

DYNAMIC THERAPIES FOR PSYCHIATRIC DISORDERS

**Brief Supportive-Expressive
Psychodynamic Therapy for
Generalized *Anxiety* Disorder**

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HISTORY AND DEVELOPMENT

The treatment approach described in this chapter represents an application of Luborsky's (1984) supportive-expressive (SE) dynamic therapy manual to generalized anxiety disorder (GAD). The treatment is brief (16 sessions) and focal in nature. While a diagnosis of GAD does not warrant a radically different treatment approach from standard brief SE, there are important treatment issues and emphases that are relevant to GAD patients, requiring this addendum to the generic SE manual. The specific elements of SE treatment as delivered to GAD patients become even more important in a research context where the mission is to standardize treatment so that studies can be replicated and efficacious treatments disseminated. Thus, on the one hand, we are not attempting to present a "new" dynamic therapy, but on the other hand, we are attempting to provide a further level of specificity of SE treatment for GAD patients that we hypothesize will lead to better outcomes. We believe the combination of the generic manual plus this more

specific guide for applying SE to GAD can meet the goals of standardization for research yet retain the essence of the general SE approach.

The Development of Supportive-Expressive Psychotherapy

As an extension of the generic SE manual, the current GAD treatment approach is influenced by the historical developments in psychodynamic psychotherapy as described by Luborsky (1984). He traces the roots of SE treatment back to Freud's papers on technique (1911/1958, 1912/1958a, 1912/1958b, 1913/1958, 1914/1958, and 1915/1958). Luborsky (1984) also points to the contributions of Ferenczi (1920/1950) and Rank (1936), and later Alexander and French (1946), all of whom proposed shortening the length of psychoanalysis and differentiating psychoanalytically oriented psychotherapy from psychoanalysis per se. The explicit introduction of supportive techniques made the treatment adaptable to a broader range of patients. Luborsky (1984) describes the history of the application of SE treatment at the Menninger Foundation (Wallerstein, Robbins, Sargent, & Luborsky, 1956) beginning about 1940. He also cites the writings of Bergmann and Hartman (1977), Gill (1951, 1954), Greenson (1967), and Stone (1951) as sources of the techniques described in the generic SE manual.

The Development of SE for GAD

Influences on the Development of SE for GAD

The senior author's experiences with SE treatment since 1984 at the University of Pennsylvania Center for Psychotherapy Research have been primarily in a research context, with the goal of developing and testing specific psychosocial treatments for specific patient problems and disorders. This research orientation has led to an interest in further codifying the treatment in more explicit terms so that the training of therapists can be accomplished more efficiently and effectively and a standardized treatment can be evaluated in efficacy studies. The research orientation has also led to an interest in adapting and modifying the treatment approach, based on research evidence suggesting which aspects of treatment are of greater therapeutic importance. Many of the modifications discussed in this chapter, however, reflect the clinical orientation of the writers. In developing SE treatments at the Center for Psychotherapy Research, we have been most influenced by our discussions with, and the writings of, David Mark, a senior SE supervisor at Penn who has authored a treatment manual on the application of SE treatment to cocaine abuse. The SE approach for GAD described here continues in these directions. We have also been influenced by the writings of Horowitz (1986) on the nature and treatment of stress-response syndromes.

Why Develop a Psychodynamic Therapy Specifically for GAD?

GAD is a relatively prevalent disorder that carries significant degrees of

impairment. Lifetime prevalence of GAD using a one-month duration criterion has been reported as ranging from 4.1% to 6.6% in the Epidemiological Catchment Area (ECA) survey (Robins & Regier, 1991). Since more than 60% of the cases in this study reported a duration of illness greater than one year, we can extrapolate a tentative *DSM-III-R* prevalence estimate of approximately 2.5% to 3.5% using a more conservative six-month duration criterion. The community ECA survey found that about one-third of subjects with GAD had an onset of the disorder in their teens or early twenties (Robins & Regier, 1991). The ECA survey found that almost half of the subjects who had ever experienced GAD continued to be ill at the time of interview, and the mean duration of illness was found to be 6-10 years. Data on psychosocial impairment from the ECA survey indicate that 38% of GAD subjects characterize their emotional health as only fair to poor; 27% were receiving disability payments, and only about one-half worked full-time.

In summary, the clinical picture that emerges from recent research suggests that GAD is an early onset condition that tends to be chronic and leads to a fair degree of disability and impairment of quality of life. Thus, public health concerns provide a strong rationale for developing treatments for GAD. Behavioral and cognitive treatments for anxiety, and GAD in particular, have been shown to be helpful (see Chambless & Gillis, 1993). In addition, medication treatments for GAD have also been shown to be efficacious. Despite these advances, there are a number of reasons to develop

a dynamic therapy for GAD.

