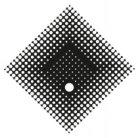
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Is IPT Time-Limited Psychodynamic Psychotherapy?

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Interpersonal psychotherapy (IPT) has sometimes but not always been considered a psychodynamic psychotherapy. The authors discuss similarities and differences between IPT and short-term psychodynamic psychotherapy (STPP), comparing eight aspects: 1) time limit, 2) medical model, 3) dual goals of solving interpersonal problems and syndromal remission, 4) interpersonal focus on the patient solving current life problems, 5) specific techniques, 6) termination, 7) therapeutic stance, and 8) empirical support. The authors then apply both approaches to a case example of depression. They conclude that despite overlaps and similarities, IPT is distinct from STPP.

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Interpersonal psychotherapy (IPT),[1] a manual-based treatment for particular psychiatric populations, has been alternately included in and rejected by the psychodynamic community. Some see it as founded on psychodynamic principles, while others dismiss it as a lightweight alternative to the psychodynamic tradition, a Band-aid therapy that misses the larger point of treating character. Until recently IPT was almost entirely a research intervention, described in clinical research trials but otherwise unfamiliar to practicing clinicians. Many may not really know what IPT is. (Perhaps that explains why so many inadvertently mislabel it "ITP.") In contrast, psychodynamic therapy has been widely used but less researched.

This article differentiates two terms that are too often loosely used: (brief) "psychodynamic" and "interpersonal" psychotherapy. The issue of whether IPT is a form of short-term dynamic psychotherapy (STPP) has been frequently broached in clinical workshops but never fully confronted in the literature, and ambiguity about the issue is evident even in the IPT manual. This issue deserves examination for several reasons:

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1. The growing prominence of IPT as a research and clinical treatment[2] suggests the need to define it relative to other psychotherapies.
2. If IPT differs significantly from STPP, it may require a distinct course of training. Such IPT training has been defined, although few trainees and clinicians have received it.[3] If the two do not greatly differ, any well-trained STPP psychotherapist may be able to deliver IPT without intensive training.
3. IPT was designed as a utilitarian psychotherapy that codified existing practices. Klerman et al.[1] wrote that "Many experienced, dynamically trained . . . psychotherapists report that the concepts and techniques of IPT are already part of their standard approach" (p. 17). A retrospective analysis of the theoretical stance of IPT may place it more firmly in relationship to the historical and conceptual contexts of earlier psychotherapies.
4. IPT has been included in some meta-analyses of psychodynamic outcome studies. IPT could provide needed empirical data for psychodynamic treatments if the two modalities belong to the same family. If they do not, trials comparing them might establish differential efficacies.

A debate arose in the research literature when Crits-Christoph[4] and Svartberg and Stiles[5] published meta-analyses of the efficacy of psychodynamic psychotherapy that yielded different results. Svartberg and Stiles[6] noted that one reason for their differing findings was that Crits-Christoph had included IPT among psychodynamic studies, bolstering his results.

Svartberg and Stiles maintained:

> Although many dynamic psychotherapists report that the concepts and techniques of interpersonal psychotherapy are part of their therapeutic skills, there are vital differences between interpersonal psychotherapy and brief dynamic psychotherapy.[6]

They then cited the IPT manual:

> For purposes of theoretical clarification and of research design and methodology, we often find it useful to emphasize the difference between interpersonal and psychodynamic approaches to human behavior and mental illness.[1] (p. 18).

Svartberg and Stiles present this distinction as definitive, but to our ears the wording they cite sounds more cautious. Crits-Christoph, who earlier conceded that IPT "may be quite distant from the psychoanalytically oriented forms of dynamic therapy more commonly practiced"[4] (p. 156), gave similarly incomplete justification for deeming IPT psychodynamic, namely that most IPT therapists in early trials were psychodynamically trained and adapted easily to IPT.[7] This hardly makes the therapies identical.

The IPT manual waffles on the issue. It contrasts IPT with "psychoanalytically oriented psychodynamic therapies," citing differences in conceptualizing the patient's problem: IPT does not use transference interpretations or focus on childhood antecedents; IPT does not attempt personality change; and IPT therapists can accept small gifts from patients without examination (pp. 166–167). Yet it also uses the words "another difference between IPT and *other* psychodynamic psychotherapies" (p. 167; our italics).

Should IPT be considered a brief psychodynamic psychotherapy? We shall briefly define the two approaches, then consider their overlap.

THE TWO APPROACHES COMPARED

Brief Psychodynamic Psychotherapy

Psychodynamic psychotherapy is a sprawling field, and even within STPP there are numerous short-term variants. These include drive/structural models,[8–10] existential

models,[11] relational models,[12–14] and integrative models.[15,16] STPP is usually designed to promote insight rather than to treat specific disorders. No form of STPP has been developed specifically to treat depression, as IPT was.

Although heterogeneous, STPP variants share the following aspects: 1) their theory about the origin of psychopathology is psychoanalytically grounded; 2) key techniques are psychoanalytic, such as confrontation, interpretation, and work in the transference; 3) patients are selected for treatment; 4) during initial sessions a dynamic case formulation is developed, and a focus based on this formulation is established and maintained throughout treatment.[17]

Although relationally focused STPPs may be gaining ground, we believe that conflict-oriented approaches still hold sway: they appear to be most widely used and are probably what most clinicians think of as STPP. We therefore define STPP as *a treatment of less than 40 sessions that focuses on the patient's reenactment in current life and the transference of largely unconscious conflicts deriving from early childhood.*

Interpersonal Psychotherapy (IPT)

Compared with STPP, IPT is an essentially unified treatment with far less history and opportunity for diffusion. Developed by Klerman, Weissman, and colleagues to treat outpatients with nondelusional major depression in a time-limited format, IPT has since been adapted for other psychiatric disorders.[18] In the initial phase (1–3 sessions), the IPT therapist diagnoses a psychiatric disorder and an interpersonal focus; links the two for the patient in a formulation; and obtains the patient's explicit agreement to this formulation, which becomes the treatment focus. In the middle phase, the therapist employs practical, optimistic, forward-looking strategies to provide relief.

Possible interpersonal foci, derived from psychosocial research on depression, are 1) grief (complicated bereavement), 2) role dispute, 3) role transition, and 4) interpersonal deficits.[1] A brief termination phase concludes acute treatment. Based on the premise that life events affect mood, and vice versa, IPT offers strategies that maximize the opportunity for patients to solve what they often see as hopeless interpersonal problems. If patients succeed in changing their life situations, their depression usually remits as well. A series of randomized controlled treatment trials has demonstrated that IPT both treats episodes of illness and builds social skills.[2,19]

Similarities and Differences

IPT is defined by its 1) time limit, 2) medical model, 3) dual goals of solving interpersonal problems and syndromal remission, 4) interpersonal focus on the patient solving current life problems, 5) specific techniques, 6) termination, 7) therapeutic stance, and 8) empirical support. We shall compare each of these elements in turn with the features of STPP, focusing on depression—the modal IPT diagnosis—as the treatment target. Table 1 contrasts IPT and STPP.

1. *Time Limit:* IPT has a strict time limit, established at its outset, ranging for acute treatment from 12 to 16 weekly sessions. Although this duration arose as a compromise between the needs of psychotherapy and pharmacotherapy in randomized trials, it has proved an adequate length and an important tool. Brevity of treatment pressures the depressed patient and the therapist to work quickly.

Psychodynamic psychotherapy, like psychoanalysis, was traditionally an open-ended treatment. Malan,[8] Sifneos,[9] Davanloo,[10] Mann,[11] Luborsky,[12] Horowitz et al.,[20,21] Strupp and Binder,[22] and others developed short-term psychodynamic interventions with more defined foci and limits. Their brevity is stated, but their exact duration is often not specified, at the outset. Some have variable[10,12,22] or time-attendant[9] lengths, based on evidence of therapeutic progress.[23] In contrast to the 12 to 16 sessions of IPT, most STPPs comprise 20 to 25 sessions.

2. *Medical Model:* The IPT focus is illness based. The patient's problem is defined as a medical illness: a mood disorder may be usefully compared to hypertension, diabetes, and other medical disorders that respond to behavioral and pharmacological interventions. Giving the patient a medical diagnosis and the "sick role"[1,24] is a formal aspect of the first phase of IPT. These maneuvers aim to help depressed patients recognize depressive symptoms as ego-dystonic and to relieve self-criticism by helping them to blame an illness (and an interpersonal situation), rather than themselves, for their difficulties. The sick role also entails responsibility to work to recover the lost, healthy role. IPT therapists, while often using psychodynamic knowledge to "read" psychological patterns of patients, carefully avoid prejudging whether patients who present with Axis I disorders such as major depression or dysthymic disorder have personality disorders.[25]

The IPT approach relieves guilt and diminishes the risk that depressed patients may unfairly blame their character rather than illness or circumstances. It avoids the potential confusion of depressive state with, say, masochistic traits.[25] In contrast, STPP often focuses on intrapsychic conflicts, unconscious feelings, and character defenses rather than formal diagnoses and the concept of illness. Many STPP practitioners may deem depressive symptoms less important than do IPT therapists, seeing such symptoms not as outcome variables but as epiphenomena of underlying characterological issues. Whereas for IPT therapists

TABLE 1. IPT and brief psychodynamic psychotherapy

Domain	IPT	Psychodynamic
Underlying model	Medical illness	Dynamic unconscious
Goals	Remission of syndrome Symptom relief	Conflict resolution (Limited) personality change
Framework		
Time limit	Always (typically 12–16 weeks)	Variable
Structure	Structured by: 1. Time limit 2. Opening question 3. Interpersonal problem area	Relatively unstructured
Focus		
Temporal	"Here and now"	"There and then"
	Relatively acute: recent past, but mostly present and future	Relatively chronic: remote past, albeit in some relation to present
Spatial	Outside office	Inside office (transference)
Material	Interpersonal	Largely intrapsychic
Formulation	Explicitly stated	Often largely tacit
Therapeutic stance	Supportive, encouraging, optimistic ally	Supportive vs. neutral observer
Techniques		
Interpretation	No	Yes
Dream interpretation	No	Yes
Trial intervention	No	Yes
Communication analysis	Yes	Yes, to a degree
Support	Yes	Yes, variably
Catharsis	Yes	Yes
Exploring options	Yes	Yes, but not systematically
Role playing	Yes	No
Psychoeducation	Yes	Not in medical sense
Termination	Focus on patient's successes; relapse prevention; a concluding phase	Focus on transference; often a crucial phase

the Axis I diagnosis is paramount, STPP psychotherapists often focus on characterological defenses, informally diagnosed "Axis II."

Following the medical model, IPT uses DSM-IV diagnosis as its inclusion criterion. Inclusion criteria for STPP tend to be factors such as feasibility of establishing a therapeutic focus, ability to form an emotional attachment, and motivation for change.[23]

3. *Goals:* IPT has dual aims: to solve a meaningful interpersonal problem, and (thereby) to relieve an episode of mood disorder. The IPT therapist defines these two targets during the initial phase, links them in an interpersonal formulation,[26] and obtains the patient's agreement on this formulation as a focus before proceeding into the main treatment phase. The formulation, a non-etiologic linkage of mood and environmental situation, explicitly states the therapist's understanding of the case:

> As we determined by DSM-IV, you are going through an episode of major depression, a common illness that is not your fault. To me it seems that your depressive episode has something to do with your father's death and your difficulty in mourning him. Your symptoms started shortly after that. I suggest that over the next 12 weeks we try to solve your problem with mourning, which we call complicated bereavement. If we solve that, your depression will very likely improve.

STPP seeks to increase the patient's understanding of his or her internal functioning. External change implicitly follows, but it is not the prime focus of treatment.

In summary: the goal for IPT is to treat a specific psychiatric syndrome by helping the patient to change a current life situation; the goal for STPP is to increase understanding of intrapsychic conflict. These approaches reflect differing concepts of psychopathology. Implicit in these definitions of therapeutic goals are their indications. IPT is indicated only for syndromes for which its efficacy has been empirically demonstrated (major depression, bulimia). STPP has been less concerned with specific diagnoses, although Horowitz and coworkers do focus on stress and bereavement syndromes.[20,21] Some forms of STPP deem significant symptomatology a contraindication.[9]

4. *Interpersonal Focus:* IPT focuses on events in the patient's current life ("here and now") outside the office and on the patient's reaction to these life events and situations. Patient problems are categorized within the four interpersonal problem areas, usually elaborated by a personalized metaphor.[25] STPP, even when emphasizing events,[20] focuses on transference in the office and the linking of extrasession interpersonal events to the transference. The phrase "here and now" in a psychodynamic context refers to what happens in STPP sessions. IPT instead concentrates on recognition of recent traumatic life events, grieving their costs but simultaneously emphasizing the positive potentials of the present and future. IPT is "coaching for life" more than introspection.

5. *Specific Techniques:* IPT is more innovative in its use of focused strategies than unique in its particular techniques. For each interpersonal problem area there is a coherent set of strategies. Nonetheless, several key techniques are frequently used. Some, but not all, derive from psychodynamic practice (see Table 1).

Sessions begin with the question, "How have things been since we last met?" This focuses the patient on the interval between sessions and elicits either a mood or an event. The therapist then helps the patient to link the two. Depressed patients soon learn to connect environmental situation and mood and to recognize that they can control both through their actions. Starting with a recent, affectively charged event allows sessions to move to the interpersonal problem area, maintaining the focus without rendering the discussion intellectualized or affectless.

Having discovered a recent life situation, the therapist asks the patient to elaborate events and associated feelings to determine

where things might have gone right or wrong (communication analysis). The therapeutic dyad explores what happened, how the patient felt, what the patient wanted in the situation, and what options the patient had to achieve it. If the patient handled the situation less than optimally, role playing may prepare the patient to try again.

IPT does not use STPP interventions such as genetic or dream interpretations. Both approaches pull for affect and catharsis. But for IPT, catharsis alone is insufficient: the patient must also transmute feeling into life changes. Catharsis in STPP may lead the patient to an increased sense of safety in sessions, facilitating subsequent deeper exploration of conflicted feelings. The goal is increased self-knowledge on which the patient may act independently. Life change might be considered a good outcome of STPP, but it would come as a by-product of insight. By contrast, IPT emphasizes action rather than exploration and insight, in part because mobilization and social activity benefit depressed patients. The IPT therapist actively supports the patient's pursuit of his or her wishes and interpersonal options.

STPP therapists help patients focus on transferential and interpersonal themes (e.g., Luborsky's Core Conflictual Relationship Theme[12]); however, sessions are less structured by the therapist and more dependent on the patient's generating material—which it might be difficult for depressed patients to do productively.

6. *Termination:* In IPT, termination means graduation from therapy, the bittersweet breakup of a successful team. It is a coda to treatment, important but secondary to the middle phase. The final sessions address the patient's accomplishments, the patient's competence independent of the therapist, and relapse prevention.

Termination in STPP is a more important phase than in IPT and concentrates far more on the patient's responses to therapy ending: indeed, the therapy often turns on this.[8] A key STPP technique is working through the separation issues of termination, especially as manifested in the transference.

7. *Therapeutic Stance:* STPP tends toward therapist neutrality and relative abstinence in order to allow the transference to develop, whereas the IPT therapist assumes the openly supportive role of ally. A practical, optimistic, and helpful approach is deemed necessary to counter the negative outlook of depressed patients. Although encouraging patients to develop their own ideas, IPT therapists offer suggestions when needed. When the patient does something right, the therapist offers congratulations—a "cheerleading" style that might disconcert some STPP therapists.

IPT and STPP share some attributes: time constraint, narrow focus, and modality-trained therapists. Both use support, a warm alliance, and careful exploration of interpersonal experiences. They share a positive, empowering, collaborative stance. Most STPP therapists use traditional analytic techniques (transference or genetic interpretation, clarification, confrontation, defense analysis) to help patients explore and understand themes or conflicts. IPT also might use clarification to aid a depressed patient's understanding of an interpersonal dispute. Some STPPs specify that therapists should be relatively supportive[11] or active.[8]

An illustrative difference between the two approaches might arise with an irritable, depressed patient at risk to develop a negative transference to his therapist. The STPP therapist would allow the transference to develop, then interpret it to the patient to explore its meaning. The IPT therapist would focus the patient on interpersonal relationships and events in the patient's outside life that might provoke anger or irritability, and would also blame the depressive disorder itself when appropriate. This active, outward-looking approach minimizes the opportunity for a negative transference to build: rather, the therapist becomes the patient's ally in fighting depression and outside problems. (This reverses the psychoanalytic principle that transference

brings into the therapeutic relationship patterns that the patient enacts everywhere. In IPT, if the patient has feelings about the therapist, there is probably a culprit elsewhere.) Resolving outside problems and depressive symptoms cements the therapeutic alliance, so that negative transference—which may reflect the patient's clouded depressive outlook—fades. If the patient's feelings unavoidably perturb the therapeutic alliance, the IPT therapist explores them as interpersonal, real-life, here-and-now issues rather than as transference.

If a patient repeatedly arrives late for sessions, the STPP therapist might explore aspects of the patient's character and feelings about the therapist that might contribute to the lateness. From the IPT perspective, this risks potentially reinforcing the patient's already excessive self-blame. The IPT therapist would excuse the patient, sympathizing that it's hard to get out of bed and arrive punctually when you feel depressed and lack energy, and acknowledging that the patient's level of anxiety might make it hard to contemplate sitting through a full session. The IPT therapist would thus blame the depression, not the patient—who feels bad enough already. The therapist would mention the time limit ("Unfortunately we only have eight sessions left, and we really need to use all the remaining time to find ways to fight your depression") in order to discourage future tardiness. Lateness in other relationships might be explored with the goal of building interpersonal skills (self-assertion, expression of anger) in these external settings.

STPP treats the patient's "resistance" to employing healthy solutions as meaningful; IPT treats the "resistance" as illness—namely, depression. The IPT "corrective emotional experience" lies partly outside the office, in the amelioration of interpersonal situations external to therapy. The STPP corrective emotional experience lies primarily inside the office, in the patient's newfound ability to express warded-off feelings to an optimally responsive person.

8. *Empirical Support:* The demonstrated efficacy of IPT in treating mood and other psychiatric syndromes in randomized clinical trials[2] sets it apart from most STPP treatments, for which empirical evidence of efficacy in treating particular syndromes is meager.[5,23] Luborsky and co-workers produced impressive results in treating opiate-maintained patients with STPP,[27] an area where IPT failed.[28] This indirect comparison suggests differences between the approaches. There have been no direct comparisons of IPT and STPP in treating major depression. Some reports suggest, however, that psychodynamic psychotherapy may not be the ideal treatment for mood disorders.[3,29] Efficacy data provide an important foundation permitting the IPT therapist to meet the depressed patient's pessimism with equal and opposite optimism. Consonant with an empirical approach, many IPT therapists serially administer depression rating instruments during treatment.

A case example may highlight differences between IPT and STPP.

Case Example

Ms. A., a 34-year-old married businesswoman, presented with the chief complaint, "I'm feeling depressed." She reported that 5 months earlier she had received a long-sought promotion, which increased her responsibility at work. Her longer working hours and heightened career opportunities increased ongoing tension with her husband over whether to have a second child. She became increasingly doubtful about another pregnancy; her husband became more insistent upon it. She reported that over the past 3 to 4 months she had experienced depressed mood, early and mid-insomnia, decreased appetite and libido, an 8-pound weight loss, low self-esteem, and greater guilt. She felt anxious and irritable with her 35-year-old computer programmer husband, her 8-year-old son, and co-workers.

Psychodynamic Approach: An STPP therapist would begin by developing a dynamic formu-

lation of the case. This formulation would comprise a specific constellation of dynamic elements: defenses, anxiety, and unconscious impulse/feeling, as well as their interrelationships. Central to the case is Ms. A.'s inability to express anger adaptively toward her husband. The reason for this might be anxiety-based fantasies about hurting and possibly losing her husband if the angry impulses were released. These impulses are defended against through 1) deflecting the impulse and directing it inward (causing depression); 2) acting out (being irritable, which is not adaptive anger); 3) displacement onto her son and coworkers; and possibly 4) taking the victim role (a self-pitying, "poor me" attitude, which is also maladaptive).

Treatment would begin with the therapist pointing out impulses, anxious fantasies, and defenses in relation to a current person (husband), a past person (father, mother), and the therapist. If the patient came late to sessions, the therapist might interpret this transferential manifestation of unexpressed anger, linking it to anxiety about expressing anger directly to her husband, or to her domineering parents in the past. Recognition of this conflict would be considered inherently therapeutic. The aim is to help the patient recognize how she defends herself against frightening angry impulses. The next step, at a deeper level, is to explore the angry impulses: to have her experience the full feeling of anger and to facilitate its expression in the transference. In the presence of a nonjudgmental therapist, this represents a corrective emotional experience for the patient and, as such, is considered key to alleviating symptoms and to limited personality change.

IPT Approach: The patient meets criteria for a DSM-IV major depressive episode,[30] an indication for IPT. If exploration revealed no other precipitant (such as complicated bereavement), the therapist would link the onset of the mood disorder to one of two probable interpersonal problem areas: either a role transition (the job promotion and its consequences) or a role dispute (with the husband over having another child). Depending on which of these intertwined themes emerged as most salient to the patient, the therapy might focus on either or both. From the presentation, it appears that her conflicts are at home (role dispute) rather than with the job per se.

The therapist would present this linkage to the patient ("Your depression seemed to start after you got your promotion and you and your husband began to argue about having another child") and would give the patient the sick role. If the patient accepted the formulation as a focus for time-limited treatment, the therapist would then discuss with the patient what she wanted: How could she balance work and home? How much pleasure does work give her? Are there ways to resolve the marital dispute? Once her wishes are determined, what options does the patient have to resolve these problems? In a role dispute with the husband, the goal would be to explore the disagreement, to see whether the couple is truly at an impasse, and to explore ways to resolve it. Addressing the role dispute might well require exploring how the patient expresses anger, which could be fine tuned through role-play in the office. With therapist support, Ms. A. would attempt to renegotiate her current life situation to arrive at a satisfactory new equilibrium. Achieving it, or at least trying to the best of her ability (her husband might be unreasonable, but she could at least handle her side of the matter appropriately), would very likely lead to remission of her mood disorder.

DISCUSSION

IPT bears similarities to some forms of STPP, but it differs sufficiently that it should be considered distinct. IPT was developed to treat depression, STPP for a range of psychopathologies. The IPT rationale does not pretend to explain etiology. Rather, IPT is a pragmatic, research-proven approach that addresses one important aspect of depressive syndromes and frequently suffices to treat them. To the extent that IPT invokes theory, it relies on psychosocial research findings (for

example, the association of marital conflicts and depressed wives[1]) and commonsense but clinically important ideas, such as "life events affect mood."

IPT and STPP may (should?) ultimately address overlapping problem areas, with the distinction that STPP seeks intrapsychic as well as interpersonal patterns. STPP uses history *and* transference to determine the focal problem. IPT sticks to history: although the patient's interpersonal behaviors in sessions may convey important information, the transference is not addressed. To a greater extent than STPP, IPT emphasizes finding concrete solutions and changing relationships, using techniques such as role playing to prepare the patient for such steps. Reflecting these distinctions, the NIMH Treatment of Depression Collaborative Research Program[31] developed adherence measures that distinguish IPT from "tangential" psychodynamic techniques.[32]

We conclude:

1. *IPT has distinct emphases.* A psychodynamic background, which most IPT therapists (beginning with Klerman and Weissman) have had, is helpful to "read" patients, to subtly manipulate (rather than interpret) the transference. But the IPT conceptualization of depression as an illness, and its focus on depressive illness rather than on characterological "roots," represents a significant difference from STPP. The emphasis on outcome and on success experiences in the patient's life has also been less characteristic of STPP. In teaching IPT to psychodynamic therapists—even Sullivanian ("interpersonal") psychoanalysts—we sometimes see them struggling to adjust to the IPT approach.

