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AN INTERPERSONAL APPROACH: TIME-LIMITED DYNAMIC PSYCHOTHERAPY[1]

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Introduction—Bridging the Theory to Practice Gap

Think of the last time you met someone who immediately rubbed you the wrong way. For no apparent reason, this person approached you in an off-putting manner—perhaps being intrusive, boisterous, or even intimidating. What was your response? You probably had some reaction—obvious or subtle—to such provocative behavior. You may have glared at the person with your heart beating rapidly and your palms clenched into fists. Or you may have lowered your head and looked away. Your reactions probably affected this person's further behavior. Over time, such interactions come to shape how we think and feel about others and ourselves. They help determine the way we interact in the world which further affects the way others respond to us. This cycle continues in an endless loop, strengthening our view of ourselves and others. Over time, the nature of these interactions forms templates in our minds of what we can expect to get from others and give to others. These templates of how our social lives work have far reaching implications for our hopes, joys, and problems. Such working models built up over past experiences in combination with our present interactions form the basis of the interpersonal approach to psychotherapy.

So, too, in therapy, the manner in which clients approach their therapists and the manner in which therapists respond to their clients have much to do with the nature of the ensuing therapeutic process and progress. As stated succinctly and accurately by a trainee learning to apply interpersonal dynamic psychotherapy, "This approach assumes that a client has unwittingly developed over time a self-perpetuating, maladaptive pattern of relating to others, and that this pattern underlies the client's presenting issues. The therapist's job is to use the clinical relationship to facilitate for the client a new experience of relating, allowing the client to break the old pattern and thereby resolve the presenting issues."

Over twenty-five years ago, Hans Strupp and Jeffrey Binder developed Time-Limited Dynamic Psychotherapy (TLDP), an interpersonal, time-sensitive approach. Previously brief treatments (twenty sessions or less) were meant to be used only with high functioning clients (e.g., above average intelligence, psychologically-minded, introspective). But TLDP was designed to be applicable to a broad range of clients, even those who had difficulties forming good working relationships (therapeutic alliances) with their therapists. The goal of TLDP is not on the reduction of symptoms as such (e.g., anxiety, depression), although improvements in symptoms are expected to occur; but rather, the focus is on changing ingrained patterns of interpersonal relatedness or personality style. TLDP makes use of the relationship that develops between therapist and client to kindle fundamental changes in the way a person interacts with others.

The interpersonal view of TLDP focuses on transactional patterns where the therapist is embedded in the therapeutic relationship as a participant observer or observing participant. There is a wonderful New Yorker cartoon that captures the essence of this viewpoint. In the cartoon, a woman from the audience is walking onto a theater stage on which an Elizabethan drama is taking place. One actor, seeing the approaching woman, says to his fellow actor, "But wait. Ellen doth approach." Ellen had been observing the play, but now she was going to enter the spotlight and join the action on stage. She at once becomes a part of the drama, but at the same time is an audience member observing the drama. So, too, in an interpersonal therapy, the clinician participates fully in trying to form a relationship with the client, and in so doing gets caught up in the client's "drama," acting out a complementary role. However, the therapist also has the ability (hopefully) and responsibility to step outside the immediate unfolding scenario and perceive the action from a more objective vantage point.

Principles in practice

The TLDP model incorporates seven basic principles:

1. People are innately motivated to search for and maintain human relatedness.

In attachment theory terms, the infant's orientation to stay connected to early caregivers is based on

survival needs. We are hardwired to gravitate toward others (e.g., newborns are more likely to gaze at designs in the shape and structure of a face than at more abstract ones). The more we are able to establish a secure interpersonal base, the more likely we are to develop into independent, mature, and effective individuals. I think of how so many people in the Twin Towers of 911, when faced with an impending horrific death, reached for their cell phones for the sole purpose of making contact with a loved one.

By recognizing this basic drive for relatedness in your clients, you have a powerful lever to promote growth. For example, a client of mine was more than reluctant to give up his daily marijuana use, but when he understood how it was creating a serious wedge between him and his wife that might cost him her love and companionship, be became motivated to quit.

2. Maladaptive relationship patterns are acquired early in life, become schematized, and underlie many presenting complaints.

How one relates as an adult typically stems from relationships with early caregivers in the following manner. If these caregivers (usually parents) are attuned to the needs of the child and are accessible, the child feels secure and is able to explore the environment feeling safe and loved. If the caregivers are inconsistent, rejecting, and/or unresponsive, the child will feel insecure and could become anxious or avoidant. Early experiences with parental figures result in mental representations of these relationships or working models of one's interpersonal world. These experiences form the building blocks of what will become organized, encoded experiential, affective, and cognitive data (i.e., interpersonal schemas) informing the child about the nature of human relatedness, and what is generally necessary to sustain and maintain emotional connectedness to others. The child then filters the world through the lenses of these schemata which allow him or her to interpret the present, understand the past, and anticipate the future. Unfortunately, these schema can become a dysfunctional, self-fulfilling prophecy if early interpersonal experiences are faulty. For example, a client of mine (Mr. Behrens) had parents who treated him in an authoritarian and harsh manner. Consequently he became overly placating and deferential because it was a way he could survive and still stay connected to them. His experiences led him to expect that others would treat him badly if he were not compliant. He entered therapy because he was living a life filled with anxiety and a sense of dread.

