share concerns or personal issues with other group participants. During the 20-minute Enactment phase of the group, the individual enacted an interpersonal situation that included group members as active participants. This stage involved five basic elements: 1) selecting a participant, 2) assigning an auxiliary, 3) using an interpersonal group process technique, 4) directing an encounter, and 5) using cognitive-behavioral strategies. An average of three enactments per group session became typical over the course of treatment.

In order to foster the therapeutic group process factors typically associated with positive treatment outcome (such as cohesion, universality, and learning/modeling),[29] we included the following interpersonal group process techniques[31] among those used during the Enactment phase: future projection, role reversal, and doubling.

With doubling, the participant (protagonist) is encouraged to express feelings evoked by an interpersonal situation. A group member is then asked to represent and establish identity with the protagonist by verbalizing what the group member feels that the protagonist is feeling. The group member confirms the accuracy of his or her feeling statements by "checking in" with the protagonist. In multiple doubling, more than one group participant is asked to identify with the protagonist. This creates multiple perspectives for both the protagonist and other group members and provides the protagonist with the feeling of being understood and supported.

The "role reversal" technique provides both role clarification and reality testing as the protagonist is asked to "step into the other's shoes." Finally, with "future projection," the protagonist acts out how she wants her future to shape itself by selecting a point in time, a place, and the people with whom she expects to be involved at that time.

Following the use of group process techniques, the individual was given affective, behavioral, and cognitive feedback. He or she, along with other group participants, gained practice in cognitive-behavioral strategies including modeling and behavioral rehearsal. The group also generated alternative solutions to the interpersonal problem presented, and the individual then role-played or enacted the new response. Overall, techniques introduced in the Enactment stage offered group members skills training in social cue recognition, empathy, self-awareness, reality testing, creation of boundaries, insight, self-efficacy, interpersonal behavioral, and problem solving.

Finally, the Affirmation stage took place during the last 5 minutes of the group. The leaders and group members specifically identified and verbally reinforced socially competent behaviors displayed by individual members in the group. For example, self-disclosure was seen as a positive step toward social relatedness and involvement, and it was reinforced as follows: "Mary, many of the members seemed to relate to what you were feeling about taking medication. Sharing your personal feelings helped other group members to open up and share their feelings as well." This phase also allowed for positive emotional closure of each session, which itself further enhanced group process (by fostering universality and cohesiveness) and increased motivation for participation.

RESULTS

Outcome Measures

1. *IBT will increase the overall social competence of people with chronic schizophrenia and schizoaffective disorders.* Enhanced social functioning was defined as overall clinical improvement in CGI, GAF, BPRS, BAT, and QLS scores. Six of the 40 participants did not complete the study and were therefore excluded from the following analysis. At baseline, the entire sample showed notable functional impairment in overall social functioning. The means and standard deviations of all clinical scales for the sample are given in Table 1. Study participants scored in the moderately impaired range of social functioning as measured by the QLS (mean = 52.45) and BAT (mean = 7.77). Because the screening process excluded those in the severe range of psychopathology, BPRS mean score (34.77) was in the mild to moderate range. Assessment of global functioning, as measured by the GAF (mean = 43.91) and CGI (mean = 3.82), showed moderate overall functional impairment for all participants.

Posttreatment scores revealed that global functioning, as measured by the GAF (mean = 45.70), showed significant improvement for the treatment groups ($F = 4.32$, df = 1,31, $P = 0.046$). As shown in Table 1, there was a significant increase (treatment groups mean score at baseline = 43.88; posttreatment mean = 50.83) in overall psychosocial and occupational functioning. The waitlist group showed a nonsignificant increase on the same measure (mean score = 43.94 at baseline vs. 45.13 at posttreatment assessment).