2. *IPT is not simply "supportive" dynamic therapy.* IPT does share some features with supportive therapies. But "supportive" has been a pejorative psychoanalytic term for any not-formally-expressive, not-insight-oriented psychotherapy.[33] As such, "supportive" encompasses not only formal psychodynamic approaches to supportive therapy,[34] but almost anything else: the term roughly translates to "not psychoanalytic." IPT is more active, has more ambitious goals (syndromal remission; helping patients to rapidly change interpersonal environments), and very likely accomplishes more than typical (if there is such a thing) supportive therapy. This was our finding in comparing IPT and a supportive, quasi-Rogerian psychotherapy in treating depressed HIV-positive patients.[35] If IPT is not psychodynamic, it is not exactly "supportive," either, although IPT therapists do provide support.

3. *IPT is distinct in its interpersonal focus.* STPP can have a strong interpersonal focus, but it need not. Even when it does, techniques and focus differ from those of IPT: for example, outside interpersonal relationships are frequently linked to transference. STPP as a whole may be moving toward a more interpersonal focus. (Lacking a consensus, it is hard to know.) If so, it is probably more skewed in that direction than much other psychodynamic psychotherapy.

Some STPP variants clearly have more interpersonal emphasis than others, and thus arguably overlap more with IPT. One example is the time-limited psychodynamic psychotherapy (TLDP) of Strupp and Binder.[22] Development of this approach was influenced by psychoanalysts such as Alexander and French, Gill, and Klein as well as STPP theorists such as Malan, Sifneos, Davanloo, and Mann.[36] During initial sessions, TLDP therapists formulate a salient maladaptive interpersonal pattern as it relates to (in order of priority) the therapist, current others, and past others. Throughout treatment, TLDP therapists identify the influence of this pattern on the patient–therapist relationship: how the patient's expectations about self and others are enacted in the transference. As described by Elkin at al.,[31] "TLDP therapists' technical approach emphasizes the analysis of transference and countertransference in the here and now" (p. 144).

Although TLDP has an interpersonal therapeutic focus, it differs drastically from the

IPT therapist's practical, outside-the-office emphasis and interventions. Indeed, TLDP may more closely resemble psychoanalysis proper than IPT in its heavy emphasis on transference and countertransference.[37]

4. *IPT and STPP differ markedly in their treatment range.* IPT is intended as a limited intervention addressing particular Axis I syndromes. STPP derives from an all-encompassing psychodynamic approach to psychopathology, yet paradoxically has often specified extremely limiting selection criteria for its application (see Sifneos,[9] for example). Absent comparative research data, we know little about the differential therapeutics[38] of STPP and its indications relative to IPT for particular diagnostic groups.

An important exception to this rule is the STPP of Horowitz and colleagues.[20,21] This focuses on one of IPT's four foci, grief reactions, but addresses them differently. Horowitz's approach is characterized by 1) general principles defined by Malan, Sifneos, and Mann, including clarification; confrontation; interpretation of impulses, anxiety, and defenses; separation and loss issues regarding the therapist and current and past others; and 2) specific principles about the handling of affects and views of self and other activated by the traumatic event, such as reality testing of fantasies, abreaction, and catharsis. The active use of the transference, the reliance on traditional psychodynamic techniques, and the aim of modifying long-standing personality patterns are but a few features differentiating this approach from IPT.

5. *Training for IPT requires a distinct approach.* We teach IPT separately, as a form of time-limited therapy distinct from STPP. This suggests important heuristic differences. Indeed, for reasons already articulated (see Table 1), conceptual and technical differences would make it difficult to teach IPT as a subtype of STPP.

6. Despite overlap, IPT and STPP are distinct. A participant in an IPT workshop said: "IPT isn't psychodynamic, but it isn't anti-dynamic, either." This puts it as well as anyone has. The obvious overlap in these therapies includes the "nonspecific" factors of psychotherapies [39] as well as the backgrounds of most of the IPT therapists trained to date. Yet differences in goals, techniques, outlook, and research data are meaningful. IPT should not be grouped with STPP. Although it may have roots in psychodynamic soil, it differs sufficiently in its outlook and practice to deserve to be considered apart.

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The Children's Play Therapy Instrument (CPTI)

Description, Development, and Reliability Studies

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The Children's Play Therapy Instrument (CPTI), its development, and reliability studies are described. The CPTI is a new instrument to examine a child's play activity in individual psychotherapy. Three independent raters used the CPTI to rate eight videotaped play therapy vignettes. Results were compared with the authors' consensual scores from a preliminary study. Generally good to excellent levels of interrater reliability were obtained for the independent raters on intraclass correlation coefficients for ordinal categories of the CPTI. Likewise, kappa levels were acceptable to excellent for nominal categories of the scale. The CPTI holds promise to become a reliable measure of play activity in child psychotherapy. Further research is needed to assess discriminant validity of the CPTI for use as a diagnostic tool and as a measure of process and outcome.

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The Children's Play Therapy Instrument (CPTI) was constructed to assess the play activity of a child in psychotherapy. It is intended to be of use to clinicians and researchers as an additional criterion for diagnosis—since children with different diagnoses tend to have different forms of play[1,2]—and as an objective instrument to measure change and outcome in child treatment. The purpose of this article is to describe the instrument and the initial reliability studies.

THE CPTI

Although several scales have recently been written to measure the play of children,[3–5] the CPTI is specifically intended to be a comprehensive measure of a child's play activity in psychotherapy. The CPTI adapts several established scales[6–9] in order to measure play activity from a variety of perspectives. The CPTI provides a tool to describe, record, and analyze a child's play activity equivalent to a mental status formulation of a child's overall function-

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ing following a clinical interview. An outline of the CPTI appears in Table 1.

Level One: Segmentation

Level One analysis addresses the different types of activity the child engages in during the psychotherapy session by segmenting the child's activity into four categories. These four categories are Pre-Play, Play Activity, Non-Play, and Play Interruption. Segmentation of the child's activity results in an overview of the distribution and span of time of various categories of the child's activity in therapy. For example, segmentation delineates a child who does not play from a child who does; it registers the activity of a child who undergoes play interruptions and contrasts it with that of a child who is capable of sustained play activity. It provides information on the ratio between play activity and non-play activity. During the session, clinical experience suggests that a child with significant emotional problems will tend to spend less time engaged in play activity and will experience interruptions due to anxiety or aggression.

Pre-Play is defined as the activity in which the child is "setting the stage" for play. She may pick up a toy and manipulate it, arrange play materials, or try out a character's voice or actions. The predominant purpose of pre-play activity is preparation. Pre-play may be prolonged in compulsive or depressed children. In some instances, the child will not progress beyond pre-play.

Play Activity begins if the child becomes engrossed in playful activity often indicated by the adult or child exhibiting one or a combination of the following behaviors: 1) an expression of intent (e.g., "Let's play."); 2) actions indicating initiative, such as definition of

TABLE 1. Outline of the Children's Play Therapy Instrument (CPTI)

Level One: Segmentation of Child's Activity
- Non-Play Activity
- Pre-Play Activity
- Play Activity
- Interruption

Level Two: Dimensional Analysis of the Play Activity

Descriptive Analysis
- * Category of Play Activity
- * Script Description of Play Activity
- * Sphere of Play Activity

Structural Analysis

Affective Components of Play Activity
- * Child's Affects Modulation
- * Affects Expressed by Child While in the Play
- * Therapist's Affective Tone

Cognitive Components of Play Activity
- * Role Representation
- * Stability of Representation (People & Play Object)
- * Use of Play Object
- * Style of Role Representation (People & Play Object)

Dynamic Components of Play Activity
- * Topic of the Play Activity
- * Theme of the Play Activity
- * Level of Relationship Portrayed within the Play Activity
- * Quality of Relationship within the Play Activity
- * Use of Language (Child and Therapist)

Developmental Components of Play Activity
- * Estimated Developmental Level of Play
- * Gender Identity of Play
- * Psychosexual Phase Represented in the Play
- * Separation-Individuation Phase Represented in the Play
- * Social Level of Play

Adaptive Analysis

Coping and Defensive Strategies
Cluster I – Cluster II – Cluster III – Cluster IV
*Normal *Neurotic *Borderline *Psychotic
*Awareness

Level Three: Pattern of Child Activity Over Time
- Continuity and Discontinuity in Play Narrative(s)

➧ *Subscale of the CPTI.

roles (e.g., "This dolly will be the teacher"; "Let's climb the mountain"); 3) an expression of specific positive or negative affects such as glee, delight, pleasure, surprise, anxiety, fear, disgust, or boredom; 4) focused concentration; 5) use of toy objects or the physical surroundings to develop a narrative.

Normal Play in children is generally an age-appropriate, joyful, absorbing activity. It is initiated spontaneously, with a developing theme carried to a resolution; there is a natural ending and then a move on to another activity. In contrast, pathological play of children with the diagnosis of severe disruptive disorders has been described as compulsive, joyless, and monotonous; the play of autistic children is joyless, nonreciprocal, repetitive, with no evident narrative and no sense of resolution; and the play of psychotic children is characterized by drivenness, sudden fluid transformations of the characters in the play, and play disruption. From the perspective of segmentation, a child optimally involved in play can consistently develop play after pre-play preparation and can unfold a play narrative ending naturally in play satiation.[10] If the length of the segments of play is sufficient for the expression of the child's narratives, the patient therapy session is being used optimally and/or the patient has improved in her capacity to play.

Non-Play refers to a variety of activities or behaviors of the child outside the realm of the play activity, such as showing reluctance, eating, reading, doing homework, or conversing with the therapist. All of these activities or behaviors have in common the absence of involvement in play activity and may have positive or negative implications in relation to therapeutic alliance and phase of treatment.

Play Interruption is operationally defined as any abrupt cessation in a play activity—for example, if the child must go to the bathroom or abruptly ends the play activity because of some extraneous distraction. The time interval of 18 to 22 seconds was pragmatically chosen because raters agreed it was a minimum interval that could be reliably timed without instruments.

Once the therapy session has been segmented, a detailed description of one play activity segment, based on the videotape, is written. This constitutes a "play narrative" that includes the setting of the play, relevant dialogue, associated affects, the child's play themes, and the child's attitudes and involvement in the play activity and with the therapist while playing. The play narrative is a central integrating database to which the rater returns when rating any of the individual subscales. The emphasis is on a frame-by-frame analysis integrating all the distinctive features of the child's play activity and concomitant affects.

Level Two: Dimensional Analysis

The Dimensional Analysis examines the play activity segment using three distinct parameters: Descriptive, Structural, and Adaptive.

Descriptive Analysis: The Descriptive Analysis includes the following subscales: 1) Category of the Play Activity, which lists non–mutually exclusive types of play activity: gross motor activity, construction fantasy, game play; 2) Script Description, which measures the child's initiatives to play, the contribution of the adult to the unfolding of the child's play, and the interaction between child and therapist in composing the play; this subscale provides information regarding the child's autonomy and reciprocity as well as a measure of therapeutic alliance between therapist and child; and 3) Sphere of the Play Activity, which indicates the spatial realms within which the play activity takes place: Autosphere (the realm of the body); Microsphere (the realm of small toys), or Macrosphere (the realm of the actual surroundings).[8] This subscale may have specific clinical reference in terms of boundaries, reality testing, maturity, and perspective taking.

Structural Analysis: The structural analysis includes the following measures of a child's play

activity: 1) Affective Components, 2) Cognitive Components, 3) Dynamic Components, and 4) Developmental Components.

Affective Components of Play Activity. The types and range of emotions brought by the child to her play reflect those feelings significant in her own life. The link between emotions and play activity is what brings play alive with understanding. Concentration and involvement characterize play activity. The overall hedonic tone may vary from positive feelings, expressing pleasure, to negative feelings, associated with conflict.[8] When distress is too threatening to the child, this will eventuate in play disruption.[8] The child's capacity to regulate expression of feelings will affect and/or reflect the organization of play.[11] The greater capacity for smooth transitions and regulation of affect reflects an integration of the child's subjective world, and it is a key to the capacity to play at the highest levels of creativity. If the child is able to gain expression of intense feelings through play, she has made giant steps toward coping and mastery. The capacity to play symbolically implies the capacity for regulation of emotions. Indeed, scenarios portrayed with intensity and a wide range of emotions can be assumed to be of great significance to the child.

Cognitive Components of Play Activity. This modified scale was based on the work of Inge Bretherton[6] on symbolic play. The structure of the social representational world is a crucial dimension of the child's play. From a cognitive perspective, it indicates the degree to which a child is capable of creating narrative structures to represent different affect-laden relationships. Beginning role-play is the child pretending he is another person, or animating a toy or another's behavior. In its most complex form, role-play becomes directorial play or narrator play, with several interacting roles, enlivened by the child with a variety of emotional themes.

Younger children are capable of only simple representations; older children may draw from a varied repertoire. The level of role representation also indicates progression and regression in the child's level of functioning. If a child is unable to achieve a given complexity of role-play, this may reflect a lack of differentiation between self and others, an incapacity for empathy with and investment in others, or cognitive limitations due to stage of development or other causes.[9,12] Further, Piaget[13] refers to failure to view reality from different perspectives as a failure in decentering. The child is unrelated to the other person and remains centered on herself in an egocentric fashion. Alternatively, others (including the therapist or toys) may be animated only as recipients or extensions of the child's activities. From this initial point, the child proceeds to playing with therapist and toys as passive recipients and begins to comprehend the give and take of reciprocal roles and their reactions.

A major advance occurs when the child is capable of expressing independent intentionality for a toy or a person. At this important juncture the child has become capable of assuming a different role, other than her own, without experiencing the threat that she herself might disappear. An example of this type of cognitive anxiety occurs on Halloween, when some young children, 3 to 4 years old, exhibit fear of being in disguise. The costume suggests to the young child that she could disappear. However, at a later age a child can tolerate donning a disguise and playing another's role; she has gained self-constancy.

Dynamic Components of Play Activity. The topic of play reveals important emotional themes to the child. A child who repetitively engages in play about particular topics is communicating about the types of conflicts he is dealing with at the time: fear of death, sexual themes, competitiveness. The theme indicates the narrative of the play enacted by particular characters. It is important to keep in mind what topics and themes might be expected for a given developmental perspective and what minor discrepancies might represent divergence from this expected pattern. The divergence may be significant in conveying a specific concern of the child.

The level of relationship portrayed within the play activity specifies the pattern of inter-

actions between play characters. The level of dyadic, triadic, and oedipal configurations places the child at different points of personality organization, from severely disturbed personalities to neurotic or normal ones.

The Quality of Relationship Within the Play Activity segment is an adaptation of the Urist Scale,[9] as written for children by Tuber,[14] and the scale of Diamond et al.[15] It assesses, through the dynamics of the narrative, the nature of the child's emotional conflicts and the extent of expression of aggression—direct, attenuated, neutralized, or sublimated—that he exercises over his subjective world, i.e., autonomous, dependent, and destructive interaction among play characters.

Developmental Components of Play Activity. This dimension compares the child's activity with play of other children of the same age, gender, and level of emotional and social development. This analysis implies an underlying epigenetic sequence to the unfolding of a child's capacity to play. It is a relative judgment and depends on cultural and social standards and values. Because play unfolds in a socially shared context, group norms are appropriate to evaluate the child's play. Ideally, play activity is consistent across developmental dimensions.

Several different sources supplied information for the compilation of these last categories. Gender identity assessment was influenced by the writing of Erikson,[8,10,16] Coates,[17] and Zucker;[18] psychosexual phases were based on the writings of Anna Freud[19] and Peller;[20] separation-individuation phases were based on the writings of Mahler;[21] and the social level of play includes Winnicott's concept of the capacity to play alone.[22]

Adaptive Analysis: The adaptive analysis assesses the overall purpose of the play activity for the playing child. The child's observable play behaviors are classified as manifesting specific coping/defensive strategies grouped into four clusters: 1) Normal, 2) Neurotic, 3) Borderline, and 4) Psychotic. These clusters may be placed in sequence in order of their appearance. The concept of a spectrum of clusters of coping and defensive strategies was based on the writings of Vaillant,[23] Perry et al.,[24] and P. Kernberg.[25]

A final subscale measures the child's awareness that he is engaged in play activity. This subscale condenses several cognitive and affective variables that determine how capable the child is of observing himself at play, or, alternatively, the extent to which he and his surroundings have been completely absorbed into the play.

As outlined above, each of the CPTI scales (Descriptive, Structural, and Adaptive) consists of several subscales (see Table 1). Depending on the interests of the examiner, he or she may use the CPTI in its entirety or may select only certain scales or combinations of subscales.

Level Three: Patterns Over Time

This level of analysis refers to patterns of the child's activity over time and seeks to assess changes in treatment. The patterns of segmentation are expected to change over time. For example, the sequence and length of the different segments of the child's activity—Preplay, Play Activity, Non-play, and Interruption—change in the course of treatment depending on the child's diagnosis and type of treatment. However, this level of analysis will not be addressed in this article.

PRELIMINARY RELIABILITY STUDY

Construction of the instrument required multiple observations of videotaped play therapy sessions. The associated discussions involved 10 experienced clinicians over a span of 3 years. The authors of the scale gleaned material from these discussions to write a manual defining the primary dimensions of the CPTI and formulating operational definitions for each scale and subscale, with clinical illustrations.

Methods and Results

A preliminary reliability study was planned using three members of the group as raters. A videotape montage consisting of eight clinical vignettes was composed by an independent clinician trained to identify the different categories of child activity. The main selection criterion was to find segments that contained at least one segment of play activity and any of the other three child activities (Pre-Play, Non-Play, and Interruption). Table 2 describes the sample.

Level One (Segmentation): The three raters (one psychiatrist, two psychologists) were child therapists, each with more than 10 years of clinical experience. They rated the eight vignettes independently, with subsequent discussions of the ratings to improve on the clarity of the segmentation in the manual.

Agreement on the segmentation of the child's activity into four categories (Pre-Play, Non-Play, Play, and Interruption) as measured by the weighted kappa coefficient was 0.69.[26] This level of agreement between the judges on segmentation is considered to be good.*

Level Two (Dimensional Analysis): Two raters (one psychiatrist, one psychologist) completed ratings for level two. Analysis of the play activity segments was done by using intraclass correlation coefficient (ICC)[28] for ordinal categories of the CPTI and kappa for the nominal ones. The most consistent subscale scores were obtained on the Descriptive dimension of the CPTI. For example, Category of Play Activity, ICC = 0.68; Script Description, ICC = 0.70; Sphere of Play Activity, ICC = 0.88.**

Among the Structural and Adaptive scales, good to excellent scores were obtained for all the subscales on these dimensions. These scores ranged from ICC 0.50 to 0.79. For example, Affects Expressed in Play, ICC = 0.77; Stability of Role Representation, ICC = 0.79; Developmental Level of Play, ICC = 0.50; Social Level of Play, ICC = 0.56. Low scores were obtained on Role Representation, ICC = 0.29; Use of Play Object, ICC = 0.33; and Use of Language, ICC = 0.32. The Adaptive dimension produced the lowest results, ICC = 0.09.

Despite acceptable levels of agreement between raters on many of the subscales, there were disparities on some subscales, which were attributed primarily to the lack of sufficient specificity in definition of categories in the manual. A decision was made to revise the scoring manual and refine the definitions.

To establish a consensual rating to be used as a standard for new independent raters, the raters of the preliminary study performed an item-by-item analysis of the ratings of the eight vignettes.

RELIABILITY STUDY: INDEPENDENT RATERS AND COMPARISON WITH CONSENSUS

Methods

Three independent raters, recruited from different institutions, rated the same eight videotaped vignettes used in the preliminary reliability study. The raters were all child psychologists, ranging in experience from 1 to 12 years in child therapy. They received 15 hours of training from one of the authors (a psychologist). The training consisted of group discussions based on definitions and descriptions of the CPTI scales found in the manual.

Eight vignettes were selected from a set of 19 videotaped play therapy sessions by an independent clinician who was trained to

* Landis and Koch[27] furnished criteria to assess the level of agreement between judges as calculated from the kappa: 0.00 to 0.39 poor; 0.40 to 0.74 acceptable to good; 0.75 to 1.00 excellent.

** Jones et al.[29] suggested 0.70 agreement as an acceptable level when complex coding schemes are used; Gelfand and Hartmann[30] recommend 0.60.

identify the different Level One categories of Child's Activity, namely Pre-Play, Play, Non-Play, and Interruption. The main selection criterion was to find segments that contained at least one Play Activity, defined as a narrative with a beginning and an end, and any of the other three Child Activities. Also, the vignettes were chosen to provide a varied array of child diagnoses, levels of therapist experience, and phases of treatment. The duration of the vignettes ranged from 4 minutes, 6 seconds, to 11 minutes, 34 seconds, with a mean of 7 minutes, 47 seconds, and a standard deviation of 2 minutes, 37 seconds (see Table 2).

To maintain each rater's accuracy, ratings sessions were split into two parts, as suggested by Hartmann,[31] each part consisting of the CPTI-based rating of four vignettes followed by a discussion with the trainer.

After the submission of the whole ratings, discussion and comparison with the authors' consensus ratings were conducted. Reliability estimates were obtained for the degree of agreement of each individual rater with the consensus. The raters contributed to the clarification of the manual categories and to their training by the exchange of opinions and clinical examples from their own experience.

Three types of reliability estimates were derived from data, according to the different types of scales constituting the CPTI and the number of raters used in the experiment.

Reliability of the categorical data obtained from the segmentation of the eight vignettes (Level One) was appraised by using a weighted kappa.[26] Disagreements between different categories have different clinical implications. For example, it is more serious to rate equally Play and Non-Play than Pre-Play and Play. Therefore, the relative importance of different types of disagreement among the four categories of the Child Activity (Pre-Play, Play, Non-Play and Interruption) was established in order to perform the data analysis. A disagreement between Play, Non-Play, or Pre-Play and Interruption gets a weight of 1.00; a disagreement between Play and Non-Play gets a weight of 0.75; a disagreement between Pre-Play and Non-Play gets a weight of 0.50; and a disagreement between Play and Pre-Play gets a weight of 0.25. However, weighted kappa is restricted to cases where the number of raters is two *and* the same two raters rate each subject (vignette).[28] In this study, we will present a mean weighted kappa derived from each pair of raters.

TABLE 2. Description of the eight vignettes

Therapist	Patient	Phase of Diagnosis	Therapy	Duration
1. 1st-year child resident	5–6-year-old boy	Adjustment reaction disorder Grief reaction	Middle–advanced	6′25″
2. Resident psychology intern	5-year-old girl	Stress disorder Physical child abuse Failure to thrive	Middle–advanced	6′54″
3. Senior therapist >15 years	5–7-year-old boy	Gender identity disorder Posttraumatic stress disorder	Early–middle	8′36″
4. Therapist 5 years	9-year-old boy	Oppositional defiant disorder	Late	11′34″
5. 2nd-year child resident	7-year-old girl	Separation anxiety disorder Avoidant disorder	Middle–advanced	8′02″
6. Psychology intern	5-year-old girl	Posttraumatic stress disorder Physical child abuse Failure to thrive	Middle–advanced	5′06″
7. Senior therapist > 15 years	9½-year-old boy	Pervasive developmental disorder Autism	Beginning	4′06″
8. Senior therapist > 20 years	10-year-old boy	Conduct disorder	Middle	9′02″

For reliability of the categorical scales from Level Two of the CPTI, namely Category of Play Activity, subscales of Child and Adult Script Description, Topic, Theme, and Gender Identity, a multiple-rater kappa is estimated,[32,33] in which the average pairwise kappas are adjusted for covariation among pairwise kappas and chance agreements.

