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**TIME-LIMITED DYNAMIC PSYCHOTHERAPY:  
AN INTEGRATIONIST PERSPECTIVE<sup>1</sup>**

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*Time-limited dynamic psychotherapy (TLDP) is an interpersonal, time-sensitive approach for patients with chronic, pervasive, dysfunctional ways of relating to others. This paper presents TLDP theory, assumptions, goals, formulation strategies, and empirical findings emphasizing its integrative elements. The thesis holds that the focus on corrective, interpersonal experiences and cyclical transactional processes provides opportunities for integration from theoretical, technique, and common factors perspectives. The therapist discerns cyclical maladaptive patterns to understand the patient's inflexible, self-perpetuating, self-defeating expectations and negative self-appraisals that lead to maladaptive interactions with others. The goal of TLDP is to help patients change these dysfunctional interpersonal patterns by fostering new experiences and new understandings that emanate from the therapeutic relationship. A case example is presented to illustrate, and a TLDP training program is described.*

Key words: interpersonal theory, experiential learning, brief therapy

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## **TIME-LIMITED DYNAMIC PSYCHOTHERAPY: AN INTEGRATIONIST PERSPECTIVE**

Hanna Levenson

“We don’t say cure. We say you had a corrective emotional experience.”  
---Therapist (Billy Crystal ) to gangster/patient (Robert DeNiro) in the movie, Analyze This

Although I was invited to submit a paper to this issue on integratively-oriented brief psychotherapies, let me be clear at the outset that the original model of Time-Limited Dynamic Psychotherapy (TLDP) was never explicitly designed to be an integrative therapy. However, there are at least five reasons why TLDP is “integration-friendly” and already contains integrative elements. First, TLDP’s focus on the importance of interpersonal relatedness, corrective emotional experiences, and patterned, recursive, transactional processes provides ample opportunities for therapeutic integration pertaining to theory, technique, and common factors. Second, TLDP concentrates on observable data where possible, avoiding complex metatheoretical constructs. Third, TLDP has a flexible framework that allows therapists to adapt it to their own unique therapeutic styles. Fourth, as a brief therapy, TLDP’s pragmatic attitude opens the door for assimilating techniques from other schools. And fifth, brief dynamic therapy by its very nature already combines elements from seemingly disparate “visions of reality” (e.g., tragic (limited, focused) and comic (active, optimistic)) (Messer, in press).

### **TLDP: AN INTERPERSONAL APPROACH**

A now classic series of studies on good and poor outcome cases treated in brief therapy reveals that patients who were hostile, negativistic, inflexible, mistrusting, or otherwise highly

resistant, uniformly had poor outcomes (Strupp, 1980a, 1980b, 1980c, 1980d). Apparently their therapists became entrapped into reacting angrily; in general, they responded antitherapeutically to the patients' pervasive negativism and hostility.

Strupp observed that these 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. Since the therapies were brief, this inability to form a therapeutic alliance quickly had deleterious effects on the entire therapy. Based on such studies and clinical experience, Strupp, Binder and colleagues developed TLDP to help therapists deal more effectively with such difficult patients.

TLDP is an interpersonal, time-sensitive approach for patients with chronic, pervasive, dysfunctional ways of relating to others. Its premises and techniques are broadly applicable regardless of time limits. However, its method of formulating and intervening make it particularly well suited for the so-called difficult patient seen in a brief or time-limited therapy. The brevity of the treatment promotes therapist pragmatism, flexibility, and accountability (Levenson, Butler, & Beitman, 1997). Furthermore, time pressures help keep the therapist attuned to circumscribed goals using an active, directive stance (Levenson & Butler, 1999). 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. 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.

A TLDP treatment manual was constructed for a research program designed to assess the degree to which clinicians could learn briefer ways of intervening with challenging patients.

This manual eventually was reproduced in book form--Psychotherapy in a New Key: A Guide to Time-Limited Dynamic Psychotherapy (Strupp & Binder, 1984). In a more recently published 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. It also places more emphasis on encouraging behavioral changes promoting experiential learning and less on insight through interpretation.

Historically, TLDP is rooted in an object-relations framework. According to object relations theory, images of the self and others evolve out of human interactions rather than out of biologically derived tensions. The search for and maintenance of human relatedness is considered to be a major motivating force within all human beings. This relational view is in sharp contrast to that of classical psychoanalysis which emphasizes predetermined mental structures to deal with conflicts between gratification of instinctual impulses and societal constraints.

TLDP 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 & Kiesler, 1982; Benjamin, 1993; Greenberg & Mitchell, 1983). Strupp and Binder (1984) make clear that their purpose is neither to construct a new theory of personality development nor to attempt a systematic integration of existing theories. Rather, we have chosen interpersonal conceptions as a framework for the proposed form of psychotherapy because of their hypothesized relevance and utility (p. 28). Nonetheless, their model does incorporate current developments in interpersonal, object-relations, and self psychology theories, as well as cognitive-behavioral and system approaches. Perspectives and findings from child development

research and neurobiology (Siegel, 1999) are also quite compatible with TLDP.

The TLDP interpersonal perspective reflects a larger paradigm shift occurring within psychoanalytic theory and practice from a one-person to a two-person psychology. This evolutionary trend (Cooper, 1987) or transitional period (Altman, 1993) is away from viewing the discharge of drives as determining the development of personality and toward focusing on the process of forming interpersonal relationships. In fact, most psychoanalytic schools are becoming less drive-oriented and more relational for various cultural, social, clinical, and scientific reasons (Messer & Warren, 1995).

The relational view of TLDP focuses on transactional patterns where the therapist is embedded in the therapeutic relationship as a participant observer; 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.

Not only psychoanalysis but other theories as well are increasingly incorporating interpersonal perspectives, for example, cognitive therapy (Safran & Segal, 1990), behavior therapy (Kohlenberg & Tsai, 1991), and gestalt therapy (Glickauf-Hughes, Reviere, Clance & Jones, 1996). Data from child development research (e.g., Stern, 1985) point to how one's world is essentially interpersonal. Now information from the field of neurobiology suggests that relationships early in life may shape the *very structures* that create representations of experience and allow a coherent view of the world. Interpersonal experiences directly influence how we mentally construct reality (emphasis added, Siegel, 1999, p. 4). This growing recognition of the import of interpersonal relatedness promotes compatibility across a variety of

theoretical and strategic viewpoints, allowing for the possibility of further integrative efforts (Anchin, 1982).