Scores on the BAT ($F = 3.01$, df = 1,27, $P = 0.094$), CGI ($F = 2.29$, df = 1,31, $P = 0.140$), QLS ($F = 2.02$, df = 1,31, $P = 0.166$), and BPRS ($F = 3.39$, df = 1,31, $P = 0.075$) were not significantly different following treatment. However, posttreatment scores on all measures showed overall improvement for the treatment groups, suggestive of a positive trend toward enhanced social functioning. In addition, although the difference was not statistically significant, the QLS-IR, a subscale score

TABLE 1. Pre and post scores (mean ± SD) for all clinical scales

Scale/Subscale	Treatment		Wait List	
	Pre	Post	Pre	Post
Behavioral Assessment Task (BAT)[a]	8.00 ± 2.90	8.69 ± 3.01	7.54 ± 3.36	6.08 ± 3.28
Global Assessment of Functioning (GAF)[b]	43.88 ± 10.9	50.83 ± 11.6	43.94 ± 8.58	45.13 ± 9.36
Clinical Global Impressions (CGI)[c]	3.77 ± 0.831	3.88 ± 1.05	3.88 ± 1.03	4.44 ± 0.892
Qualify of Life Scale (QLS)[d]	54.14 ± 21.08	60.50 ± 22.84	50.77 ± 23.55	50.83 ± 18.53
Interpersonal Relations subscale (QLS-IR)[e]	2.62 ± 1.24	3.10 ± 1.39	2.47 ± 1.49	2.35 ± 1.30
Scale for the Assessment of Negative Symptoms (SANS)[f]	46.41 ± 11.91	42.53 ± 11.07	51.19 ± 13.11	50.56 ± 12.25
Asociality subscale (SANS-AS)[g]	2.68 ± 0.972	2.13 ± 0.839	2.58 ± 0.867	2.55 ± 0.812
Brief Psychiatric Rating Scale (BPRS)[h]	32.41 ± 9.06	29.88 ± 9.45	37.13 ± 10.97	37.06 ± 11.25

[a]Total possible score = 18. Increase in total score = improved social competence.
[b]Total possible score = 90. Increase in total score = improved psychosocial functioning and symptom level.
[c]Total possible score = 7 on CGI-S (severity) and 7 on CGI-I (improvement). Decrease in CGI-I total score = improvement in global illness severity.
[d]Total possible score = 126. Increase in total score = improved interpersonal and instrumental role functioning, intrapsychic foundations, and common objects and activities.
[e]Total average subscale score = 5. Increase in subscale score = improved interpersonal relations.
[f]Total possible score = 100. Decrease in total score = reduction in negative symptoms including affective flattening or blunting, alogia, avolition/apathy, and asociality.
[g]Total average subscale score = 5. Decrease in subscale score = improved sociality.
[h]Total possible score = 126. Decrease in total score = improvement in psychopathology including thought disorder, hallucinations, and delusions.

used as an assessment of the quality of interpersonal relationships, demonstrated improvement for the treatment groups (baseline mean = 2.62, posttreatment mean = 3.10; F = 3.49, df = 1,31, P = 0.071).

2. *IBT will improve the negative symptoms that are often associated with poor treatment outcome for people diagnosed with schizophrenia or schizoaffective disorder.* Improvement in negative symptoms was defined as an overall reduction in total SANS and subscale scores. At baseline, SANS (mean = 49.80) scores for both groups were in the moderately severe average range. Following training, the treatment groups showed a nonsignificant decrease in total SANS score (baseline mean = 46.41; posttreatment mean = 42.53). There was also a nonsignificant decline in the asociality subscale score (SANS-AS) for the treatment group (F = 3.37, df = 1,31, P = 0.076). The waitlist group showed little overall and subscale score change.

Process Measure

3. *IBT will facilitate the emergence of those therapeutic group process factors found to enhance social competence in people with chronic schizophrenia and schizoaffective disorders.* On the basis of operationally defined ratings of each videotaped session (interrater reliability = 0.90), raters coded whether operationally defined verbal and nonverbal expressions of established therapeutic group process factors occurred (Table 2): both treatment groups were successful in facilitating the emergence of numerous group process factors. The following group process factors showed the largest absolute scores over the course of treatment for the Adult Day Treatment Program group: acceptance/cohesion (26), universality (58), guidance (33), vicarious learning and modeling (31), self-disclosure (91), and the development of socializing techniques (21). The Ambulatory Outpatient Clinic group showed similar results: cohesion (19), universality (38), guidance (26), vicarious learning and modeling (45), self-disclosure (89), and the development of socializing techniques (35). Self-understanding, catharsis, instillation of hope, corrective recapitulation of the primary family, altruism, imparting of information, and existential factors did not emerge with similar frequency, averaging 3 to 4 occurrences over the course of treatment.