For appraising reliability of the remaining quantitative scales of the CPTI (ordinal scale ranging from 1 to 5), an intraclass correlation coefficient is calculated, using a two-way analysis of variance, where the three raters are considered random effects. Thus, differences at the between-raters level are included as error from the analysis. The choice of this statistic is based on the wish of the authors to generalize the estimated results to raters who have at least 1 year of clinical experience and as much as 12 years of experience, so that the CPTI could be reliably used by a variety of clinicians.[34,35]

Results

Level One: Segmentation: Agreement among three raters on the segmentation of a child's activity into four categories (Pre-Play, Play Activity, Interruption, and Non-Play) as measured by the weighted kappa coefficient was 0.72.

Level Two: Dimensional Analysis: Interrater reliabilities measured by the kappa coefficient for the twelve categorical subscales of the CPTI indicate an average coefficient of 0.65, with range 0.42 to 1.00 (Table 3). The single exception was 0.12, Initiation of Play by Adult.

The kappa statistic is extremely sensitive to an unbalanced distribution of categories (presence versus absence), and this sensitivity accounted for some of the variability in our results.

The intraclass correlation coefficients for the 25 main ordinal subscales of the CPTI—specifically the global scores for Script Description, Affective, Cognitive, Developmental, and Dynamic components; Adaptive functions; and Awareness—show a mean tendency of 0.71, with a range from acceptable to excellent (ICC 0.52–0.89). However, there are two subscales at unacceptable levels of reliability, namely Separation-Individuation Phases Represented in the Play (ICC = 0.43), an increment over earlier findings but still below acceptable levels, and Borderline coping/defensive mechanisms (ICC = 0.45), lower than the acceptable levels obtained for other coping/defensive mechanisms.

Generally, the new raters did almost as well as the authors of the scale and in several instances were able to obtain higher levels of interrater reliability. Significant improvements were seen in Style of Role Representation: Play Object (ICC = 0.83, compared with 0.38); Separation-Individuation Phase Represented in the Play (ICC = 0.43, compared with 0.21).

Individual Rater Agreement With the Consensus: Each rater's performance was compared with the standard provided by the consensus of the authors of the scale. Results indicate that, overall, satisfactory to excellent agreement with the standard was obtained by all three judges. For example, the intraclass correlation coefficients for seven main subscales of the CPTI—specifically the global scores for Script Description, Affective, Cognitive, Developmental, and Dynamic components; Adaptive functions; and Awareness—show a mean of ICC = 0.81 (range 0.61–0.94) for Rater A; a mean of ICC = 0.84 (range 0.69–0.92) for Rater B; and a mean of ICC = 0.84 (range 0.71–0.96) for Rater C.

Further comparisons were performed for each individual vignette and revealed a similar pattern of results on the main structural categories of the CPTI. Raters A, B, and C reached good to excellent agreement with the standard. The intraclass correlation coefficients for the four main structural categories of the CPTI, specifically the global scores for Affective, Cognitive, Developmental, and Dynamic components, show a mean of ICC = 0.62 (range 0.58–0.85) for Rater A; a mean of ICC = 0.73 (range 0.59–0.81) for Rater B; and a mean of ICC = 0.69 (range 0.63–0.75) for Rater C.

TABLE 3. Interrater reliability among three raters as measured by kappa and intraclass correlation coefficients (ICC)

Variable	Kappa	% Agreement[a]	ICC
Category of the Play Activity Segment	0.50	81.0	NA
Script Description of the Play Activity Segment (Global)	NA		0.89
Script Description (Child)	NA		0.86
Initiation of Play	1.00	100.0	NA
Facilitation of Play	1.00	100.0	NA
Inhibition of Play	0.47	87.2	NA
Ending of Play	0.52	80.0	NA
Script Description (Adult)	NA		0.87
Initiation of Play	0.12	44.4	NA
Facilitation of Play	1.00	100.0	NA
Inhibition of Play	0.42	86.1	NA
Ending of Play	1.00	100.0	NA
Contribution of Participants (Child)	NA		0.89
Contribution of Participants (Adult)	NA		0.57
Sphere of the Play Activity	NA		0.92
Affective Components of the Play Activity Segment (Global)	NA		0.84
Child's Affects Modulation	NA		0.70
Affects Expressed by the Child while in the Play	NA		0.73
Therapist's Affective Tone	NA		0.66
Cognitive Components (Global)	NA		0.80
Role Representation	NA		0.72
Stability of Representation (People)	NA		0.83
Stability of Representation (Play Object)	NA		0.84
Use of Play Object	NA		0.88
Style of Role Representation (People)	NA		0.64
Style of Role Representation (Play Object)	NA		0.83
Dynamic Components of the Play Activity Segment (Global)	0.63	92.3	0.68
Topic of the Play Activity Segment	0.66	94.1	NA
Theme of the Play Activity Segment	0.60	90.7	NA
Level of Relationship Portrayed within the Play Activity Segment	NA		0.82
Quality of Relationship within the Play Activity Segment	NA		0.70
Use of Language by the Child	NA		0.68
Use of Language by the Therapist	NA		0.57
Developmental Components of the Play Activity (Global)	NA		0.62
Estimated Developmental Level of Play	NA		0.90
Gender Identity of Play	0.90		NA
Psychosexual Phase Represented in the Play	NA		0.72
Separation-Individuation Phase Represented in the Play	NA		0.43
Social Level of Play: Interaction with the Therapist	NA		0.63
Adaptive Analysis of the Play Activity (Global)	NA		0.65
Cluster I	NA		0.81
Cluster II	NA		0.64
Cluster III	NA		0.45
Cluster IV	NA		0.60
Awareness	NA		0.52

[a]Percentage agreement among the three judges.

These comparisons were derived from the consensual mean and standard deviation scores obtained for each vignette (Table 4). One should note that vignettes that are associated with high mean scores and small standard deviation scores are mainly associated with the middle–advanced and late phases of treatment, whereas low mean scores and large standard deviation scores are associated with vignettes from the beginning or middle phases of treatment.

DISCUSSION

These preliminary studies demonstrate the feasibility of using the CPTI to measure a child's activity in psychotherapy. The CPTI provides a means to identify play activity within a psychotherapy session. The play activity is then measured from three different perspectives: descriptive, structural, and adaptive. Each of these dimensions consists of individual subscales that are operationally defined. The quantification of these subscales provides both the flexibility to derive individual profiles of play activity in psychotherapy and a methodology to identify relevant dimensions of a child's play activity.

Training procedures established the credibility of these measures in assessing play activity. The independent raters, with varying levels of experience, required 15 hours of training to reach satisfactory levels of agreement. This result is preliminary evidence to suggest CPTI may be a usable tool for researchers and clinicians who receive a minimum of 15 hours of intensive training.

Despite the small number of vignettes used to establish the reliability of the instrument, it must be stated that the vignettes embrace the whole spectrum of the different ordinal scales. The vignettes that showed higher mean scores with smaller standard deviations were associated with the middle–advanced and late phases of treatment; lower mean scores with larger SDs were associated with vignettes from the beginning or middle phases of treatment. Likewise, the raters were consistently able to make these sensitive distinctions. However, in some subscales using the kappa, reliabilities were lowered by a preponderant representation of one of the categories over the other; for example, (Adult) Initiation of Play ($\kappa = 0.12$) and Functional analysis: Cluster II ($\kappa = 0.41$). This disproportionate pattern was likely to lower the reliability coefficient each time a disagreement on the less represented category was encountered.

The Separation-Individuation category of the Developmental scale gave results below acceptable standards. A closer examination of raters' individual ratings showed a wide discrepancy among raters. This scale clearly required further definition, particularly as it pertains to higher-functioning children. Further work on clarifying the phases of separation-individuation represented in the child's play resulted in a revision of the definitions of these categories in the manual. Specifically, new examples illustrating these phenomena in

TABLE 4. Means and standard deviations of the average rating for the main structural categories of each vignette

	Vignette Number and Phase of Treatment							
	1	2	3	4	5	6	7	8
Variable	M-A	M-A	M-E	L	M-A	M-A	B	M
Affective (Global)	3.2 ± 1.1	4.2 ± 0.8	2.8 ± 1.7	3.7 ± 0.9	3.5 ± 1.1	4.1 ± 0.6	1.7 ± 2.3	2.7 ± 2.1
Cognitive (Global)	3.7 ± 1.2	3.9 ± 0.5	2.9 ± 2.1	2.9 ± 0.5	3.5 ± 1.2	4.3 ± 1.2	1.5 ± 1.6	3.4 ± 1.3
Dynamic (Global)	4.2 ± 0.6	2.7 ± 1.4	2.7 ± 2.4	3.3 ± 1.1	2.7 ± 1.5	3.5 ± 0.6	1.7 ± 2.1	2.9 ± 1.9
Developmental (Global)	3.0 ± 0.9	3.1 ± 0.7	2.8 ± 1.5	3.3 ± 0.9	2.9 ± 0.8	3.1 ± 0.9	1.4 ± 2.2	2.7 ± 1.8

Note: Phases of treatment: M-A = middle–advanced; M-E = middle–early; L = late; B = beginning; M = middle.

children with mild emotional disorders were added in the training. In the prior reliability studies, raters had experienced difficulty making meaningful reference to these categories, except in cases of severe disturbance (psychosis and autism). After a 2-month hiatus, the Separation-Individuation subscale was readministered to the group of three trained raters, and the results obtained were good: ICC = 0.63.

Looking toward the future, a larger database is required, to include both clinical and nonclinical children, to establish definitive reliability and to validate the sensitivity and specificity of the CPTI as a diagnostic tool that discriminates distinctive psychopathological profiles and is sensitive to changes occurring in the course of treatment.

SUMMARY

We described the development of a new and comprehensive measure of a child's play activity in psychotherapy, the CPTI, and presented reliability studies. Using the instrument and accompanying manual, raters were trained to obtain satisfactory to excellent levels of agreement on the segmentation and dimensions of a child's play activity occurring within a psychotherapy session. In addition, each of these trained raters obtained good to excellent agreement with the consensus standard for the scale reached by the authors of the scale. Future planned studies include obtaining reliability on a larger new sample of play sessions and evaluating sequences of play sessions over time. In addition, future validity studies are planned to investigate the concurrence of play profiles with diagnostic categories, attachment behaviors, and outcome variables. These preliminary findings indicate that the CPTI holds promise to become a diagnostic instrument and outcome measure of a child's play activity in psychotherapy.

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Affect and Therapeutic Process in Groups for Chronically Mentally Ill Persons

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A dynamic group treatment model for chronically ill persons allowing them to determine the frequency of attendance empowers the members and potentiates group development. This format respects patients' needs for space as represented by missed meetings. In this context, absences are formulated as self-protective and self-stabilizing acts rather than as resistance. In an accepting, supportive environment, members can be helped to explore affects and gain insight into their behaviors. A clinical example illustrates patients' examination of the meaning of missing and attending sessions, with particular focus on intensity of involvement, autonomy, and control. In the process of testing the therapist and group, members show capacity to gain insight into recent in-group and extra-group behaviors.

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The ravaging effects of schizophrenic and bipolar illness on thought and affect remain a therapeutic challenge. The multiple biological, social, and emotional needs that are the basis and consequence of severe and persistent mental illness defy simplistic solutions. Medication may alleviate some of the chaos but fails to reverse or halt impairment in essential areas of human functioning—relations with the self and with others from which come a sense of wellness and comfortable regard.

For many patients, the illness may have begun in childhood, even before overt clinical features were present or were of sufficient intensity to justify a clinical diagnosis. Many first-person reports attest to patients' recollections of feeling different, estranged, or isolated from peer groups. Before the onset of a diagnosable illness, impairments may be expressed in the social domain as diminished interpersonal responsiveness, poor eye contact, and failures in expression of positive affect. Subtle motor symptoms add to these individuals' relational awkwardness.[1] After the onset of clinical illness, the personal and societal costs escalate.

Innovative psychosocial treatment approaches have been partially effective in alleviating patients' disabilities. Case management and assertive community treatment have focused on providing services to severely im-

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paired individuals who require assistance in everyday living. Social skills training and vocational rehabilitation address aspects of social impairment. Psychoeducational programs, including family management, are valuable additions to the overall treatment armamentarium. Amidst this plethora of interventions, the place of psychotherapy, and in particular long-term group psychotherapy aimed at assisting patients in their efforts to improve their psychosocial functioning, has been relegated to lesser overall importance.

Research findings for psychotherapy of schizophrenia have not been robust, and as a result research efforts in this area have nearly vanished. This has occurred in part because of the hypothesized lack of effectiveness of psychotherapy when compared with medications and in part because of problems inherent in funding and conducting psychotherapy research. The difficulties are magnified when it comes to research on group treatment.

Reviews of psychotherapy for schizophrenia suggest that outpatient group treatment may help patients improve social functioning.[2,3] The treatment process is described as occurring in a two-step sequence: 1) a stabilization phase, which focuses on reducing and stabilizing positive symptoms and maintaining patients in the community; and 2) a rehabilitation phase, in which emphasis is on social adjustment relationships, interpersonal relations, and vocational possibilities.[4]

In the stabilization phase, treatment emphasizes patients continuing their medications and becoming more informed about their illness through supportive and educational strategies. This approach is particularly salient with the current practice of brief periods of hospitalization.

In the rehabilitation phase, the emphasis shifts to exploration of patients' capacities to form and sustain social relations and to determination of vocational capacities. Change in these latter sectors takes place much more slowly and is more difficult to assess. Yet it is in this rehabilitation phase that long-term psychotherapy, including group therapy, can have a significant impact on interpersonal and intrapsychic functioning. In this process patients can slowly gain greater control over their affects and develop insights into aspects of their relationships with others and with self.

The salience of addressing the social and interpersonal sectors of functioning in chronic mental illness was reported in a survey by Coursey et al.[5] Chronically ill patients in rehabilitation settings were asked to rate the importance of 40 therapeutic topics. The highest rated items clustered in a category described as "illness-intensified life issues" and encompassed independence, developing self-esteem, relationships, and feelings. Other categories, rated important at least two-thirds of the time, included adverse secondary consequences of the illness, self-management of the disorder, and coming to terms with the disability. These findings bring into focus patients' awareness of a continuity in their life and an appreciation that their condition has added a particularly devastating dimension to difficulties that may have been present prior to the onset of their clinical illness.

In the context of a history of social disappointments and emotional injury or rejection, it would be unrealistic to expect patients engaging in treatment to rapidly reveal their inner experiences and risk being retraumatized without thoroughly testing their environment. They will test and retest the therapist and the group to assess the safety of the situation. The clinician who "sticks with it" despite the personal difficulties—which may include both countertransferences and the real aspects of the relationships—will find opportunities to gain understanding of patients' efforts to cope, protect themselves, and work toward making positive changes in their lives.

THE CHANGING FACE OF PSYCHOTHERAPY

The quality of the relationship between patient and therapist is recognized as the foundation on which the therapist can assist the patient in gaining self-awareness and psychological

growth. Among the many theoretical advances there are two important strands: the consistent use of an empathic stance[6–8] and increasing attention to the therapist's affect.[9–11]

Self psychology has enabled clinicians to gain greater understanding of the patient's "use" of the therapist as a selfobject to fulfill missing or incompletely formed psychological functions, including containment of affects. Therapists can experience considerable dysphoria when they feel depersonalized and treated as a function. Recognizing this phenomenon as an archaic selfobject transference helps clinicians maintain their emotional equilibrium. In turn, therapists, by maintaining their balance, can more effectively help patients understand themselves.

A second valuable theoretical contribution, the "higher mental functioning" hypothesis described by Weiss and Sampson, explicates patients' interactions as conscious and unconscious testing in the therapeutic encounter. The tests are "designed" to determine if pathogenic beliefs in childhood should be sustained.[12–14] Skolnick,[15] working with psychotic and borderline individuals, writes, "No matter how withdrawn or bizarre these individuals may seem, or how much they try to destroy links with others, often there remain disguised pleas for help and attempts to communicate about the agonies of becoming and relating" (p. 243). Apprehending the confusing and disturbing affects evoked in the clinician in response to the "test" provides information about the patient's therapeutic hopes.

These and other theoretical advances have contributed to changes in therapeutic technique. Writing primarily within a self psychological framework, Lichtenberg et al.[16] note that they emphasize emotions as a guide for "appreciating self-experience and the desires, wishes, goals, aims, and values that come to be elaborated in symbolic forms" (p. 9). In psychotherapy of psychosis, affect "serves as the 'handle' that the psychotherapist 'grabs' in the effort to help the patient tolerate unbearable feelings and subsequently to reorganize his or her behavior in interpersonally productive ways" (p. 12).[9] The clinician's capacity to examine his or her affects stirred in the treatment transactions and then to use these responses to advantage becomes a central element in the conduct of treatment.

The focus on affects contributes to therapy becoming a more collaborative venture in which clinicians no longer make interpretations as the "truth," but instead offer interventions that encourage patients to make necessary "corrections." This stance recognizes that the patient's self experience is central, and that each participant has important emotions that can mutually enhance understanding. Thus, a patient's rejection or incomplete acceptance of a therapist's interpretation is not considered solely as resistance, but as a potential message regarding the impact on the patient of the therapist's interventions.

In group psychotherapy the complexity of communication is multiplied manifold. Interactions take place in relation to authority, to peers, or to the group as a whole. Particularly salient for individuals with chronic mental illness are fears of being unable to maintain a sense of themselves in a potentially threatening situation, with the possibility that they will experience further psychic disruption. The source of these potential injuries arises not only from the clinician, but from member-to-member interactions, or from member-to-subgroup or group-as-a-whole interactions.

In the process of emotionally joining a group, members may experience intense and potentially disorganizing affect stimulation that occurs in relation to others and within themselves. The group can come to represent or simulate life experiences, before or after the onset of the illness or in or outside the family. Old defensive and adaptive patterns will emerge, primarily as resistances or as tests to determine if the individual will be traumatized in the present as in the past. Thus the obvious cautious engagement and sense of mistrust displayed by most patients is understandable. Even with an optimal empathic response, change, if it is to occur, will take place slowly.

The model of the flexibly bound group is designed to collaboratively empower members and potentiate respect for each person's capacity to engage in treatment. The central element of the model is a group structure in which patients, after attending four sessions, choose the frequency with which they wish to attend meetings. This agreement, which reflects patient behavior but diminishes the potential for patients to feel pressure to attend each session as well as lessening the clinician's concerns about attendance, results in a group formation of core and peripheral subgroups. Group development is delayed, but over time the group becomes cohesive, and members can begin to address their intragroup relationships. In this context, it becomes possible to explore absences and for individuals to examine the reasons they give for their absences and gain insight into their failures to attend in accord with their agreement.

The following illustration examines the impact of a treatment structure that builds in flexibility of attendance, but without precluding discussion of absences in members learning about themselves and their affect states in relation to others.

ILLUSTRATION

The group, which has been in existence for over a decade, has achieved considerable stability, with a current census of 8 members. No persons have been added in the past 2 years. With the exception of Greg, who is diagnosed with mild mental retardation and a dependent personality disorder, all members have a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder. The group structure has evolved with a core subgroup of 5 persons who attend more than 75% of the meetings; 2 members who attend intermittently; and 1 who appears at widely spaced intervals. Members had engaged sufficiently to interact with one another and were no longer turning almost exclusively to the therapist.

The vignette illustrates patients' capacity to work with affects related to group absences and to gain insight into aspects of their behavior. Following a small meeting, with 2 or 3 persons present, it is possible to explore experiential aspects of group membership by focusing on subgroups (those who were present and those who were absent), thereby not isolating any single individual.

Sessions are 45 minutes long. All are videotaped, with the camera operator in the room and in view of the members. The vignette presented below was transcribed from the videotape and then edited for ease of presentation.

The session was particularly striking in members' movement of chairs. The seats had been set up in a horseshoe shape for videotaping but were pulled back by the patients in a manner that lessened the sense that they were sitting in a semicircle. However, within the first 12 minutes of the meeting, there were 5 instances of patients moving their seats more fully into their original position. At a point in the meeting at which the most distant member, Carl, seemed more engaged, the therapist invited him to bring his chair closer, a request with which he complied.

The meeting took place in mid-December. Three weeks previously, the group had not met because of the Thanksgiving holiday. Additionally, members had been informed there would not be a meeting between Christmas and the New Year holiday. These circumstances created a sense of discontinuity, and in the session prior to that illustrated in the vignette only Rita and Greg had been present. The focus of that session had been Greg's fears that he would be separated from his mother, whose deteriorating health made hospitalization appear imminent.

The following session began with 6 of the 8 members present. The therapist was 3 minutes late. After the therapist's entry into the room there was an initial subdued silence.

THERAPIST: What's been happening?

LORNA: You could say that we are all so sedated. [*laughs*]

RITA: Well, it's the first time in a couple of weeks that everybody has been here, I think. [*pulls in*

her chair] It seems like the last couple of times a lot of people weren't here. Last week it was just Greg and me.

JACK: I had a bad cold last week. I could have come, but I didn't want to spread my germs. But I didn't feel good either.

RITA: I wouldn't, either. That would have made you crabby.

JACK: I'm crabby enough as it is.

GREG: There was only Rita and I here.

RITA: We got a lot accomplished, though.

Following a brief interchange in which it is acknowledged that there have been prior meetings with only one or two members present, the interaction continues.

JACK: [*moves his chair into the circle*] So who did all the talking? Greg?

RITA: He had some problems at home he needed to talk about.

JACK: It was good that he had a chance to talk about them.

This comment seems to invite closure, but Rita (while moving her chair in more) continues the discussion of the previous week's topic, and Greg relates that his mother has improved and remains at home. Rick has wondered if prayer had helped her, and Greg responds that indeed they had prayed. When this discussion has run its course, the therapist intervenes.

THERAPIST: We were talking about one side of it: what it's like for Greg and Rita to be here. What about the others? What's it like to miss?

JACK: I needed to miss because I was sick, but the reason, I mean, I'm here practically every week. I could say I'm here every week. I just want to get away from it for a while. Not that I didn't get away Thanksgiving, but there was no group Thanksgiving. I wanted to be away when there was a group once. So I was glad to get away for a while.

RITA: I think it's good.

JACK: Once in a great while.

RICK: I was away for two or three weeks. I wanted to be here.

GREG: You didn't want to be here?

RICK: I *did* want to be here. I was having depression and stuff.

RITA: That's the worst part of it. When you want to be here and your depression keeps you away.

RICK: Yeah, well I wasn't doing anything else, either.

THERAPIST: What happens here? The two of you [Rita and Jack] are saying the same kind of thing. Though I would expect in part that others feel the same, can you say what it is about the group that you want to get away from, or is it something inside you or something about yourself?

JACK: Well, it's kind of equivalent to being on the job every day for a year and just the pressure every day. Every day and the routine, not a boring routine; the routine of it all and it's just like . . . I didn't go anywhere on vacation, but it felt like I was on vacation from the group, and I do feel better after I did that, and I do. [*Greg pulls his chair closer into the group*.]

LORNA: It's kinda like working on something. Each one of us has a different story.

THERAPIST: [*to Lorna*] Can you say more? Does it feel better to work on it at times alone or in the group? Can you identify when you might want to get away? What's happening inside you?

LORNA: Well, I never really want to get away, but I am asleep until 10:00 or 10:30 in the morning, which I have been doing lately. That kinda happens. It is good to get away at times. It is intense. All these . . . you know, everybody is so different.

THERAPIST: To feel others' problems at times feels intense.

LORNA: Yeah, I don't know exactly; it would be depression.

This theme related to missing meetings continues. Initially, Carl echoes the view that he "sort of likes missing," and he has so many things he is doing, but then he acknowledges that it is a relief not to have to listen to others. Rick indicates that the day he comes to the group is the only day he does anything, that otherwise his week is empty. Jack's ambivalence emerges, but he indicates that he would benefit from being away one time.

THERAPIST: It is different if one makes that decision [to be away] rather than the group not meeting. That is when you miss a week when you decide, rather than when there isn't a group scheduled.