While early childhood experiences are usually the major contributor to the development of life-long patterns, there are some situations where life-altering adult experiences have overwhelmed previous templates. While I was working at a Veterans Administration Hospital several years ago, I had the opportunity of treating many Vietnam combat veterans. These (chiefly) men had had, for the most part, nurturing childhh0ods but were now anxious, hypervigilant, suspicious, and sometimes combative. Their horrible war experiences had so dramatically changed their previously benign models of how their social worlds worked that they were now seeking and needing help.

3. Such patterns persist because they are maintained in current relationships (circular causality).

From a TLDP framework, the individual's social expectations are not seen as fixed at a certain point, but rather as continually changing as he or she interacts with others. Although one's dysfunctional interactive style might be learned early in life, this style must be supported in the person's present adult life for the interpersonal difficulties to continue. However, what often happens is that people act in ways that provoke in others the very behavior they are so afraid of getting. Let's go back to my client, Mr. Behrens. His placating and deferential behavior became well practiced into adulthood. As an adult, his meekness allowed others to take advantage of him at best and treat him harshly at worst. In other words, his submissiveness invited the very behavior he was most afraid of (dominance by others). Furthermore, since his template was derived and perpetuated out of his awareness, he continued to be at its mercy. I am reminded of the saying that a fish has no idea of water. So it is with working models. They have an enormous impact on our lives, but we just take them for granted as the way life is.

On the other hand, if my client could have the experience of being assertive and being treated with respect instead of harshness, this would run counter to his internalized working model. From a TLDP perspective with more and more of these experiences, he would be expected to shift (over time) to a more robust and enlivened view of himself and his relational world.

4. Therefore, in TLDP, clients are viewed as stuck, not sick.

Clients are seen as trapped in a rut which they helped dig, not as deficient. The goal of therapy is to help them get out of that rut.

5. Maladaptive relationship patterns are reenacted in the therapeutic relationship.

The client interacts with the therapist in the same dysfunctional way that characterizes his or her interactions with significant others (i.e., transference), and tries to enlist the therapist into playing a complementary role (i.e., countertransference). From an interpersonal therapy perspective the therapist is pulled to join the client in

acting out his or her lifelong dysfunctional style. As an interpersonal therapist, I see this as an ideal opportunity, because it provides me with the very situation that gets the client into difficulties in the outside world. I have a chance to observe the playing out of the client's maladaptive interactional pattern, and to experience what it is like to try to relate to that individual. I become the participant observer mentioned earlier. The interactionist position of TLDP holds that the therapist cannot help but react to the client—that is, the therapist inevitably will be pushed and pulled by the client's dysfunctional style and will respond accordingly. The therapist inevitably becomes "hooked" into acting out the corresponding response to the client's inflexible, maladaptive pattern. I think of it as the therapist's unwittingly becoming the client's dance partner in a well-rehearsed two-step.

To go back to my subservient, placating, anxious client, in the initial sessions I found myself becoming more reassuring, more confident, and more directive in my manner than usual—more "the expert." I was being hooked into a complementary style that fit with his lead in the dance.

It is critical that the therapist eventually get unhooked. To do this, the therapist must realize how he or she is fostering a replication of the dysfunctional pattern. Then the therapist can use this information to attempt to change the nature of the interaction in a more positive way, thereby engaging the client in a healthier mode of relating. In addition, the therapist can collaboratively invite the client to look at what is happening between them (i.e., metacommunicate), either highlighting the dysfunctional reenactment while it is occurring or guiding the client to a healthier, more functionally adaptive way of relating through a series of new experiences.

Since dysfunctional interactions are sustained in the present, the therapist can concentrate on the present to alter the client's dysfunctional interactive style. Working in the present allows change to happen more quickly because there is no assumption that one needs to work through childhood conflicts and discover historical truths. This emphasis on the present has tremendous implications for treating interpersonal difficulties in a brief time frame.

6. TLDP focuses on one chief problematic relationship pattern.

While clients may have a repertoire of different interpersonal patterns depending upon their states of mind and the particulars of the situation, the emphasis in TLDP is on discerning what is a client's most pervasive and problematic style of relating. In opera, when characters walk onto the stage, the orchestra plays their theme music. In TLDP I think of looking for the client's predominant melody. Figuring out what is the chief pattern is a matter of logic (what gets subsumed under what) and clinical experience.