### **ASSUMPTIONS ESSENTIAL TO TLDP TREATMENT**

The TLDP model makes five basic assumptions that greatly affect treatment:

#### **1. Maladaptive relationship patterns are learned in the past**

Disturbances in adult interpersonal relatedness typically stem from faulty relationships with early care givers--usually in the parental home. Bowlby (1973) elaborated 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 (interpersonal schemas) informing one about the nature of human relatedness, and what is generally necessary to sustain and maintain emotional connectedness to others. The child 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.

#### **2. Such maladaptive patterns are maintained in the present**

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 it interacts with others. Data from neurobiology seem confirmatory, that 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. For example, if a child has

learned to be placating and deferential because he grew up in a home with authoritarian parents, he will unwittingly and inadvertently attempt to maintain this role as an adult by pulling for others to act harshly toward him.

This focus 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.

### **3. Dysfunctional relationship patterns are reenacted in vivo in the therapy**

A third assumption is that the patient 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. 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 opportunity to observe the playing out of the maladaptive interactional pattern, and to experience what it is like to try to relate to that individual. 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.

#### 4. The therapeutic relationship has a dyadic quality

A corollary assumption to the TLDP concept of transference is that the therapist also enters into the relationship and becomes a part of the reenactment of the dysfunctional interpersonal interaction. In Sullivan's terms (1953), the therapist becomes a *participant observer*. 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). 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 (1987), patients 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).

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.

### **5. The TLDP focus is on the 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.

### **GOALS**

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

#### **New Experience**

The first and major goal in conducting TLDP is for the patient 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 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, 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 patient has a different appreciation of self, of 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 focus of these new experiences centers on those that are particularly helpful to a particular patient based on the therapist's formulation of the case (see below). The therapist identifies what he or she could say or do (within the therapeutic role) that would most likely subvert or interrupt the patient's maladaptive interactive style. The therapist's behavior gives the patient the opportunity to disconfirm his or her interpersonal schemata. The patient 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 patient'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.

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, 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 patient 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 patient needs is an experience, not an explanation.

There are definite 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 the expected 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 (Sampson & Weiss, 1986; Weiss, 1993) in which opportunities for change occur when patients test their pathogenic beliefs in the context of the therapeutic relationship.

The concept of a *corrective emotional experience* described more than 50 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. Twenty years ago, Goldfried (1980) elucidated the concept of common clinical strategies that cut across various theoretical orientations. He gave the example of providing the patient with new corrective experiences as one example of such a common factor, and specifically mentioned that the work of Alexander and French emphasized the importance of encouraging their patients to engage in previously avoided actions in order to recognize that their fears and misconceptions about such activities were groundless (p. 994). By focusing on the importance of experiential learning, Alexander and French suggested that change could take place even without the patient's insight into the etiology of their problems.

Decades of clinical and empirical data within psychology clearly support this conclusion

(Bergin & Garfield, 1994). Now there appear to be neurobiological data indicating that *most* learning is done without conscious awareness (Siegel, 1999). This view has major implications for the techniques one uses. It questions the pursuit of insight as a necessary goal, and thereby challenges the use of interpretation as the cornerstone of psychodynamic technique. From an empirical standpoint, Henry, Strupp, Schacht, and Gaston (1994) present data indicating that transference interpretations in particular may not be effective and may even be countertherapeutic.

Alexander and French's concept of the corrective emotional experience has been criticized for promoting manipulation of the transference by suggesting that the therapist should respond in a way diametrically opposite to that expected by the patient. For example, if the child had been raised by an intrusive mother, then the therapist should maintain a more restrained stance. The TLDP concept of the new relational experience does not involve a direct manipulation of the transference; nor is it solely accomplished by the offering of a "good enough" therapeutic relationship. Specifically, a therapist can help provide a new experience by selectively choosing from all of the helpful, mature, and respectful ways of being present in a session those particular aspects that would most effectively undermine a specific patient's dysfunctional style.

### **New Understanding**

The second goal of providing a new understanding focuses more specifically on cognitive changes than the first goal just discussed, which emphasizes more the affective-behavioral arena. The patient'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 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. In this way 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.

Differentiating between the idea of a new experience and a new understanding helps the clinician attend to aspects of the change process that would be most helpful in formulating and intervening as efficiently and effectively as possible. In addition, since psychodynamically-trained therapists are so ready to intervene with an interpretation, placing the new experience in the foreground helps them regroup and focus on the "big picture"--how not to reenact a dysfunctional scenario with the patient. This emphasis on the new experience is a departure from the central role of understanding through interpretation in the original TLDP model (Strupp & Binder, 1984). It is my current thinking that experiential learning broadens the range of patients who can benefit from brief therapies, leads to more generalization to the outside world, and permits therapists to incorporate a variety of techniques/strategies that might be helpful.

### **INCLUSION/EXCLUSION CRITERIA**

TLDP was developed to help therapists deal with patients 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. Previously, I (Levenson, 1995) endorsed the TLDP selection criteria as outlined by Strupp and Binder (1984). My present thinking is that TLDP

may be helpful to patients even when they do not quite meet these criteria as long as adequate descriptions of their interpersonal transactions can be elicited.

There are five major selection criteria for determining a patient's appropriateness for TLDP: 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. 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 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, patients need to be *willing to examine feelings* that 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). Because of my emphasis on the experiential goal, the strength of the patient's ability to step back from feelings and metacommunicate what is going on is less important than in the original model.

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 should exist. Patients cannot be out of touch with reality or so impaired that they have difficulty appreciating that their therapists are separate people.

## **TLDP FORMULATION**

### **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 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) (Binder & Strupp, 1991).

