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CYCLICAL MALADAPTIVE PATTERNS: CASE FORMULATION IN TIME-LIMITED DYNAMIC PSYCHOTHERAPY

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Historical Background

Time-Limited Dynamic Psychotherapy (TLDP) is an interpersonal, time-sensitive approach for patients with chronic, pervasive, dysfunctional ways of relating to others. Its goal is to modify the way a person relates to him or herself and others. The focus is not on the reduction of symptoms per se (although such improvements are expected to occur), but rather on changing ingrained patterns of interpersonal relatedness or personality style.

While the framework of TLDP is psychodynamic, it incorporates current developments in interpersonal, object-relations, and self psychology theories, as well as cognitive-behavioral and system approaches. The type of formulation we discuss in this chapter--the cyclical maladaptive pattern--is structured to inform the therapist about the patient's present mode of relating, the goals for the work, and how to keep the therapy attuned to these goals.

TLDP makes use of the relationship that develops between therapist and patient to kindle fundamental changes in the way a person interacts with others and him or herself. Its premises and techniques are broadly applicable regardless of time limits. However, its method of formulating and intervening makes it particularly well suited for the so-called "difficult patient" seen in a brief or time-limited therapy. Its particular strengths include: (1) applicability to the treatment of difficult patients (broad selection criteria), (2) relevance and accessibility for psychodynamically-trained clinicians who want to work more effectively and more efficiently, (3) empirical scrutiny of the model, (4) a flexible framework that allows therapists to adapt it to their own unique therapeutic styles, and (5) avoidance of complex metatheoretical constructs by staying close to observable data where possible.

A treatment manual describing TLDP was developed for research purposes and published in book form--Psychotherapy in a New Key: A Guide to Time-Limited Dynamic Psychotherapy (Strupp & Binder, 1984). A clinical casebook, Time-Limited Dynamic Psychotherapy: A Guide to Clinical Practice (Levenson, 1995), translates TLDP principles and strategies into pragmatically useful ways of thinking and intervening for the practitioner. In Key Competencies in Brief Dynamic Psychotherapy, Binder (2004) outlines basic competencies needed to conduct dynamic-interpersonal therapy in general with a strong emphasis on TLDP.

Historically, TLDP is rooted in an object-relations framework. It embraces an interpersonal perspective, as exemplified by the early work of Sullivan (1953), and is consistent with the views of modern interpersonal theorists (e.g., Anchin and Kiesler, 1982; Benjamin, 1993; Greenberg and Mitchell, 1983). The relational view focuses on transactional patterns where the therapist is embedded in the therapeutic relationship as a participant observer or observing participant; transference is not considered a distortion, but rather the patient's

plausible perceptions of the therapist's behavior and intent; and countertransference does not indicate a failure on the part of the therapist, but rather represents his or her natural reactions to the pushes and pulls from interacting with the patient.

Conceptual Framework

Principles

The TLDP model adheres to 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" (Bowlby, 1973), the more likely we are to develop into independent, mature, and effective individuals.

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 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. Bowlby (1973) held that 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 one about the nature of human relatedness, and what is general necessary to sustain and maintain emotional connectedness to others. The child then filters the world through the lenses of these schemata which allows 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 child might be placating and deferential because his parents were authoritarian and harsh toward him. He would have an expectation that others would treat him badly if he were not compliant. The danger is not only that his submissiveness might invite the very behavior he was most afraid of (dominance by others), but also that since his "working model" of the interpersonal world was out of his awareness, he would continue to be at its mercy.

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

This emphasis on early childhood experiences is consistent with the basis for much of psychoanalytic thinking. However, from a TLDP framework, the individual's personality is not seen as fixed at a certain point, but rather as continually changing as he or she interacts with others. Data from neurobiology seem confirmatory; while relationships play a crucial role in the early years, this shaping process occurs throughout life (Siegel, 1999, p. 4). Although one's dysfunctional interactive style is learned early in life, this style must be supported in the person's present adult life for the interpersonal difficulties to continue. To go back to our example—the placating and deferential behavior of the child becomes well practiced into adulthood. As an adult, his compliance allows others to take advantage of him at best, and treat him harshly at worst. If he had experiences as an adult (e.g., being assertive and not being punished, being

treated with respect and like he had a voice) that ran counter to his internalized working model, from a TLDP perspective he would be expected to shift (over time) to a more robust and enlivened view of himself and his relational world.

This reasoning is consistent with a systems-oriented approach, which holds that the context of a situation and the circular processes surrounding it are critical. Pathology does not reside within an individual, but rather is created by all the components within the (pathological) system. According to systems theory (Bertalanffy, 1969), if you change one part of the system, the other parts must also change, since the entire system seeks a new level of stabilization.

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.

5. Maladaptive relationship patterns are likely to be reenacted in the therapeutic relationship.¹

A fifth assumption is that the patient is likely to interact with the therapist in the same dysfunctional way that characterizes his or her interactions with significant others (i.e., transference), and may try to enlist the therapist into playing a complementary role (i.e., countertransference). From an interpersonal therapy perspective this reenactment is an ideal opportunity, because it provides the therapist with the very situation that gets the patient into difficulties in the outside world. The therapist is given the chance to observe the playing out of the maladaptive interactional pattern, and to experience what it is like to try to relate to that individual. In Sullivan's terms (1953), the therapist becomes the *participant observer* mentioned earlier. The relational-interactionist position of TLDP holds that the therapist cannot help but react to the patient—that is, the therapist inevitably will be pushed and pulled by the patient's dysfunctional style and will respond accordingly. This transactional type of reciprocity and complementarity (i.e., interpersonal countertransference) does not indicate a failure on the part of the therapist, but rather represents his or her "role responsiveness" (Sandler, 1976) or "interpersonal empathy" (Strupp & Binder, 1984). In such reenactments, the therapist inevitably becomes "hooked" into acting out the corresponding response to the patient's inflexible, maladaptive pattern (Kiesler, 1988), or in Wachtel's terms (1993), patients may induce therapists to act as "accomplices."

That the therapist is invited repeatedly by the patient (unconsciously) to become a partner in a well-rehearsed, maladaptive two-step has its parallels in the recursive aspect of mental development. For example, children who have experienced serious family dysfunction are thought to have disorganized internal mental structures and processes as a result; these disorganized processes impair the child's behavior with others, which causes others not to respond in empathic ways, thereby disorganizing the development of the mind still further (Lyons-Ruth & Jacobwitz, 1999). It's a case of the rich get richer and the poor get poorer.

To get oneself unhooked, it is essential that the therapist realize how he or she is fostering a replication of the dysfunctional pattern, and use this information to attempt to change the nature of the interaction in a more positive way, thereby engaging the patient in a healthier mode of relating. In addition, the therapist can collaboratively invite the patient to look at what is happening between them (i.e., metacommunicate), either highlighting the dysfunctional reenactment while it is occurring or solidifying new experiential learning following a more functionally adaptive interactive process.

Since dysfunctional interactions are presumed to be sustained in the present, including

the current patient-therapist relationship, the therapist can concentrate on the present to alter the patient'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 patients 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 patient's most pervasive and problematic style of relating (which may need to incorporate several divergent views of self and other). This is not to say that other relationship patterns may not be important. However, focusing on the most frequently troublesome type of interaction should have ramifications for other less central interpersonal schemas and is pragmatically essential when time is of the essence.