JACK: It might be a week that there is no group scheduled, and you might really need one. And when you choose your own, maybe it's for a good reason. Maybe you are running away from something, but at least you are in control. [*moves his chair further into the circle*]

THERAPIST: [*to Rita*] Where does this fit for you?

RITA: I might handle what they do the same way. I might not come once in a while. Also I might handle it another way in the group. You used to say I talked too much. Maybe I talked too much because . . . what other people say upset me, and I . . . then it won't upset me so much.
JACK: So you didn't have to listen to somebody else.
RITA: I might. I'm saying that it could be.
RICK: You don't talk too much any more.
RITA: Maybe I'm getting better. [*pause*] I felt bad because nobody was coming because [*referring to a prior meeting*] me and Rick were talking all of the time.
CARL: It's so hot in here. I'm getting hot.
RITA: You're not getting sick, are you?

Not hearing the metaphor, the therapist refocuses back to feelings about regularly attending the meetings. Jack begins to express the idea that he wishes attendance were mandatory. He elaborates that he feels tension while in the group and that he is "forced to think harder in here than anyplace else." The therapist again intervenes, suggesting that each individual has his or her own "internal monitor" that helps regulate attendance, and asks again for descriptions of the inner feelings. Carl, who acknowledges that being busy is an excuse, says that the group is the place where he talks to people the most, except when he is on the phone. At this point, the therapist invites Carl to move his chair into the group, and he complies. These interactions took place within the initial 15 minutes of the meeting.

DISCUSSION

This vignette illustrates the capacity of some chronically ill persons to engage in a discussion of the intensity of their feelings stimulated by participating in group psychotherapy, and to gain insight into aspects of their self-protective behaviors. Participating in group therapy provides opportunities for patients to become more flexible in managing affects. A group also represents a threat, since patients fear that they will be unable to maintain their personal boundaries and will be flooded with their own and others' affects. The result is a tendency to miss sessions or terminate treatment.[17] However, absences can be understood not only as a defense, but as a test as well. The test might be formulated, "If I assert my independence and decide not to come to a meeting, will I be criticized, punished, neglected, or ignored altogether?" If this and similar tests are passed, patients may increase their trust in others and begin to tolerate and integrate their affects.

Rita begins with the bland statement that people have not been present for several weeks. The affective meaning of this is not initially apparent but emerges in the ensuing process. Jack indicates that his absence was due to his cold, but his gratuitous comment, "I didn't want to spread my germs," may be understood as a metaphor for fears that he would emotionally infect others. The interchange focuses on being "crabby" as the uncomfortable emotion.

The emotionally salient central theme of separations and losses is illustrated by Rita's continued discussion with Greg of his mother's illness and the possibility of her requiring hospital care. The dyadic form of this discussion, as if only Rita and Greg were present, reenacted the prior week's session. The therapist's inquiry framed members' enactment as belonging to one of two subgroups: those present and those absent the preceding week. The interpretation emerged from the therapist's listening "and not bother[ing] about keeping anything in mind."[18] Such interventions have been labeled "disciplined spontaneous engagements" and represent the therapist's "generative intent" emerging from knowledge of the patients.[16] Contributing to the intervention was the therapist's experience with group treatment and his appreciation that patients were more willing to share feelings and engage in the group if they were part of a subgroup.[19]

The model of the flexibly bound group does not preclude discussion of absences. Over time a rhythm of attendance becomes established, and members know, and respond, when others do not attend in accordance with their usual agreement. In this session, members' responses ranged from describing meetings as boring to describing them as intense.

This latter feeling is addressed by Jack and by Carl, who indicates that it is a relief not to have to listen to others.

After the therapist differentiates between missing due to canceled sessions and missing through a patient's personal decision, Jack is able to summarize the central theme as a conflict that "you have control even if you are running away." Lotterman[20] (p. 115) reflects on the importance of control in the psychotherapy of patients diagnosed with schizophrenia:

> Schizophrenic patients are enormously sensitive to intrusion and what to them feels like coercion. If they feel invaded or violated, they will flee. . . . [They] can travel far down the path of self-destruction with little concern, and can quickly bring themselves and their treatments to the brink of collapse. . . . The therapist is caught between the Scylla of overactivity and intrusiveness, and the Charybdis of being lulled by the patient's bland denial until suddenly the treatment is destroyed.

The flexibly bound group model enables the therapist to comfortably permit missing, which thereby allows patients to maintain a degree of sanction-free control.

A paradox is involved in discussing patients' fears of being overwhelmed and accepting, if not encouraging, their choosing to distance themselves. The therapist, by verbalizing patients' needs to have control, accepts their needs to create personal space and distance. Members are then prepared to explore fears of losing control and being unable to manage personal boundaries. Out of this therapeutic stance emerges the patients' wish for involvement, which had been partially obscured. The members' wish for greater engagement is enacted in behavior as they draw their chairs into the group circle.

Coursey et al.[5] reported that 84% of the surveyed schizophrenic patients preferred shorter, less frequent individual sessions (less than 30 minutes, less than once a month). With this treatment dosage, ¾ of respondents indicated that therapy had brought positive or very positive changes to their lives. Thus it is not surprising that attendance in a more complex social setting of a group will be linked to absences. Over time, absences may decrease and greater engagement take place. Moving one's chair outside the circle represents a mini-distancing. When patients have a sense of control and acceptance, they are freer to diminish that distance. Jack's comment equating running away with control was directly linked to his moving his chair into the circle.

The therapist, not consciously recalling Rita's history of monopolizing meetings, turned to her to ask where this fit in for her. Rita said that she used a different behavior (talking) to achieve the similar goal of creating space. In this process, Rita's self-reflection demonstrated the paradox and represented a step in addressing a more difficult issue, her anxious fantasy that her excessive talking had been the cause of others' recent absences.

I would suggest that the integrative act (insight) of linking talking with control enhanced Rita's self-esteem. An experience of discovery and a concomitant experience of self-efficacy had taken place. In that context, Rita revealed her thought that she was the cause of the absences. This process reverses the more typical sequence in which insight in the present leads to insight into the past. The past and present are intertwined, and integration of the two does not follow a set formula.

For Carl, who had positioned himself on the group periphery, this sequence turned up the "heat" of involvement, and he complained. His position is echoed by Jack, who states how he is forced to think harder in the group than anywhere else. After the therapist frames the situation in terms of an "internal monitor," thereby diminishing the risk of group-wide criticism, Carl exposes his behavior as an excuse. At this point Carl is able to accept the therapist's invitation to move his chair more into the group circle.

COMMENT

Schizophrenic patients are not prone to be introspective. Most individuals are content to

seal over their psychotic experience, and only a small proportion are motivated to integrate the experience as part of their lives.[21] An important contribution to patients' difficulties in engaging in treatment is their lack of insight into their illness behaviors. Deficits in insight exist even in stable outpatients and contribute substantially to their limited participation in social activities and interpersonal communication.[22] By achieving insight into their illness, patients may lower barriers to engagement. Involvement in the group process may induce a positive, reinforcing spiral of insight and an increasingly emotionally satisfying engagement both in and out of the group setting.

Acknowledging that others are important and meaningful is a risky business. Many experiences preceding the onset of the illness have been perceived as emotionally toxic. With the establishment of a chronic course, patients are subjected to further trauma as aspects of their illness further alienate them and disrupt social relationships. The lack of insight is often manifested as denial of need for others. Thus, the process of testing to determine the nature of others' responses is an expectable interpersonal process.

Additional major components of the schizophrenic illness are the negative symptoms of apathy, low motivation, and disengagement, which may be an amalgam of biological and emotional elements. As demonstrated in studies of expressed emotion, these affective experiences, which often become particular targets for family hostility, may override the therapeutic benefit of medication.[23,24] Patients' vulnerability to injury represents a significant therapeutic challenge as they place barriers to forming potentially therapeutic relationships, and they are particularly alert to any transaction that criticizes their distancing and self-protective mechanisms.

Clinicians face a formidable task of helping shape a group milieu in which patients will abandon their preferences for sealing over and for brief, widely spaced sessions and move to a position in which they will risk reflecting and searching for meaning in their interactions. A central element in achieving these goals is emotional affirmation that will sustain patients through the inevitable affective stimulation intrinsic to group interactions.

Bacal[25] asserts that patients are seeking "optimal responsiveness," not optimal frustration. Similarly, Teicholz[26] notes that "frustration becomes not a positive developmental principle in its own right, but an inevitable concomitant of the human condition, to which specific environmental response is required in order to help the developing child or the patient master otherwise overwhelming affective experience" (p. 148). The intensity of an individual's response to a "hurtful" interaction (as experienced by the individual, even if the interaction is considered "appropriate" by the observer) is a product of the person's biological heritage, his or her developmental influences, and the current environment. Experiences of optimal responsiveness, particularly to affectively significant transactions, affirm the value of the injured person, a process that stabilizes the individual and encourages growth.

The clinical example illustrates a therapist's interventions that are based on valuing the establishment of a positive therapeutic climate and appreciating patients' communicative efforts as transmitted by missing sessions. These behaviors are understood not merely as resistances, but as self-protective and self-stabilizing responses, particularly in the sector of managing affect. Within the framework of the therapist's recognizing the behaviors as tests, members may feel appreciated and empowered, and they may be able to explore affects that were previously walled off and achieve insight into aspects of their interactions.

We have incomplete knowledge of the pathophysiology of schizophrenia. Current treatment models are sufficiently broad to take into account biological vulnerability and psychosocial stress. Inevitably, there will be fluctuations in patients' clinical state as they experience stress arising from intrapsychic or interpersonal conflicts. With their presumed biological deficits, patients with schizophrenia appear to need extended periods of treatment,

requiring therapeutic persistence, patience, tolerance of ambiguity and strong affects, and a willingness to stick with the patient.[27] One session in which patients exhibit self-reflection and insight into their behavior represents only a small step on their road to improved functioning. Many fluctuations will occur in the treatment process, and therapeutic persistence is essential. The rewards for both therapist and patient, however, are substantial.

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Teaching Psychiatric Trainees to Respond to Sexual and Loving Feelings

The Supervisory Challenge

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The intimate nature of the psychodynamic psychotherapy process requires that trainees be educated to deal competently with sexual and loving feelings that arise during psychotherapy. The absence of substantive teaching on these complex treatment issues places a responsibility on the psychotherapy supervisor to educate trainees about the erotic aspects of transference/countertransference. A model of supervision addressing sexual feelings in treatment relationships is proposed and discussed with reference to clinical vignettes.

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Although trainees often encounter sexual and loving feelings in therapeutic relationships, specialized curriculum addressing sexual dilemmas and boundary issues is often absent from graduate coursework and clinical training programs for mental health professionals.[1–8] With inadequate preparation, trainees run the risk of engaging in destructive behavioral enactments or developing restricted practice styles that stunt the psychotherapeutic process.[1–3,5–8] Unfortunately, this same lack of formal curriculum leaves many supervisors inadequately prepared to deal with sexual feelings and the resultant complex clinical issues in supervision.[5,7,9–13]

In this article, I propose a model of individual psychodynamic clinical supervision that addresses sexual feelings in trainees and in their treatment relationships. The psychotherapy supervisor is in a unique position to foster in the trainee more confidence and competence in his or her ability to manage these complex treatment situations in an ethical and therapeutically sound manner. This model of individual supervision increases trainees' comfort, confidence, and ability to respond to sexual and loving feelings in the treatment

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relationship with a formulation that advances the treatment process. It aims to provide trainees with a psychodynamic framework for analyzing and managing erotic and loving feelings. Examples of how the supervisor introduces and manages the emergence of sexual feelings, and of the use of the supervisor's self as a model, are provided and discussed.

Of course, in psychotherapy supervision, one attends to all intense feelings in therapeutic relationships, including among others rage, disgust, and grief. For the purposes of this article, the exclusive focus is on sexual feelings and longings.

ROLE OF THE SUPERVISOR

The intimate nature of the psychotherapy process requires that trainees be educated to deal competently with erotic feelings and longings that naturally arise during phases of psychotherapy. Presently, many trainees' concerns about the technical handling of erotic and loving aspects of treatment go unanswered, and others are frightened by the much-talked-of slippery slope of misconduct.[1,3,5,6,10] The prevalence of sexual misconduct by psychotherapists of all disciplines suggests that increased training and education about the erotic aspects of clinical work is indicated.[1–5]

The issue of how much, if at all, supervision should focus on the student's intrapsychic issues and person is a long-standing debate.[12–15] Many supervisors and trainees have made a clear and conscious effort to restrict discussion to the patient's data as a way to protect the trainee from any risk of boundary confusion between supervision and personal therapy. This approach neglects crucial areas of psychotherapeutic discourse and instruction, namely, the discussion and sorting out of projective identifications and mutual enactments by therapists and patients. Thus, for many supervisory dyads, personal feelings and issues and their effect on the psychotherapeutic relationship and process become a part of the dialogue of supervision only when a serious problem or a boundary violation occurs. Clearly, this is too late.

Trainees may feel dangerously isolated and inadequately prepared for the intense and intimate nature of the psychotherapy process. Supervision may, in fact, be the only arena where models for understanding and psychodynamically managing erotic and loving feelings are discussed. The shame, phobic dread, and self-consciousness associated with these feelings in clinical practice require that the supervisor initiate the discussion of these issues and feelings.

The supervisor may establish a milieu of safety and openness where learning can occur by offering the following frame for the supervisory relationship and for work around these issues. Consider the following comments to a supervisee:

> Clinical work often evokes strong feelings including attraction and sexual arousal, in our patients and ourselves. It is to be expected. Often, these feelings signal important information about our patients' development and relational difficulties, and about ourselves, and the therapeutic work to be done. Supervision is a place to sort out the nature and meaning of these feelings when they arise to guide your clinical work. I trust as these issues present themselves to you in your clinical work, you will bring them to supervision. I will be happy to share with you my own experience struggling with these issues as we feel it's useful. I neither want to pry nor do I want to leave you to struggle alone with these complicated feelings.

A matter-of-fact introduction to sexual feelings and longings diminishes the embarrassment and shame trainees may fear around the discussion of such feelings, and in my experience it increases the possibility of meaningful dialogue as they raise such issues and feelings.

Supervision for the purpose of understanding and managing erotic transference/countertransference focuses attention on the student's personal feelings and self. Addition-

ally, the supervisor assumes a self-revelatory stance in supervision with regard to these clinical issues and consciously uses herself as a demonstration model for the trainee. The probability of a parallel process between the trainee's supervisory experience and the patient's psychotherapy experience has been noted.[3,7,12–15]

GUIDELINES FOR SUPERVISION

Suggested Teaching Strategies

1. *Combating Taboo and Silence:* The legacy of silence, stigma, and shame surrounding these feelings and issues needs to be addressed in supervision. The supervisor directly and simply addresses feelings of self-consciousness and dread by normalizing these feelings. Trainees long for mentors in regard to these issues and are deeply appreciative of supervisors who share ways in which they have understood and managed erotic feeling states in their own practices. Personal disclosures by supervisors of erotic feelings, useful interventions, and dilemmas with patients are invaluable when judiciously shared. Supervisors who model the process of not knowing, of developing hypotheses, of bearing intense affect, and of muddling through to a useful understanding and intervention are particularly valued.[1,3,5,12–15]

Many trainees express the wish for supervisors of a specific gender. In my experience, some trainees may find it is more possible for them to raise these issues with a supervisor of one gender and overwhelmingly difficult with someone of the other gender.

2. *Introducing Phases of the Process of Mastery:* The literature suggests that for trainees, the process of mastering this clinical material has identifiable stages.[1,3,5,7] The process of attaining comfort with sexual material involves shifting from concrete to symbolic understandings, from a focus on external factors to attention to intrapsychic and interpersonal issues, and from a simple one-sided analysis to more complex formulations.[3] For the supervisor, a thorough understanding of the normative developmental sequence of mastering these issues is useful. The most important points for supervisors to bear in mind and to communicate to trainees are discussed below.

Erotic and loving feelings, when unexpected or unprepared for, are frightening and overwhelming.[1,3,6] The power of these feelings to startle and disorient trainees needs to be recognized. The sense of anxiety and powerlessness may be so intense that trainees temporarily lose the distinction between erotic and loving feelings on the one hand and behaviors on the other.[1,3] Commonly, at first, trainees react and respond to sexual feelings, fantasies, and erotic dreams as if the feelings were unethical or a manifestation of misconduct.[1–3] This sense of anxiety and danger is infectious. Sometimes supervisors respond as if these feelings were dangerous or "inappropriate" as well. Consultations from a trusted colleague may be of benefit to the supervisor as she attempts to assess degree of risk and to sort out the meaning of these feelings to the patient, the trainee, and the treatment process.

In the process of mastering the feelings of powerlessness associated with intense erotic or loving states, trainees may first focus on boundary issues and treatment contracts. Harsh assessments of themselves and their patients often mark the early phases of engagement with these intense states and complex treatment situations.[1,3,5,12] Trainees worry that they will humiliate or harm a patient with an unhelpful intervention. Supervisors need to reassure trainees, support the distinction between feelings and behaviors, and give permission for the trainee to experience and explore these feeling states.[1–8,11–13] Supervisors who communicate to trainees an abiding faith in their learning process and convey information about the normative developmental phases of mastering these aspects of psychotherapy are valued.

3. *Teaching Trainees to Listen to Physical Sensations:* Supervisors guide the trainee to listen to

her body and physical sensations. Often, the first signs of sexual tension in a therapeutic relationship are experienced in shifting physical sensations, a sense of emotional stirring or arousal and of interpersonal heat in the trainee's body.[1,3,16–21] These may be accompanied by sexual longings, fantasies, and night or day dreams accompanied by feelings of intense pleasure that are coupled with dread, guilt, or shame. Often, these conflicting images, sensations, and affects are confusing and deeply unsettling to the trainee. With supervisorial support and instruction, trainees learn to rely on these physical sensations to inform and guide them through exploration of the multiple layers of meaning so that they can reach a clearer understanding of the possible transference/countertransference enactments and useful therapeutic interventions.[2,3,6,16–24]

4. *Offering Models of Therapeutic Action:* Trainees can be offered a developmental and a relational model of therapeutic action. A relational model views psychotherapy as a two-person model and relies on the integration of interpersonal, object relations, and self psychology theories.[17–24] A developmental model focuses on strivings and deficits in self-consolidation.[17–19,25–27] Deficits or delays in self-consolidation and strivings for affect mastery compel the patient to rely on others for support of a fragile sense of self and troublesome affects. The patient delivers into the therapeutic relationship the earlier developmental needs for self-growth and consolidation and reenacts predetermined relational paradigms that are a source of conflict. The therapist is cast in various roles by the patient in order to recreate the patient's well-established relational matrix with the hope of a different outcome.

Erotic states in therapeutic relationships are best understood as a mixture of needs, unresolved longings, repetition of earlier object relations, and the real relationship for both trainee and patient.[3,7,16,21,28,31] Arriving at a useful understanding often requires analysis of both parties' contribution. Employing these models, the supervisor instructs the trainee and models the exploration of erotic feelings from both the trainee's and patient's perspective with the understanding that these feelings signal information about developmental issues and relational experiences.

Questions the supervisor may pose to assist a trainee in the exploration of these issues from the patient's experience include:

- Do these feelings inform you about developmental deficits, developmental gains, boosting of self-esteem, wishes for admiration? What developmental issues and attendant affects are being longed for, repeated, or defended against with these feelings?
- Do these feelings defend against more intolerable affects—for example, disappointment, hate, grief, expression of rage, sadism, terror around others, or denial of vulnerability/dependency?
- Do these feelings represent an unconscious effort to maintain positive feelings, a wish to be loved, to be cherished, or to love another?
- Do these feelings signal a reenactment of an earlier traumatic relationship or experience of exploitation with a trusted other?

With experience and practice, trainees will develop and integrate a model of conceptualization that fits their personal and clinical style. Models of therapeutic action offered by supervisors assist trainees with this developmental task.

Consider the following vignette:

A female trainee troubled by sexual feelings for a male patient who has been in treatment with her for 2 years presents the case in supervision. The patient, a 40-year-old, physically attractive man employed as the CEO of a well-known major company, presents for treatment of interpersonal difficulties. From the trainee's perspective, the patient has a glamorous life filled with extensive international travel to exotic destinations, enormous interpersonal and financial power, and success. The trainee finds this patient to be irresistibly attractive and enormously appealing.

During sessions, the trainee catches herself staring at this man's body and being filled with erotic fantasies. The trainee wonders how to make sense of these feelings.

The supervisor begins with, "It's good that you let yourself feel and know about these feelings. Often, these feelings are unsettling for therapists. Usually these sensations and feelings alert us to important information about our patient, the phase of the psychotherapy, and ourselves. Let's begin by assuming there is some projective identification process operating here. What might these feelings be telling us about your patient? For example, if we look at these feelings as symbolic communications about your patient's wishes, needs, and reenactments, what's your understanding of the possible meaning? We don't need to have the 'right answer.' What's helpful is to generate possible hypotheses and try them out."

The supervisor begins by giving the trainee support in several ways. The supervisor normalizes the trainee's experience and protects her self-esteem while explaining how to proceed by offering a cognitive instructive approach.[12–15,22] By normalizing the trainee's experience and providing a cognitive frame of reference, the supervisor supports the trainee in efforts to manage the experience of being overwhelmed, of not knowing, and of feeling helpless, with the accompanying feelings of shame. Support also takes the form of praise or admiration for the trainee's courage and efforts.

5. *Increasing Capacity to Tolerate and Analyze Intense Sexual States:* Supervision aims to increase the trainee's capacity to endure intense sexual feeling states. The supervisor assists the trainee in the development of tolerance and understanding of her own and her patients' affective experiences. Often, the best supervisory approach is to begin with a patient-focused discussion detailing the subjective experience of the patient and the relationship to the trainee.[3,7,13] A supervisory focus on the patient's inner experience and developmental issues is recommended for the inexperienced trainee or for those who are particularly fearful of affect. With the development of tolerance for and familiarity with their own affective responses, trainees can turn their attention to analyzing erotic sensations and feelings, with the following understandings.

Erotic transference/countertransference represents a complex interaction and process between trainee and patient, involving a mixture of the real relationship and past object relationships for both parties. These intense states represent transferences from both the patient and trainee and are best understood as a joint creation between trainee and patient.[1–3,16,17,20,21,25,27,31,33] Trainees' and patients' sexual feelings and declarations of love have multiple and varied meanings, representing wishes, fears, conflicts, unacknowledged and defended-against affects, and developmental delays and gains. For the trainee, understanding and responding therapeutically requires a self-reflective stance where the trainee allows herself to freely fantasize and follow her own associations and feelings. If one follows physical sensations, affect, and fantasies, then it is possible to explore the origins of these symbols, and their meanings to the trainee and the patient in the treatment process, and arrive at a therapeutically useful stance. The trainee needs adequate support and instruction to assist her in bearing the intense and disorienting affect involved and exploring the questions, "Is this me or is this you?"; "Is this now or is this then?" (P. L. Russell, personal communication, 1982); and "What is the meaning of these feelings/fantasies to this patient, this therapist, and at this juncture in the treatment?"

The supervisor recognizes that this approach holds the potential for embarrassment and heightened anxiety in the trainee. Supervisors must remain alert to the trainee's sense of emotional privacy and make allowance for individual differences in affect tolerance and mastery.[13–15,22,23] Some trainees may or may not choose to explore these issues personally in supervision and may remain more patient-focused. Equipped with a model for conceptualization, these trainees may choose to

examine privately the affects and issues involved. Other trainees may choose appropriately to take these feelings to personal therapy. Supervision is not intended to explore or work through the trainees' conflicts around sexual feelings and issues. Rather, the ultimate educational goal is to assist the trainee with the identification and management of intense affect and the development of a psychodynamic formulation with regard to erotic transference/countertransference. Containment and symbolic understanding of these feeling states is crucial in order to decide how best to use this information therapeutically.