DISCUSSION

The first hypothesis was that IBT would lead to an increase in overall social competence for people diagnosed with schizophrenia or schizoaffective disorders. GAF scores showed significant improvement for the treatment groups only. The treatment groups also improved across the board on all outcome measures. The significant increase in GAF scores suggests that measuring specific cognitive-behavioral components (as is typical in social skills training outcome studies) may reflect a limiting approach to addressing the dynamic process of interpersonal learning and functioning. Rather, social functioning may reflect an inclusive and interdependent assemblage of components that, combined, results in global social competence.

In testing the second hypothesis, the effects of IBT on negative symptoms were examined. Although nonsignificant, total SANS scores showed positive changes for both treatment groups. Similarly, SANS asociality subscale scores approached statistical significance for those who participated in the treatment groups (Table 1). Positive changes in SANS scores, combined with significant GAF score changes for the treatment groups, lend further credence to the proposition that a reduction in negative symptoms increases overall psychosocial and occupational functioning.

The third hypothesis allowed us to explore whether IBT facilitates the emergence of therapeutic group process factors. Both treatment groups showed cumulative occurrences of numerous therapeutic process factors. The results of this study suggest that the IBT model is a salient facilitator of many of the therapeutic

TABLE 2. Therapeutic group process factors: operational definitions

Universality: The individual verbalizes at least one sentence indicating that he or she understands the other's perspective because "it happened to them, too."[41]

Altruism: Any event, no matter how trivial, initiated by a group member that is helpful to either the leader or another group member. For example, passing a tissue or moving a chair for an enactment or role-play is viewed as an altruistic act.[41]

Acceptance/Cohesion: "Any statement or act that clearly defends the group against internal or external threat, e.g., voluntary attendance; participation; mutual help or defense of group standards."[29]

Self-disclosure: Sharing personal issues and/or problems with group members, leading to an "increase in involvement in the group."[29]

Self-understanding: "Members learn something important about themselves through feedback from others in the group."[30]

Catharsis: "This occurs when there is a release of tense emotions, either positive or negative, such as when a group member cries after disclosing something sensitive or the group roars with laughter over a shared event."[41]

Instillation of hope: "Members express optimism about their being in the group as well as optimism gained from witnessing changes in others."[26]

Development of social skills: This factor refers to the feedback available to members from this group concerning social interaction.

Vicarious learning and modeling: "A phenomenon where members benefit from observing the therapy of another patient with similar problems,"[29] often leading to experimentation with more adaptive social behavior.

Interpersonal learning: This occurs when members respond to other group members in a more constructive manner than had been previously observed in group.

Imparting of information: This occurs when members or group leaders share specific information with other group members.

Guidance: "Direct advice or suggestions from group members about how to reach a desired goal."[29]

Existential issues: "This occurs when the common bonds of inevitable death, loneliness, and suffering are shared by group members."[30]

Corrective recapitulation of the primary family: "This is the ability of a member to 'work through' the feelings established in the family of origin and come to a corrective understanding of those feelings within the group."[30]

group process factors found by researchers to be significantly instrumental in enhancing overall social functioning.[29] Because of the relatively short length of treatment,[29,31] factors such as "recapitulation of the primary family" and "existential issues" did not emerge with the same frequency. Although there is little research exploring what is "good enough" process for people with chronic mental illnesses, this study points to the IBT model as a step toward quantifying group process in a meaningful way.

In general, the data support all three hypotheses and illustrate that IBT, by its structure, may create the conditions within which social skills can be enhanced and translated to psychosocial and occupational areas. The IBT model may provide individuals with a learning prototype in which to integrate the skills learned in training into numerous social situations beyond those practiced in group sessions. Overall, these findings suggest that the IBT approach, seemingly irrespective of outpatient treatment site, promises to more succinctly and successfully address the multidimensionality of social functioning and competence and to offer an inclusive approach to the reduction of negative symptoms and the acquisition of social skills.