7. The change process will continue after the therapy is terminated.

The goal in TLDP is to interrupt the client's ingrained, repetitive, dysfunctional cycle. In so doing, the intention is to promote forays into healthier behavior, which theoretically would be responded to differently (more positively) by others, thereby increasing the probability that the person will again engage in a more satisfying manner. At the end of a brief therapy, such changes have only begun to take hold. It is expected that overtime as one has more opportunity to practice such functional behaviors, the interactions with others and the resulting more positive internalized schemas would become strengthened. As I like to say, the therapy sessions end, but the therapy continues in the real world.

Keys to conceptualization

In the past, psychodynamic brief therapists used their intuition, insight, and clinical savvy to devise formulations of cases. While these methods may work wonderfully for the gifted or experienced therapist, they are impossible to teach explicitly. One remedy for this situation was the development of a procedure for deriving a dynamic, interpersonal focus--the Cyclical Maladaptive Pattern (CMP). Briefly, the CMP outlines the idiosyncratic vicious cycle of maladaptive interactions that a particular client manifests with others. These cycles or patterns involve inflexible, self-defeating expectations and behaviors, and negative self-appraisals, that lead to dysfunctional and maladaptive interactions with others.

The role of the CMP is critical in TLDP. Specifically, the CMP plays a key role in guiding the clinician in formulating a treatment plan. I use the CMP as an organizational framework that makes a large mass of data comprehensible and leads me to think of ways of intervening that could be helpful. A CMP should not be seen as an encapsulated version of "the Truth," but rather as a plausible narrative, incorporating major components of a person's current and historical interactive world. A successful TLDP formulation should provide a blueprint for the therapy. It helps me describe the nature of the problem, leads me to figure out the goals for treatment, serves as a guide for the types of interventions I might choose, enables me to anticipate reenactments within the context of the therapeutic interaction, and provides a way to assess whether the therapy is on the right track—in terms of outcome at termination as well as in-session mini-outcomes. The focus provided by the CMP permits the therapist to intervene in ways that have the greatest likelihood of being therapeutic. Thus there are possibilities for the therapy to be briefer and more effective. As you can see, the CMP is invaluable for the interpersonal therapist.

To derive a TLDP formulation, the therapist lets the client tell his or her own story in the initial sessions rather than relying on the traditional psychiatric interview that structures the client's responses into categories of information (e.g., developmental history, education). By listening to how the client tells his or her story (e.g., deferentially, cautiously, dramatically) as well as to the content, the therapist can learn much about the client's interpersonal style. The therapist also explores the interpersonal context of the client's symptoms or problems. When did the problems begin? What else was going on in the client's life at that time, especially of an interpersonal nature?

Then the clinician obtains data that will be used to construct a CMP. As I listen to clients in the opening session(s), I pay attention to and seek out information by using four categories:

Acts of the Self. These acts include the thoughts, feelings, motives, perceptions, and behaviors of the client of an interpersonal nature. For example, "When I meet strangers, I think they wouldn't want to have anything to do with me" (thought). "I am afraid to go to the dance" (feeling). "I wish I were the life of the party" (motive). Sometimes these acts are conscious as those above, and sometimes they are outside awareness, as in the case of the woman who does not realize how jealous she is of her sister's accomplishments.

Expectations of Others' Reactions. This category pertains to all the statements having to do with how the client imagines others will react to him or her in response to some interpersonal behavior (Act of the Self). "My boss will fire me if I make a mistake." "If I go to the dance, no one will ask me to dance."

Acts of Others toward the Self. This third grouping consists of the actual behaviors of other people, as observed (or assumed) and interpreted by the client. "When I made a mistake at work, my boss shunned me for the rest of the day." "When I went to the dance, guys asked me to dance, but only because they felt sorry for me."

Acts of the Self Toward the Self (Introject). In this section belong all of the client's behaviors or attitudes toward him or herself—when the self is the object of the interpersonal pattern. How does the client treat him or herself? "When I made the mistake, I berated myself so much I had difficulty sleeping that night." "When no one asked me to dance, I told myself it's because I'm fat, ugly and unlovable."

Interactive Countertransference. In addition to the four patient categories, an important fifth category pertains to the therapist. When I am with a client, I ask myself what is it like to try to relate to this person. Am I pushed or pulled to respond in a certain way? For example, am I anxious, solicitous, or withdrawn? Remember how earlier I described how I became directive in talking with Mr. Behrens?

The therapist's feelings and behaviors as they pertain to the client are just as important to recognize and track in an interpersonal treatment as those of the client. This complementary way of responding is called the interactive (i.e., interpersonal) countertransference (i.e., responding to the client's transference to the therapist). You have probably heard of countertransference as referring to the therapist's unconscious conflicts and unique responses to the patient because of these unresolved conflicts. Here I am using countertransference in a different sense—to refer to how the therapist gets pushed and pulled by the client, regardless of the therapist's own unique personality make-up. I would expect any therapist to get pulled in similar ways in interacting with certain clients. If you were working with Mr. Behrens, you would probably be more assertive and directive with him, because he is so submissive. Of course, each therapist has a unique personality that contributes to the particular shading of the reaction which is elicited by the client (e.g., when you are directive, it might look different from my version), but the TLDP perspective is that the therapist's behavior is chiefly shaped by the client's evoking patterns.