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 person's proclivity to 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 had more opportunity to practice such functional behaviors, the interactions with others and the resulting more positive internalized schemas would become strengthened. In other words, the therapy sessions end, but the therapy continues in the real world.

Goals

The TLDP therapist seeks to provide a *new experience* and a *new understanding* for the patient.

New experience.²

The first and major goal in conducting TLDP is for the patient to have a new experience. "New" is meant in the sense of being different and more functional (i.e., healthier) than the customary, maladaptive pattern to which the person has become accustomed. And "experience" emphasizes the affective-action component of change--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 and independently) rather than specific, content-based behaviors (e.g., being able to go to a movie alone).

The new experience is actually comprised of a set of experiences throughout the therapy in which the patient has a different appreciation of himself or herself, of the therapist, and of their interaction. These new experiences provide the patient with experiential learning so that old patterns may be relinquished and new patterns may evolve.

The therapist determines the type of new experiences that are particularly helpful to a particular patient 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 subvert the patient's maladaptive interactive style. The therapist's behavior gives the patient the opportunity to disconfirm his/her interpersonal schemata. This in vivo learning is a critical component in the practice of TLDP. The patient has the opportunity actively to try out new behaviors in the therapy, to see how they feel, and to notice how the therapist responds. This information then

informs the patient's interpersonal schemata of what can be expected from self and others.

These experiential forays into what for the patient has been frightening territory make for heightened affective learning. A tension is created when the familiar (though detrimental) responses to the patient's presentation are not provided. Out of this tension new learning takes place. Such an emotionally intense process is what "heats up" the therapeutic process and permits progress to be made more quickly than in therapies that depend solely upon more abstract learning (usually through interpretation and clarification). As Frieda Fromm-Reichmann is credited with saying, what the patient needs is an experience, not an explanation.

There are parallels between the goal of a new experience and procedures used in some behavioral techniques (e.g., exposure therapy) where clients are exposed to feared stimuli without negative consequences. Modern cognitive theorists voice analogous perspectives (e.g., Safran & Segal, 1990) when they talk about interpersonal processes that lead to *experiential disconfirmation*. Similarities can also be found in the Plan Formulation Method of Harold Sampson and Joseph Weiss (1986; see also Weiss, 1993) in which change occurs when therapists pass their patients' "tests".

The concept of a *corrective emotional experience* described 60 years ago is also applicable (Alexander & French, 1946). In their classic book, Psychoanalytic Therapy: Principles and Applications, Alexander and French challenged the then prevalent assumption concerning the therapeutic importance of exposing repressed memories and providing a genetic reconstruction. In TLDP a therapist can help provide a new experience by selectively choosing from all of the helpful, mature, and respectful ways of being in a session those particular aspects that would most effectively undermine a specific patient's dysfunctional style.

With sufficient quality or quantity of these experiences, patients can develop different internalized working models of relationships. In this way TLDP promotes change by altering the basic infrastructure of the patient's transactional world, which then reverberates to influence the concept of self. This emphasis on *experiential learning* allows TLDP to benefit a wider range of patients (broader selection criteria) than many other types of psychodynamic brief therapies that emphasize understanding through interpretation.

New understanding.

The second goal of providing a new understanding focuses more specifically on cognitive changes than the first goal which emphasizes the affective-behavioral arena. The patient's new understanding usually involves an identification and comprehension of his or her dysfunctional patterns. To facilitate a new understanding, the TLDP therapist can point out repetitive patterns 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 patients' behaviors can also be beneficial. Patients 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.

Although the two TLDP goals have been presented as separate entities, in actuality the new experience and the new understanding are part of the same picture. Both perspectives are always available, but at any one time one becomes figure and the other ground. New experiences, if they are to be more than fleeting events, have elements of representations (understandings) of self and others. Similarly, new understandings, if they are to be more than mere intellectualizations, have experiential and affective components.

However, in teaching TLDP a conceptual division is made between the idea of a new experience and a new understanding for heuristic reasons; it helps the trainees attend to aspects of the change process that are helpful in formulating and intervening quickly. In addition, since psychodynamically-trained therapists are so ready to intervene with an interpretation, placing the new experience in the foreground helps them grasp and focus on the "big picture"--how not to reenact a dysfunctional scenario with the patient.

The Cyclical Maladaptive Pattern

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 clinician, 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) (Schacht, Binder & Strupp, 1984).

Briefly, the CMP outlines the idiosyncratic "vicious cycle" of maladaptive interactions a particular patient gets into when he or she relates to others. These cycles or patterns involve inflexible, self-perpetuating behaviors, self-defeating expectations, and negative self-appraisals, that lead to dysfunctional and maladaptive interactions with others (Butler & Binder, 1987; Butler, Strupp & Binder, 1993). The CMP comprises four categories that are used to organize the interpersonal information about the patient:

1. Acts of the self. These include the thoughts, feelings, motives, perceptions, and behaviors of the patient 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 take the promotion" (feeling). "I wish I were the life of the party" (motive). "It seemed she was on my side" (perception). "I start crying when I get angry with my husband" (behavior). 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.

2. Expectations of others' reactions. This category pertains to all the statements having to do with how the patient 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."

3. 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 patient. "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."

4. Acts of the self toward the self. In this section belong all of the patient's behaviors or attitudes toward oneself--when the self is the object of the interpersonal pattern. How does the patient 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."

In addition to the four categories of the CMP, the therapist should also consider his or her reactions to the patient. How are you feeling being in the room with this patient? What are you pulled to do or not do? The therapist's internal and external responses to the patient provide important sources of information for understanding the patient's life-long dysfunctional interactive pattern. One's reactions to the patient should make sense given the patient's interpersonal pattern. Of course, each therapist has a unique personality that might contribute to

the particular shading of the reaction which is elicited by the patient, but the first assumption from a TLDP perspective is that ideally the therapist's behavior is *predominantly* shaped by the patient's evoking patterns (i.e., the influence of the therapist's personal conflicts is not so paramount as to undermine the therapy).

The CMP provides an organizational framework which makes comprehensible a large mass of data and leads to fruitful hypotheses. A CMP should not be seen as an encapsulated version of Truth, but rather as a plausible narrative, incorporating major components of a person's current and historical interactive world. It is a map of the territory--not the territory itself (Strupp & Binder, 1984). In addition, a successful TLDP formulation should provide a blueprint for the entire therapy. It describes the nature of the problem, leads to the delineation of the goals, serves as a guide for interventions, enables the therapist 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. Yet the CMP is a fluid working formulation that is meant to be refined as the therapy proceeds. The focus provided by the CMP permits the therapist to intervene in ways that have the greatest likelihood of being therapeutic. Thus the therapy can be briefer and more effective at the same time.

Inclusion/Exclusion and Multicultural Considerations

TLDP was developed to help therapists deal with patients who have trouble forming working alliances due to their life-long dysfunctional interpersonal difficulties. However, from a relational point of view, many symptoms (e.g., depression, anxiety) and problems in living (e.g., marital discord) stem from one's impaired relatedness to self and other; consequently a wide range of clinical issues and presentations could be successfully addressed using TLDP.