Future studies should evaluate the efficacy of offering IBT on a weekly basis, a treatment consistent with most insurance and managed care regulations. Recent investigations have begun to explore the roles of verbal memory, executive functioning, vigilance, and other neurocognitive deficits found in schizophrenia in social skills acquisition and social competence.[16,17,20] Once specific neurocognitive processes are adequately identified and linked to functional outcomes (such as social and occupational functioning), the IBT model, because of its inclusive and focused structure, may be useful in providing an integrated cognitive remediation and social skills training model. Lastly, and as part of investigating whether IBT treatment gains are maintained, follow-up assessments of at least 6 months posttreatment should be administered. In addition, other

cognitive-behavioral and interpersonal process strategies may be introduced to assess whether additional factors emerge, enhance factors already present, and improve generalization and relapse rates. Negative symptomatology may also be measured at intervals (such as every 4 weeks) to monitor stability over time and to further assess which group process factors may be more or less instrumental in reducing negative symptoms.

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Book Reviews

Challenges in Clinical Practice: Pharmacologic and Psychosocial Strategies

Edited by Mark H. Pollack, Michael W. Otto, and Jerrold F. Rosenbaum
New York, Guilford Press, 1996, 504 pages,
ISBN 1-57230-067-1, $55.00

Reviewed by Marijo B. Tamburrino, M.D.

Challenges in Clinical Practice addresses pharmacologic and psychosocial strategies for treatment-resistant disorders. Opening each chapter is like personally inviting the authors to sit down with you and share the wealth of their clinical wisdom and expertise. What is refreshing is the practical and very specific nature of the information presented. For example, where other books may make vague suggestions to "augment with thyroid" in refractory depressed patients, these authors give exact T_3 and T_4 dosages, with recommendations about response time and duration of augmentation after response. In discussing the strategy of combining selective serotonin reuptake inhibitors (SSRIs) and bupropion to treat refractory depression, again the authors are specific, recommending that the clinician "add bupropion in twice-daily doses of either 75 mg or 100 mg to the original SSRI." Besides being very thorough and clearly written, the book conveys a tone of compassion and respect for persons suffering from these difficult disorders.

The book is divided into five major sections: mood disorders, anxiety disorders, eating disorders, side effects of neuroleptics and antidepressants, and other disorders. The section on other disorders covers schizophrenia, substance use disorders, personality disorders, attention-deficit/hyperactivity disorder, premenstrual disorder, and refractory insomnia. If you don't find information in the text, there are generous listings of references after each chapter. Even the relatively short, 14-page chapter on management of refractory insomnia contains 64 references.

Challenges in Clinical Practice makes a significant contribution to the literature by providing so much practical information that is well organized and thoroughly researched. The discussions on antidepressant-induced side effects should be mandatory reading for every psychiatry resident and practicing psychiatrist. In a few pages, the authors succinctly outline the areas of sexual function affected by antidepressants, and they give up-to-date management recommendations. Fatigue, myoclonus, and paresthesias are just a few of the other side effects that receive careful attention.

This book presents extensive cognitive-behavioral strategies for several disorders, including major depression, social phobia, generalized anxiety disorder, panic disorder, and eating disorders. The discourse on eating disorders is sufficiently clear and detailed that after reading this chapter, one could incorporate at least some aspects of the cognitive-behavioral approach into one's treatment. The cognitive-behavioral therapy (CBT) described in this book for bulimia nervosa, for example, consists of three stages. The first stage (sessions 1–8) stresses patient education and normalizing eating patterns through the scheduling of regular meals and healthy snacks. In stage 2 (sessions 9–16), there is an emphasis on cognitive structuring, focusing on the distorted perceptions of shape and weight. Patients are taught to identify and question dysfunctional reasoning and "black-and-white thinking." Stage 3 (sessions 17–19) is designed to prevent relapses by doing exercises such as writing a list of interventions that helped in the past. It is welcome to find a book that emphasizes the importance of both psychopharmacology and psychotherapy, even if most of the psychotherapy discussions are limited to CBT. Therapists who engage in other forms of psychotherapy may be disappointed in the authors' focus on CBT to the exclusion of other valued psychotherapy approaches.

I highly recommend this book to all mental health professionals. I believe psychiatry residents and practicing psychiatrists, in

particular, would find the text and accompanying references invaluable in their day-to-day management of treatment-refractory patients.