After gathering information on the five categories, the therapist's listens for themes in the emerging material by being sensitive to commonalities and redundancies in the client's transactional patterns over person, time, and place. The therapist's reactions to the client should make sense given the client's interpersonal pattern.

All of this information is used to develop a CMP narrative—a narrative that tells a story of the client's predominant dysfunctional interactive pattern. For example, a short-hand narrative for Mr. Behrens might sound something like, this is a man who is anxious and deferential (Acts of the Self), and expects others to be forceful and decisive (Expectations). Other people in his life take advantage of Mr. Behrens' submissiveness, and his therapist was directive and assured with him (Acts of Others). These responses from others confirm for Mr. Behrens that the world is unsafe and leaves him feeling vulnerable and inadequate (Introject). Feeling this way about himself leads to his being anxious and deferential, and we come full circle.

The CMP can be used to foresee likely transference-countertransference reenactments that might inhibit treatment progress. By anticipating client resistances, ruptures in the therapeutic alliance and so on, the therapist is able to plan and improvise appropriately. Thus when therapeutic impasses occur (e.g., Mr. Behrens is a passive and not an active participant in his treatment), the therapist is not caught off guard, but rather understands the situation and is ready to act appropriately—a necessity when time is of the essence. From the CMP formulation, the therapist

then discerns the goals for treatment . For specifics on this process, see the section on Short and Long-Term Goals.

The last step in the formulation process involves the continuous refinement of the CMP throughout the therapy. In a brief therapy, the therapist cannot wait to have all the "facts" before formulating the case and intervening. As the therapy proceeds, new content and interactional data become available that might strengthen, modify, or negate the working formulation.

Interventions and therapeutic process

Implementation of TLDP does not rely on a set of techniques. Rather it depends on therapeutic strategies that are useful only to the extent that they are embedded in a larger interpersonal relationship. These strategies should not be thought of as separate techniques applied in a linear, rigid fashion, but rather as guidelines for the therapist to be used in a fluid and interactive manner. Table 1 contains a list of commonly used TLDP intervention strategies.

Insert Table 1 here

In TLDP, the therapist specifically addresses what is going on between the therapist and client as they try to form a working relationship (Strategy 1). This focus on the here-and-now transactions provides the building blocks for understanding how the interaction may be a microcosm of the client's interpersonal difficulties in general. The therapist actively encourages the client to explore thoughts and feelings about the therapist (Strategy 2) and conversely to discuss how the client imagines the therapist might think or feel about the client (Strategy 3). In this way the therapist can begin to get a sense of the way the client puts together his or her interpersonal world. It can sometimes be helpful for the therapist actually to self-disclose his or her countertransferential pull to the client's specific behaviors (Strategy 4). In this way the therapist can guide exploration of possible distortions in the client's perceptions of others or help the client appreciate his or impact on others. For example, with Mr. Behrens, I said to him that I noticed I was treating him like a child at times and I found this curious since I usually did not interact with clients in this way.

Throughout the therapy, the therapist attempts to discover and discuss with the client any themes emerging in the content and process of the client's relationships (Strategy 5). These explorations enable the client to become more aware of problematic patterns of behavior (CMP). Asking about how the client treats him or herself (Strategy 6) can further be used to understand how interpersonal processes between others influence the person's view of self and vice versa.

The therapist can help depathologize the client's CMP by guiding him or her in understanding its historical development. From the TLDP point of view, symptoms and dysfunctional behaviors arise when individuals attempt to adapt to situations which threaten their interpersonal relatedness. For example, in therapy Mr. Behrens began to understand that as a child he had to be subservient and hypervigilant in order to avoid beatings. This realization enabled him to view his present passive style less negatively and allowed him to have some compassion for his childhood plight.

` In TLDP the most potent intervention capable of providing a new understanding is thought to be the therapist's linking the client's recurrent patterns of behavior to transactions between the therapist and client (Strategy 7). While most of the therapy will be devoted to examining the client's problems in relationships outside the therapy, it is chiefly through the therapist's observations and interpretations about the reenactment of the cyclical maladaptive pattern in the sessions that clients begin to have an in vivo understanding of their behaviors and stimulus value. By ascertaining how an interpersonal pattern has emerged in the therapeutic relationship, the client has perhaps for the first time the opportunity to examine the nature of such behaviors in a safe environment.