Briefly, the CMP outlines the idiosyncratic vicious cycle (Wachtel, 1997) of maladaptive interactions that a particular patient manifests in conjunction 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 (Butler & Binder, 1987; Butler, Strupp & Binder, 1993). Since the CMP focuses on schematized representations of self and other, it provides another juncture fostering integrative cross-talk. As stated by Goldfried and Newman (1986), "[a] number of contemporary writers have independently suggested the possibility that a common [integrative] language may ultimately come from the field of experimental cognitive psychology and social cognition . . . . Concepts such as [schema,] [scripts,] and [metacognition] have the potential for covering therapeutic phenomena observed by clinicians of varying orientations" (pp. 46-47).

Development and use of the CMP in treatment is essential to TLDP. It is not necessarily shared with the patient but may well be, depending on the patient's abilities to deal with the material. For some patients with minimal introspection and abstraction ability, the problematic interpersonal scenario may never be stated *per se*. Rather, the content may stay very close to the presenting problems and concerns of the patient. Other patients enter therapy with a fairly good understanding of their own self-perpetuating interpersonal patterns. 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.

In either case, the CMP plays a key role in guiding the clinician in formulating a treatment plan. It provides an organizational framework which makes a large mass of data comprehensible 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). A successful TLDP formulation should provide a *blueprint* for the 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. 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.

### **Constructing the CMP**

To derive a TLDP formulation, the therapist lets the patient tell his or her own story (Step

1) in the initial sessions rather than relying on the traditional psychiatric interview that structures the patient's responses into categories of information (e.g., developmental history, education). 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?

The clinician obtains data that will be used to construct a CMP (Step 3). This process is facilitated by using four categories to gather, organize, and probe for clinical information:

Acts of the Self. These acts 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). 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 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."

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."

Acts of the Self Toward the Self (Introject). 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."

For the fourth step, the therapist then listens for themes in the emerging material by being sensitive to commonalities and redundancies in the patient's transactional patterns over person, time, and place. 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 Acts of Others components of the CMP, the therapist becomes more aware of his or her countertransference reenactments (Step 5).

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 TLDP perspective is that 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).

By using the four categories of the CMP and the therapist's own reactions to the developing transactional relationship with the client, a CMP narrative is developed describing the patient's predominant dysfunctional interactive pattern (Step 6). The CMP can be used to foresee likely transference-countertransference reenactments that might inhibit treatment

progress. By anticipating patient resistances, ruptures in the therapeutic alliance and so on, the therapist is able to plan appropriately. Thus when therapeutic impasses occur, the therapist is not caught off guard, but rather is prepared to capitalize on the situation and maximize its clinical impact--a necessity when time is of the essence.

From the CMP formulation, the therapist then discerns the goals for treatment . The first goal involves determining the nature of the new experience (Step 7). This new experience should contain *specific*, possibly mutative, transference-countertransference interactions (Gill, 1993). The therapist-patient "interaction has to be about the right content--a content that we would call insight if it became explicit" (p. 115). After determining the nature of the new experience, the therapist can use the CMP formulation to determine the second goal for treatment, the new understanding (step 8) of the clients dysfunctional pattern as it occurs in interpersonal relationships.

The last step (9) 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. 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.<sup>1</sup>

The CMP is only one of the formal ways relationally-oriented therapists can represent patterned, repetitive interpersonal transactions. Some others include the Core Conflictual Relationship Theme (CCRT; Luborsky, 1984), Plan Diagnosis Method (Weiss & Sampson,

1986), Structural Analysis of Social Behavior (SASB; Benjamin, 1982), and Role-Relationship Models Configuration (Horowitz, 1987). This focus on patterned, recursive, interpersonal processes provides additional opportunities for therapeutic integration at the formulation and intervention level.

### **TLDP STRATEGIES**

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*. Since the focus is on experiential interpersonal learning, theoretically any intervention that could facilitate this goal could be used. However, it is critical for the therapist to understand how the meaning and impact of such interventions taken out of their original context might shift when they are incorporated within TLDP (Messer, 1992). Moreover, any intervention (even such psychodynamic stand-bys as clarification and interpretation) must be assessed with regard to how much they might alter the interpersonal interchange in an undesirable direction or reenact the patient's CMP. Also in brief therapies, therapists are more directive and active (Levenson & Butler, 1999). They are more willing and (hopefully) able to incorporate a variety of potentially useful strategies as a way of working and patients come to expect this more pragmatic attitude.

Here I would like to focus on one treatment strategy that has most relevancy from an integrationist perspective, since this strategy incorporates behavioral, experiential, and interpersonal elements.<sup>2</sup> Specifically, the therapist needs to provide opportunities for the patient to have new experiences of oneself and/or the therapist that are designed to help disrupt, revise, and improve the patient's CMP. The following examples illustrate how to intervene with two

patients with seemingly similar behaviors but differing experiential goals. Marjorie's maladaptive interpersonal pattern suggested she had deeply ingrained beliefs that she could not be appreciated unless she were the charming, 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 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 patients a new interpersonal experience--an opportunity to disconfirm their 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 is thought to promote change by altering the basic infrastructure of the patient's transactional world, which then reverberates to influence the concept of self.

### **TERMINATION**

Since TLDP is based on an interpersonal model, with roots in attachment theory and

object relations, issues of loss are interwoven through 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 patient has had "enough" therapy? In doing TLDP, I use five sets of questions to help the therapist judge when termination is appropriate. First and foremost, has the patient evidenced interactional changes with significant others in his or her life? Does the patient report more rewarding transactions? Second, has the patient 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 patient are relating (from parent-child to adult-adult)? Fourth, has the therapist's countertransferential reaction to the patient shifted (usually from negative to positive)? And fifth, does the patient 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 patient 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, nonprofessional 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 patient 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 patients 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 (Cummings, 1995).

### **TRAINING**

In the Brief Psychotherapy Program (BPP) at the California Pacific Medical Center in San Francisco, clinical service is combined with a comprehensive, structured training program for psychiatry residents and psychology interns. BPP training consists of a 1-hour didactic seminar and a 2-hour group supervision per week for 5-7 trainees at a time over a 6 month training rotation. The didactic portion of the training covers the theoretical and clinical aspects of TLDP. Videotapes of actual therapy sessions (conducted by the supervisor as well as by beginning students) are used to illustrate important basic principles, strategies, and common therapeutic dilemmas. Commercially available instructional videotapes are also used.<sup>3</sup> As trainees watch videotapes of 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 propose interventions, to think aloud about the reasons for their choices, to disclose how they are reacting to the material, and to anticipate the moment-to-moment behavior of the patients and therapists. 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; Schacht, 1991).