Consider the following vignette:

In supervision, a trainee in her late twenties discusses a male patient whom she feels is attracted to her. Her patient's feelings of attraction make her uncomfortable. Through her body language and descriptions of the patient it becomes clear to the supervisor that the feelings of attraction and perhaps arousal are mutual between the patient and the trainee. After exploring and attending to her questions and concerns about her patient's feelings and developing a patient-based formulation, the supervisor inquires about the trainee's feelings toward this patient. The trainee is aware of a special fondness for her patient and describes the qualities of person she finds admirable and even attractive. With further discussion, the trainee reports paying closer attention to her personal appearance and dressing attractively on the days she meets with him, and she anxiously recounts an erotic dream. In the dream, the trainee is making love to her patient and discusses with the patient concerns about being lovable.

The supervisor comments: "Thank you for sharing your feelings and the dream. This is useful information. I wonder if this patient has become very special to you, in a personal way. It is important that you figure out what this patient and your relationship with him mean to you. You do not have to discuss this with me, although I would be happy to help you if you wish. What's important is that you understand why this patient has become so significant in your inner life. If it would be useful, I can share with you a personal experience with similar feelings toward a patient and how I made sense of it for myself."

In the supervisory dialogue, the supervisor praises the trainee for acknowledging her feelings and revealing the dream, but also pushes her to deepen and expand her understanding of the meaning of these feelings in herself and to her patient. The trainee begins by accepting the supervisor's offer to share a personal experience. The supervisor responds with:

> This reminds me of a patient I treated whom I felt overwhelmingly attracted to, and I, like you, dreamt of a sexual encounter with this patient. This treatment occurred during a time in my life when I was without a significant other. My personal longings contributed to my special attachment and sexual feelings toward my patient. It helped me to know this about myself.

Sharing a clinical vignette exposes more of the supervisor's professional self and her own experience with these issues. The sharing of the personal professional experience takes the focus off the trainee and her feelings for a moment and places the focus on the supervisor.[2,15] By example, the supervisor's self-revelation declares that identifying and processing these feelings and dilemmas is a normative aspect of professional development. Following the supervisor's comments, the trainee accepts the invitation to approach her exploration of the therapeutic relationship in a more anxiety-provoking and personally intense way. She deepens her exploration of attraction and erotic fantasies about this patient with the following insights.

On reflection in supervision, the trainee came to view her sexual feelings and fantasies as primarily a reflection of her intense attachment to this patient as a longed-for love object, and as a response to her patient's gratifying idealization of her. The trainee shared that her intimate partner had relocated recently to a distant city. The intensity of her affective response to this patient signaled to her the depth of her own sense of loneliness, and perhaps grief over the relocation of her lover. As she became more compassionate and in touch with her own personal vulnerabilities, needs, and longings, she observed more clearly the ways in which her patient was flirtatious and beckoned her closer. The trainee now clearly understood how her erotic dream was connected to her own wishes and needs as well as her patient's.

Supervision aims to increase trainees' comfort with their inner experience and their capacity to examine it compassionately. It also helps trainees accept the inevitability of enactments by therapists and patients. The normative process of attaining comfort and mastery of erotic feelings for trainees involves shifting from concrete concerns to symbolic understandings.[1,3,7,13] In my experience, in the beginning phases of engagement with these issues trainees' thinking is concrete, and they seem to lose their capacity for abstract and symbolic thinking. It is as if sex is sex, although even beginning clinicians know that psychotherapy is characterized by images, multiple and varied metaphors, and shifting symbols.[2] The supervisor may be of particular help here as she assists the trainee in managing anxiety, which often allows for the shift to symbolic understanding.[1–3,13–15] Gabbard and Lester's[33] consideration of the "thickness" and "thinness" of both the therapist's internal boundaries (access to unconscious processes) and her external boundaries (within and between the therapist and patient) is relevant here. While acknowledging variations in innate individual capacities with regard to permeability of inner boundaries, supervision ideally assists the trainee in developing as fully as individually possible the capacity to fantasize and productively employ fantasy for mastering intense countertransference states.[2,7,17] The supervisory challenge and task is to initiate and conduct the discussion in a respectful and bounded manner that in fact proves useful to the trainee, the patient, and the therapeutic process.

Consider the following supervisory vignette:

A male trainee in great subjective distress presents a 3-month treatment relationship for supervision. The patient, a young woman, presents with severe depression, social phobia, intermittent drug abuse, and a childhood history of abuse and abandonment. Beginning in the third session, the patient presents with an erotic transference as revealed in requests to be hugged and to sit in his lap, comments on his clothing and body, and invitations to meet for a drink. The trainee feels overwhelmed with anxiety, confusion, and uncertainty about where to set the therapeutic boundary.

The supervisor assists the trainee in conceptualizing the patient's issues and presentation from a dynamic, developmental perspective and arrives at an understanding of what might be clinically useful. After this discussion, it becomes clear that the trainee is still experiencing great distress. The supervisor comments, "You look upset." The trainee responds, "I am, please give me a minute." The supervisor continues, "Would you be comfortable talking about your feelings here? Perhaps it has something to do with this treatment?" The trainee responds, "I don't know exactly why I'm so upset. It's about this patient. I'm not sure it will be OK with you to discuss personal feelings here." The supervisor reassures the trainee that continuing the discussion of his feelings is appropriate and fine. However, the supervisor suggests that they also pay attention to the trainee's level of comfort and privacy.

The supervisor begins with, "What's your understanding of why you're so upset?" The trainee comments, "My feelings of wanting to physically comfort this patient are much too strong, confusing, and overwhelming at moments. I don't think I can work with this patient. It's too difficult for me." The supervisor asks, "How do you make sense of your wish to comfort this patient?" The trainee then shares that this patient's history resembles that of his own family and that this patient reminds him of a troubled younger sibling whom he had been very involved with as a surrogate parent. As a child, he felt compelled to honor his sibling's requests for nurturance even at personal cost to himself. He's not sure he can separate his feelings about his sibling from this patient and is concerned about his capacity to manage his affect and maintain therapeutic boundaries. The trainee and supervisor discuss ways for the trainee to modulate his affect, remain patient-focused, and take the next step in the treatment.

The supervisor suggests the trainee take up these intense feelings and issues in his personal therapy. The supervisor wishes to support and preserve the trainee's self-esteem during his struggle to manage raw and overwhelming feelings, commenting, "It's brave of you to be so self-revealing in here. Clinical work may be deeply emotionally stirring. I know it has been in my professional work. I admire your willingness to

be attuned to your inner experience and how it affects your work. When we are open to ourselves and our patients, we become reacquainted with our unfinished business. It happens to all therapists. If it would be helpful, I can share an experience of mine struggling with overwhelming feelings for a patient." Finally, the supervisor asks, "Has this discussion felt OK for you?"

6. *Considering Countertransference Use and Misuse:* Internal and intersubjective exploration of the meaning of these feelings presents the trainee with a broad array of choices about how best to use this information to advance therapeutic aims. After thoughtful decision-making and a considered response, trainees may decide to use this information directly through interpretations, clarifications, or comments to patients.

All direct comments to patients about erotic feelings require skill and sensitivity. Direct use of countertransference data, although a delicate process, works best if all comments are compassionate, self-enhancing, and instructive.

Direct disclosure of therapists' sexual feelings to a patient is likely to frighten the patient, particularly in light of the incidence of professional sexual misconduct, and it is not recommended.[7,18–20,29,30] Davies[27] describes a case in which she directly disclosed sexual feelings to a patient with what she feels were ultimately successful results. However, the patient initially felt intruded upon, even assaulted, by his analyst's unsolicited disclosure.

Ehrenberg[21] wisely warns us to be alert to the possibility that any effort to attend to one set of transference/countertransference issues may be a form of resistance with respect to other issues. Therapists and trainees do well to exercise restraint with regard to direct disclosure of sexual feelings to patients even if they can justify them based on a belief in the centrality of the countertransference experience. Although a minority propose such disclosures, as yet there are not enough data to support such proposals, and we must be aware of the real possibility of burdening or traumatizing our patients and unnecessarily derailing a psychotherapy. Research and more published accounts of therapists' experiences, both positive and negative, with direct disclosures are needed. Thoughtful discussion of the usefulness and danger of such disclosures continues.

Unhelpful Supervisory Responses

Unhelpful supervisory responses may emerge if there is difficulty in establishing safety in the supervisory relationship or if the supervisor lacks the clinical skill to manage these treatment dilemmas. The supervisor needs to be alert to several areas of potential difficulty with regard to establishment of a psychologically safe interpersonal educational milieu. Although a supervisor will be aware of trainees' vulnerabilities and issues, intrusive personal comments or interpretations are never useful or appropriate.[13–15] Pressure or demands for a trainee's self-disclosure, even in the context of helping her work more effectively with patients, may be harmful to the trainee, the supervisory relationship, and the open exploration of clinical material.

Supervisors who reflexively or universally view these treatment dilemmas as indicative of character issues or boundary maintenance problems confuse the educational context with the treatment context. Supervisors who deny or ignore these feelings or alternatively become overly concerned about these feelings are likely to be of little help to trainees. Trainees in these types of supervisory relationships are unlikely to allow themselves to be vulnerable or to present anxiety-provoking clinical material in supervision.

Causes for Concern

Gabbard and Lester[33] outline several factors they view as red flag indicators of concern about a trainee's performance. A trainee who demonstrates a marked, repetitive pattern of boundary crossings with the absence of self-observing capacity about the treatment relationship and the therapeutic process warrants

careful attention. Practitioners who engage in a pattern of boundary crossings without self-reflection and critical examination may, indeed, harm patients.

The capacity of trainees to discuss and study the inevitable transference/countertransference enactments is critical to the development of a non-exploitative therapeutic relationship. In particular, trainees who consciously or unconsciously misrepresent their conduct in the treatment process signal to the supervisor serious personal difficulties. Self-observation and revelation by trainees in supervision is at times crucial and contributes to the therapy of the patient and the education of the therapist.[3,6,7,12,13,15] Trainees who are unwilling or unable to consider alternate perspectives and new data about themselves and their patients are of concern.

CONCLUSIONS

All trainees will at some point be faced with sexual and loving feelings in their psychotherapeutic work. The incidence of professional sexual misconduct by all disciplines indicates the continued need for training on the erotic aspects of clinical practice.[3–8,30,33] While we now have much clinical data and sophisticated information about how to understand and manage these feelings in therapeutic relationships, this information has not yet been integrated into core curriculum. Presently, the psychodynamic psychotherapy supervisor, who may or may not feel adequately prepared, is the primary clinical teacher around these complex clinical situations.

Matter-of-fact integration of the understanding and management of sexual feelings into supervision is indicated. Addressing trainees' dread and self-consciousness concerning identification and discussion of these feelings and issues opens up the possibility of dialogue and is helpful. Clear articulation of models of therapeutic action is valued by trainees and promotes feelings of competence.

Employing a developmental model for affective mastery around sexual feelings is useful. Supervisors who share experiences about their own development of mastery struggling with these issues become important models for trainees' professional development. A safe, shame-free, trustworthy supervisory relationship provides the arena for open dialogue, self-revelation, and deep clinical curiosity about these issues for both the trainee and patient.

If the supervisor creates an atmosphere of mutual exploration with a heightened awareness of the possibility for shame and humiliation and remains sensitive to the trainees' subjective experience, these issues may be openly, honestly, and fruitfully discussed. Emphasis and empathic attunement to the trainees' development of the sense of professional self is critical. Supervision becomes an arena to promote mastery and demystify complicated erotic treatments and transference/countertransference enactments.

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A Helpful Way to Conceptualize and Understand Reenactments

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Attempts to understand the purpose and the etiology of reenactments can lead to confusion because reenactments can occur for a variety of reasons. At times, individuals actively reenact past traumas as a way to master them. However, in other cases, reenactments occur inadvertently and result from the psychological vulnerabilities and defensive strategies characteristic of trauma survivors. This article offers a means to conceptualize and understand the many ways in which reenactments can occur. Psychotherapeutic strategies are offered to help individuals integrate past traumas and decrease their chances of becoming involved in destructive reenactments.

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Victims of trauma often experience a wide range of psychiatric symptoms, including intrusive recollections of the trauma, numbing and avoidance of stimuli associated with it, anxiety, hypervigilance, and other symptoms indicative of increased arousal.[1–3] Many individuals re-create and repetitively relive the trauma in their present lives.[1–6] These phenomena have been called *reenactments*.[5] For example, it has been found that women who were sexually abused as children are more likely to be sexually or physically abused in their marriages.[7] It has been noted that traumatized individuals seem to have an addiction to trauma.[8] A number of researchers have observed that retraumatization and revictimization of people who have experienced trauma, especially trauma in childhood, are all too common phenomena.[7,9,10]

Several ideas have been suggested to explain the phenomenon of reenactments. Some conceive reenactments as spontaneous behavioral repetitions of past traumatic events that have never been verbalized or even remembered.[11,12] Patients may express their internal states through physical action rather than with words.[13,14] Freud[15] noted that individuals who do not remember past traumatic events are "obliged to repeat the repressed material as a contemporary experience, instead of . . . remembering it as something belonging to the past" (p. 12). He further hypothesized that the

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obligatory repetition of painful situations from one's past may result from the death instinct or "an urge inherent in organic life to restore an earlier state of things" (p. 30). Indeed, it has been noted that the compulsion to repeat may have an almost biological urgency.[11] Others suggest that reenactments result from the psychological vulnerabilities characteristic of trauma survivors.[5,7,14,16] As a result of a range of ego deficits and poor coping strategies, trauma survivors can become easy prey for victimizers. Other writers understand reenactments as a means of achieving mastery: a traumatized individual reenacts a trauma in order to remember, assimilate, integrate, and heal from the traumatic experience.[1,12,17,18]

A definitive understanding of reenactments and the function they serve remains elusive. Herman[5] has written that there is something uncanny about reenactments. While they often appear to be consciously chosen, they have a quality of involuntariness. In addition, although it has been theorized that reenacting a past trauma is a way an individual attempts to master it, lifelong reenactments and reexposure to trauma rarely result in resolution and mastery.[8,17] Understanding and addressing the fact that traumatized people typically lead traumatizing lives remains a great challenge.[6]

Reenactments can arise from very different underlying dynamics and can result in vastly different outcomes. Thus, an understanding of the purpose of reenactments must be multidimensional. A conceptualization and understanding of the many different ways in which reenactments can occur will also help to shed light on why traumatized individuals often do not achieve mastery and will help to organize and focus clinical intervention.

In this article I have broken down reenactments into four general categories. In the first, reenacting as an attempt to achieve mastery, individuals more actively reenact a traumatic situation from their past. Some of these efforts are adaptive resolutions of earlier traumas; others, however, are reflective of a maladaptive process and can lead to continued revictimization and difficulties. In the other three types of reenactments, I suggest that reenactments occur in inadvertent and unintentional ways. In reenactments caused by rigidified defenses, defenses lead to reenactments and to the problems that the original defenses sought to avoid. With reenactments caused by affective dysregulation and cognitive reactions, intense affective and cognitive reactions produce others that can lead to a reenactment. And finally, with reenactments caused by ego deficits, trauma survivors' psychological vulnerabilities can often lead to reenactments and revictimization. This classification admittedly is somewhat artificial, since elements from several categories often play a role in the manifestation of a particular reenactment. The categories are not all-inclusive, and there are other ways to conceptualize reenactments. However, this breakdown serves to illustrate the various ways that reenactments can evolve.

REENACTMENTS AS AN ATTEMPT TO ACHIEVE MASTERY

Individuals may actively reenact elements of a past traumatic experience as a way to cope with and master it. At times, the attempt is an adaptive process that facilitates the successful resolution and working through of the earlier trauma. In other cases, however, the effort to master the trauma is a maladaptive mechanism and the strategy results in continued distress and difficulties for the individual.

The distinction between adaptation and maladaptation can be difficult to make, since all coping mechanisms are inward struggles to adapt to life and to master its challenges.[19] In addition, because trauma can affect many spheres of functioning, the individual may have adaptively mastered certain aspects of the trauma, but in other areas the resolution may be less than adequate. For example, Peck[20] described an individual who was violently beaten as a child and who adaptively mastered this trauma by becoming a homicide detective and

having a driven search for crime. However, despite his effective mastery in the vocational realm, his intimate relationships were marked by competitiveness, detachment, and underlying terror.

Notwithstanding this difficulty, adaptation can be distinguished from maladaptation in that adaptive responses are characterized by a more flexible coping style, they are motivated more by the present and future than by the past, and they make use of secondary process thinking.[19,21] In addition, with adaptation, emotions stemming from the past are less overwhelming and destabilizing, and overgeneralized negative schemas about self and others have been altered.[22,23] As Pine[24] has noted, these adaptive changes enable the person "to respond to the present free of the categories of experiencing laid down in the past" (p. 175).

Reenacting Indicative of Adaptation

It has been suggested that actively reenacting a past trauma can provide an opportunity for an individual to integrate and work through the terror, helplessness, and other feelings and beliefs surrounding the original trauma.[1,12,17,18] Freud posited that mastery could be achieved by actively repeating a past uncontrollable and unpleasurable experience.[15] Control can slowly be reestablished by repeatedly experiencing what once had to be endured.[21,25] For example, a woman who was sexually abused as a child and who, as a result, was terrified of physical contact involved herself in massage therapy training. Placing herself in a situation reminiscent of her past trauma and exploring her massage therapy experiences in psychotherapy enabled her to work through her overwhelming affect related to her past sexual abuse and diminished her fear of physical contact. We can also see this process in normal grief work: reexperiencing the feelings of grief, telling stories about a lost loved one, and repeatedly confronting every element of the loss until the intensity of the distress has remitted can enable the individual to assimilate the event and to work through the feelings surrounding the trauma.[26]

Psychotherapy can also help individuals to more fully work through and effectively master a previous trauma. With the adjunct of therapy and the benefit of insight, the detective mentioned earlier[20] who adaptively coped with past physical abuse by becoming a detective and taking on highly risky situations began to exercise better judgment and no longer felt as strongly compelled to take on situations involving physical risk.

Reenacting Indicative of Maladaptation

In many cases, actively reenacting a past trauma can be more reflective of a maladaptive defensive posture than an adaptive process. For example, many childhood victims of sexual abuse become abusers of others.[27,28] In these cases, reenacting past abuse by becoming an active abuser is a defensive stance that ensures that the terror and helplessness related to the old traumatic situation or relationship do not get reexperienced. In addition, the abusive act allows the individual to express and direct rage at others. This way of being in the world is an attempt to master the previous trauma, but it is a maladaptive one because it does not result in a reworking and integration of the individual's traumatic past and it victimizes others in the process.

Childhood sexual abuse has also been linked to prostitution in adulthood.[29,30] Chu[17] describes a woman who explained her prostitution as a way to control men through sex and as an attempt to have active control of a previously passively experienced victimization. Although this has explanatory value, it is a maladaptive resolution of the earlier sexual abuse. The woman is now controlling rather than being controlled, but the old drama of past object relations is still being played out in the present. An adaptive mastery of the earlier conflict has not been achieved; men are still feared, they still need to be controlled, and revictimization often continues to occur.

An individual may also seek out a person who is like a past abuser and reenact a past traumatic relationship out of a need to change the other person in order to feel better about herself. For example, a woman who was abused by her father and who blamed herself for this found herself in a relationship with an abusive man. The woman's unconscious attraction to this person was rooted in a desire to get him to treat her well, which, if successful, would have ameliorated her feelings of self-blame and badness. She never succeeded, however, and a reenactment occurred. Although her effort was an attempt to master an earlier conflict, it was a maladaptive one: she continued to be involved in a destructive relationship where her needs were never met.

Trauma survivors may also be drawn to establish relationships that are similar to past significant relationships because there is comfort in familiarity. For example, a man who was emotionally abused by his aloof, distant mother ends up in a relationship with a woman with similar traits. Another woman who was sexually abused by her father and brothers acts in sexually provocative ways with others. It has been found that when animals are hyperaroused, they tend to avoid novelty and perseverate in familiar behavior regardless of the outcome. However, in states of low arousal they seek novelty and are curious.[31] For many victims of childhood abuse, dealing with other people on an intimate basis is a high-arousal state because past relationships have been marked by terror, anxiety, and fear. As a result, when establishing relationships, they avoid novelty and form relationships that, even if destructive, are similar to past ones. Maladaptive reenactments can also occur because a person seeks out and "chooses" a powerful, caretaking (and sometimes abusive) figure to solidify a shaky self-concept and a fragile sense of self.[5,16,23] In addition, survivors of childhood abuse who suffer from self-hatred, an internal sense of badness, and a sense that they deserve mistreatment may gravitate to others who resonate with this negative self-concept, and past experience can then be recapitulated.[17]

REENACTMENTS CAUSED BY RIGID DEFENSES

As suggested above, individuals for various reasons often actively reenact elements of past traumatic relationships. However, even when there is no active reenactment of a past trauma, a person's defensive armor and rigid way of defending against the reexperiencing of traumatic affect can inadvertently lead to a reenactment. As Krystal[32] has noted, "Among the direct effects of severe childhood trauma in adults is a lifelong dread of the return of the traumatic state and the expectation of it" (p. 147). People learn how to avoid their ultimate dread through rigid characterological changes,[14] which are the mental "fingerprints" of who they are. Unfortunately, inflexible and rigid defenses can lead to the very problems that the original defenses attempted to avoid.

As an example, a man who was constantly preoccupied with abandonment because his mother abandoned him and his family when he was a young boy continued to be plagued by unresolved dependency concerns. To ensure that he was never again abandoned, he developed extremely possessive and clinging relationships with women. Since the man was so suffocating, women typically left him, and he reexperienced the pain of abandonment again and again. Through his own behavior, which was designed to prevent loss, abandonment, and terror, he inadvertently caused a reenactment to occur. Another woman who had a rejecting relationship with her father coped with her fear of again being rejected by establishing relationships with "losers" she did not really love. Although these "losers" did not meet her emotional needs, which was a reenactment of her past relationship with her father, she avoided her greatest fear, namely rejection by someone whom she truly loved. In these cases, reenactments occurred in paradoxical ways: through efforts to avoid an overwhelming, disintegrating state of trauma, these individuals made decisions and choices that backfired and led, after all, to reenactments.

REENACTMENTS CAUSED BY AFFECTIVE DYSREGULATION AND COGNITIVE REACTIONS

Trauma survivors who have not integrated past feelings surrounding the trauma can become flooded and overwhelmed by them.[33] Intense anger, disappointment, and fear can be triggered in interpersonal relationships, and the present situation can be perceived and responded to in the same way as the old trauma.[5,14] For example, a man who had not worked through his parents' neglect of him became flooded with rage, hurt, and disappointment when a friend failed to return a phone call. The man understood this omission as proof that he was not cared about, which was a reenactment of his earlier relationship with his parents. The man then withdrew from his friend, which further re-created his isolation and loneliness.

Reenactments may also occur when an individual reexperiences and expresses intense feelings from the past that are then reacted to by another. For example, a woman who was physically abused by her father when she was a child continued to feel rage and anger. Her father also used to criticize her, which made her feel worthless. As well as having a fragile self-esteem and extreme sensitivity to criticism, this woman often perceived harsh criticism even when it had not been expressed. In her current relationships with men, when she received any criticism she overreacted and reexperienced her rage, which she expressed in vicious and hostile ways. Not only did this frequently cause her relationships to end in fights, but often the verbal fights would turn physical and the woman would again be abused.