Five major selection criteria are used in determining a patient's appropriateness for TLDP (Strupp & Binder, 1984).³ First, patients 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. Most therapists have confronted the enormous (and frequently insurmountable) problem of trying to treat people who are court-referred or "dragged" into the consultation room by an exasperated family member.

Second, patients 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, patients 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 patients do not actually have to walk in the door indicating that they have difficulties in relating to others. Rather, in the give-and-take of the therapeutic encounter, they must evidence signs of being willing to consider the possibility that they have problems relating to others.

Fourth, patients need to be *willing to examine feelings* which may hinder more successful relationships and may foster more dysfunctional ones. Also, Strupp and Binder (1984) elaborate that the patient needs to possess "sufficient capacity to emotionally distance from these feelings so that the patient and therapist can jointly examine them" (p.57).

And fifth, patients should be capable of having a *meaningful relationship* with the therapist. Again, it is not expected that the patient initially relates in a collaborative manner.

But the potential for establishing such a relationship needs to exist. Patients cannot be out of touch with reality or so impaired that they have difficulty appreciating that their therapists are separate people. It would be impossible to conduct an interpersonal therapy if the patient did not know where he or she ended and the therapist began.

The exclusionary criteria for TLDP are very similar to criteria for red-flagging patients in other brief dynamic approaches (MacKenzie, 1988). Specifically, the TLDP exclusionary criteria are:

- * Patient is not able to attend to the process of a verbal give-and-take with the therapist (e.g., patient has delirium, dementia, psychosis, or diminished intellectual status).

- * Patient's problems can be treated more effectively by other means (e.g., patient has a specific phobia or manic-depressive illness).

- * Patient cannot tolerate the interpretative, interactive therapy process, which often heightens anxiety (e.g., patient has impulse control problems, abuses alcohol and/or substances, or has a history of repeated suicide attempts).

Since TLDP acknowledges that both therapist and client bring their own personal qualities, history and values to the therapeutic encounter, it is potentially sensitive to the interactive 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 models. 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 idiosyncratic CMP. For example, in the case to be presented below, the therapist is a Caucasian man who has a medical degree. The client is an African-American woman, an office administrator, and old enough to be his mother. She complains of other people keeping her at arm's length and feeling inferior. Is this to be understood as part of her idiosyncratic CMP, or as part of set of experiences she shares with other women of color in our society. And if it is shared by others with a similar cultural background, is her manifestation of it more extreme? In this particular case, the client describes how she longs for closeness with her *female relatives*, and feels different from them in her ability to achieve this intimacy. Thus, our 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 she feels held at arm's length because she is working with a white male (a *cultural* transference-countertransference reenactment). If this is the case, her therapist could make a seriously erroneous error by inferring that this is a more global problem for her. 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). In this case, the therapist noted that the client felt her *female relatives* were not trustworthy and that she needed to protect herself from them by distancing herself. Having said this, however, the therapist must always be vigilant for cultural ignorance and bias having an untoward effect on the therapy.⁴

Regarding multicultural considerations of the short-term nature of TLDP, it has been found repeatedly that most people regardless of background prefer briefer therapies (Sue, Zane, & Young, 1994). However, until there are research data to inform us, “mental health professionals should exercise caution in using brief models with diverse populations and should adapt them to the unique cultural and social situation of the client” (Welfel, 2004, p.347). To our knowledge there is no TLDP outcome research examining the influence of cultural variables. However, there are some intriguing (albeit limited) relevant publications. Using Asian American students, participants were randomly assigned to read either a cognitive therapy (CT) or TLDP treatment rationale for depression (Wong, Kim, Zane, Kim, & Huang, 2003). Those with low levels of white identity rated the rationale of CT as more credible than that for TLDP, while those with high white identity, however, did not rate the two treatment rationales differently. However, further analyses reveal that these students (who were not actually clients) were only moderately involved in the task, possibly limiting generalizability to actual patient populations. On the other hand, Li (2003), in a theoretical study, makes the case for how TLDP is well suited to the needs of Chinese Americans by examining the parallels between ten TLDP values and the core principles of Confucianism, Taoism, and Buddhism. She optimistically argues that TLDP may someday become the psychotherapeutic treatment of choice for the Chinese American population.

With regard to use of TLDP with different age groups, we have seen patients from 18-92 in our studies and clinical practices. Noting that conflicts in current, close relationships are commonly presented complaints by older clients, Nordhus and Nielsen (1999) extended the application of TLDP to elderly adults by presenting a case illustration. “We find the cyclical maladaptive patterns format especially valuable for the therapeutic endeavour itself as well as for supervising the process (p. 946).”

Flasher (2000) also makes a case for using TLDP formulation with an age group at the opposite end of the continuum—children. She notes that while TLDP was developed for use with adults, “this interpersonally-based model is viewed as consistent with recent literature in child development and psychopathology which emphasizes the centrality of peer relationships,

interpersonal schema, and social attribution biases in the development of maladaptive interpersonal behavior (p. 239).” Flasher demonstrates with a case study that TLDP formulation can be used to individually tailor treatment for children with aggression, rejection, and other problematic interpersonal patterns.

With regard to gender bias, Levenson and Davidovitz (2000) found that male therapists devoted a significantly greater percentage of their clinical time to brief therapy than did their female counterparts, and were more likely to prefer shorter-term therapies. However, little is known regarding brief therapy outcome depending upon the therapist’s gender.

Steps in Case Formulation

 Insert Table 1 here

Table 1 contains the steps in TLDP formulation and intervention. These "steps" 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. In the initial sessions, the therapist lets the patient tell his or her own story (Step 1) rather than relying on the traditional psychiatric interview, which structures the patient's responses into categories of information (e.g., developmental history, education, etc.). By listening to *how* the patient tells his or her story (e.g., deferentially, cautiously, dramatically) as well as to the content, the therapist can learn much about the patient's interpersonal style. The therapist then explores the interpersonal context of the patient's symptoms or problems (Step 2). When did the problems begin? What else was going on in the patient's life at that time, especially of an interpersonal nature? By using the four categories of the CMP and his or her own reactions (Step 3), the therapist begins to develop a picture of the patient's idiosyncratic, interpersonal world, including the patient's views of self and expectations of others' behavior. The therapist listens for themes in the emerging material by seeing commonalities in the patient's transactional patterns over person, time and place (Step 4). As part of interacting with the patient, the therapist will be pulled into responding in a complementary fashion, recreating a dysfunctional dance with the patient. By examining the patterns of the here-and-now interaction, and by using the Expectations of Others' Reactions and the Behavior of Others components of the CMP, the therapist becomes aware of his or her countertransference reenactments (Steps 5 & 6). The therapist can then help the patient explore his/her reactions to the relationship which is forming with the therapist (Step 7). By incorporating all the historical and present interactive thematic information, the therapist can develop a narrative description of the patient's idiosyncratic primary CMP (Step 8). From this formulation, the therapist then discerns the goals for treatment (Step 9). The first goal involves determining the nature of the new experience (Step 10). The therapist discerns what he or she could say or do (within the therapeutic role) that would most likely subvert or interrupt the cyclical dynamic nature of the patient's maladaptive interactive style. Consistent with this way of conceptualizing a new experience, Gill (1993) suggests that what is needed are *specific* mutative transference-countertransference interactions. The therapist-patient "interaction has to be about the right content--a content that we would call insight if it became explicit" (p. 115).