A very common error in technique is for the therapist, who is alert to discerning relationship themes, to point out such patterns to the client long before the client has had the opportunity to experience such redundancies in interacting with the therapist. These types of premature interpretations are usually met with surprise, hostility, and/or confusion on the part of the client and can lead to serious ruptures in the working alliance. If the therapist has decided it is the apt time to link a recurrent pattern of behavior with others to transactions between the client and him or herself, he or she should make them as detailed and concrete and possible. Such specificity helps the client experientially recognize himself or herself in the situation.

In Strategy 8 the therapist addresses obstacles (e.g., coming late, silence) that might influence the therapeutic process. In TLDP these obstacles often are the meat surrounding the CMP skeletal structure. That is, such defensive maneuvers help the therapist discover the manner in which the client tries to maintain a familiar, albeit, dysfunctional pattern. Resistance from the perspective of TLDP is viewed within the interpersonal sphere--as

one of a number of transactions between therapist and client. The assumption is that the client is attempting to retain personal integrity and ingrained perceptions of himself or herself and others. The client's perceptions support his or her understanding of what is required to maintain interpersonal connectedness. Resistance in this light is the client's attempt to do the best he or she can with how he or she construes the world.

Therefore, the manner in which the client "resists" will be informative regarding the client's interactive style. The therapist often has the experience of hitting a wall when confronted with the client's resistance. This wall often demarcates the boundaries of the client's CMP. Rather than continue to hit the wall in an attempt to break through it, the TLDP therapist can stand back, appreciate the wall, and invite the client to look at the wall also (i.e., metacommunication). Such an approach often avoids power-plays with hostile clients and helps to promote empathy and collaboration. Because the focus in TLDP is on the interpersonal interaction, the therapist always has the process (between therapist and client) to talk about when a therapeutic impasse has occurred. It is this focus on the interactive process that is absolutely essential to this interpersonal approach.

One of the most important treatment strategies is providing the opportunity for the client to have a new experience of oneself and/or the therapist that helps undermine the client's CMP (Strategy 9). The following examples of how to intervene with two clients with seemingly similar behaviors but differing experiential goals illustrate the strategy. Marjorie's maladaptive interpersonal pattern suggested she had deeply ingrained beliefs that she could not be appreciated unless she were the charming, effervescent ingénue. When she attempted to joke throughout most of the fifth session, her therapist directed her attention to the contrast between her joking and her anxiously twisting her handkerchief. (New experience: The therapist invites the possibility that he can be interested in her even if she were anxious and not entertaining.)

Susan's life-long dysfunctional pattern, on the other hand, revealed a meek stance fostered by repeated ridicule from her alcoholic father. She also attempted to joke in the fifth session, nervously twisting her handkerchief. Susan's therapist listened with engaged interest to the jokes and did not interrupt. (New experience: The therapist can appreciate her taking center stage and not humiliate her when she is so vulnerable.) In both cases the therapist's interventions (observing nonverbal behavior; listening) were well within the psychodynamic therapist's acceptable repertoire. There was no need to do anything feigned (e.g., laugh uproariously at Susan's joke), nor was there a demand to respond with a similar therapeutic stance to both presentations.

In these cases the therapists' behavior gave the clients a new interpersonal experience--an opportunity to disconfirm their own interpersonal schemata. With sufficient quality and/or quantity of these experiences, clients can develop different internalized working models of relationships. In this way TLDP is thought to promote change by altering the basic infrastructure of the client's transactional world, which then influences the concept of self. My experiential goal for Mr. Behrens was to help him experience himself as being assertive and in charge, and correspondingly to experience me as less directive and controlling. I deferred to him whenever possible and followed his direction. At first, this made him uncomfortable, since it was so out of keeping with his experience. Over time, however, he took more and more the lead and we developed a collaborative relationship rather than a hierarchical one.

The last strategy is designed to support exploration of the client's reactions to the time-limited nature of TLDP. Issues of loss are interwoven throughout the therapy and do not appear just in the termination phase. Toward the end of therapy, the best advice for the TLDP therapist is to stay with the dynamic focus and the goals for treatment, while examining how these patterns are evidenced when loss and separation issues are most salient.

How does the TLDP therapist know when the client has had "enough" therapy? In doing TLDP, I use five sets of questions to help me judge when termination is appropriate. First and foremost, has the client evidenced interactional changes with significant others in his or her life? Does the client report more rewarding transactions? Second, has the client had a new experience (or a series of new experiences) of himself or herself and the therapist within the therapy? Third, has there been a change in the level on which the therapist and client are relating (from parent-child to adult-adult)? Fourth, has the therapist's countertransferential reaction to the client shifted (usually from negative to positive)? And fifth, does the client manifest some understanding about his or her dynamics and the role he or she was playing to maintain them?

If the answer is "no" to more than one of these questions, then the therapist should seriously consider whether the client has had an adequate course of therapy. The therapist should reflect why this has been the case and weigh the possible benefits of alternative therapies, another course of TLDP, a different therapist, nonpsychological alternatives, and so on.