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Legally Safe Mental Health Practice: Psycholegal Questions and Answers

By Robert H. Woody
Madison, CT, International Universities Press (Psychosocial Press), 1996, 121 pages,
ISBN 1-887841-04-0, $24.95

Reviewed by Carl Greiner, M.D.

Robert Woody, Ph.D., Sc.D, J.D., has a new book, *Legally Safe Mental Health Practice*, that is a useful and informative source for both psychiatric residents and staff. The author's background as both a therapist and an attorney provides a valuable grounding for this topic. His down-to-earth style and question-and-answer format make this book highly accessible. Most legal terms are defined, and one does not find the turgid style usually associated with legal matters. The text's organization into coherent chapters such as "Care and Negligence," "Records," and "Business Issues" allows for focused reading.

The strengths of this work are many. Practical problems are dealt with straightforwardly. For instance, the algorithm on dealing with a subpoena was useful to this reader. Specifically, the therapist's option of making a motion to quash a subpoena to protect client confidentiality is a revelation. In a similar fashion, the review of ownership of medical records and their protection would be an eye opener for most residents. One of the major values this book offers is in introducing topics where the resident's likely response would be, "I never thought of that!"

The greatest value of this book would be in aiding senior residents in their transition into practice. Woody has sound advice about procuring ongoing supervision to minimize the ongoing legal risk: "The greatest legal protection will come from having a formal supervisory relationship with a supervisor who has strong credentials and professional stature. . . . Bringing in only 'problem cases' reduces the legal protection." Although many in practice may not follow this model, he provides a point for consideration. Woody clearly acknowledges the changing environment in health care and makes a strong case for the legally sensitive issues in joining a practice. The problems of vicarious liability for others in the practice would encourage the new practitioner to take a close look at the entire group with whom she or he will be associating. The bibliography includes standard texts for further reading.

The weaknesses of his book are the flip side of its strengths. Woody offers no footnotes to support his opinions. The avuncular style that makes for easy reading leaves one with concerns about other points of view or contradictory case law. These deficiencies can be minimized by checking his observations with an attorney familiar with your jurisdiction. He can also be idiosyncratic with blanket statements regarding the academic world and what constitutes effective treatment. The comments about effective therapy can best be tracked by regular journal reading.

On balance, I would recommend this book for senior residents to aid in the transition to practice. The sections on record keeping, forensic services, and dual relationships would be valuable for all residents and staff. The book fills the niche of "what I wanted to know about the law but didn't know where to look." The book would be best used in a course format where discussion would allow participants to discern the "rough edges" in his presentation.

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Time-Managed Group Psychotherapy: Effective Clinical Applications

By K. Roy MacKenzie
Washington, DC, American Psychiatric Press, 1997, 453 pages, ISBN 0-88048-863-8, $67.50.

Reviewed by
Suzanne L. Cohen, Ed.D., C.G.P., F.A.G.P.A.

Roy MacKenzie's new book *Time-Managed Group Psychotherapy* will be most useful to those who are developing a group program as an integral part of the service delivery of mental health care. MacKenzie makes a strong argument for the necessity for all psychotherapy delivery systems to respond to the realities of limited resources. A group therapy program modeled after MacKenzie responds to those realities.

In Section I, MacKenzie reviews the current status of the behavioral health delivery system and the effectiveness of the group modality. As in his earlier book, *An Introduction to Time-Limited Group Psychotherapy,*[1] he reviews the literature and research on small-group process and therapeutic factors. This review is one of the most comprehensive and well discussed in the group therapy literature. MacKenzie develops and describes what he calls generic group psychotherapy; that is, the therapeutic contract, operations, bond, self-relatedness, and in-session impact that are present in all group therapies, regardless of theoretical orientation.

MacKenzie moves to assessment of the patient, including multimodal diagnosis, in Section II. Interpersonal diagnosis, often neglected in the standard diagnostic evaluation, is emphasized. An extremely useful interpersonal worksheet is included in the appendix. Implementation of the generic group is the subject of Section III. Here MacKenzie thoroughly describes the developmental stages of the group, what can be expected from the group, and the role of the group therapist in each stage.