Traditionally in TLDP the most potent intervention capable of providing a new understanding (Step 11) is thought to be the examination of the here-and-now interactions

between therapist and patient. It is chiefly through the therapist's observations about the reenactment of the cyclical maladaptive pattern in the sessions that patients begin to have an in vivo understanding of their behaviors and stimulus value. By ascertaining how the pattern has emerged in the therapeutic relationship, the patient has perhaps for the first time the opportunity to examine the nature of such behaviors in a safe environment.

It is usually helpful for the therapist to share his or her formulation with the patient *at whatever level the patient can comprehend it*, and to collaborate with the patient to derive a mutual understanding of the dysfunctional nature of his or her interactions. However, the degree to which a patient can join the therapist in elaborating a new life narrative is limited by such factors as his or her intellectual ability, capacity for introspection, psychological-mindedness, and the quality of the therapeutic alliance.

The therapist can help depathologize (Step 12) the patient's current behavior and symptoms by helping him or her to understand their historical development. From the TLDP point of view, symptoms and dysfunctional behaviors are the individual's attempt to adapt to situations threatening interpersonal relatedness. For example, in therapy a passive, anxious client began to understand that as a child he had to be subservient and hypervigilant in order to avoid beatings. This learning enabled him to view his present interpersonal style from a different perspective and allowed him to have some empathy for his childhood plight.

The last step (13) 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.

Application to Psychotherapy Technique

We consider the formulation to be essential to the understanding of the case. It is not necessarily shared with the patient, but may well be depending on the patient's abilities to deal with the material. Rather than presenting intellectual generalizations to the patient, the shared understanding of what is important to work on in the therapy is a collaboratively derived process. For some patients with minimal introspection and abstraction ability, the problematic interpersonal scenario may never be stated per se. Rather, the focus may stay very close to the content of the presenting problems and concerns of the patient (e.g., wanting to be accorded more respect at work). The therapist, however, is constantly using the CMP to inform him or herself regarding how to facilitate a new experience of self and other in session (e.g., the patient's experiencing himself as a respected and responsible partner in the therapeutic process).

Some patients enter therapy with a fairly good understanding of their own self-defeating and self-perpetuating interpersonal patterns (e.g., "I have decided to come into therapy at this time because I can see I am going to get fired from this job, just like all the other jobs, if I don't stop antagonizing my boss"). In these cases, the therapist and patient can jointly articulate the parameters that foster such behavior, generalize to other situations where applicable, and readily recognize its occurrence in the therapy.

The CMP is critical for guiding the therapist in the direction of the most facilitative interventions. The following examples of two patients with seemingly similar behaviors but differing CMPs will illustrate. Marjorie's maladaptive interpersonal pattern suggested she had deeply ingrained beliefs that she could not be appreciated unless she were the entertaining,

effervescent ingenue. 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 cheerful.)

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 patients the opportunity to disconfirm the patients' own interpersonal schemata. With sufficient quality and/or quantity of these experiences, patients can develop different internalized working models of relationships. In this way TLDP promotes change by altering the basic infrastructure of the patient's transactional world, which then reverberates to influence the concept of self.

Case Example

At the time of her therapy, Mrs. Follette was a 59-year-old, African-American, employed, widow with three grown daughters. She had been in individual and group therapy several times in the past. Her therapist was Dr. David, a male fourth year psychiatry resident who was a trainee in the Brief Therapy Program run by the first author. During his first session with Mrs. Follette, Dr. David was unsure how he could be of help to her. She presented with no clear agenda--only saying that she had some memory difficulties. She had been referred by the Neurology Service when they could find no evidence of an organic problem. Dr. David did some formal mental status testing, but also did not find any discernable memory impairment. By the third session, Mrs. Follette said her memory was "no longer bothering me." At this point it was not clear what she wanted to accomplish in the therapy.

However, Dr. David relied on the TLDP case formulation procedures to help him begin to understand why Mrs. Follette was there and what he could do to help—to discern the “dysfunctional mental working model and corresponding maladaptive interpersonal pattern that *is hidden in plain sight*” (Binder, 2004, p. 141, emphasis added). He used the categories of the CMP to gather, classify, and probe for interpersonal information. Table 2 contains some of Mrs. Follette's dialogue (in parentheses) in the first session organized according to the four components of the CMP.

 Insert Table 2 about here

When initially formulating the CMP, some therapists become concerned about whether they have correctly placed what the patient is saying into the right category. There are simple guidelines, such as the patient's own behavior toward others usually go under Acts of the Self, whereas behaviors directed toward the self usually go under Introject. But sometimes the meaning of a particular behavior (whether it is directed at others or toward the self) is not so

obvious. Fortunately, one need not become obsessed with the correct placement because these categories are primarily designed to be of heuristic value—to help the therapist elicit, assess, and organize large amount of incoming data; eventually all components will be combined into one narrative.

Following the TLDP steps to case formulation, Dr. David also observed how and what he was feeling and thinking in her presence. He became aware of the emotional tone and sequence of transactions with her as the sessions progressed. He took note of how her descriptions of her interactions with others displayed redundant themes which could be woven together into recurring patterns. By the end of the third session, Dr. David was able to discern a style of relating that he conjectured was quite problematical for Mrs. Follette. Based on her interactions with him, what she said about her relationships with others, and his reaction to her, he derived a narrative version of her CMP. (See Table 2.)

Since Dr. David was able to derive a cyclical maladaptive pattern, and Mrs. Follette met the basic selection criteria for TLDP with no exclusionary criteria, she was accepted into treatment. The patient, however, could not come to therapy on a weekly basis. Every other week she had to take business training classes during the time she would ordinarily meet with Dr. David. So a revised schedule was agreed on; Mrs. Follette would come to therapy every other week. In total, she was to receive ten sessions spread over twenty weeks.

Dr. David summarized Mrs. Follette's interpersonal narrative as follows: This is a woman who puts out signals that she does not need anything from anyone, because she fears no one will be there for her if she were vulnerable. She keeps her guard up, so as not to get harmed, but her distancing behaviors (her pseudo-independence) puts others off, ensuring the very reaction she most fears.

From this initial formulation, Dr. David derived the two goals of treatment. The new experience was for Mrs. Follette to experience herself as letting down her guard and becoming vulnerable while interacting with a therapist who neither backed away nor intrusively made demands of her. The new understanding was for her to begin to appreciate how her distancing behaviors caused others to move away.

How Formulation Relates to Treatment Interventions

Dr. David could now see how Mrs. Follette's CMP had been reenacted in the early sessions with him. At the beginning of the therapy, he had felt detached and confused in the sessions. After constructing Mrs. Follette's CMP, Dr. David began to appreciate how his reaction to the patient was not a hindrance, but rather an in vivo example of what needed to shift if the therapy were to be beneficial.

The first few minutes of the fifth session (which took place during the tenth week of therapy) captures the patient's interactive style. Although Dr. David had derived his understanding of Mrs. Follette's maladaptive interactional pattern some weeks before, he found this present interchange quite consistent with his working formulation. Comparing ongoing clinical material to the CMP is one way of constantly refining the working formulation.

Therapist: Any thoughts?