As with most brief therapies, TLDP is not considered to be the final or definitive intervention. At some point in the future, the client may feel the need to obtain more therapy for similar or different issues. Such

additional therapy would not be viewed as evidence of a TLDP treatment failure. In fact it is hoped that clients will view their TLDP therapies as helpful and as a resource to which they could return over time. This view of the availability of multiple, short-term therapies over the individual's life span is consistent with the position of the therapist as family practitioner.

Short and long-term goals

The TLDP therapist seeks to provide a new experience and a new understanding for the client. The first and major goal in conducting TLDP is for the client to have a new relational experience. "New" is meant in the sense of being different and more functional (i.e., healthier) than the maladaptive pattern to which the person has become accustomed. And "experience" emphasizes behaving differently and emotionally appreciating behaving differently. From a TLDP perspective, behaviors are encouraged that signify a new manner of interacting (e.g., more flexibly, more independently) rather than specific, content-based behaviors (e.g., going to a movie alone). The new experience is actually composed of a set of focused experiences throughout the therapy in which the client has a different appreciation of self, of therapist, and of their interaction. These new experiences provide the client with experiential learning so that old patterns may be relinquished and new patterns may evolve.

The focus of these new experiences centers on those that are particularly helpful to a particular client based on the therapist's formulation of the case. The therapist identifies what he or she could say or do (within the therapeutic role) that would most likely alter or interrupt the client's maladaptive interactive style. The therapist's behavior gives the client the opportunity to disconfirm his or her interpersonal schemata. The client can actively try out (consciously or unconsciously) new behaviors in the therapy, see how they feel, and notice how the therapist responds. This information then informs the client's internal representations of what can be expected from self and others. This in vivo learning is a critical component in the practice of TLDP.

A tension is created when the familiar (though detrimental) responses to the client's presentation are not provided. Out of this tension new learning takes place. Such an emotionally intense, here-and-now process is thought to "heat up" the therapeutic process and permit progress to be made more quickly than in therapies that depend solely upon more abstract learning (usually through interpretation and clarification). I believe this experiential learning is important for doing brief therapy, and becomes critical when working with a client who has difficulty establishing a therapeutic alliance or exploring relational issues in the here-and-now. As Frieda Fromm-Reichmann is credited with saying, what the client needs is an experience, not an explanation.

The second goal of providing a new understanding focuses more specifically on cognitive changes. The client's new understanding usually involves an identification and comprehension of his or her dysfunctional patterns. To facilitate such a new understanding, the TLDP therapist can point out repetitive patterns (i.e., metacommunicate) that have originated in experiences with past significant others, with present significant others, and in the here-and-now with the therapist. Therapists' disclosing their own reactions to the clients' behaviors can also be beneficial. In this way clients begin to recognize how they have similar relationship patterns with different people in their lives, and this new perspective enables them to examine their active role in perpetuating dysfunctional interactions.

The therapist (in conjunction with the client) aims to generate new experiences and new understandings. In reality, the therapist is pleased with any movement possible toward these goals, with the understanding that even slight shifts might result in major changes down the road. The short-term goals are to give the client repeated tastes of what it is like to interact more fully and flexibly within the therapy and to some extent to experiment with what is being learned in his or her outside social world. The long-term goals, which the brief therapist understands will be achieved after the therapy is concluded, include the person's having a richer set of interactions with others stemming from and reinforcing his or her more satisfying sense of self.

Using the relationship

In TLDP, the therapy is all about using the relationship. As has been previously described, the TLDP therapist uses the relationship to help figure out the problematic pattern (formulation) and to provide corrective transactional experiences (intervention).

Adapting the approach

TLDP was developed to help therapists deal with clients who have trouble forming working alliances due to their life-long dysfunctional interpersonal difficulties. However, it could be applicable for anyone who is having difficulties (e.g., depression, anxiety, emptiness) that affect their relatedness to self and other. Strupp and Binder (1984) outlined five major selection criteria for determining a client's appropriateness for TLDP: First, clients must be in emotional discomfort so they are motivated to endure the often challenging and painful change process, and to make sacrifices of time, effort, and money as required by therapy. Second, clients must come for appointments and engage with the therapist—or at least talk. Initially such an attitude may be fostered by hope or faith in a positive

outcome. Later it might stem from actual experiences of the therapist as a helpful partner.

Third, clients must be willing to consider how their relationships have contributed to distressing symptoms, negative attitudes, and/or behavioral difficulties. The operative word here is willing. Suitable clients do not actually have to walk in the door indicating that they have made this connection. Rather, in the give-and-take of the therapeutic encounters, they evidence signs of being willing to entertain the possibility. It should be noted that they do not have to understand the nature of interpersonal difficulties or admit responsibility for them to meet this selection criterion.

Fourth, clients need to be willing to examine feelings that may hinder more successful relationships and may foster more dysfunctional ones. The person must also be capable of distancing from these feelings so that the client and therapist can collaborate to examine them.