Individuals can also reexperience and subsequently become overwhelmed by fear that has never been integrated. When they encounter a threatening situation, trauma survivors may reexperience their old, unresolved feelings of terror and helplessness. These feelings will then overwhelm their psyches and prevent them from taking appropriate action, thus leading to a reenactment and revictimization.[5,17]

Understanding reenactments in this fashion should not be construed as imposing blame on trauma survivors for their victimization. There can be no justification for the abuse of others, and victimizers must always take responsibility for their actions. These examples are offered to demonstrate that in select situations, depending on who is encountered and what defenses are put into use, a reenactment can develop when unresolved feelings and beliefs resulting from past traumatization are reexperienced in the present.

REENACTMENTS CAUSED BY GENERAL EGO DEFICITS

Although methodological and research problems arise in attempting to ascertain the long-term effects of childhood abuse, there appear to be many associated long-term psychological effects. These long-term effects typically include depression and low self-esteem, drug and alcohol abuse, self-abusive behavior, anxiety, learning difficulties, impaired interpersonal relationships including an inability to trust others, identity disturbances, and helplessness.[10,34] Again without blame to the trauma survivor, early childhood abuse can lead to ego deficits that render an individual susceptible to both reenactments and repeated revictimization. For example, a woman who developed poor self-esteem and identity disturbances as a result of having been raised in an abusive childhood environment found herself unable to leave an abusive relationship. On many levels, she lacked the internal resources to separate herself from her abusive partner. The difficulty she had in trusting others also prevented her from turning to others to obtain the help she so badly required. The learned helplessness model also played a role in her tolerance for the abuse, since she believed that nothing could be done about it anyway. Another trauma survivor's alcohol and

drug use resulted in a reenactment and revictimization when, under the influence of alcohol or drugs, she was victimized due to impaired judgment and loss of consciousness.

Deep-seated disturbances in identity, self-concept, and security in the world can also render individuals vulnerable to being enticed by others who resonate with and counter these ego deficits. Because of early trauma, a person can feel helpless, fragile, and out of control. In turn, the person may be extremely susceptible to anyone who can take control, who can gratify dependency needs, and who can elegantly counter the individual's extreme sense of powerlessness, insecurity, and vulnerability.[5] In this regard, Kluft[16] has discussed incest survivors who became sexually victimized by their therapists.

Another factor that can contribute to the frequent reenactments of trauma survivors is the use of dissociative defenses.[5,16] Trauma survivors often tolerate mistreatment and abuse because of their habitual use of this defensive style. Whether it is physical abuse, abusive remarks, emotional neglect, or a partner's drinking or drug use, individuals with a history of trauma seem to minimize, block out, not see, and tolerate such abuse. Although this may have an adaptive value since it allows the person to tolerate the situation, simultaneously it will inhibit appropriate action, and past abuse may be reenacted.

IMPLICATIONS FOR TREATMENT

Ongoing reenactments are a reflection that a patient is continuing to act in stuck and rigidified ways. In addition, reenactments often lead to revictimization and related feelings of shame, helplessness, and hopelessness. Consequently, an important goal of treatment is facilitating an understanding and control of reenactments. Reenactments are caused in part by powerful unconscious forces that must eventually be verbalized and understood. Thus, in order to address reenactments and to break their repetitiveness, the therapist should help the individual to understand why they occur. However, before proceeding into this phase of treatment and exploring past traumatic relationships and experiences, the therapist must first have achieved a strong and solid therapeutic alliance with the patient.[35] In addition, the patient's safety must be firmly established, and any acute problem areas, such as chemical abuse problems or ongoing self-destructive behavior, need to be stabilized.[5] Once these issues have been resolved, exploratory therapy may begin.

As the patient becomes aware that a pattern of dysfunction is evident, the therapist can suggest that it might be useful to try to understand this. Using as a framework the categories of reenactments that have just been discussed, the therapist can explore which of them could be playing a role in a particular patient's reenactment. It will generally be more helpful to intimate that a pattern of destructive interaction appears to be occurring and to then explore how this takes place than to suggest that the patient is reenacting a trauma. Furthermore, even if the reenactment is due to a more active process, the patient is not truly reenacting a past trauma, but rather a traumatic relationship. Consequently, in such cases it will be more productive to suggest this latter process, which is closer to the patient's subjective experience.

Once both the patient and the therapist understand what the patient is doing that contributes to the reenactment, the next task is to explore why the patient feels and acts in such ways. Inevitably, this will lead back historically to the traumatization that triggered and continues to cause the resulting feelings and behavior. Considerable time must be devoted to discovering how life was experienced for the patient as a child, because it must be ascertained how it influenced the individual, how the patient learned to cope, and what feelings were experienced.[5,23] The overwhelming fear, terror, and related beliefs that the patient originally experienced in childhood must first be validated and acknowledged by both therapist and patient. In turn, in order to break the

pattern, the patient must process and work through the entire traumatic experience throughout the course of therapy with the support of the therapist.

An example is the therapy of a man who came for treatment because he had been feeling uncontrollably angry. He reported that he had been raised by an extremely physically abusive mother and a distant, removed father. He had been in therapy previously and felt that he had worked through many of his past issues, which indeed he had. As therapy progressed, it became evident that much of his rage was due to mistreatment and emotional abuse by his lover, which appeared to be a reenactment of his past relationship with his mother. When he recounted interactions when his lover had treated him "like dirt," he displayed little affect and often shrugged it off even when his friends made comments to him about his lover's mistreatment of him. As his nonchalance and his tendency to block off emotion were pointed out to him, he was able to see how he tended to brush off his feelings, and he recognized how he had learned to do this at an early age to tolerate his mother's abusive behavior toward him. This led to an exploration of his early childhood environment, and over time he became significantly more aware of his feelings. He learned to attend to them and to use his feelings as a guide for action. He eventually left his lover because he no longer wanted to be the recipient of the lover's abuse.

Patients will eventually come to see that whereas their feelings, beliefs, and ways to defend against overwhelming terror were appropriate and justified in the past, such intense feelings and defensive operations may no longer be as necessary. Through a painstakingly close examination of the individual's past and a process of allowing the patient to experience the intensity of the old traumatic feelings within the safety of the therapeutic relationship, the patient is given the opportunity to integrate the entire traumatic experience.[36]

Wolf[37] has articulated this process in the following way: "A patient's self is strengthened by re-experiencing the archaic trauma, with its associated affects, in the here-and-now of a therapeutic situation that allows an integrating and self-enhancing restructuring of the self" (p. 103). Once the trauma has been integrated, the patient's feelings will be less intense and more manageable, and the person will be able to exercise better judgment as well as use less rigid defenses.

Although some patients may not have the ego strength or desire to explore early traumatization, therapy can still be of considerable benefit. Even without a full reworking of the individual's past traumatization, reenactments can be stopped by helping the patient to respond differently in the world through behavioral and cognitive change.

Throughout the course of therapy, the therapist's own countertransferential feelings should be examined and used to help understand patients' problems with reenactments. Boredom, anger, rage, or sexual feelings experienced throughout the course of therapy can be useful in understanding what patients engender in others that may play a role in the reenactments they experience. Without blaming patients for their reenactments, therapists can help them to better understand their vulnerabilities and how they may contribute to their own exploitation.

For example, a 32-year-old female patient with a long history of childhood sexual abuse noted to her therapist that she had been abused in many of her past relationships. In the early course of therapy, the therapist began to explore with her how it was that others took advantage of her, which did not prove to be particularly productive. As the therapy progressed, however, the therapist became aware of his own wish to take control of the patient's life, to rescue her, and to tell her what to do. When he examined these feelings, he became more cognizant of how timid and frail the patient's presentation was, and he decided that it would helpful to explore this. He began by inquiring how the patient imagined others viewed her. With specific questions about whether she thought others viewed her as

powerful or powerless, the patient eventually began to better understand how she presented to others, which, in turn, played a role in her victimization. The therapist's awareness of his own feelings when working with the patient was the catalyst for this line of questioning that enabled the therapy to progress.

Whatever tools are used, the healing that needs to occur is not a short-term process. Successful clinical work can take years because the goals are to help patients work through overwhelming affect, modify their internal object relationships and cognitive structures, and change their basic ways of being in the world. Such work is necessary, however, if we are going to diminish their vulnerabilities and decrease their chances of getting involved in destructive reenactments.

SUMMARY

In this article I have proposed a useful way to codify and conceptualize reenactments and offered strategies for addressing them in the therapeutic process. Although trauma survivors may actively reenact elements of past traumas, reenactments can also occur in inadvertent ways that result from psychological vulnerabilities and defensive strategies. In addition, although an active reenacting of a past traumatic situation may reflect an adaptive process, in other cases it may be a maladaptive defensive strategy that can cause the individual repeated difficulties. Understanding the many different ways in which reenactments can arise will help to focus and sharpen clinical intervention.

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Expectancy, the Therapeutic Alliance, and Treatment Outcome in Short-Term Individual Psychotherapy

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Patient and therapist expectancies regarding the "typical session" were measured during a controlled trial of short-term, time-limited individual psychotherapy. Relationships between expectancy ratings and measures of the therapeutic alliance and treatment outcome were examined. Significant relationships were tested in the presence of a competing predictor variable, either pre-therapy disturbance (depression) or the patient's quality of object relations (QOR). Expectancies were associated strongly with the alliance but only moderately with treatment outcome. In most instances, expectancy and QOR combined in an additive fashion to account for variation in alliance or outcome. The patient's capacity for mature relationships and expectancies for therapy appear to be important determinants of treatment process and outcome. The clinical value of establishing accurate, moderate expectancies prior to therapy is considered.

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Expectancies about psychotherapy include beliefs about the duration of treatment, the process of therapy, and the outcome of treatment. In 1959 Frank[1] suggested that the beliefs or attitudes a patient brings to therapy have an important influence on the process and outcome of treatment. Expectancy variables have since occupied an awkward place in psychotherapy research: while continuing to hold promise as significant components of the change process, they have received only inconsistent empirical support.[2]

The most reliable finding in the literature is the direct relationship between the expected and actual duration of treatment.[3] Confirming any significant effects of expectancy on therapy outcome has been difficult because of discrepant findings across studies. Methodological differences may help explain the inconsistency of results.[2] For therapists' ratings of outcome, the effects of outcome expectancy appear negligible.[4] Stronger findings have emerged when the patient's ratings are considered, with expectancy accounting for 8% to 12% of the variation in therapy outcome. Reviews of research on individual[5] and group therapy[6] conclude that expectancy variables do have some promise as predictor variables

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and should be considered more systematically by clinicians and researchers.

To deal with certain methodological difficulties, Perotti and Hopewell[7] suggest the effects of expectancy should be differentiated according to the stage of therapy. Initial outcome expectancies are subject to revision as treatment progresses and thus may lose their predictive power. In contrast, initial expectancies regarding the therapy relationship may be more important because they represent the patient's preparedness for early engagement in, and presumably benefit from, the treatment process. We adopted this rationale for an examination of initial expectancy ratings collected during a controlled trial of short-term individual (STI) psychotherapy conducted in Edmonton.[8] We predicted that our measures of expectancy would be strongly and directly associated with ratings of the therapeutic alliance, but only weakly if at all related to measures of therapy outcome.

We previously reported that the time-limited interpretive therapy evaluated in the controlled trial was effective on both statistical and clinical grounds.[8] We also found direct relationships between patient and therapist ratings of the therapeutic alliance and treatment outcome.[9] Similar direct relationships have been highlighted in reviews.[10,11] Our present examination of the relationships of patient and therapist expectancies to alliance and outcome had four objectives:

1. To assess the simple relationships between initial patient and therapist expectancies regarding the "typical session" and measures of the therapeutic alliance.
2. To assess relationships between expectancy and therapy outcome.
3. To assess predictive relationships involving measures of the degree of confirmation or disconfirmation of initial expectancies by subsequent session evaluations collected during the course of treatment. Frank[1] and his colleagues[12] argued that the confirmation of expectancy should be directly related to therapy benefit.
4. To evaluate the simple relationships between expectancy and alliance or outcome against the prediction provided by two competing variables. One competing predictor variable was a quantitative measure of the patient's developmental level of interpersonal relations. Our clinical trial of STI therapy provided evidence that the patient personality variable quality of object relations (QOR) was directly related to the therapeutic alliance and treatment outcome.[9] We used the patient's initial level of depressive symptoms, based on pre-therapy scores from the Beck Depression Inventory,[13] as the second competing predictor variable.

METHODS

The reader is directed to the original report of the controlled trial[8] for methodological details.

Setting and Procedures

The setting for the clinical trial was the Psychiatric Walk-In Clinic, Department of Psychiatry, University of Alberta Hospitals Site in Edmonton. Patients were matched in pairs on QOR, age, and gender, and then randomly assigned to immediate or delayed therapy and to one of eight project therapists. During a 3-year period, 86 of 105 patients who began therapy completed the protocol. Sixty-four of these were chosen to form a sample that was balanced for QOR, treatment condition (immediate vs. delayed), and therapist.

Patients and Therapists

Diagnoses were made by the assessing therapist according to DSM-III[14] after an initial assessment and consultation with a staff psychiatrist. For the sample of 64 patients, 72% received Axis I diagnoses, the most frequent being affective (27%), impulse control (7.8%), or anxiety (6.3%) disorder. An Axis II diagnosis was assigned for 27% of the sample, the most

frequent being dependent (14%) or avoidant (5%) disorder. The average age of the patients was 32 years (SD = 8, range = 21–53 years), and 62% were female. Three psychiatrists, one psychologist, and four social workers served as therapists in the study. Their average age was 40 years, and they had practiced individual therapy for an average of 11.5 years.

Therapy

The time-limited therapy was dynamically oriented and followed a technical manual that drew on the approaches of Malan[15] and Strupp and Binder.[16] Interpretation and clarification were emphasized relative to support and direction. Twenty weekly sessions of 50 minutes' duration were planned; the average number of sessions attended was 18.8. The technical nature of the therapy was verified by a content analysis of therapist interventions for eight sessions (numbers 4, 7, 9, 11, 14, 16, 18, and 20), using the Therapist Intervention Rating System.[17] On average, there were 44 interventions, 11 interpretations, and 5 transference interpretations per session, confirming that the therapists had been active, interpretive, and transference-oriented.

Predictor Variables

Expectancy Variables: Patients completed a series of expectancy ratings as part of the initial outcome assessment. The first two sessions of STI therapy were commonly used for history-taking and development of rapport. Therapists completed expectancy ratings after the second therapy session. Expectancy ratings regarding the "typical session" were based on a modified version of Stiles's Session Evaluation Questionnaire (SEQ).[18] As commonly used, the SEQ involves the rating of 12 semantic differential items (e.g., good–bad, easy–difficult) in response to the sentence stem, "This session was . . . ." Two scores, based on the underlying factor structure of the SEQ reported by Stiles,[18] are obtained: Depth-Value represents the perceived usefulness of the session, and Smoothness-Ease represents the perceived comfort of the session. Scores range from a minimum of 1 to a maximum of 7. To represent expectancies at pre-therapy and early therapy, respectively, the patient and therapist rated the SEQ items in response to the sentence stem, "The typical therapy session will be . . . ." This approach allowed us to derive scores for expected session usefulness (Depth-Value) and expected session comfort (Smoothness-Ease).

Patients and therapists completed the usual form of the SEQ after each session. The two session evaluation scores were aggregated across all sessions for each participant. The difference (evaluation minus expectancy) was calculated for each measure for both patient and therapist, and represented the discrepancy from expected usefulness (Depth-Value) and comfort (Smoothness-Ease). Positive discrepancy scores indicated that the overall session evaluations exceeded initial expectancies (confirmation); negative scores indicated that the overall session evaluations failed to meet initial expectancies (disconfirmation).

Quality of Object Relations: A personality variable, QOR is defined as a person's internal, enduring tendency to establish certain types of relationships with others.[19] The dimension ranges across five levels of object relations (primitive, searching, controlling, triangular, and mature). In the clinical trial, the assessment of QOR comprised two 1-hour clinical interviews.

During the assessment, the lifelong pattern of relationships is examined. The interviewer considers the overall pattern of relationships in terms of behavioral manifestations, regulation of affect, regulation of self-esteem, and historical antecedents for each of the five levels. The interviewer then distributes 100 points among the five levels and derives a single global score ranging from 1 to 9.

At the primitive or low end of the 9-point scale, relations are characterized by inordinate dependence, extreme reactions to real or imagined loss, and destructiveness. At the mature end, relations are characterized by equity and

the expression of love, tenderness, and concern. It is common for two overall scores of equal value to represent different patterns of object relatedness.

Since we conducted the STI therapy trial, the QOR assessment has been streamlined to a single hour of interview time, and reliability has been improved. In the clinical trial, the reliability between the interviewer and an independent rater using an audiotape was assessed for a sample of 50 cases. A stringent index of reliability, the intraclass correlation coefficient for the individual rater [ICC(1,1)], was used. A reliability coefficient of 0.50 was obtained.

For the current investigation, the overall QOR score (a continuous measure) was used as a predictor variable.

Initial Disturbance: The pre-therapy score on the Beck Depression Inventory[13] was used to represent initial disturbance, measured as severity of depressive symptoms prior to therapy. The BDI is a commonly used outcome measure with established psychometric properties.

Dependent Measures

Therapeutic Alliance: The alliance was defined as the nature of the working relationship between patient and therapist. The two participants independently rated six 7-point items. Four "immediate" items were rated after each therapy session, and two "reflective" items were rated after each one-third of the therapy (at sessions 7, 14, and 20). Three immediate items addressed whether the patient had talked about private, important material, had felt understood by the therapist, and was able to understand and work with the therapist's interventions. The remaining immediate item concerned the overall usefulness of the session. The two reflective items addressed Luborsky's concept of the helping alliance (collaboration and helpfulness).[20] Each set of six item ratings was aggregated across sessions or thirds; aggregate ratings were then subjected to a principal components analysis. One patient-rated alliance factor and two therapist-rated alliance factors (immediate, reflective) were derived.

Therapy Outcome: The STI therapy outcome battery included several well-established self-report and interview measures of the patient's psychiatric symptomatology, interpersonal functioning, and personality functioning. The patient's individual target objectives were developed with the assistance of an independent assessor. Patient, therapist, and assessor ratings of target objective distress were included in the outcome battery. A total of 23 outcome variables were available; 19 were measured both before and after therapy (residual gain scores), and the remaining 4 were measured at post-therapy only (rated benefit scores). Seven variables were eliminated because of redundancy or a low response rate.

TABLE 1. Clinical trial of STI (short-term individual) therapy: outcome factors and variables

Outcome Factors and Variables	Variable Loadings
General Symptoms and Dysfunction (39% of variance)	
Emotional reliance[21]	0.82
Self-esteem[22]	0.78
Depression[13]	0.76
Present interpersonal functioning[23]	0.74
Anxiety[24]	0.74
Symptomatic distress[25]	0.73
Life satisfaction	0.60
Individualized Objectives (10% of variance)	
Overall usefulness as rated by patient	0.76
Target objective severity as rated by patient	0.70
Overall usefulness as rated by therapist	0.68
Target objective severity as rated by assessor	0.66
Work role functioning[26]	0.48
Social-Sexual Adjustment (8% of variance)	
Sexual role functioning[26]	0.83
Social role functioning[26]	0.52
Target Severity and Family Role Disturbance (7% of variance)	
Target objective severity as rated by therapist	0.73
Family role functioning[26]	0.46

The results of a principal components analysis of 16 post-therapy outcome variables are presented in Table 1. The analysis identified four factors. The first three factors were retained to represent change due to treatment. Measures of improvement at post-therapy were the following: I, General Symptoms and Dysfunction (patient self-report); II, Individualized Objectives (patient, therapist, and independent assessor); and III, Social-Sexual Adjustment (assessor).

Approach to Analysis

The relationships among the predictor variables (expectancy, discrepancy, QOR, BDI), and between the predictor and dependent variables (alliance, outcome), were examined by using Pearson product-moment correlation coefficients. Expectancy and discrepancy variables having significant simple relationships with alliance or outcome were then considered in a series of hierarchical multiple regression analyses. The regression analyses assessed the strength of the relationship against the prediction provided by competing variables.

The regression analysis for each simple relationship (expectancy or discrepancy with alliance or outcome) followed the same sequence. On the first step, a competing predictor (QOR or BDI) entered the equation. The expectancy or discrepancy variable was entered on the second step. The interaction variable (product of the two predictors) was entered on a third step. The regression was then repeated with the order of entry of the two (main effect) predictors reversed. All predictor variables were centered (the sample mean subtracted from each patient's score) to control for a form of error variance, nonessential ill-conditioning,[27] which is defined as shared variance that is not due to a real association in the population. Specifically, predictor and dependent variables with similar measurement scales would contribute to nonessential ill-conditioning and raise the likelihood of type I error.

TABLE 2. Descriptive statistics for predictor and dependent variables

Variable	Name	Mean ± SD
Predictor variables		
Session expectancy		
Patient Depth-Value	PTDV	5.06 ± 0.90
Patient Smoothness-Ease	PTSE	3.81 ± 0.76
Therapist Depth-Value	THDV	4.56 ± 0.50
Therapist Smoothness-Ease	THSE	4.07 ± 0.52
Session discrepancy		
Patient Depth-Value	PTDVD	0.26 ± 0.58
Patient Smoothness-Ease	PTSED	0.14 ± 0.33
Therapist Depth-Value	THDVD	0.04 ± 0.20
Therapist Smoothness-Ease	THSED	0.03 ± 0.14
Quality of object relations	QOR	4.69 ± 1.17
Beck Depression Inventory	BDI	14.13 ± 10.40
Dependent variables		
Therapeutic alliance		
Patient impression	TAP	5.89 ± 0.73
Therapist immediate impression	PET	5.03 ± 0.58
Therapist reflective impression	HAT	4.27 ± 0.72

Note: The *n* for the variables ranged between 61 and 64. Outcome factor scores had a mean of 0 and SD of 1. PT = patient; TH = therapist; DV = depth-value expectancy; SE = smoothness-ease expectancy; DVD = depth-value discrepancy; SED = smoothness-ease discrepancy.

RESULTS

The *noncentered* means and standard deviations for the therapeutic alliance, expectancy, QOR, and initial disturbance are presented in Table 2. Overall, patients expected that sessions would be significantly more useful ($t = 3.91$, df = 61, $P < 0.0001$) but significantly less comfortable ($t = –2.21$, df = 62, $P < 0.03$) than their therapists did. The mean discrepancy between session evaluations and expectancies was significantly larger (indicating greater *confirmation*) for patients than for therapists, both for usefulness ($t = 2.97$, df = 61, $P < 0.005$) and for comfort ($t = 3.17$, df = 62, $P < 0.002$). In general, most patients reported that the experience of therapy sessions met or exceeded their initial expectations.

Correlations Between Predictor Variables

Table 3 presents the intercorrelations among the 10 predictor variables. Except for the two therapist expectancy ratings (THDV, THSE), which were independent, each remaining pair of variables (e.g., the two patient expectancy, two patient discrepancy, and two therapist discrepancy variables) were significantly correlated. Overall, expectancy ratings were significantly and inversely related to the respective discrepancy scores. These relationships indicated that the higher the initial expectancy, the greater the likelihood of *disconfirmation*; that is, of a failure of session evaluations to meet expectations.

Two additional patterns of intercorrelation were identified. First, confirmation of the patient's expectancy of session comfort was associated with confirmation of the therapist's expectancies of both session comfort and usefulness. Second, confirmation of the therapist's expectancy of session comfort was directly associated both with *lower* patient expectancies of usefulness and *confirmation* of patient-expected usefulness. These relationships indicated a degree of patient–therapist interdependence in the evaluation of whether initial expectancies were confirmed by the actual experience of therapy sessions.

QOR was independent of the expectancy and discrepancy variables and was inversely related to initial disturbance. Patient expectancies were inversely related to initial disturbance: the greater the patient's depressive symptoms at pre-therapy, the lower the expectancies of session usefulness and comfort.