Patient: Not really. No. Not any real thoughts. Things are just moving along. Do you got any thoughts? What about your thoughts? (Laugh) Oh, goodness!

Therapist: What kind of thoughts were you speaking of?

Patient: You mean what kind of thoughts that I was speaking of when I asked you what your

thoughts were?

Therapist: Uh huh.

Patient: Oh, your thoughts about me, [Uh huh.] and what we've been doing. (pause) If it is helping you.

Therapist: If it is helping me?

Patient: Yeah, right, to accomplish your goals.

Therapist: Hmmm. What do you see as being my goal?

Patient: Well, must be to become a--what--a psychiatrist or what? What? A psychiatrist?

Therapist: Uh huh.

Patient: How is that coming?

Therapist: It's interesting that you would view therapy as being something to help me [Yeah, it is. . .] in my goal.

Patient: . . . isn't it?

Therapist: I suppose in general everything I'm doing is leading me towards that. Ah, but I wonder if you think of our meeting as being more for me than for you? It sounded like that is what you were suggesting.

Patient: Hmmm. Well, I think for both, really. You know, this is a dual purpose situation. I come in here and this is to help you get, I guess your certification or whatever it is. And, ah, you're helping me, and I'm helping you--in a way.

Therapist: Does that, I wonder, if that leaves any room for caring?

In this exchange, Dr. David's responded (briefly) to the realities of his being in training. He confirmed the patient's perception that he was getting something for himself out of their meeting, but then turned the discussion back to the larger issue of their interaction. In an attempt to introduce an affective tone into the you-scratch-my-back-I'll-scratch-yours nature of the interchange, Dr. David brought up the possibility of caring.

According to Mrs. Follette's CMP, she does not believe others will be there to provide closeness when needed. By suggesting that caring might be an important ingredient of their relationship, Dr. David was providing a mini new experience that ran counter to Mrs. Follette's expectation of how others behave. In the middle of the same session (Session 5) termination issues are discussed. Because sessions were every other week, her treatment was half over at this point.

Therapist: The one thing that I'm thinking about too, is what you brought up earlier in the session about therapy's ending and, you know, where the, ah, we sort of talked about the last week of this will be the first week of June, [Uh huh.] which is June fourth. I'm wondering how you feel about that and how that's affecting . . .

Patient: I feel very fine about that because, ah, I don't have any burning issues . . .

It is important in a time-limited therapy for both patient and therapist to be aware of the finiteness of the therapy. Here the therapist asks the patient for her feelings about the impending ending date, to which the patient replies that she "feels fine." However, the therapist, understanding the patient's tendency to pull back during times of perceived vulnerability, explored Mrs. Follette's reaction as illustrated in the next interaction.

Therapist: The one thing you said once though was, ah, you wanted to make sure that you didn't start to depend on 2:30 on Thursdays. [Uh huh.] Because when that ends then you're left without, without that [Hmmm.] and that would be a very uncomfortable feeling. [Uh

huh.] So it just makes me wonder, ah, that your comfortable feeling about ending June fourth, ah, is OK because the feeling that, well, I'll just make sure that I don't get too dependent on this, and make sure that I hold back to a certain degree. Then we could end June fourth and it won't matter, because I never will have allowed myself to depend on this in the first place.

Patient: Well, that's a form of protection, you know. If I don't protect me, who will, you know? And I'm not saying that's true, but it could be, you know, it could be.

Here the therapist did not take the patient at face value and blankly accept what she had said. Nor did he contradict her or infer that his perceptions were superior to hers. What he did was question her "comfort" in terms of other things she has previously mentioned. He reminded her that she had said she did not want to depend on their sessions. He then wondered out loud if she were feeling comfortable about ending soon because of her fears about becoming dependent.

Several times during the fifth session, Dr. David gently confronted Mrs. Follette with what she herself said in previous sessions. These interventions led the patient to justify her "holding back" as a form of "protection," so that she did not become a "babbling nut." Here again, Dr. David explored her strategy of avoiding becoming a "blithering basket case."

The patient disagreed that she had fears about becoming devastated should she get into this "old stuff" too deeply, because she had other "release valves" in her life. Again, Dr. David reminded her of what she said earlier in the therapy: "And yet you said before that that's one of the things you might do for protection is never to get involved in the first place as a way to make sure you were together when you walked out the door." In this way, Dr. David confronted Mrs. Follette's disavowal of her tendency to avoid and distance.

Dr. David used gentle confrontation several times throughout this fifth session. He stayed very close to the material Mrs. Follette was introducing, and used this information in an empathic way to confront her rigid, withdrawn stance. His approach combined content and process. What he said is important in terms of her defensive pattern, but how he said it in the context of their relationship was even more significant. Dr. David was providing Mrs. Follette with a series of new experiences in which she was being heard and responded to--he was helping her wrestle with facing her fears.

Mrs. Follette then talked about how she and Dr. David need to be on the "same plane." She told him she was aware that he always had an "agenda." Midway into the session she launched into an acknowledgement of how she and Dr. David talked about the "relationship between the therapist and the client."

Patient: So, so we sit in here and we talk about the relationship between the therapist and the client. (Laugh)

Therapist: What do you think about that?

Patient: (Laugh) I think it's fun! I really do.

Therapist: Uh huh. What do you think about that? Anything come to mind? What's coming up for you . . . talking about our relationship?

Patient: Well, it certainly makes for a better ra . . . ah, feeling, you know, to come out here [Uh huh.] and see and talk to you, you know, because we do have that type of relationship, ah, you know, it always helps. [Uh huh.] Ah, you know, ah, you know, it help me. We won't talk about whether it helping you or not. But anyway, a dimension, ah, that, ah, that may be something else that we, I may need to throw out on the table, ah, for us to discuss.

When the patient said that talking about their relationship was fun, she said it in a very

open and honest manner. At that moment she appeared to be more present and more affectively connected to Dr. David than she had been previously. Talking about the relationship within the context of that relationship is a very intimate thing to do. The very process demands trust. Continuing with the last interchange, Dr. David picked up on the patient's "hint" that there might be something else that she might need to discuss.

Therapist: Something particular in mind that you were . . . [Huh?] Something particular in mind that you were thinking of when you said that?

Patient: Uh huh, yeah, uh huh.

Therapist: What, what was that?

Patient: (Chuckle) It is funny, you know, ah, of all the therapy sessions I've been in, I've never brought up the fact that my step-father, ah, (pause) demanded, when I was about, what, 20, 21, whatever. Ah, my mother had, ah, gone to Chicago for the summer and ah, you know, we were there, and, ah, you know, and it's pretty hard to say he made me have sexual intercourse with him. But you know, it came down to that. And that didn't bother me until, oh, I guess about maybe ten years ago, and then, you know, whatever, it came back very vividly. And, ah, out of all the therapists that I've been to and talked to, I've never brought that one little aspect up. And, you know, I was really curious about that. You know, I was wondering about that, ah, why I never, you know, brought that up as an issue, that it happened. . . .

Therapist: (Softly, in measured tones) That's a pretty heavy duty [Uh huh.] thing to have gone through. [Uh huh.] This was not just a step-father but he raised you like . . .