Each trainee is assigned to videotape one patient for an entire therapy (up to 20 sessions) using the TLDP model. The average number of actual sessions is approximately 14 (due to vacations, illnesses, holidays, and cancellations). Trainees write up their CMPs and goals at the

beginning of therapy and share these with the others in the class. In this way, the driving force of the therapy is made explicitly salient, and supervision focuses on how to devise strategies designed to further the goals consistent with the formulation.

Each trainee 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. In addition, 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, 1999).

In both instruction and supervision, I strongly believe that videotape is an essential part of TLDP training, since it provides a vivid account of what actually occurs in therapy, permitting an examination of the nuances of the therapeutic relationship. In addition, the realistic context provided by videotape can be used to facilitate an active wrestling with relevant material, which counteracts the negative effects of inert knowledge (Schacht, 1991). What is important is to focus on specific therapist-patient interactions, using a very brief segment of tape. (See Levenson and Strupp (1999) for specific recommendations concerning training in brief dynamic

psychotherapy.)

## RESEARCH

Several research programs investigating TLDP have been undertaken since the 1970's, yielding a steadily growing body of empirical findings pertaining to process and outcome dimensions of this short-term treatment approach, and to specific effects of TLDP training on therapists. From the standpoint of psychotherapy process, it appears from a series of studies done at Vanderbilt University in the 1970's (Vanderbilt I), that therapists become entrapped into reacting with negativity, hostility, and disrespect, and, in general, antitherapeutically when patients are negative and hostile. Moreover, the nature of therapists' and patients' behavior in relation to one another has been shown to be associated with the quality of therapeutic outcome. Thus, Henry, Schacht, and Strupp (1986) reexamined several cases from the Vanderbilt I project using the SASB (Benjamin, 1982). The SASB employs a circumplex model to discern and code patterns of transactions as distributed along the two axes of affiliation-disaffiliation and independence-interdependence. Findings indicate that in the cases with better outcomes, the therapists were significantly more "affirming and understanding," more "helpful and protecting," and less "belittling and blaming." Patients who had poorer outcomes were significantly less "disclosing and expressing," more "trusting and relying" (passively and deferentially so), and more "walling off and avoiding." Further, multiple communications (e.g., simultaneously accepting and rejecting) by both the patients and therapists were related to poorer outcomes.

In another series of findings on the therapeutic process and its impact, Quintana and Meara (1990) found that patients' intrapsychic activity became similar to the way they perceived their therapists treated them in short-term therapy. Harrist, Quintana, Strupp, and Henry (1994)

went one step further. Using the SASB to assess cases from a three-year investigation of the effects of TLDP training on therapist performance (Vanderbilt II), they found that patients internalized both their own and their therapists' contribution to the therapeutic interaction and that these internalizations were associated with better outcomes.

The VA Short-Term Psychotherapy Research 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.

In the VAST Project long-term follow-up study (Bein, Levenson, & Overstreet, 1994), patients were reassessed a mean of three years after their TLDP therapies. Findings reveal that patient gains from treatment (measured by symptom and interpersonal inventories) 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. Other analyses indicate that patients were more likely to value their therapies the more they perceived that sessions focused on TLDP-congruent strategies (i.e., trying to understand their typical patterns of relating to people, exploring childhood relationships, and trying to relate in a new and better way with their therapists).

Using the VAST Project data, Hartmann and Levenson (1995) examined the meaningfulness of TLDP case formulation in a real clinical situation. CMPs (written by the treating therapists after the first one or two sessions with their patients) were read by five

clinicians who did not know anything about the patients or their therapies. These raters were able to agree on the patients' interpersonal problems solely based on the information contained in the CMP narratives. A study by Johnson and colleagues (1989) warrants attention in this context as well insofar as it addressed, from a different vantage point, the clinical meaningfulness and reliability of CMP formulation. They found that the relationship themes identified with a modification of the CMP coded by the SASB were similar to themes derived using the CCRT method, providing an important demonstration that concurrence exists in relationship themes identified by different methods for assessing maladaptive interpersonal patterns.

The study by Hartmann and Levenson (1995) using the VAST Project data also revealed important relationships between patients' CMPs and facets of clinical process and outcome. Specifically, their data indicate that there is a statistically significant relationship between what interpersonal problems the raters felt *should* have been discussed in the therapy (based only on the patients' CMPs) and those topics the therapists said actually *were* discussed. Perhaps most meaningful is the finding that better outcomes were achieved the more these therapies stayed focused on topics relevant to the patients' CMPs. Thus, these preliminary findings indicate that the TLDP case formulations convey reliable interpersonal information to clinicians otherwise unfamiliar with the case, guide the issues that are discussed in the therapy, and lead to better outcomes the more therapists can adhere to them.

Research has also demonstrated specific effects of TLDP training on therapists who are learning this approach. The previously mentioned three-year investigation of the effects of TLDP training on therapist performance (Vanderbilt II) indicated that while 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), many of the project therapists did not reach an acceptable level of TLDP mastery (Bein et al., 2000). The Vanderbilt II findings also revealed some unintended and potentially untoward training effects. For example, after training the activity level of the therapists increased, giving them more of an opportunity to make "mistakes." As a consequence, these therapists appeared less approving and less supportive, and delivered more disaffiliative and complex communications to patients.

In another training study, Levenson and Bolter (1988) examined the values and attitudes of psychiatry residents and psychology interns before and after a six month seminar and group supervision in TLDP. They found that after training there were significant changes in the students' attitudes (e.g., willingness to be more active) as measured by a questionnaire designed to highlight value differences between short-term and long-term therapists (Bolter, Levenson, & Alvarez, 1990). Other research has supported these findings (Neff, et al., 1997).