And fifth, clients should be capable of having a meaningful relationship with the therapist. Again, it is not expected that the client initially relates in a collaborative manner. But the potential for establishing such a relationship should exist. Clients cannot be out of touch with reality or so impaired that they have difficulty appreciating that their therapists are separate people. Previously, I (Levenson, 1995) endorsed the Strupp and Binder selection criteria. My present thinking, however, is that TLDP may be helpful to clients even when they do not quite meet these criteria as long as the therapist can adequately describe their interpersonal transactions. This hypothesis needs to be empirically tested.

Development and use of the CMP in treatment is essential to TLDP. It is not necessarily shared with the client but may well be, depending on the client's abilities to deal with the material. For some clients with minimal introspection and abstraction ability, the problematic interpersonal scenario may never be stated as such. Rather, the content may stay very close to the presenting problems and concerns of the client. Other clients enter therapy with a fairly good understanding of their own self-perpetuating interpersonal patterns. In these cases, the therapist and client can jointly articulate the parameters that foster such behavior, generalize to other situations where applicable, and readily recognize their occurrence in the therapy.

Since TLDP acknowledges that both therapist and client bring their own personal qualities, history and values to the therapeutic encounter, this theory has the potential to be especially sensitive to the factors involved in treating clients from different races, cultures, sexual orientations, etc. However, as pointed out by LaRoche (1999), proponents of the interpersonal-relational approach could do a much better job of explicitly considering the larger context in which any therapy takes place. "It seems crucial to extend . . .[the notion] of transference to include the organizing principles and imagery crystallized out of the values, roles, beliefs, and history of the cultural environment " (p. 391, emphasis added). Thus, it is of paramount importance that the therapist be aware of and understand how cultural factors (in the inclusive sense of the word) may be playing a role in the patient's lifelong patterns and in interpersonal difficulties including those that might manifest between therapist and patient. From a relational point of view, the client's interpersonal style outside of the therapy office is an amalgamation of one's specific problems, attachment history, sociocultural context, strengths, life stage, familial factors, and values, just to mention a few. All of these contribute to the client's assumptive world, or working model. If a therapist did not consider these factors, important interactive dimensions could be missed or misunderstood, thereby endangering the entire therapeutic process and outcome.

As part of this understanding, the therapist should have some comprehension (based on the available clinical and empirical data in the literature) of the normative interpersonal behavior and expectations for people with similar backgrounds (cultural data). And this should be distinguished (to the extent possible) from the individual's CMP (idiosyncratic data). For example, in one of the cases presented below, the client is a 22 year old, African-American man. I, a white woman, am old enough to be his mother. He complains of fears of being controlled, ignored, and vulnerable. Is this to be understood as part of his idiosyncratic CMP, or as part of set of experiences he shares with other black men in our society? And if it is shared by others with a similar cultural background, is his manifestation of it more extreme? To the extent that this client is having these issues with people in his life who are of the same gender and race, the hypothesis that these experiences have an idiosyncratic component is strengthened.

In addition, within the therapy office, the therapist must also consider how cultural factors take on an active role. Perhaps this client is saying he feels ignored and vulnerable because his therapist is someone from the dominant, white culture (a cultural transference-countertransference reenactment). If this is the case, his therapist could make a seriously erroneous error by inferring that this is a more global problem for him. From a TLDP perspective, it is important to be aware of the dangers of making assumptions based solely on transference-countertransference enactments. This again highlights the importance of a comprehensive and evolving formulation using the CMP categories.

The best way to judge if a CMP is more an artifact of differences between therapist and client, is to gauge the therapist-patient interactions in the here and now of the therapy sessions in light of what the patient says about expectations of and behavior from other people (especially to the extent that they are of the same race, gender, age, or other relevant parameters. Having said this, however, the therapist must always be vigilant for cultural ignorance and bias having an untoward effect on the therapy. Ridley (2006), writing on multicultural considerations in case formulation, points out that models that rely on the scientist-practitioner model and use hypothesis testing allow an examination of cultural elements in a relatively seamless way. He particularly notes that "TLDP incorporates continual evaluation and refinement of working hypotheses."

Finding your niche

The dynamic interpersonal approach runs the gamut from those who emphasize the internalized representations of the client's world to those who focus on the impact of the larger society and everything in between (e.g., TLDP). What they have in common is that they do not see "pathology" as emanating from inside the person in a biologically predestined way, but rather as located in the transactional world in which that individual resides. Furthermore, there is more of an emphasis on the real life experiences of people. There are several different therapeutic approaches within this model. (See Levenson, Butler, Powers, and Beitman, 2002 and Messer and Warren, 1995 for more information on various brief, dynamic-interpersonal models.)