Patient: Well, right, yeah. I always looks at him as my father, right. And, ah, ah, you know, someone that you think of as your father, when they do one of those, you know, and what not, it make you very, ah, very distant, very distant.

The patient was able to tell her therapist a secret she had been keeping for 39 years. However, she told about the rape in her characteristic, intellectualized ("I was really curious"), minimizing ("that one little aspect") manner. Dr. David did not engage with the patient on this level, but rather responded affectively in content and tone. He correctly ascertained that to engage with Mrs. Follette in a discussion about understanding the timing of her sharing her secret would be colluding with her avoidance of her need to be comforted and acknowledged and would inhibit their connecting on a more affective level. His commenting on the "heavy duty" nature of her experience is similar to his introducing the concept of "caring" earlier. Dr. David was trying to see if Mrs. Follette could relate to him and to her own experience on an emotional level. His affective reaction to hearing her secret also validated his perception that she had endured a truly traumatic incident when she was younger.

After hearing the secret, experienced therapists can imagine several different therapeutically valid ways Dr. David could have gone (e.g., referral to an incest survivor group). However, he chose to stay within the frame of the CMP and continue focusing on Mrs. Follette's vulnerability, trust, and distance issues. The patient herself, after revealing her secret, talked about an interpersonal consequence consistent with Dr. David's conceptualization (pseudoindependence vs. intimacy). "It make you very, very distant--very distant." Dr. David maintained the focus by asking Mrs. Follette if she had felt more distant from her father since then, and then expanded this specific behavior to the broader implications of her distancing style with other people in general. This pattern recognition helps patients discover motifs in their manner of relating; "It must have made it very difficult to have anybody that you could trust, if

your own father did this to you." The patient readily agreed to this interpretation.

In the closing minutes of this same session, Dr. David explored with the patient how he experienced a change in her manner of interacting with him in the session.

Therapist: I just want to point something out. I've commented before about that feeling of there being a shell around you--that distance. I noticed when you came in today, there was very much that feeling again [Of what?], there being a shell around you [Oh.] But that somewhere in the middle of the session it feels like that shifted. [Uh huh.] I feel a lot more openness and warmth about you [Uh huh.] now as opposed to early in the session. [Um huh.] Are you aware of that? Do you feel any difference?

Patient: Um . . .(pause). Yeah, I think I do. I think so. I've reached some, I've reached some, ah, real, ah, decisions about, you know, about myself and about where I want to go. And the fact is, I can't move on if I'm holding all these things. You know, I can't move. [Yeah.] I mean, I can't be a part of, you know, be with other people and feel comfortable [Uh huh.] as long as I'm keeping a whole lot of stuff. . . . But you know, I feel a lot looser, and a lot more at ease, and a lot. . . . You know, I want to let go of some of these things I've been holding. You can't hold something, what, ah, 37, 8 years and it not affect you. You have to let it go.

Therapist: So, in other words, you think holding some of these things inside helps to create a distance between you and other people?

Patient: Yeah. I guess so. I think so. Ah huh, I think so.

In this interaction, Dr. David shared the positive changes he observed in Mrs. Follette, consistent with his formulation. In brief therapy especially, one needs to make the patients aware of what they are doing right. We need to build on their strengths and make their positive changes obvious to them. Quite often when patients begin relating in a more positive way, they are completely unaware of it. Therapists can be quite helpful to patients in pointing out these changes. Unfortunately, often with a medical model, we become more accustomed to pointing out dysfunctions and deficits. When Dr. David introduced what Mrs. Follette was doing differently, he did so by examining its interpersonal effect on him. He said that he felt a lot more openness and warmth somewhere in the middle of the session; it was Mrs. Follette who made the connection between appearing more open and sharing her secret.

As the session was about to come to an end, Mrs. Follette mentioned that although she ordinarily would skip a week, she thought she might be able to get away in time to make an appointment with Dr. David the very next week. We understand this as in-session evidence that she felt more trusting and safer with Dr. David. She had taken risks in this fifth session and Dr. David had not exploited her increased vulnerability. It seemed she could now extend herself even further and let herself become more involved in her therapy with him.

By the end of therapy, both patient and therapist thought the brief therapy had been quite helpful. Mrs. Follette responded to several self-report measures to assess outcome in TLDP (SCL-90R, Derogatis, 1983; Inventory of Interpersonal Problems, Horowitz, Rosenberg, Baer, Ureno, & Vallasenor, 1988). Her symptomatic distress level dropped to a quarter of what it was on intake. For example, at intake she indicated that a loss of sexual interest or pleasure was causing her moderate distress; at termination she reported this problem was not bothering her at all. Similarly, Mrs. Follette's interpersonal distress level dropped in half. For example, at intake she responded that trusting other people too much was causing her quite a bit of distress; by termination this had ceased being a problem. Furthermore, at termination, Mrs. Follette stated

her problems were much better and Dr. David likewise thought that she had made considerable progress.

Six months after Mrs. Follette ended her brief therapy, the Director of the Brief Therapy Program (HL) contacted her for a semi-structured follow-up interview. In this interview Mrs. Follette was asked some general questions about her therapy with Dr. David. The following excerpt comes after the patient talked about what she had gained from the therapy.

Interviewer: And have you been able to use what you've experienced and learned in your therapy since then? Has it made a difference?

Patient: Oh, yes. Oh, yes. Oh, yes. I think the amazing thing about it is that because I've come into my own, my relatives treat me differently. And I don't know if maybe instead of my being . . . Hmm. (pause) I don't know how to put it. But it seems as though they recognize the newness in me, and therefore things they said and did before they did not do. And maybe because they felt like, I have not become defiant or anything, but I've become my own person.

Interviewer: And somehow you communicated that to them?

Patient: Right. Right. Without saying that. Right.

Interviewer: Do you have any idea what they're picking up?

Patient: I have no idea. I guess it's, ah, (pause) I don't know. I have no idea. Maybe the video, one can see oneself. But in so much as I cannot mentally see myself, I don't know what it is that I'm now throwing out to other people that they're getting. There is a new Joan Follette. It's not the old Joan Follette. And even people that I haven't seen in a long time, there's something about me that's different and they mention it.

Interviewer: They do?

Patient: Either you've become prettier or something. They don't know what it is. And I know what it is. Because I have decided that, that ah, I guess I have a lot more confidence in myself. And I think that's the thing that maybe's coming out and they see. (pause) So it's been a real growing process. In other words, I've come of age.