Simple Predictions

Table 4 presents the simple relationships among the 10 predictor variables (QOR, initial

TABLE 3. Intercorrelations of predictor variables

Variables	PTSE	THDV	THSE	PTDVD	PTSED	THDVD	THSED	QOR	BDI
Session expectancy									
Patient Depth-Value	0.37**	0.09	0.12	–0.70***	–0.40**	–0.08	–0.27*	0.08	–0.40**
Patient Smoothness-Ease	1.0	0.01	0.02	–0.42**	–0.42**	–0.12	–0.17	–0.10	–0.34**
Therapist Depth-Value		1.0	0.00	–0.25	–0.22	–0.56**	–0.44**	0.07	–0.06
Therapist Smoothness-Ease			1.0	–0.06	0.02	–0.26*	–0.26*	0.14	0.05
Session discrepancy									
Patient Depth-Value				1.0	0.55**	0.16	0.31*	0.15	0.22
Patient Smoothness-Ease					1.0	0.36**	0.43**	0.04	0.07
Therapist Depth-Value						1.0	0.77***	–0.04	–0.03
Therapist Smoothness-Ease							1.0	–0.15	0.07
Quality of object relations								1.0	–0.32*

Note: Range of *n*'s for the correlations was 62–64. Abbreviations of variables are defined in Table 2.
*$P < 0.05$; **$P < 0.01$; ***$P < 0.001$.

disturbance, 4 expectancy, 4 discrepancy) and the 6 dependent variables (3 therapeutic alliance, 3 post-therapy outcome).

From previous work,[9] we knew that QOR was directly associated with the patient-rated alliance, the therapist-rated reflective alliance, and improvement on two of the three outcome factors (I and II). The BDI score was inversely associated with the patient-rated alliance.

Expectancy and Alliance: Three expectancy–alliance relationships were identified, each involving a distinct pair of expectancy and alliance variables associated with the same rating source. First, the patient's expectancy of usefulness was directly associated with the patient-rated alliance. Second, the therapist's expectancy of usefulness was directly associated with the therapist-rated immediate alliance. Third, the therapist's expectancy of session comfort was directly associated with the therapist-rated reflective alliance. These correlations indicated that expectancy accounted for 18% to 40% of the variation in alliance ratings.

Expectancy and Outcome: Expectancies regarding session comfort were directly associated with improvement at post-therapy. Three significant relationships were identified, each involving one of the three outcome factors. The patient's expectancy of session comfort was directly associated with benefit on General Symptoms and Dysfunction (I) and Social-Sexual Adjustment (III). The therapist's expectancy of session comfort was directly associated with benefit on Individualized Objectives (II). These correlations indicated that expectancy accounted for 7% to 10% of the variation in outcome scores. This was considerably less than the variation of alliance accounted for by expectancy.

Discrepancy and Alliance/Outcome: Confirmation of each of the patient's initial expectancies (usefulness, comfort) was directly associated with the therapist's rating of the reflective alliance. Discrepancy scores were not significantly associated with therapy outcome.

Multivariate Relationships

Expectancy–Alliance: Three relationships were tested: patient-expected usefulness and patient alliance; therapist-expected usefulness and

TABLE 4. Simple relationships between predictor and dependent variables

	Dependent Variables					
	Alliance			Outcome		
Predictor Variables	**TAP**	**PET**	**HAT**	**I**	**II**	**III**
Quality of object relations	0.29*	0.05	0.28*	–0.25*	–0.35**	–0.07
Beck Depression Inventory	–0.27*	–0.17	–0.04	0.10	0.14	0.14
Session expectancy						
Patient Depth-Value	0.46***	0.18	0.00	–0.06	–0.15	–0.03
Patient Smoothness-Ease	0.09	0.00	–0.23	–0.26*	–0.02	–0.31*
Therapist Depth-Value	–0.07	0.63***	0.15	–0.06	–0.24	–0.19
Therapist Smoothness-Ease	0.13	0.14	0.42***	–0.19	–0.31*	0.03
Session discrepancy						
Patient Depth-Value	0.02	–0.08	0.26*	–0.14	–0.14	0.03
Patient Smoothness-Ease	0.04	–0.05	0.26*	–0.03	–0.06	0.08
Therapist Depth-Value	–0.02	–0.17	0.06	0.01	0.02	0.23
Therapist Smoothness-Ease	–0.15	–0.18	–0.03	0.23	0.17	0.18

Note: Range of *n*'s of the correlations was 62–64. TAP = patient-rated impression; PET = therapist-rated immediate impression; HAT = therapist-rated reflective impression of the therapeutic alliance. I = General Symptoms and Dysfunction; II = Individualized Objectives; III = Social-Sexual Adjustment.
*$P < 0.05$. **$P < 0.01$. ***$P < 0.001$.

therapist immediate alliance; and therapist-expected comfort and therapist reflective alliance. For the first relationship, initial disturbance (depression) was considered as the first competing predictor variable. Initial disturbance was predictive of the patient-rated alliance, as described above. However, in the presence of the expectancy variable (patient usefulness), this contribution did not attain significance. In all of the remaining analyses, the pre-therapy BDI score was found not to account for significant proportions of criterion variance. As a competing predictor variable, initial disturbance will not be addressed further.

Remaining with the patient-expected usefulness–patient alliance relationship, our next step in the analysis was to consider QOR as a competing predictor variable. Table 5 presents the regression analysis. Both predictors (QOR, expectancy) were significant, but the interaction was not. Proportions of alliance variance accounted for were averaged across the pair of regression analyses conducted to test each expectancy–alliance relationship. QOR accounted for 7%, and the expectancy variable for an additional 26%, of the variation in the patient-rated therapeutic alliance.

Therapist-expected usefulness emerged as the only significant predictor of the therapist-rated immediate alliance. For the relationship between therapist-expected comfort and the therapist-rated reflective alliance, a similar pattern of findings was evident: both predictors (expectancy and QOR) were significant, and the interaction was not. QOR accounted for 7%, and the expectancy variable for an additional 16%, of the variation in the therapist-rated reflective alliance.

Expectancy–Outcome: Three relationships were tested: patient-expected comfort and General Symptoms and Dysfunction (I); patient-expected comfort and Social-Sexual Adjustment (III); and therapist-expected comfort and Individualized Objectives (II). Analyses with QOR as the competing predictor again resulted in important findings.

Table 6 presents the results of the regression analysis for General Symptoms and Dysfunction (I). QOR and patient-expected comfort both emerged as significant predictors, but the interaction did not. Each predictor accounted for roughly 7% of the variance in symptomatic improvement. Patient-expected comfort emerged as the only significant predictor of Social-Sexual Adjustment (III). For Individualized Objectives (II), both predictors emerged as significant, and the interaction did not. QOR accounted for approximately 11% of the variance in improvement, and therapist-expected comfort accounted for an additional 8% of outcome variance.

Discrepancy–Alliance: The two patient discrepancy variables having significant relationships with the therapist's reflective alliance were themselves highly correlated ($r = 0.55$, df = 60, $P < 0.0001$). To maintain consistency with the other analyses, separate regression analyses

TABLE 5. Patient Depth-Value expectancy as a predictor of patient alliance (TAP)

Step and Variable	R^2	ΔR^2	Overall F	Overall df	Overall P	Partial F	Partial df	Partial P
Competing predictor: QOR								
1. QOR	0.08		5.56	1,62	0.03			
2. PTDV	0.33	0.25	14.85	2,61	0.0001	22.76	1,61	0.0001
Reverse order of main effects								
1. PTDV	0.27		22.48	1,62	0.0001			
2. QOR	0.33	0.06	14.85	2,61	0.0001	5.46	1,61	0.03
3. Interaction	0.36	0.03	11.03	3,60	0.0001	2.82	1,60	0.11

Note: QOR = quality of object relations; PTDV = patient-rated expectancy of session Depth-Value.

were conducted to test the strength of each discrepancy–alliance relationship on its own.

For the regression analysis involving discrepancy scores for patient-expected usefulness, QOR and the discrepancy variable both emerged as significant predictors of the alliance, but the interaction did not. For the analysis involving the discrepancy scores for patient-expected comfort, there was evidence for significant independent contributions by each predictor and for the interactive effect. Table 7 presents the result of the regression analysis. QOR accounted for approximately 8%, patient comfort accounted for approximately 7%, and the interaction accounted for an additional 9% of the variance in the therapist-rated reflective alliance. The interaction indicated that the greater the confirmation of the patient's expectancy (the more positive the discrepancy between experienced and expected comfort), the stronger the direct effect of the patient's QOR on the therapist's general perception of the alliance.

Expectancy and Alliance as Joint Predictors of Outcome

We returned to the expectancy variables at this point in the analysis. We were interested in whether expectancies would still significantly account for outcome variance when the prediction afforded by the therapeutic alliance was considered first. Three hierarchical regression analyses were conducted. For outcome factor I (General Symptoms and Dysfunction), the predictors were QOR, each of the alliance variables in turn, and patient-expected comfort. QOR accounted for 7% of outcome variance, as above, but when alliance and expectancy were in the equation the direct effect of QOR was no longer significant. Alliance accounted for 7% to 13% of outcome variance; each alliance variable provided for significant prediction in the regression. The patient expectancy rating, when entered last, accounted for an additional 6% to 14% of outcome variance and was also a significant predictor in each analysis. For outcome factor II (Individualized Objectives), the predictors were QOR, the alliance variables, and the therapist's expected comfort. QOR accounted for 12% and the alliance for 19% to 22% of outcome variance, but therapist expectancy did not provide for a significant additional contribution. For outcome factor III (Social-Sexual Adjustment), the predictors were the alliance variables and patient-expected comfort. Only the expectancy variable accounted for significant outcome variance (9%–11%). These additional analyses indicated that patient expectancy, but not therapist expectancy, provided for a significant prediction of outcome over and above the prediction afforded by the alliance.

DISCUSSION

We studied patient and therapist expectancy ratings as potential predictors of the therapeu-

TABLE 6. Patient Smoothness-Ease expectancy as a predictor of improvement on outcome factor I, General Symptoms and Dysfunction

Step and Variable	R^2	ΔR^2	Overall F	Overall df	Overall P	Partial F	Partial df	Partial P
Competing predictor: QOR								
1. QOR	0.06		4.23	1,62	0.05			
2. PTSE	0.15	0.09	5.18	2,61	0.008	6.46	1,61	0.02
Reverse order of main effects								
1. PTSE	0.07		4.48	1,62	0.04			
2. QOR	0.15	0.08	5.18	2,61	0.008	5.74	1,61	0.03
3. Interaction	0.15	0.00	3.49	3,60	0.03	0.0	1,60	0.99

Note: QOR = quality of object relations; PTSE = patient-rated expectancy of session Smoothness-Ease.

tic alliance and treatment outcome. The analyses demonstrated that expectancies regarding the experience of therapy sessions are strongly and directly related to the quality of the therapeutic alliance. Relationships between expectancy and outcome proved to be less strong but still substantial. In the multivariate analyses, expectancy variables frequently combined additively with quality of object relations in accounting for variation in alliance and outcome. In an analysis examining the joint prediction of outcome, QOR, the alliance, and patient expectancy were found to independently contribute to therapy benefit. We will consider the results and their clinical implications in the sequence that was followed in the preceding section.

The simple descriptive analyses (direct comparisons of patient and therapist ratings, correlations among the predictor variables) proved to be quite informative. High expectancies were clearly related to the experience of disconfirmation—that is, disappointment with actual therapy sessions. In direct comparisons of the expectancy ratings, patients expected significantly more session usefulness but significantly less session comfort than therapists. To put this another way, therapists had moderate expectancies about therapy sessions relative to patients. The two therapist expectancy variables were found to be independent of one another, which also suggested that the therapists had a more differentiated picture of the therapy process. In effect, it is likely that therapists "know what to expect" as therapy begins. This clinical understanding of the therapy process should be employed during the preparation phase to modify any patient expectations that appear to be overly optimistic or idealized.

Correlations between patient and therapist discrepancy scores indicated that there is a clear dyadic interdependence when session experiences are evaluated against expectancies. Patient discrepancy scores were significantly more positive than were therapist discrepancy scores. For the patients, the actual experience of therapy was generally in line with or exceeded their expectations, suggesting that for most of them, therapy was a reasonably positive experience.

Overly optimistic or idealized expectations thus may not be a frequent occurrence, but they should definitely be addressed if they are identified early in the treatment process. Ensuring that the patient has reasonable expectancies about the treatment experience will militate against disappointment. Although this point was not addressed by our analyses, it is also possible that reasonable expectancies that are shared by the patient and therapist would be even more strongly associated with the quality of the therapeutic collaboration.

Substantial expectancy–alliance relationships were identified. For patients and therapists, expectancies of session usefulness were directly associated with the strength of the respective alliance ratings. Beginning therapy with the expectation that individual sessions will be productive may help ensure that the

TABLE 7. Patient Smoothness-Ease discrepancy as a predictor of therapist reflective alliance (HAT)

Step and Variable	R^2	ΔR^2	Overall F	Overall df	Overall P	Partial F	Partial df	Partial P
Competing predictor: QOR								
1. QOR	0.08		5.44	1,62	0.03			
2. PTSED	0.14	0.06	5.03	2,61	0.01	4.26	1,61	0.05
Reverse order of main effects								
1. PTSED	0.07		4.37	1,62	0.05			
2. QOR	0.14	0.07	5.03	2,61	0.01	4.96	1,61	0.03
3. Interaction	0.23	0.09	6.02	3,60	0.001	7.01	1,60	0.01

Note: QOR = quality of object relations; PTSED = patient-rated discrepancy of session Smoothness-Ease.

therapy relationship is also productive, or at least is perceived as productive. The therapist's expectancy of session comfort was directly associated with his or her rating of the reflective alliance. This relationship suggests that if the therapist believes he or she will be comfortable in the therapy, again perhaps as a result of a productive preparation, more general perceptions of the treatment relationship will also turn out to be positive.

Expectancy–outcome relationships were notably smaller in absolute value than expectancy–alliance relationships. This discrepancy supports the findings of Perotti and Hopewell,[7] which suggest that expectancies may have more direct effects on the establishment of the therapeutic alliance than on the actual outcome of treatment. Expectancies regarding session comfort were nonetheless clearly associated with treatment benefit. For patients, who completed these ratings prior to meeting the therapist, expectancies of session comfort may have reflected "preparedness" and a positive intention to engage in meaningful self-examination. For therapists, who completed ratings after two sessions, expectancies regarding comfort may have reflected positive impressions of the patient and of the potential for collaboration.

Patient expectancies of comfort were directly associated with symptom improvement and overall adjustment in social activity and intimate relationships. Expecting sessions to be relatively comfortable may indicate openness to the relationship with the therapist and the process of therapy. A simple assessment of the patient's expectancy of session comfort could be used as an early indicator of potential change in symptomatic and interpersonal distress. Therapist expectancies of comfort were directly associated with positive change on individualized objectives for therapy. Therapist expectancies of comfort may reflect an estimation of the potential for collaboration on the patient's problems, involving judgments about appropriateness and capacity for therapy, the usefulness of any preparation, and the therapist's own experience with treatment for similar problems.

Relative to expectancy ratings, the discrepancy scores were less fruitful as predictor variables. Confirmation of the patient's expectancies was directly associated with the therapist's reflective alliance. If the patient finds that sessions meet or exceed expectations, the therapist's general perception of the therapeutic alliance is positive. A reasonable confirmation of the patient's expectancies may represent a therapist objective for the early stages of therapy.

Multivariate analyses aimed at testing the robustness of the simple relationships involving the expectancy and discrepancy variables. The competing predictors included an index of the patient's capacity for healthy interpersonal relationships (QOR) and an established measure of initial symptomatic distress (BDI). The first set of regression analyses considered the three expectancy–alliance relationships. Initial disturbance was eliminated as a significant predictor in one analysis, and it did not have a significant relationship with the criterion in any subsequent analyses. QOR was significant as a competing predictor in two of three analyses, in each case accounting for roughly 7% of the variation in the quality of the therapeutic alliance. In sharp contrast, expectancy was a significant predictor in all three analyses and accounted for a large proportion (16%–40%) of variation in the alliance. The prediction provided by QOR and expectancy was additive.

This finding has implications for the selection and preparation of patients for short-term interpretive therapy. A capacity to establish a good working relationship (selection) and the expectation that work will occur comfortably and productively during therapy sessions (preparation) are strongly associated with a positive therapeutic alliance.

The second set of regression analyses tested the three expectancy–outcome relationships. A similar pattern of findings emerged. QOR was predictive of improvement in two of three analyses. In all three analyses, the expectancy variable made a significant single or additional contribution to the prediction. Expectancy accounted for roughly 8% of outcome variance in each instance.

The third set of regression analyses considered the relationships between confirmation of the two patient expectancies and the therapist-rated reflective alliance. When the patient discrepancy score for expected usefulness was used as a predictor, the familiar pattern of findings emerged: both quality of object relations and the discrepancy variable accounted for significant proportions of alliance variance, but the interaction did not. The therapist's rating of the general quality of the therapeutic alliance was elevated when the patient presented with a good capacity for interpersonal relationships and a belief in the usefulness of the therapy process.

When the patient discrepancy score for expected comfort was used as a predictor, all three effects (QOR, patient discrepancy, and the interaction) emerged as significant. Thus, confirmation of the expectancy that sessions would be comfortable increased the likelihood that the patient's capacity for satisfying relationships would be put to use in the work of therapy. Ensuring that the patient is comfortable with the demands of the therapy process prior to and during sessions allows for the development of the best possible patient–therapist relationship. This multiplicative effect represented an important independent contribution to the prediction of the therapist-rated reflective alliance.

The final set of regression analyses was prompted by our interest in the joint prediction of outcome by three variables: the quality of object relations, the therapeutic alliance, and expectancy. If expectancy accounted for outcome variance over and above the contributions of QOR and the alliance, this would underscore the importance of the relationship. The results showed that symptomatic improvement was strongly predicted by the alliance and the patient's expectancy of session comfort; QOR was eliminated as a predictor when these variables were present in the regression equation. Change on individualized objectives was predicted by QOR and the alliance, but not by therapist expectancy. Change in broader overall adjustment was predicted solely by the patient's expectancy of session comfort.

Taken together, the results of these additional analyses suggest two conclusions. First, patient expectancies are strong predictors of therapy outcome, but therapist expectancies are not. Second, the patient's capacity for a good relationship, the patient's expectancy that the therapy sessions will be comfortable, and the actual experience of a strong therapeutic alliance all represent consistently strong determinants of therapy benefit.

The strength of our findings with measures of patient and therapist expectancy was somewhat of a surprise, particularly given the simplicity of the expectancy rating. The findings clearly argue for the preparation of patients for short-term, time-limited individual psychotherapy. Referring therapists, or the treating therapist at the time of a treatment contract, should seek to reinforce moderate patient expectancies. Overly high expectancies are likely to be painfully disconfirmed and perhaps increase the likelihood of a treatment dropout. Reasonable expectancies represent one goal for the patient's preparation for therapy. In terms of expectancies regarding session usefulness, the patient should understand that each session contributes to overall benefit and by itself is unlikely to have dramatic effects on the presenting problem.

In terms of expectancies regarding session comfort, the patient should be clear that some degree of session difficulty is associated with the hard work of a successful psychotherapy. After therapy has actually started, one aspect of the therapist's activity should be to engage the patient in a "good" working process[28] and reinforce the patient when this is achieved.

Confirming an early expectancy that sessions can be productive and comfortable may make it more likely that the patient and therapist will be able to establish a good working relationship. This confirmation can also allow the patient's capacity for healthy relationships to come more fully to the fore in the therapy process. In turn, the patient's actual experience of a strong alliance can be the foundation for a successful treatment outcome.

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GRAND ROUNDS

Most of the articles that have been published in this Grand Rounds section to date have described psychotherapy case histories. The current piece from the Payne Whitney Clinic at The New York Hospital-Cornell Medical Center is different. Drs. Kalman and Goldstein present the results of a survey that provide empirical support for the much discussed but little studied effects of managed care on psychiatric practice. As might have been anticipated, psychiatrists involved in managed care organizations reported less financial reward and less emotional satisfaction in their private practices than did psychiatrists not involved in managed care. The ability to conduct psychotherapy, as opposed to relegation to a strictly psychopharmacological role, was an important component of psychiatrists' satisfaction with practice.

Kalman and Goldstein thus raise a key issue confronting psychiatry today: how to preserve psychotherapy as an integral facet of psychiatric practice in an era of managed care and cost containment. Many psychiatrists consider psychotherapy a core aspect of their professional identity and believe that there are advantages to psychiatrists' conducting psychotherapy, at least with selected patient populations. For example, plausible arguments can be raised for having a single mental health professional—the psychiatrist— provide psychotherapy and psychopharmacology interventions for patients who need combined treatment, and for psychiatrists to function as psychotherapists for patients with complex or severe Axis III disorders.

There are almost no data, however, to corroborate or contradict these assertions. (A recent report in Psychiatric Services *found that psychiatrist-provided combined psychotherapy and pharmacotherapy cost less than split therapy, but this research did not examine treatment outcome [Goldman et al. 1998; 49:477–482].) In the absence of proof that psychotherapy by psychiatrists is superior to psychotherapy by other mental health professionals, cost-driven managed care organizations have sought the latter, less expensive alternative. This is apparently endangering the psychiatrist-psychotherapist as a species in the managed care jungle. Research to demonstrate the particular psychotherapeutic skills of psychiatrists, although complex to undertake, may be essential to sustain them.*

–John C. Markowitz, M.D., Grand Rounds Editor

Satisfaction of Manhattan Psychiatrists With Private Practice

Assessing the Impact of Managed Care

THOMAS P. KALMAN, M.D.
MARTIN A. GOLDSTEIN, M.D.

OVERVIEW OF THE STUDY

This study surveyed a sample of Manhattan-based private psychiatrists regarding aspects of their professional activities: general practice characteristics (size of practice, managed care participation), economic factors (yearly gross revenues, fee schedules), attitudes toward managed care, patterns of psychotherapy delivery, and career satisfaction. A questionnaire was sent to 100 randomly selected medical school voluntary faculty with a return envelope designed to ensure anonymity. Forty-three percent of those surveyed returned completed questionnaires.

Gross revenues were nearly level for the years 1993–1995; however, those psychiatrists engaged in managed care averaged approximately 20% lower annual revenues than those not on a provider panel.

Managed care participants were significantly less satisfied with practice than were nonparticipants. Respondents reported diminishing opportunities for the practice of psychotherapy, and the perception that psychiatry was becoming a more difficult profession was widely held across groups.

The study data support anecdotal accounts of demoralization among private practice psychiatrists, specifically documenting lower income and professional satisfaction ratings among managed care participants versus nonparticipants.

BACKGROUND

Few developments in organized medicine have progressed as rapidly as the emergence of managed care in the United States in the 1990s. Although not new, such managed systems have newly dramatic prevalence. The common purpose of all managed care approaches is the control of health care expenditures, theoretically without compromising the quality of care administered and the well-being of patients. As of 1995, more than 58 million Americans were receiving medical care under the auspices of such organized systems.[1] Even in New York City, where the establishment of managed care organizations (MCOs) was long resisted and their growth lagged well behind levels in other parts of the country, their recent expansion has been explosive. Between 1993 and 1995, managed care penetration in New York State increased

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from 23% to 31%, with a greater than 50% increase (from 18% to 29%) in New York City for the same time period.[2]

Mental health care, long feared as an enormous cost item for insurance companies, has been a featured target of managed care. Initially, cost control efforts were directed toward reducing inpatient expenditures, since hospitalization accounted for the bulk of costs. Later, MCOs targeted outpatient treatment as patients were shifted from hospitalization to community-based management.[3,4] In fact, only psychiatry, among all medical fields, has seen the emergence of superspecialized management entities: organizations such as Merit Behavioral Care, American Psych Management, and dozens more, are routinely employed by MCOs to manage the mental health benefits of enrollees.