### **CLINICAL ILLUSTRATION**

Mr. Johnson was a 74 year-old man who was about to be discharged from an inpatient psychiatry unit. I knew very little about him prior to our first session. I had been told he was diagnosed with major depression, and was a retired widower, with four grown children. Mr. Johnson had cooperated with treatment during his one month, inpatient treatment, which consisted of individual sessions with a psychiatrist, antidepressant medications, and milieu therapy.

Much of Mr. Johnson's background emerged in a piecemeal fashion as the therapeutic alliance strengthened and he became more aware of the relevancy of his personal history. I

eventually learned that Mr. Johnson's father was an alcoholic and his mother was "a saint." He said he felt love for his father until he saw him beat his mother when he was about ten years old. He lived his early adult years as a loner, obtained a college degree in education and became a teacher. Following this he married a woman who was referred to in the inpatient records as "a domineering alcoholic." There was continual marital stress and at one point when they came close to divorcing, Mr. Johnson was psychiatrically hospitalized. When his wife suddenly died of cancer, he was left to raise four children, the youngest of whom was his ten year old daughter, Susan. His older daughter left to get married, and his teen-age sons ran away to work on a fishing boat.

Mr. Johnson lived with Susan in an interdependent relationship for 12 years until they were evicted. Susan left to find a place of her own. Mr. Johnson then moved into an apartment with his younger son and his son's girlfriend. About a year later he was again hospitalized and then referred to me for outpatient treatment. His goal was to "not be depressed."

### **Formulation**

Because of space constraints, I cannot fully articulate here how I derived the data for the patient's rudimentary CMP.<sup>4</sup> Suffice it to say, I was looking for repetitive themes built around the four categories of the CMP. In addition, I was mindful of my own countertransference. In order to obtain a narrative of Mr. Johnson's interactive themes, I strung together the components of the CMP combined with my own reactions to tell a story of his pattern of role relationships. Those themes that occurred over time, across situations, and with a number of different persons gained preeminence.

In the first session Mr. Johnson presented as the proverbial cork floating on the sea of

life. He was an isolated, depressed, dependent man who expected that others knew best what he should do, so he waited for them to assume responsibility for his life. Others did step in and direct him, because they initially felt sorry for him, they were worn down by his complaining, or because they felt guilty for not wanting to do more. However, eventually they became frustrated and irritated by his defeatist attitude and sometimes became angry and/or rejected him. While Mr. Johnson may have initially complied with others' directives and demands, he ended up not feeling helped, but rather rejected, unloved, and worthless. Unable to feel effective and nurtured, he became more helpless and hopeless, leading to his increased isolation and depression, completing the cycle. Consistent with the behavior from others, I also was aware of having negative feelings toward Mr. Johnson. As he told his story, I found myself becoming somewhat bored, irritated and emotionally disconnected. There were also some feelings of pity for his plight as an elderly man who felt abandoned by his children.

From this initial CMP I considered what *new experience* of our interaction would provide a healthy disruption in his usual pattern. I reasoned that a more empowered, active sense of himself leading to more confident behaviors with me might help jog him out of the familiar rut of his dependency and despondency. And the experience of not being rescued from his helplessness nor punished for his decisiveness, nor alienating me with his independence, might further encourage him to begin to internalize a new relationship model.

In terms of a *new understanding*, I assessed that Mr. Johnson's recognizing that his feelings were important (especially the more energizing ones) would be helpful to him in directing his own life. In addition, I hoped he could see that he was already making decisions and taking actions that impacted people. I wanted him to have some awareness that if he

changed his customary passive pattern he would not necessarily be deserted--in fact, in many ways he was his own worst enemy. Finally, it would be critical for him to appreciate his strengths and capabilities and have some compassion for how and why he might have needed to develop such a style of relating.

I concluded that while Mr. Johnson met the five basic selection criteria, his concrete thinking style, impoverished descriptions of his relationships, and limited ability to reflect on his own behavior would call for a correspondingly more didactic and directive version of TLDP. At the conclusion of the first session, I offered Mr. Johnson a 20 session brief therapy and suggested we could focus on ways to help him feel less hopeless and depressed. Despite his lack of psychological-mindedness and a depression severe enough to warrant hospitalization, I was encouraged by the relative clarity of his interactive pattern. Given his dependency needs and difficulties with losses, a specific time limit would be expected to raise the saliency of these issues and thereby facilitate the work. When I proposed the focus and time-frame, Mr. Johnson was characteristically compliant and resigned. (□Whatever you say, doctor. Whatever you say.□). I wondered if I had already fallen into a countertransferential reenactment of taking too much control and direction, thereby colluding with his helpless stance. I thought it likely, given Mr. Johnson's CMP, that I could become hooked into reenacting several scenarios with him such as becoming impatient/angry with his passivity, directive in response to his submission, and/or as hopeless as he was.

By the end of the first session, I had a rudimentary blueprint of the therapy, consisting of the case formulation, the goals, and anticipated stuck spots in the treatment. In the second session, Mr. Johnson explained that he felt responsible for his daughter's moving out of the

apartment they had shared for 21 years.

### **Course of Treatment**

*Therapist: So this is what has been gnawing away at you, has been Susan's leaving and the role you might have played in it?*

*Patient: Yeah. And then our being used by real estate people over and over gain. We've had to move. Not over and over again, but we've had to move. We're stranded out there. Now Susan pays too high rent for her salary, because she doesn't have anything left. And it's. . .I don't know. We did have enough money and a pretty happy life. But of all of a sudden we're up against it like all the street people almost.*

*Therapist: Do you think Susan's sorry she moved?*

*Patient: I don't know. (plaintively) She still calls me Daddy. But then when she's gone, you know she's with her friends. I guess she's forgetting me and it hurts. (emphatically) It hurts. I don't see her. She says, 'Oh, Dad, I have other things to do.' I ask her to come over--I say, let's meet and have an afternoon. (mimicking daughter) She says, 'I have other things I have to do.' One of her friends has a boat in College View. They go out on the bay--(pejoratively) baying it. And I just feel left out.*