This interchange illustrates the chief principle whereby TLDP is thought to generalize outside the therapist's office. Hopefully, a patient's experience in the brief therapy helps disconfirm his or her ingrained dysfunctional interpersonal expectations and thereby encourages him or her to try out new, but shaky behaviors with other people. In this particular case, Mrs. Follette was able to be more vulnerable, trusting, and self revealing (i.e., removed the "shell" surrounding her) in her sessions, encouraged by Dr. David's positive therapeutic stance (e.g., nonintrusiveness, empathic understanding, gentle confrontation) and adherence to the thematic interpersonal issue. In this follow-up excerpt Mrs. Follette clearly evaluated the benefits from therapy in interpersonal terms. She gave evidence that she was trying out more available, approachable attitudes and behaviors with her relatives who began seeing her as literally more attractive. She then related how her relatives in turn "treat me differently." She was unsure ("I have no idea") exactly what she was communicating to them to get them to act differently, but she knew they saw "something about me that's different." What is critical here is not the patient's precise understanding of some abstract principle about her CMP, but rather her ability to generalize her experiential learning with Dr. David to others in her life. Here then are the beginnings of a cyclical *adaptive* pattern. Although the brief therapy sessions had ended, Mrs. Follette continued the therapeutic work.⁵

Training

Clinical Aspects of Training

For the reader who is curious to learn more about TLDP case formulation and intervention, we recommend a multifaceted approach including reading, supervision, consultation (expert or peer), and workshops with instructional videotapes. There are presently two TLDP manuals available: Psychotherapy in a New Key: A Guide to Time-Limited Dynamic Psychotherapy (Strupp & Binder, 1984) describes the basic principles and strategies of TLDP; Time-Limited Dynamic Psychotherapy: A Guide to Clinical Practice (Levenson, 1995) provides a practical and pragmatic casebook approach. Instructional videotapes are also commercially available.⁶ After reading further about TLDP, we advise becoming familiar with the steps in TLDP formulation and intervention outlined in Table 1 and reviewing the Vanderbilt Therapeutic Strategies Scale (VTSS) and accompanying manual included in the appendices of the Levenson (1995) book. Next, therapists can practice devising CMP formulations and TLDP goals for their problematic patients (e.g., those with poor therapeutic alliances). Going through this exercise even for on-going patients in long-term therapies can be quite informative for helping therapists see more clearly where they might be unintentionally colluding with patients in some dysfunctional dynamic. For those therapists who wish to try out a TLDP therapy, we advise video or audio-taping sessions, and then reviewing these sessions using the VTSS to assess adherence and deficient areas needing further attention and/or guidance. Peer (or if possible, expert) consultation is invaluable in becoming aware of nuances in the therapeutic interchange that inform the CMP. A new learning format is now available, consisting of an interactive website where those learning TLDP can submit their formulations on three target cases, and then receive an expert's version (Levenson, in press). In addition, workshops on TLDP occur nationally and regionally through universities and professional associations.

When teaching TLDP to clinicians (whether they be neophytes to the field or experienced professionals), we have preferred to use small-group supervision focusing on video- or audiotapes of therapy hours in combination with didactic sessions, also using videotapes to illustrate teaching points (Levenson & Strupp, 1999).⁷ As trainees watch the tapes of these sessions in a stop-frame approach, they are asked to say what is going on in the vignettes, to distinguish between relevant and irrelevant material, to proposed interventions a therapist might use, to justify their choices, and to anticipate the moment-to-moment behavior of the patients. This learning approach is consistent with the teaching format of "anchored instruction," where knowledge to be learned is specifically tied to a particular problem using active involvement of the learner in a context that is highly similar to actual conditions (Binder, 1993, 2004; Schacht, 1991).

Each trainee videotapes a patient for an entire therapy (up to 20 sessions) and then privately reviews his or her entire videotape of that week's session and selects portions to show in the group supervision. This format allows trainees to receive peer and supervisory comments on their technique as well as to observe the process of a brief therapy with other patient-therapist dyads. In this way, trainees learn how the model must be adapted to address the particular dynamics of each case and also what is generalizable about TLDP across patients. At the beginning of therapy, trainees devise a CMP and goals for their patients. Changes are made in the formulations as clinical knowledge grows, allowing trainees to observe the reciprocal process of formulation informing the direction of the therapy, which then informs the nature of the formulation.

Levenson has delineated ten similarities between supervision in TLDP and TLDP itself (e.g., work actively with trainee resistance; focus on trainees' having a new experience as well as gaining knowledge; expect trainees will continue to incorporate and integrate what they have learned after the training rotation is over) (Levenson, Butler & Bein, 2002). The reader who is particularly interested in TLDP training is referred to the book by Levenson (1995), since it contains actual transcripts of exchanges between supervisor and trainees as they deal with clinical and didactic material.⁸

Research Studies of Training

Strupp and his research group undertook a direct investigation into the effects of training on therapist performance. These studies (Vanderbilt II) explored the effects of manualized training in TLDP for 16 experienced therapists (8 psychiatrists and 8 psychologists) and 80 patients. The main results indicate that the training program was successful in changing therapists' interventions congruent with TLDP strategies (Henry et al., 1993b), and that these changes held even with the more difficult patients (Henry et al., 1993a). However, a later analysis suggested that many of these therapists did not reach an acceptable level of TLDP mastery (Bein, et al., 2000).

Among the more striking findings were differences in training effects due to whether the therapist was in Trainer A's or Trainer B's group. Trainer A's therapists showed greater changes in adherence to TLDP. Inspection of differences between the two trainers' styles indicated that Trainer A's approach was more directive, specific, and challenging. This finding led the investigators to suggest how to maximize training effects:

- Choose competent but relatively less experienced therapists.
- Select therapists who are less vulnerable to negative training effects (e.g., less hostile and controlling).
- Assume that even experienced therapists are novices in the approach to be learned.
- Provide close, directive, and specific feedback to therapists and focus on therapists' own thought processes.

Regarding the training of beginning therapists, Kivlighan and his colleagues found that the clients of novice TLDP therapists reported more therapeutic work and more painful feelings than those seen by control counselors (1989), and live supervision was more likely to foster TLDP skills when compared to videotaped supervision (1991). Multon, Kivlighan, and Gold (1996) demonstrated that prepracticum counselor trainees were able to increase their adherence to TLDP strategies with training; furthermore, a related study (Kivlighan, Schuetz & Kardash, 1998) found that the more trainees focused on learning as an end in itself they better they did. In another training study, Levenson and Bolter (1988) found that trainees' values and attitudes toward brief therapy became more positive after a six month seminar and group supervision in TLDP. Other research has supported these findings (Neff, Lambert, Lunnen, Budman, & Levenson, 1997).

In an innovative study, LaRue-Yalom (2001) sought to study the long term (average = nine years) outcome of training in TLDP. Participants were 90 professionals who previously (on average, nine years ago) learned TLDP during their 6-month outpatient rotation at a large medical center. Results indicated that these professionals still used TLDP and called upon aspects of their TLDP training in their daily work. Many said they had integrated TLDP strategies into their long-term work as well.

Research Support for the Approach

The background for TLDP comes from a program of empirical research begun in the early 1950's. Strupp (1955, 1960) found that therapists' interventions reflected their personal (positive or negative) attitude toward the patients. Later work (Strupp, 1980) revealed that patients who were hostile, negativistic, inflexible, mistrusting, or otherwise highly resistant, uniformly had poor outcomes.

Strupp reasoned that the difficult patients had characterological styles that made it very hard for them to negotiate good working relationships with their therapists. In such cases the therapists' skill in managing the interpersonal therapeutic climate was severely taxed, and they became trapped into reacting with negativity, hostility, and disrespect. Since the therapies were brief, this inability to form a therapeutic alliance quickly had deleterious effects on the entire therapy.

Henry, Schacht, and Strupp (1986) found that for poor outcome cases (no change in the patients' introjects) therapists and patients manifested more hostile communications, and amount of therapists' hostile and controlling statements were related to the number of patients' self-blaming statements. Furthermore, therapists whose pretherapy self-ratings revealed more hostility directed toward themselves were more likely to treat their patients in a disaffiliative manner. And all of this occurred by the third session of therapy! A later investigation (Hilliard, Henry, & Strupp, 2000) further demonstrated that patients' and therapists' introjects have a direct effect on the therapy process, which affects outcome.