Section IV, Group Models for Clinical Service Systems, is a wholly developed group therapy delivery system, beginning with a plan for a group program. MacKenzie delineates 10 types of groups, all in time-limited format, addressing focal problems (depression, panic disorder, eating disorders, substance abuse), problems in living (interpersonal problems, crisis intervention, personality problems), and inpatient groups. This section is invaluable not only in setting up groups, but also in managing specific group members' work through a problem-solving approach.

The importance of time, its meaning, and its use as a therapeutic factor have not always been recognized in the literature on time-limited therapy. MacKenzie devotes a full chapter to the meaning of time and its relationship to termination. MacKenzie recognizes the tremendous contribution of James Mann to our understanding of time limits to therapy.[2,3] Two aspects of time as a therapeutic factor are that 1) the termination process is an opportunity to revisit and work through unresolved separation and individuation issues and 2) the reality of a time limit from the beginning of therapy brings into sharp relief existential awareness of limits of time, imperfections, and the fact that dependency needs can never be completely fulfilled. When the question of time is kept continually before the group members, as MacKenzie emphasizes, responsibility for progress and change rests more largely on the group. When time-limited groups do not work with time as a therapeutic factor, group members can feel cheated and deprived when the end draws near. Acting out of feelings of disappointment is more likely when such feelings are not acknowledged or expressed.[4]

The theoretical position of this book is primarily cognitive-behavioral and interpersonal. What of the psychodynamic and group dynamic perspectives? Institutional pressures

and continuing change in the health care environment affect the development of group therapy programs. It is essential to recognize the unconscious or covert processes in individuals, groups, and institutions. Success of a group program depends on the acknowledgment and exploration of the complexities of group life.

MacKenzie identifies an important area for further research and study when he notes, "All three mainstream approaches to psychotherapeutic treatment of resistant depressed states . . . have been reported to have significant recurrence rates." MacKenzie offers the option of a monthly meeting for patients who have completed a time-limited group and who are highly likely to have a recurrence of symptoms. These meetings would be called "Maintaining your Interpersonal Health."

There may be a subgroup of patients who are not candidates for time-limited groups but are candidates for ongoing, open-ended group therapy as a highly effective and economic treatment of choice.[5] Individual therapy, more costly in time and money, is less necessary when such patients are well established in a highly supportive and consistent group environment. Loosely structured monthly meetings, which MacKenzie suggests, require further research to establish their possible efficacy.

Time-Managed Group Psychotherapy is a worthwhile addition to the literature on group therapy in general and on time-limited group therapy in particular. It is comprehensive, theoretically consistent, and creative in its approach to financial limitations in health care delivery. It will be especially useful to those practitioners who wish to implement a group program. MacKenzie's blueprint offers a solid foundation.

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Children and Grief: When a Parent Dies

By J. William Worden
New York and London, Guilford Press, 1996, 190 pages, ISBN 157-230-1481, $26.95

Reviewed by Joel P. Zrull, M.D.

This book attempts to take the findings of the Harvard Child Bereavement Study and apply them to the clinical understanding of an intervention with children who have lost a parent to death. Throughout most of the book the author has skillfully interwoven research data with quotes and vignettes of children and adolescents who were part of the study. The richness of the data is apparent not only in their presentation in this book, but also as evidenced by the many other articles they have generated. The quotes and vignettes attest to the hands-on approach of the author.

Understanding of the child and of bereavement has informed the systematic approach of the investigators. Most impressive is the attention to details such as developmental level, gender of the child, gender of the deceased and living parent, family size, and sibling order, to mention only a few. Intervention is also approached in a systematic fashion, but with the approach of a clinician who has extensive experience with children and families

who are bereaved.

The early chapters are written in a manner that includes many quotes and vignettes about the children and families that make them come alive and well illustrate the author's points. This is equally true of the epilogue. Chapters five and six take a substantially data-oriented approach that is thorough, but inclusive enough that the reader is happy to come upon the very effective chapter-ending summaries.

The latter portion of the book is devoted to intervention methods and devices. This too is comprehensive, but the reader longs for more quotes and vignettes to be able to complete the imagery of the process extending from evaluation to intervention.

A word about the literature review is in order. The review is extensive both in breadth and in coverage of the evolution of work in this area over time. The reference list is extensive and should be helpful to those who would like further reading about grief in children.

This is a readable and practical contribution to the clinical understanding of children who have lost a parent.