*Therapist: (matter-of-factly) Well, you are.*

*Patient: I am. (lamenting) Yeah, I'm really left out. So, I don't know . . . (resigned tone, voice becomes plaintive and trails off)*

*Therapist: The least she could do after you went to all the trouble of raising her and giving her things was stick around for the rest of your life.*

*Patient: Anyway, I guess these are the things, the . . .*

*Therapist: (interrupting) How do you feel about what I just said?*

*Patient: What did you say? (pause) The least she could have stuck around? (pause) I'm not that possessive. Really, I'm not that possessive to want her to stick around. I just want her in the same household. That's what I really want.*

*Therapist: (nodding) Yeah. How do you feel about the fact that I said the least she could do is not move out?*

*Patient: I don't know. If I answer that it would seem like a selfish answer. If I just said, well, I feel that she's unjust, or she's unfair, it would be a selfish answer on my part. Because I know kids have to grow up and go their own way.*

*Therapist: Well, you know that in your head, but I'm really asking how your gut feels.*

*Patient: (begins crying) I don't want her to go! I want to be with her. She's my little kid. (pause) Oh, Christ. You know, my wife and I fought quite a bit and she always won. And she was able to domineer me completely. And we just withdrew from each other. So when she died, I turned all my love that I would normally have toward a wife, toward this little kid who didn't leave me. My two sons left me and my older daughter left me. I never would have sold the house if they had all stuck together, but they started giving me all kinds of trouble. As I said. And I think all this frustrated feeling I had toward my wife because she was--she insisted on being boss. And it really bothered me. I was angry inside all the time at her. I turned on to this young girl all the feelings. So what it amounts to is I love Susan. I want her to be around. It's a fatherly love but it's a real close attachment. And I don't want it broken. (pause) If Susan goes, I don't really have anybody. (pause) Well, I'm feeling sorry for myself but that's the truth of the matter. (sighs) Anger at myself for making (pause), you know, for getting rid of a house that*

*could have kept us all together.*

At the beginning of the hour, I was wondering if Mr. Johnson were angry with his daughter for not being with him in his time of need, especially given that he was there for her as a child. My statement ("The least she could do. . . is stick around for the rest of your life.") was intended to be an empathic connection with what I sensed was his longing for his daughter and anger toward her that she was not living up to her part of the implicit quid pro quo. My hunch was confirmed a few seconds later when Mr. Johnson stated that he "only wanted her in the same household!" My intervention was designed to say "out loud the thought that can't be spoken, [and thereby] increase the likelihood that the patient will begin to be exposed to the therapeutically relevant cues" (Wachtel, 1992, p. 340). However, despite my conscious intentions to be empathic, there was a sarcastic tone to my voice and the phrasing of the words I used seemed condescending.

Based on my working understanding of Mr. Johnson's CMP, I judged that my provocative statement was a countertransferential reenactment displaying my irritation and frustration with his self-pity. From a TLDP perspective, the goal is not to avoid becoming ensnared in an interactive web with the patient, but rather to make use of this entanglement to further the therapeutic process. Fortunately, I was aware of this reenactment as soon as the words left my lips (the "observing participant").<sup>5</sup> In addition, Mr. Johnson's changing the subject ("Anyway . . .") was another clue that something significant had just transpired. I surmised that Mr. Johnson probably was having some internal reaction to my provocative statement about his daughter's obligation to him. I, therefore, asked him how he felt about what I had just said to him.

Could he avail himself of the opportunity to express his anger (either toward me or about his daughter) and then see whether there were dire consequences? My stepping back and inviting Mr. Johnson to examine what had transpired between us was an opportunity for him to have a new interpersonal experience--specifically, to be more assertive in expressing his negative feelings. In addition, I was also concerned that my harsh comment might have ruptured the developing working relationship between us. One of the ways to try to repair a rupture in the therapeutic alliance is to address the patient's problematic feelings about what is transpiring between therapist and patient (Foreman & Marmar, 1985; Safran & Muran, 2000). In a brief therapy, in particular, it is critical to discuss in the here and now of the therapy anything that might contribute to a negative transference. However, in his characteristic style, Mr. Johnson did not tell me directly how he was feeling. At this point I was hypothesizing that this entire interchange--his passive and martyr-like presentation precipitating my frustration and insensitivity possibly causing him to feel criticized and to withdraw--was a mini-reenactment of what transpires outside of therapy.

I see such a rupture in the therapeutic alliance as consistent with what Safran and Segal (1990) writing on interpersonal processes in cognitive therapy call a "useful window into the patient's subjective world" (p.89). From a TLDP perspective, it affords the therapist an opportunity to understand more fully the schemata behind a patient's CMP, since the nature of the patient's underlying characteristic construal of self and others is thereby implied, and to learn how to provide the patient with a mini-new experience in the service of modifying the maladaptive schemata sustaining his or her CMP.

Following this interchange, Mr. Johnson described what happened when he and his wife

argued-- "[S]he always won. And she was able to domineer me completely. And we just withdrew from each other." Perhaps I had fallen into an interactional pattern like the one he had had with his wife. Rather than tell me directly I was too overbearing, Mr. Johnson alludes to how he was dominated by his wife. Interactional psychoanalytic theorists such as Gill (1982) refer to this behavior as an "allusion to the transference." In this way, Mr. Johnson may have unconsciously (and more safely, indirectly) communicated to me his views about our present interaction. The TLDP therapist should be alert to the possibility that comments about other people are disguised communications about how the patient experiences the therapeutic relationship and what the consequences might be. Would he keep his anger "inside all the time" and "withdraw" from our therapeutic work if I continued to respond to his passivity in a "domineering" fashion?

Mr. Johnson came to the third session hungry (he had not eaten breakfast) and having soiled his pants (due to a stool softener). He was almost saying in an infantile fashion, "Feed me. Change me. Take care of me." I was increasingly more confident in my formulation--Mr. Johnson's indirect and childlike stance was preferable to taking the risk of stating his needs and showing his anger because he feared the more direct route would result in physical or emotional abandonment. Later in the session, Mr. Johnson said he felt sad having been left alone for three days by his family. However, I hypothesized that he might also have felt angry at being abandoned yet again. Repeatedly we see the same theme of his feeling sad and blaming himself rather than feeling anger and confronting others. Given his early childhood experiences with a violent, alcoholic father, such an interpersonal pattern is quite understandable. Whenever I attempted to engage Mr. Johnson in a discussion of his feelings about being left alone, he

switched to complaining that he could not concentrate because he had not had anything to eat that morning.