Quintana and Meara (1990) found that patients intrapsychic activity became similar to the way patients perceived their therapists treated them in short-term therapy. A study examining relational change (Travis, Binder, Bliwise, & Horne-Moyer, 2001) found that following TLDP, patients significantly shifted in their attachment styles (from insecure to secure) and increased the number of their secure attachment themes.

Johnson, Popp, Schacht, Mellow, and Strupp (1989), using a modification of the CMP, found that for a single case, relationship themes were identified that were similar to themes derived using another psychodynamic relationship model (Core Conflictual Relationship Theme method, CCRT; see Chapter 5, this volume). (See Henry, 1997, for more information on this CMP modification and interpersonal case formulation.)

The VA Short-Term Psychotherapy Project--the VAST Project--examined TLDP process and outcome with a personality-disordered population (Levenson & Bein, 1993). As part of that project, Overstreet (1993) found that approximately 60% of the 89 male patients achieved positive interpersonal or symptomatic outcomes following TLDP (average of 14 sessions). At termination, 71% of patients felt their problems had lessened. One-fifth of the patients moved into the normal range of scores on a measure of interpersonal problems.

A VAST Project long-term follow-up study of this population (Bein, Levenson, & Overstreet, 1994; Levenson & Bein, 1993), found that patient gains from treatment were maintained and slightly bolstered. In addition, at the time of follow-up, 80% of the patients thought their therapies had helped them deal more effectively with their problems. In a naturalistic effectiveness study of 75 patients treated with TLDP, neurotic and psychosomatic patients evidenced significant improvement at termination, as well as 6-month and 12-month follow-ups (Junkert-Tress, Schnierda, Hartkamp, Schmitz, & Tress, 2001). Those diagnosed with personality disorders also improved, but to a lesser degree.

Hartmann and Levenson's (1995) study using the VAST Project data found that TLDP case formulation is relevant in a real clinical situation. CMP case formulations written by treating therapists (after the first one or two sessions with their patients) conveyed reliable and valid data to other clinicians. Perhaps most meaningful is the finding that better outcomes were achieved the more these therapies stayed focused on topics relevant to these patients' CMPs.

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Table 1
Steps in TLDP Formulation and Intervention

1. Let the patient tell his or her own story in his or her own words.
2. Explore the interpersonal context related to symptoms or problems.
3. Use the categories of the CMP to gather, categorize, and probe for information.
4. Listen for themes in the patient's content (about past and present relationships) and manner of interacting in session.
5. Be aware of reciprocal reactions (countertransferential pushes and pulls).
6. Be vigilant for reenactments of dysfunctional interactions in the therapeutic relationship.
7. Explore patient's reaction to the evolving relationship with the therapist.
8. Develop a CMP narrative (story) describing the patient's predominant dysfunctional interactive pattern.
9. From this CMP, outline the goals for treatment.
10. Facilitate a new experience of more adaptive relating within the therapeutic relationship and/or with others in the patient's life consistent with the CMP (Goal 1).
11. Help the patient identify and understand his or her dysfunctional pattern as it occurs with the therapist and/or others in his or her life (Goal 2).
12. Assist the patient in appreciating the once adaptive function of his or her manner of interacting.
13. Revise and refine the CMP throughout the therapy

Table 2. Mrs. Follette's Cyclical Maladaptive Pattern

Acts of the Self: Patient feels self-conscious in the presence of others, particularly peers in a non-working environment. Patient maintains a "shell" around herself which allows her to keep others at "arm's length." ("I don't want to be depending on anyone. I don't care what other people think.") Although she longs for closeness and acceptance, she fears intimacy. ("It makes me nervous when other people get too close to me.") As a result, she remains somewhat isolated and alone. ("I spend most of my time alone and that suits me fine. I'm doing very well, thank you.") Patient believes she does not need other people. She repeatedly sets professional goals for herself which she eventually meets, but is then left feeling unfulfilled.

Expectations of Others: Patient believes others are not dependable. ("If you depend on people, you will be disappointed every time. When you need someone, they will not be there. Other people always want you to do things for them. They really don't care about one.") She believes others are not willing to provide closeness and nurturance when needed. She expects others will be hurtful to her if she depends on them, and thinks others will treat her better the more she is independent. Patient believes others are often not honest with her. She also expects that others will perceive her as inferior.

Acts of Others Towards Self: Patient's fears of allowing others to get close to her or to know her by revealing things about herself leads others to feel alienated and distanced. ("My aunt is just concerned with herself, and really isn't interested in what I have to say. My daughters have each other and don't need me much.") Others view the patient as being strong and independent and not interested in, or in need of their help or friendship. Some others treat the patient as if she

were inferior. (“All the support I’ve gotten in the past has been misleading. Members of my family said I wasn’t college material.”)

Acts of the Self Toward Self (Introject): Patient sees herself as having an inferior mind, and therefore feels she is inadequate. (“Once I reach my goals, I feel unsatisfied with myself. My memory is failing me and that really bothers me. Maybe the way I am is because my umbilical cord was wrapped around my neck when I was born.”) She considers herself to be unlovable. Patient feels guilty. She sees herself as vulnerable with a need to preserve control and appear strong. She has a heightened sense of responsibility for her own well being.

Therapist’s Reaction to Patient: Dr. David felt superfluous and put off by her seeming self-sufficiency and apparent disinterest in his help.

Notes

1. Recently some clinicians and researchers have appropriately questioned the inevitability of in-session dysfunctional reenactments of the most pervasive pattern displayed with significant others (e.g., Binder, 2004; Connolly et al., 1996).
2. The goal of a new experience presented here and elsewhere in more detail (Levenson, 1995) is a modification of that originally presented by Strupp and Binder (1984).
3. Previously we endorsed the TLDP selection criteria as outlined by Strupp and Binder (1984). Now one of us (HL) considers that TLDP may be helpful to patients even when they may not quite meet these criteria, as long as the therapist is able to discern the redundant themes involved in their interpersonal transactions.
4. Of course one cannot overlook the fact that this client may see her relatives (i.e., people of the same race) as untrustworthy because of introjected racism from the dominant white culture. Thus, the TLDP therapist is wise to adopt the point of view that cultural parameters and interpersonal working models are inextricably intertwined.
5. Whereas all clinicians and researchers are well aware of the multiple factors that could account for such a positive self-report of treatment outcome (e.g., need to please the interviewer, avoidance of conflict, justification of investment in the therapy), Mrs. Follette's demeanor during the interview (e.g., more eye contact, more relaxed posture, more use of "I," less vague statements, etc.) were consistent with her account of the changes she had experienced in her life.
6. For instructional videotapes contact: Hanna Levenson, Levenson Institute for Training, 2323 Sacramento Street, 2nd Floor, San Francisco, CA 94115 (Liftcenter@aol.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.
7. See Levenson and Strupp (1999) for specific recommendations concerning training in brief dynamic psychotherapy.
8. For further discussions about training, see Levenson and Burg (2000), Levenson and Evans (2000), and Levenson and Davidovitz (2000).

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