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The Making of a Psychotherapist

By Neville Symington
Madison, CT, International Universities Press, 1996, 222 pages, ISBN 0-8236-3083-8, $37.50 (also published by Karnac Books, London)

Reviewed by William E. Powles, M.D., F.A.G.P.A.

Intriguing, serious reading, this volume is no textbook on training, nor yet an autobiographical odyssey. Rather, it is an edited compendium of unpublished addresses, including many clinical vignettes, on the attributes of the psychotherapist and the nature of depth psychotherapy, together with a specific viewpoint reviewed below. Part One (seven chapters) is called Personal Qualities; Part Two (eight chapters) is called Professional Dilemmas (i.e., clinical challenges). The author, trained as a psychoanalyst in Britain, practices and teaches in Australia. He has already published four books, which I hope to track down.

This is a difficult book to summarize. I elect to review four themes or theses running through it:

1. *Training.* Symington takes psychotherapy most seriously. He would have four years of *full-time* training in a curriculum to include not only wide technical reading, but also great literature and courses on religion, as well as supervised clinical work. The "invention model" of personal creativity is to be stressed over the "academic model" of thorough knowledge. He offers no specifications for technique.

2. *Psychotherapy and Psychoanalysis.* "Psychotherapy means healing of the soul," a process very distinct from psychoanalysis, whose goal is self-knowledge. But this emphatic distinction evaporates in the text itself, where psychotherapy and psychoanalysis are indistinguishably interwoven.

Psychotherapy is to be lengthy and hard, reconstructive work. Nonanalytic methods, even Kohut's propositions, are treated roughly as superficial. And despite Symington's strong interest in interpersonal transactions, there is no mention of group psychotherapy.

3. *Creative Self-Understanding.* This element is at the center of psychotherapy. For both therapist and patient it is tool, goal, touchstone for process and outcome; it is the therapist's shield and buckler with difficult patients. The centrality of self-understanding explains, I believe, why Symington's initial professions give way to a homogenization of psychotherapy and psychoanalysis.

Other attributes of the psychotherapist (which can be fostered by training) include courage, which fortifies the therapist against pain, both patient's and therapist's, and militates against fleeing from or denying the truth. And there are also imagination and curiosity, without which "it is not possible for someone

to be a safe psychotherapist." (Wish I'd written that!)

4. *Psychotherapy and Religion*. Here we have the true distinctiveness of this book. The psychotherapy movement is "in moral crisis" (bankruptcy, stagnation). It has lost the revolutionary spirit in which Freud challenged Victorian puritanism. Indeed, for this mindless, knee-jerk, superego-laden attitude, particularly around sexual matters, psychotherapy has now substituted an equally mindless, knee-jerk permissiveness, or "nominalism."

Psychotherapy "needs a religious principle." Symington notes that the undertaking of psychotherapy is a moral decision and goal-setting is a moral judgment; the patient is morally responsible for attending to his or her mental health. In the search for the real self—for healing of the soul—the detailed analysis of values, value conflicts, and the nature of the good are of the essence. A tyrannical superego is always the sign of a fragmented personality; a mature conscience is the barometer and guiding light of a unified and healthy personality. All these are religious concerns!

Psychotherapy needs dialogue—difficult and prolonged if necessary—with religious minds. The place of conscience in proper mental health needs new scrutiny. Practically, psychotherapy has a real opportunity to help in the major area rather neglected by the great religions; namely, guidance on issues of human intimacy and sexuality. This area is of great relevance in today's postindustrial, increasingly urbanized and alienated society.

Who should read this book? It is too heavy, and not operational enough, for beginners or trainees. Philosophers of psychiatry, psychotherapy, religion, and pastoral care would, I think, get a great deal from it. Two kinds of psychotherapists (and analysts) really should read it. First, there are experienced journeymen knowledgeable in their craft, perhaps tired, jaded, skeptical about what they are doing, and needing just such a stimulus as this book offers. Second, trainers, teachers, and clinical supervisors would also, I believe, get a new slant on what they are passing on to a new generation of therapists. Such a perspective is welcome in these days, when psychotherapy is in danger of becoming more and more a mere commodity to be bought and sold.

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INFORMATION FOR CONTRIBUTORS

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