*Patient: (half-hearted laugh) (pause) There isn't a place in here where I could get a tomato juice or anything?*

*Therapist: No, not here.*

*Patient: (Distressed) Oh, boy.*

*Therapist: Mr. Johnson, you are saying two different things. You're saying you would have trouble sitting here continuing with our session because you haven't had breakfast; then you say it's more than that. You would have trouble sitting here talking because you're upset about the things that have gone on this week and it would make this session hard anyway.*

*Patient: Well, they decided to go up to Oregon to visit some people, and they just left, and I've been alone for three days in the house and I haven't been going out.*

*Therapist: But right here, sitting here now, do you feel talking with me is difficult because we'll be talking about some upsetting things, or do you think sitting here talking with me is difficult because you didn't have breakfast this morning?*

*Patient: I think it's because I didn't have breakfast.*

In my training classes, I like to show the videotape of this session and stop the tape here. I ask the trainees what they would say or do at this point. Most of the them, if they have been trained in long-term psychodynamic psychotherapy, volunteer various interpretations (e.g., "I was wondering if you might be feeling angry because your family abandoned you;" "It seems like you want to avoid talking about upsetting things;" "Does this remind you of how you interact with your family?"). After I hear these various interventions, I ask the students to

evaluate if such communications will help Mr. Johnson take a step toward feeling more activated and empowered (i.e., the experiential goal emanating from the formulation of the case). Usually the trainees have no difficulty seeing that their (accurate) interpretations would only serve to make the patient feel worse because they so easily can be heard as blaming indictments, a conclusion reached by interpersonal researchers (Henry, et al., 1994).

Since my goal for the therapy was to have Mr. Johnson feel more empowered and display more assertive behaviors instead of feeling so dependent and being so compliant, I let that goal guide my intervention. I, therefore, asked *him* to clarify whether being hungry or knowing we would be talking about some upsetting things was making it difficult to be in the session. When he replied that it was because he was hungry, I did not interpret his response as an indication of resistance. Rather, I took his response seriously (which does not mean I automatically believed him), and simply asked him what would keep him from getting something in his stomach right then. I was trying to afford Mr. Johnson the opportunity to make a decision in his own behalf--to take care of what *he* saw as *his* needs.

Resistance from the perspective of TLDP is viewed within the interpersonal sphere--as one of a number of transactions between therapist and patient. The patient is attempting to retain personal integrity and ingrained perceptions of him or herself and others. The patient's perceptions support his or her understanding of what is required to maintain interpersonal connectedness and safety. Resistance in this light is the patient's attempt to do the best he or she can with how he or she construes the world (Kelly, 1955).

*Patient: If I just got something in my stomach I would feel better.*

*Therapist: Uh-huh. And what keeps you from getting something in your stomach right now?*

*Patient: I'd have to go over to the cafeteria over there.*

*Therapist: That's right.*

*Patient: (Sigh)*

*Therapist: And what would keep you from deciding to do that?*

*Patient: (Sigh) Well, the fact we're having a session, and I don't want to be rude.*

*Therapist: So rather than be rude, you'll sit there and be uncomfortable for an hour.*

*Patient: Well, I don't know. I guess so. Unless you'd let me go.*

*Therapist: Unless I'd let you go?*

*Patient: (Taken aback) Well, I feel obligated to come and see you, because you're helping me.*

*Therapist: (pause) Mr. Johnson, it seems you're faced with a dilemma. Right here, right now, with me in this room. And the dilemma is can you concentrate and really make use of the time, or do you need some food in you to be able to do that. Your dilemma is whether to take care of you or to take care of me.*

After this segment, Mr. Johnson tried to avoid making an active decision in the room by simply continuing to talk. After listening to him for a couple of minutes, I interrupted him and said that I was not clear as to what his decision was--whether he had decided to stay or to get something to eat. Mr. Johnson said that he was feeling better and could stay.

I would have felt more secure in Mr. Johnson's truly having had a new experience, if he had chosen to leave the session, and chance my displeasure. This would have clearly been the riskier choice and a significant break with his familiar pattern. Nonetheless, he voiced his decision, and our interaction around the breakfast issue had raised the saliency of his customary way of denying his own needs in favor of what he thinks others want.

In the process of exploring why Mr. Johnson did not decide to get something to eat, I pointed out one level of the interpersonal dynamic that was occurring between us in the here-and-now. "Your dilemma is to take care of you or to take care of me." Exploring patterns that constitute dysfunctional transactions between patient and therapist is a critical step in accomplishing the second goal of helping the patient have a new understanding.

In the fourth session, Mr. Johnson talked about loaning money to his younger daughter. This money allowed her to live separately from him--something I knew from the second session he did not want. ("I just want her in the same household.") This afforded me the opportunity to ask Mr. Johnson how he felt about loaning her money with the intent of seeing if he could express some of his more negative feelings as a way for him to feel more empowered and entitled.

Not unexpectedly, Mr. Johnson had considerable difficulty expressing his anger. Although I was still interested in Mr. Johnson's feelings, I became *more* interested in his manner of interacting with me--in this case, how he subverted showing anger.

After attempting to get at Mr. Johnson's affect directly several times without success, I commented on the process. ("Seems like this is a difficult question.") This led Mr. Johnson to claim that his feelings were unknown to him. With more probing, he was able to say his feelings were hidden. I then asked him if there might be a good reason to keep the feelings hidden from his point of view (i.e., allying with the resistance). I decided to raise the issue of a "good reason" because I suspected, based on Mr. Johnson's CMP, that he feared that I would be displeased, condemning, or incited to delve deeper by his withholding.