If your temperament is more introverted and you detest being focused, then the make-every-session-count emphasis of TLDP is not going to be easy for you. Similarly, if you can only bear to see yourself as a neutral, always benign professional who is trying to help an impaired individual, the two-person framework implicit in the interpersonal approach would not be for you. The interpersonal therapist has to be prepared to get into the transactional game as a participant-observer and should not be content to sit on the safer, more distant sidelines offering wise comments as an observer/healer. In the role of participant-observer we may learn some things about our attitudes and behaviors that may challenge our concepts of who we think we need to be as helpers.

Process and case suggestions

As you approach each of the three cases on the accompanying CD, give yourself some time to really imagine sitting across from the person depicted. See yourself attempting to have an interpersonal relationship with each one—a professional relationship—but a relationship nonetheless.

See Elena, a 17 year old, Mexican-American female. She is not making good eye contact with you. She is clearly anxious, tense, and frustrated. Picture yourself there with her. Let Elena tell her own story. As she does, be aware of what you are feeling and thinking. As Elena begins to talk about her past and present, begin to see how her life is filled with people important to her. How does she react toward these people? How do they react toward her? Do you begin to hear some similar themes? Try to hear the melody of the interaction (the process) not just the lyrics (although the content of what she is saying may also be of importance.) As the session goes forward, are there ways you feel yourself pushed or pulled to interact with Elena? For example, do you find yourself ready to propose solutions to her dilemmas. She is so young and so needs some sound advice, or does she? Perhaps you know what it is like to be the good child.

Let yourself also be fully in the room when you turn to the case of Jane, a Caucasian woman in her 50's. She was referred by her cardiologist and you can see that she is frustrated just being there. She shares some of her difficulties, but also reassures you that "everything is good" in her life. She so steadfastly maintains that she is fine except for a heart problem that you wonder what to do next. But as you listen to her story, definite themes emerge. The conflicts Jane is experiencing might seem clear to you, but she is definitely in the dark. What an awkward position to be in as a therapist. Will she let you in? Could your perceptions be wrong? Perhaps she really does have a heart condition that could cause her to die if it's not discovered soon. You start thinking about going into another profession.

Now do the same kind of immersion with Theo. He is a 22 year old, African-American senior in college. People are of extreme importance to him. In fact, his main impetus for entering therapy is that his girlfriend told him that she would end their relationship if he did not seek help. Theo is a bit of a puzzle. He says he often feels as though he is "going to explode," but in the session he seems quite calm and even tempered. He keeps good eye contact with you. As you listen to him, themes begin to emerge. He is so lonely and people in his life seem to have treated him badly. Will you experience him as intimidating or will he see you as experiencing him in this way and if so, how can you maintain an alliance with him?

Summary and suggested readings

To learn more about TLDP, there are three major texts (Binder, 2004; Levenson, 1995; Strupp & Binder, 1984). There are also several helpful videos that demonstrate the actual practice of TLDP with clients.[2] Workshops

and in-depth training in various models of interpersonal therapy are given nationally and internationally. Ongoing clinical supervision, preferably with videotape or audiotape is the best way to increase one's competence in learning how to apply theoretical concepts and clinical strategies in real case situations. I personally have found this way of working to be a very rewarding and involving way to help people.

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Table 1
Vanderbilt Therapeutic Strategies Scale*

TLDP Specific Strategies

1. Therapist specifically addresses transactions in the client-therapist relationship.
2. Therapist encourages the client to explore feelings and thoughts about the therapist or the therapeutic relationship.
3. Therapist encourages the client to discuss how the therapist might feel or think about the client.
4. Therapist discusses own reactions to some aspect of the client's behavior in relation to the therapist.
5. Therapist attempts to explore patterns that might constitute a cyclical maladaptive pattern in the client's interpersonal relationships.
6. Therapist asks about the client's introject (how the client feels about and treats himself or herself).
7. Therapist links a recurrent pattern of behavior or interpersonal conflict to transactions between the client and therapist.
8. Therapist addresses obstacles (e.g., silences, coming late, avoidance of meaningful topics) that might influence the therapeutic process.
9.+ Therapist provides the opportunity for the client to have a new experience of oneself and/or the therapist relevant to the client's particular cyclical maladaptive pattern.
10. Therapist discusses an aspect of the time-limited nature of TLDP or termination.

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+ Item written by H. Levenson

Footnotes

1. Some material in this chapter is from Time-Limited Dynamic Psychotherapy: A Guide to Clinical Practice (copyright © 1995 by Hanna Levenson, reprinted by permission of Basic Books, a division of Perseus Books, LLC).

2. For instructional TLDP videotapes contact: Levenson Institute for Training (LIFT), 2323 Sacramento Street, Second Floor, San Francisco, CA 94115 (Liftcenter@aol.com; www.HannaLevenson.com); American Psychological Association, 750 First Street NE, Washington, DC 20002; Psychological and Educational Films, 3334 E. Coast Highway #252, Corona del Mar, CA 92625.