American psychiatry has met the advent of managed care with combinations of trepidation, hysteria, ignorance, and, not unexpectedly, demoralization. The American Psychiatric Association has become polarized by fierce critics and ardent supporters of behavioral health care management within its ranks. The position of the former is well summarized by Inglehart: "The application of managed-care principles to mental health and substance-abuse services has provoked unprecedented turmoil in the profession by eroding the autonomy of practitioners, squeezing their incomes, and forcing them into constricted new roles."[5] Conversely, proponents hold that managed care offers enhanced access to care for more people, and they accept the premise that constraints on open-ended care are necessary to prevent abuses. Other psychiatrists support efforts at health care reform, hoping that control over escalating costs will be followed by parity of insurance coverage for treatment of mental disorders.[6,7]

With as many as 70% of insured Americans receiving mental health care through managed care systems,[8] practitioners will inevitably be affected. Yet despite the obvious need to assess the impact of managed care on psychiatry, there is surprisingly little useful information available about the impact of managed care on private practice, which is still the predominant delivery mode of outpatient psychiatric treatment in the United States. The literature currently consists of three types of material: 1) numerous highly subjective tabloid-style articles, 2) a few large informal surveys, and 3) a small number of systematic surveys of heterogeneous groups of mental health professionals.

A large 1988–1989 overview of psychiatrists' professional activities (N = 19,431) documented a decline in private practice and dramatic diversification of practice settings.[9] The authors attributed these trends to economic pressures, principally the growth of MCOs. The proportion of psychiatrists listing private practice as their primary work activity declined from 58%, a majority, in 1982 to 45% in 1988. The same study also documented the extensive prevalence of cost-shifting (in which psychiatrists charge higher fees to their private, non–managed care patients) across a broad range of services.[10]

A 1995 multidisciplinary survey of psychotherapists (N > 200, including psychiatrists, psychologists, social workers, and others) documented a reduced psychotherapy caseload among 43% of respondents, increased use of time-limited techniques (a managed care hallmark) in 51%, and reduced income among 61% of psychiatrists.[11] Sixty-three percent of responding psychiatrists reported an increase in disallowed claims due to managed care.

Another study (N > 100) suggested that psychiatrists' incomes decline as their managed care participation increases.[12] The authors (the Medical Group Management Association) noted that "psychiatrists are not expected to do well under managed care because these organizations typically restrict psychiatrists' use to medication management."

Between these few data-based surveys and the subjective diatribes that pour forth ("Managed Care May Save the Profiteers but Kill the Doctors;"[13] "Earning a Living: A Blueprint for Psychiatrists;"[14] "Reversing Managed

Denial;"[15] etc.), there exist several informal surveys purporting to reflect the state of psychiatric practice in this age of economic change.

A 1993 survey of the chairs of regional Private Practice Committees of the American Psychiatric Association offered the following dismal impressions:

> Psychiatrists as a group have grave misgivings about their future and that of their profession. A sense of anxiety and foreboding was expressed even by those practitioners who personally were doing well. Words such as scared, depressed, anxious, apprehensive, confused, subdued, pessimistic, and demoralized were used in nearly all the returned questionnaires. Many indicated that incomes were declining or were being maintained only by the expenditure of a great deal of extra effort. Most said that professional autonomy had been severely eroded by managed care and other forms of oversight.[16] (p. 19)

A 1994 *New York Times* review of the effects of managed care on the practice of psychotherapy across professional disciplines further reported lowered incomes, diminished autonomy, and general discouragement with private practice.[17] A 1995 *Wall Street Journal* series detailed changes in psychiatric practice wrought by managed care. One article focused on insurers' pressuring psychiatrists and other clinicians to minimize psychotherapy and emphasize medication for patients, virtually regardless of diagnosis:

> Managed care companies, with their mandate to cut costs, make no bones about their preference for treating mental health problems with drugs. Not only do they limit coverage for psychotherapy, they often pay psychiatrists more per hour to supervise drug treatment than to provide counseling.[18]

Another article in the *Wall Street Journal* series reported the malaise and discouragement of practitioners, detailing the conflicts within the profession described above. Noting the 12% decline in U.S. medical school graduates who chose psychiatry residency training between 1988 and 1994, the authors asserted that one consequence of the economic deterioration of the practice "climate" is diminishing interest in the specialty by medical students.[19]

Given the conflicting passions aroused by managed care, it is striking that so few data exist to inform the debates that rage among psychiatrists. This dearth of empirical information prompted our study: an attempt to quantify more systematically the state of private psychiatric practice in a part of New York City, and to assay the mood, attitudes, and professional satisfaction of a group of practitioners in the mid-1990s. Our hypotheses: 1) MCO providers would report lower professional satisfaction than non–MCO providers; and 2) changes in practice nature (such as decreased opportunities for performing psychotherapy) and economic changes (such as lower income) would be observed as correlates for differences in satisfaction rating. In other words, changed levels of satisfaction would be linked to MCO-related changes in what practitioners do and what they get paid for doing it.

METHODS

Using the alphabetical faculty directory of the Department of Psychiatry of Cornell University Medical College, Payne Whitney (Manhattan) campus, we selected every third nonsalaried (voluntary faculty) psychiatrist who had been out of residency for at least 3 years and was engaged in full-time private psychiatric practice in Manhattan. If a selected individual did not meet these criteria, the next name in sequence was chosen. This procedure was followed to reach the desired *N* of 100 (representing a balance of feasibility and statistical adequacy). The total pool of eligible individuals was approximately 300 from a faculty roster of nearly 500.

A mailing was sent in early 1996 to this group of 100 asking that they anonymously

complete a two-page questionnaire about private psychiatric practice. A stamped, preaddressed envelope was included together with a cover letter that explained the purpose of the study and assured the addressees that their responses would be kept confidential. A follow-up telephone call was made 1 month after the mailing in an attempt to maximize returns.

The questionnaire, designed by the investigators, contained 24 items, some of which had multiple components. Areas of inquiry included general aspects of practice (such as duration, participation in managed care and Medicare, numbers of patients in treatment, and prescribing activity for non-MD therapists), economic factors (including gross practice revenues for 1993–1995, referral activity, and fee schedules), satisfaction with aspects of practice, and attitudes about managed care and other issues. Some questionnaire items related to the practice of providing medication backup to nonmedical therapists were drawn from a previously published validating study.[20] Overall professional satisfaction ratings for two times periods, "currently" and "in the past," were reported via a Likert scale, ranging from 1 = very dissatisfied to 5 = very satisfied.

Statistical analysis (*t*-tests for independent and paired samples) of responses was performed by using the Statistical Package for the Social Sciences (SPSS Inc., Chicago, IL).

RESULTS

Forty recipients returned completed or partially completed questionnaires. An additional 7 were returned to the investigators undelivered, yielding an overall response rate of 43% (40/93).

General Characteristics of Respondents' Practices

Forty-six percent of respondents identified themselves as participants in one or more managed care programs. Eighty-seven and a half percent reported that in the past year they had been asked by a prospective new patient whether they belonged to a managed care panel. Seventy-five percent of respondents stated that they treat Medicare patients. Twenty-five respondents (62.5%) identified themselves as providing psychopharmacologic treatment for patients treated by a nonmedical psychotherapist, with 28% reporting that they were doing more medication backup than they had 3 years earlier. General characteristics of the respondents are listed in Table 1.

Economics

Mean annual gross revenues of all respondents from patient care showed minimal changes during the interval surveyed: $195,724, $203,800, and $201,267 for 1993, 1994, and 1995, respectively (a 4% increase followed by a 1% decrease).

Differentiating respondent revenue data according to years in practice revealed a significant diminution in the revenue difference between older, more veteran psychiatrists (those in practice longer than 15 years) and their younger colleagues. Analysis of mean annual revenues by years in practice appears in Table 2.

There was no statistically significant difference in the age distribution of MCO participants relative to nonparticipants.

Annual average patient care revenues differed considerably according to respondents' managed care participation status (Table 3).

Medication Backup

Nearly two-thirds of the respondents provide medication backup for nonmedical psychotherapists. Seventy-six percent of those providing medication backup believed that this activity involves greater liability exposure than if they were the sole providers of care (providing both psychotherapy and medication). Thirty-six of 37 respondents agreed with the statement: "Medication backup could im-

plicate the psychiatrist as legally responsible for the patient's treatment by the nonmedical therapist." Almost half of respondents who provide medication backup (48%) feared a decline in income should they cease to provide such services. One hundred percent of respondents (n = 40) reported that prescribing for patients in psychotherapy with someone else is less gratifying than providing both components of care.

Satisfaction With Practice

The satisfaction ratings of the respondents are listed and compared in Table 4; as noted above, 5 is the highest level of satisfaction and 1 is the lowest.

TABLE 1. General characteristics

Characteristic	*n*	%
Years in practice		
< 15	17	47.5
> 15	23	57.5
Number of active patients		
< 25	11	27.5
25–40	19	47.5
> 40	10	25.0
MCO panelist		
Yes	18	45.0
No	22	55.0
Treat Medicare patients		
Yes	30	75.0
No	10	25.0
Medication backup		
Yes	25	62.5
No	15	37.5

Note: MCO = managed care organization.

The data indicate a significant difference between current and past (3 years earlier) mean levels of professional satisfaction (3.9 vs. 4.4). But when respondents' satisfaction scores are broken down according to managed care participation, the decline in satisfaction from 3 years earlier appears attributable to the subgroup of respondents who are managed care providers (3.4 [current] vs. 4.4 [past]). In contrast, non–managed care participants' satisfaction scores remained steady (4.2 [current] vs. 4.4 [past]). Managed care participants and nonparticipants did not significantly differ in past levels of satisfaction (4.4 vs. 4.4), but did differ significantly with respect to current satisfaction (3.5 vs. 4.2; $t = 2.28$, $P < 0.03$). Half of the respondents who were managed care participants reported participation in greater managed clinical activity than 3 years ago, further suggesting that managed care participation is associated with declining professional satisfaction with practice.

Among non–managed care providers (n = 22), the most common reasons cited for nonparticipation were eroded confidentiality (73%), inadequate fees (55%), and comfort in the solvency and security of their practices (50%).

Thirty-three of 40 respondents (83%) found practice more difficult now than 3 years ago; 70% were happier in practice 3 years ago than currently; and 70% of respondents reported that they would not recommend a career in private practice to a graduating psychiatry resident. Seventy percent of respondents felt that psychiatry as a specialty is worse

TABLE 2. Mean annual revenues by years in practice

Category	1993	1994	1995
Practicing < 15 yrs (n = 12, 13, 13)	$135,417	$157,308	$158,308
Practicing > 15 yrs (n = 17, 17, 17)	$238,294	$239,353	$234,118
Difference	$102,877	$82,045	$75,810
t-test of difference	$t = 3.18$, $P < 0.004$	$t = 2.34$, $P = 0.027$	$t = 2.00$, $P = 0.055$
All respondents (n = 29, 30, 30)	$195,724	$203,800	$201,267

off in the current economic climate than other medical specialties.

As shown in Table 5, where revenue data are combined with satisfaction scores, the increasing income disparity between MCO participants and nonparticipants parallels an increasing satisfaction rating disparity.

DISCUSSION

This study was undertaken to provide more information about the current state of New York City private psychiatric practice in the context of the growth of managed care through the mid-1990s. The investigators hoped to discover whether data support pervasive subjective impressions of pessimism and disillusionment that informal discussions with colleagues and the aforementioned anecdotal literature suggest. Unfortunately, the results appear to support many of the common perceptions.

Although satisfaction scores seem acceptable (mean satisfaction score for all respondents was 3.9 of a possible 5), they may actually constitute a disappointing result when one considers that private practice represents the chosen career activity of these highly trained professionals affiliated with a prominent medical college.

Examining satisfaction ratings according to managed care provider status lent support to the hypothesis that the changes wrought by managed care are indeed affecting the satisfaction of practitioners. Respondents participating in managed care were significantly less satisfied than counterparts who were not MCO-affiliated. Further support for the notion that managed care participation negatively affects professional satisfaction comes from the significant decline in satisfaction ratings of managed care providers compared with their ratings 3 years earlier. This decrease suggests that exposure to managed care takes its toll over time on the satisfaction of practitioners. Again, non-MCO providers reported no significant change in professional satisfaction over the three-year interval.

A major short-term cost-cutting (though not necessarily long-term cost-effective) strategy of managed care involves selectively referring patients for psychotherapy to nonmedical professionals whose rates of remuneration are significantly lower than those of psychiatrists. Thus, MCO psychiatrists are decreasingly providing psychotherapy to managed care patients, their role being often limited to brief "med-check" visits. Increased competition for psychotherapy patients has compelled many psychiatrists to take on more medication backup cases to maintain their incomes. This constellation of circumstances (psychiatrists economically bound to continue providing a service that is less gratifying yet involves greater liability exposure) would seem to yield a climate antagonistic to professional satisfaction.

A study by Simon and Born[20] of physicians' 1994 incomes across all specialties revealed a 4% decrease from the previous year. In our study, respondents' incomes increased by 4% during the 1993–1994 interval and subsequently fell by 1% for 1994–1995. Because Manhattan has lagged behind the rest of the country in managed care penetration, a delayed income decline among Manhattan psychiatrists is not surprising. The authors of the national survey suggest that physicians' incomes are a useful barometer for tracking

TABLE 3. Mean revenues, in dollars, by managed care provider status

Variable	1993	1994	1995
MCO participant	177,571	183,933	179,286
MCO nonparticipant	212,667	223,667	220,500
Difference	35,096	39,734	41,214

Note: MCO = managed care organization.

changes in the economic climate in which medicine is practiced; specifically, they suggest that income statistics are valid as a tool for tracking the impact of managed care.[20] In our study, even though the finding did not achieve statistical significance, it is striking that non–managed care psychiatrists achieved gross incomes that were 20% to 23% greater than the mean incomes for managed care participants during the 3 years surveyed.

As noted, the increasing income disparity between MCO participants and nonparticipants paralleled an increasing satisfaction rating disparity (Table 5). But those results also show that money alone cannot explain declining satisfaction scores among managed care participants. A revenue disparity existed in 1993, when satisfaction scores were approximately equal, suggesting that other aspects of managed care participation (more clinical oversight, for example) may contribute to declining professional satisfaction.

The implications of our findings for patient care are collectively ominous. Diminished professional satisfaction and economic compensation may lead current practitioners

TABLE 4. Mean satisfaction scores by subgroup

Comparison	Satisfaction Score	*n*	*t*	*P*
All respondents, current	3.9			
All respondents, past	4.4			
t-test		39	2.88	0.006
MCO participants, current	3.5			
MCO nonparticipants, current	4.2			
t-test		18,22	2.28	0.028
MCO participants, past	4.4			
MCO nonparticipants, past	4.4			
t-test				NS
MCO nonparticipants, current	4.2			
MCO nonparticipants, past	4.4			
t-test				NS
MCO participants, current	3.4			
MCO participants, past	4.4			
t-test		17	3.52	< 0.003

Note: MCO = managed care organization; NS = not significant.

TABLE 5. Mean annual revenues, in dollars, and satisfaction ratings according to managed care participation

Variable	1993	1994	1995
Mean revenues			
MCO participant	177,600	184,000	179,300
MCO nonparticipant	212,700	224,000	220,500
Difference	35,100	40,000	41,200
Percent difference	20%	22%	23%
Satisfaction scores			
MCO participant	4.41		3.50
MCO nonparticipant	4.41		4.23
Comparison	No significant difference		$t = 2.28$, $P = 0.028$

Note: MCO = managed care organization. Satisfaction scores are ratings on the questionnaire of past versus current satisfaction.

away from patient care and deter promising potential clinicians from establishing practices as they choose less embattled career paths. Over time psychiatric practitioners of psychotherapy may diminish in number, leaving this work to the nonmedically trained and jeopardizing the welfare of patients whose care would lack the relevant and often mandatory medical perspective and expertise. At the very least, declining professional satisfaction can yield a dangerously fertile environment for negative countertransference.

As with most questionnaire surveys, numerous caveats apply to interpretation of these data. The questionnaire, an original construction, appears to meet the requirements of face validity (for instance, individual items manifestly address issues that relate to an assessment of satisfaction with practice),[21] but it lacks replication or control through other uses or studies. Especially vulnerable to criticism is the retrospective assay of past satisfaction. However, prior to its distribution the questionnaire was reviewed by experienced researchers, resulting in revisions that achieved consensus acceptability. Another concern involves the response rate and hence the representativeness of the respondents. For mailed surveys, a response rate of 50% is generally considered adequate for data analysis and reporting;[21] the current work, with a rate of 43%, falls below that level.

Further reasons for caution in interpreting the generalizability of the results are that this study canvassed a particular geographic region (New York City) and a particular economic market (the upper east side of Manhattan). However, the service delivery region we looked at may represent, for reasons already mentioned, one of the final frontiers of managed care's impact on psychiatry, thereby providing a fertile substrate for assessing managed care's current influence on private practice. Offsetting this shortcoming is the likely representativeness of the respondents. Since the questionnaire was mailed to a randomly selected subgroup drawn from a homogeneous population (voluntary faculty, full-time private practitioners), there is little reason to suspect significant variation among respondents, nonrespondents, and those who were not included in the mailing.

Yet despite these caveats, the dilemma seems clear: without managed care participation, a practitioner may lack an adequate flow of new patients, so the future may mandate a reconciliation to lower earnings and administrative oversight. MCOs have not had difficulty filling their provider panels, suggesting that the fear of declining patient flow with nonparticipation in managed care has so far outweighed the decreased compensation for working in such settings.

Perhaps the greatest irony in this still-evolving saga is that the upheaval may be unwarranted: outpatient psychiatric practice may never have contributed to the runaway expenditures that so alarmed third-party payers.[22] As reforms aimed at inpatient abuses spread, the private psychiatrist became caught up in the juggernaut of cost-control mechanisms and oversight. Hymowitz remarked in a *Wall Street Journal* article:

> What's really sad is that outpatient therapy was never part of the rising-cost problem. Even when therapy benefits were very generous, every study showed that 85% of patients ended treatment before the 25th visit on their own. . . . In addition, utilization rates have been steady for 15 or 20 years. There really is no reason to manage outpatient therapy, and the management of it costs almost as much as the therapy itself. . . . The big cost problem was inpatient care. . . . The average number of outpatient therapy visits has been six to eight (per patient) for decades . . . so trying to clamp down on outpatient services to control costs doesn't make sense.[8]

QUESTIONS AND ANSWERS ABOUT MANAGED CARE TRENDS

Q: What can we as psychiatrists do about the trends you report?

A: Well, on the provider side, if psychiatrists

refused to join MCOs, that would have an impact—but there's no sign of that being remotely possible. There is no shortage of psychiatrists willing to join MCO provider panels.

Q: You have focused on provider-side satisfaction. Is there any good information regarding satisfaction on the consumer side?

A: Not much. One reason for this, especially in psychotherapy delivery, is that as quality assessment becomes more data-driven, the issue of patient confidentiality remains a large and unresolved problem. But large numbers of anecdotal reports of dissatisfaction with quality are showing signs of producing effects—for instance, in the form of possible federal legislation leading to better MCO quality assessments (such as HMO report cards) and guaranteeing patient rights.

Q: Satisfaction is a complex concept. Are you sure your survey elicited all the important determinants that affect professional satisfaction for your study sample?

A: No. In fact, we're sure that it didn't. More detailed demographic data, better measurement of putative MCO-related practice effects, and consideration of factors related to the overall medical economic environment are crucial additional points that future studies should incorporate.

Q: Given that we will never go back to the old ways and that cracks are appearing in the managed care system, do you see any signs of going to a single-payer system?

A: It may be on the horizon, but relatively far off. When President Clinton's federal health care initiative was defeated, insurance companies were empowered to create their own product. So given the relatively recent political defeat of a national health plan, and the economic power of health insurance companies, it's unlikely that a federally based single-payer system will arise in the near future.

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BOOK REVIEW

The Symptom-Context Method: Symptoms as Opportunities in Psychotherapy

By Lester Luborsky
Washington, DC, American Psychological Association, 1996, 422 pages, ISBN 1-55798-354-2, $39.95

Reviewed by Myron F. Weiner, M.D.

Lester Luborsky has been a psychotherapy researcher for 50 years. In this complicated and data-filled volume, which contains much work published earlier, he summarizes his work on examining events in individual psychotherapy through contemporaneous recordings. His technique, the symptom-context method, analyzes by the Core Conflictual Relationships Theme (CCRT) method the context in which symptoms occur or are reported in psychotherapy.

After describing the origins of his method and his techniques of data collection and analysis, Luborsky presents material on the results of the CCRT method for determining the context of both psychological and psychophysiological phenomena. Psychological phenomena include momentary forgetting and depressive mood shifts occurring within psychotherapy sessions and the reporting of phobic symptoms occurring outside the therapeutic situation. Psychophysiologic phenomena include abdominal pain, migraine-like headache (subjective perceived phenomena), and petit mal seizures and premature ventricular contractions of the heart (physiologic events). He contrasts symptomatic behaviors (a symptom defined as something that impairs function) with nonsymptomatic behaviors that occur in psychotherapy—laughing, self-touching, crying (in a family therapy)—and he also includes touching of treasured objects by young children in day care. The book concludes with application of the symptom-context technique to psychotherapy.

In Luborsky's intraindividual method, each person serves as his or her own control. Multiple raters blinded to the symptomatic behavior or physiologic event determine the predominant context in which it occurs during psychotherapeutic sessions by sampling a segment of 50 to 500 words from process notes or tape recordings before and after the behavior or physiologic event occurs or is reported.

From these samples, raters formulate themes, which are then contrasted with themes from portions of sessions in which no symptom emerges or was reported. Sessions as a whole are rated by the CCRT method to ascertain the central relationship patterns that emerge from the narratives (what the patient wanted from the other person, how the other person responded, and how the patient responded in turn).

By this method, Luborsky reports, for example, that momentary forgetting during psychotherapy was associated with Involvement with Therapist, Rejection, Helplessness, Hopelessness, and Hostility to Therapist. He suggests that an individually specific theme precedes a symptom that arises in psychotherapy.

With regard to depressive mood shifts during treatment, he finds support for the dynamic theories of depression and for a depressive cognitive style. Luborsky holds that his method will be a valid basis for testing theories of symptom formation. He predicts that future researchers will learn more about the biology of symptom formation, but that they will always continue to find that psychological issues are contributing factors.

With regard to the technique of psychotherapy, in Luborsky's view his work shows that for treatment to be effective, it is important to interpret the main symptom-context theme while not alienating the patient and while maintaining the therapeutic alliance. The symptom-context theme (usually Hopelessness, Lack of Control, Anxiety, Feeling Blocked, or Helplessness) parallels the CCRT, whose resolution is held to be associated with positive outcome of therapy. Thus, dynamic therapists may need to attend more directly to the *origin* of symptoms, and behavior thera-

pists may need to increase their attention to the *context* in which symptoms occur.

The strength of Luborsky's method is its capacity to detect the psychological determinants of symptom formation that occurs during and outside of psychotherapeutic sessions. A weakness of his method is that it equates therapy outcome with CCRT resolution. One cannot argue that a good therapeutic result is prima facie evidence of having achieved a thorough CCRT resolution. The result may be unrelated to CCRT resolution. Another weakness in terms of outcome is the absence of a control condition in which CCRT resolution was not used, or even a placebo condition. Who can say that CCRT resolution is any better than placebo or medication?

The strength of this book is the rigorous application of a specific technique to a variety of psychological and physiologic events. Going through the data is tedious, but the extensive data presented make it clear that Luborsky's conclusions are externally validated rather than based on the clinical impressions that may often be misleading.[1] Not for the average clinician, this book is for those interested in the process of scientific psychotherapy research.

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