My next intervention was psychoeducational, explaining why people might keep feelings

hidden, even from themselves. I was inviting Mr. Johnson to explore the reasons he might go through life not acknowledging what he feels. However, he was not willing to engage with me on this level and became flustered. As a way to help him tune into what he does feel, I asked him to concentrate on his bodily sensations. Given that he often somaticized his emotional pain, I asked him to communicate in a way that was familiar to him. His response (“I’m so constipated.”) was relevant on two levels--literally (I am physiologically blocked) and symbolically (I am psychologically blocked). In response, I interpreted that he was more comfortable talking about his physical feelings than his emotional ones.

Later on in the session, I shared an observation with Mr. Johnson. (“I notice that when I ask you these kinds of questions, you tear up and your voice gets a little quivery. Do you notice that too?”) By keeping my process comment at a basic descriptive level, I hoped to avert his supersensitivity to being blamed. I then asked him what he was feeling at those moments. My goal here was to help him become curious about his own behaviors as markers for understanding his feelings and the effect he has on others. In response, Mr. Johnson replied in a stuttering voice that he wanted to keep his feelings hidden and not talk about them. In keeping with the goal of wanting to promote his taking risks in letting people know his wants and needs directly, I did not chastise him (e.g., interpret his withholding). Instead I underscored what he said. (“I think you are saying something very important, Mr. Johnson. You’re saying you *want* to keep the feelings hidden.”) Following this interchange, I conveyed to him I would be open to changing the subject if he wished.

Toward the end of this session, Mr. Johnson again complained that he was constipated. He mentioned that he had a stool softener in his car and said he would like to leave the session

early to take it. From a physiological standpoint, it would not have made much difference if he took the stool softener immediately or when our session ended. But subjectively, this seemed like a big step for Mr. Johnson--to put forth his needs despite his expectation that they might conflict with my desire to have him remain in the session.

In the previous session, he decided not to leave to get something to eat. In this session, his saying that he wanted to leave early appeared to be an unconscious test to see if I really would "let him go." I was encouraged by Mr. Johnson's direct statement of what he wanted to do. Here was another opportunity in the therapy for him to have a different experience of himself and me. Rather than interpreting what I thought was going on, I simply told him I would look forward to seeing him at our usual time next week.

Throughout the rest of the therapy I stayed focused on the goals for the treatment. I felt free to use various interventions that might facilitate his feeling more assertive and empowered and less passive. For example, I used behavioral rehearsal (to feel what it might be like to assert his needs in an anticipated new living situation), and the gestalt empty-chair technique (to talk to himself as a boy), allowing him to be more compassionate with himself for his "failure" to protect his mother. In this particular case, the use of such techniques did not appear to jar Mr. Johnson. Given the brevity of the therapy, Mr. Johnson was accustomed to my using a variety of pragmatically-designed strategies. Furthermore, since the interventions were all designed to achieve one major goal, they had a common theme, lending to their coherence (i.e., phenomenologically they made sense).

However, it is important to note that because of Mr. Johnson's dependency needs and his comfort with my taking control, I broached the possibility of using these techniques in a low key,

collaborative way. I was also ready to process their use should Mr. Johnson's reaction be untoward or result in a reenactment of his CMP. However, it is not just the introduction of techniques from other schools that needs this careful monitoring. The TLDP therapist needs to attend to the present relational context and sequella for judging the appropriateness as well as the effectiveness of any intervention. The critical question is what is an intervention's potential for promoting the idiosyncratically defined new experience.

Glickauf-Hughes et al. (1996) describe a gestalt technique of encouraging the client to "say no." They indicate that "it is important to help clients truly know that they can choose to say 'no,' even to suggestions by the therapist" (p. 50). As an example of this technique, they illustrate saying to a client who was saying no indirectly, "My hunch is that you really didn't want to answer that question. Can you say to me 'No. I don't want to answer that question right now'" (p.51). However, for Mr. Johnson, the use of such an intervention would be counterproductive; he might submissively follow my instructions to say no or learn that such "assertive behaviors" would please me. In either case, Mr. Johnson would not have had to risk my disapproval if he said no, and therefore not have the full experience of confronting me. The opportunity for disconfirming his own pathogenic beliefs would have been lost (Weiss & Sampson, 1986).

### **Termination**

Mr. Johnson began our last session by relating how his children were visiting more and inviting him to do things. His improved relationships with them illustrate the chief principle whereby TLDP is thought to generalize. Ideally, patients' experiences in brief therapy help disconfirm their ingrained dysfunctional interpersonal expectations, and alter their internalized

views of self and others, encouraging them to try out new, but shaky, behaviors with other people. In Mr. Johnson's case, he took risks to be more assertive with me in the therapy. His increased confidence in his abilities to get his own needs met led him to be less anxious, placating, and resentful. As a result, his children experienced him as more delightful to be around and consequently involved him more in their lives. Since this was what Mr. Johnson wanted in the first place, he was happier and further encouraged to be more independent in his life. In this way, Mr. Johnson would be expected to be able to continue his therapeutic work in his naturalistic environment, even though the sessions with me would be coming to a close. Such continued therapeutic work is at the crux of TLDP, since a brief treatment can usually only get the patient moving in the desired direction, not take him to the final destination.<sup>6</sup>

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## FOOTNOTES

1. In addition to the CMP presented here, there is a form that incorporates the SASB (Schacht & Henry, 1995), and Henry (1997) has developed the Interpersonal Case Formulation, a method for describing and explaining interpersonal patterns using the SASB.
2. For information on more traditional TLDP interventions, the reader is referred to the Vanderbilt Strategies Scale (Levenson, 1995, Appendix).
3. For instructional TLDP videotapes contact: Levenson Institute for Training (LIFT), 2323 Sacramento Street, Second Floor, San Francisco, CA 94115; American Psychological Association, 750 First Street NE, Washington, DC 20002; Psychological and Educational Films, 3334 E. Coast Highway #252, Corona del Mar, CA 92625.
4. For more specifics on developing a CMP, including an elaboration of Mr. Johnson's CMP, see Levenson (1995).
5. Of course this awareness is never comprehensive or complete (see Safran & Muran, 2000).
6. For a session by session commentary including a video portrayal of this case and information on Mr. Johnson's 1-year and 6-year follow-up, see Levenson (1998).