First, dynamic therapy continues to be a widely practiced form of treatment in the community (see Jensen, Bergin, & Greaves, 1990), suggesting that many patients with GAD are commonly being treated with dynamic therapy. Developing and standardizing a particular dynamic therapy for GAD accomplishes the important first step of making it possible to evaluate the efficacy of dynamic therapy with this disorder.

Second, there are a number of limitations to medication treatments for GAD, particularly benzodiazepine, including (1) inadequate improvement in a subset of patients (about 30%) (Greenblatt, Shader, & Abernethy, 1983a); (2) negligible effect on the core symptom of worry (Rickels et al., 1982); (3) side effects, including attentional, psychomotor, cognitive, and memory-impairing effects as well as possible teratogenic risk in female patients of childbearing age (who constitute a majority of the GAD population); (4) abuse liability, physical dependence and withdrawal, and negative effects on coping and stress response capabilities (Greenblatt, Shader, & Abernethy, 1983b; Rickels, Schweizer, & Lucki, 1987; Woods, Katz, & Winger, 1992); and (5) high relapse rates—for example, Rickels et al. (1987) reported an 81% anxiety recurrence rate at one year for patients who had received four weeks of diazepam therapy.

Although behavioral and cognitive treatments have had some success in the treatment of GAD, missing from these approaches is a treatment focus on the interpersonal factors involved in GAD. (See the discussion of psychodynamic factors in GAD later in this chapter.) A psychodynamic approach could lead to broader life improvements, which might increase the general quality of life and also lower relapse rates.

Psychodynamic Theories of Anxiety

The rationale for the development of a manualized psychodynamic therapy for GAD comes not only from the limitations of other approaches and public health concerns about the disorder but also from the longtime interest in the psychodynamic camp in the theory and treatment of anxiety from a psychodynamic perspective. Psychodynamic writers from Freud through Sullivan, Fairbairn, Klein, and Kohut have all proposed ideas about the etiology and treatment of anxiety. (See Zerbe, 1990, for a review.) Whether the chronic anxiety problems ("anxiety neurosis") described by these theorists are the same problem known as GAD is unclear. However, our assumption is that some part of the chronic anxiety in at least a subset of GAD patients has a psychodynamic component.

Freud actually proposed two theories of anxiety. In his earlier writings (before 1926), he suggested that anxiety is the consequence of repressed or

nondischarged libido. Zerbe (1990) summarizes Freud's theory: "Repressed libido is transformed or converted into anxiety, which then reappears as free-floating anxiety or as an anxiety equivalent (i.e., symptom)" (p. 173). Psychoanalysis, or dynamic psychotherapy, encourages disclosure of warded-off, unacceptable sexual feelings, which in turn brings the anxiety out in the open to be channeled in a more productive direction, including appropriate expression of sexuality. Freud's later theory of anxiety was the "signal" theory (see Compton, 1972): a small amount of anxiety from a perceived danger "signals" the ego to be alert to the threat. Defenses, including symptoms and inhibitions, are then activated in order to keep the threat out of consciousness so that it does not become overly traumatic. If the defenses fail, a full anxiety attack occurs. Treatment is oriented toward insight about the perceived danger so that the patient can see that the danger is not as great as what he or she imagines.

Later psychodynamic writers extended the theories of anxiety in different ways. Karen Homey (1950) proposed that hostile impulses outside of consciousness lead to neurotic anxiety. The therapist's task is to bring these hostile impulses into awareness and help make them more acceptable. Sullivan (1953), on the other hand, focused more on anxiety as a function of anticipated disapproval from the primary caregiver earlier in life. He emphasized the importance of the therapist providing a climate of security that provides the context for patients to gradually develop their own security

operations over time. This context of therapeutic security is similar to the later notion of the "therapeutic alliance" (Greenson, 1967), which is also a major component of SE treatment. Fromm-Reichmann (1955) added to the Sullivanian perspective by emphasizing the anxiety-producing role of distorted views of other people, such views having originated in prior relationship experiences. These distorted interpersonal patterns not only are a function of anxiety but produce further anxiety. Therapists need to have patients develop better ways of relating to others by first helping them understand when they are perceiving others in a distorted way based on earlier relationship experiences. The SE model incorporates these concepts in terms of the core conflictual relationship theme (CCRT), which is one way of defining the patient's distorted relationship experiences.

The object relations theorists also contributed to the psychodynamic literature on the etiology and treatment of anxiety. Fairbairn (1952) emphasized the separation conflict originating in infancy. Although the child has deep feelings of dependency on the primary caregiver, too much closeness generates a fear of being engulfed and of loss of identity. As the natural desire to separate develops, greater distance from the caregiver leads to feelings of isolation and loneliness. Both sides of the conflict generate anxiety. This conflict needs to be mastered in order to achieve mature relationships and reduce anxiety. Klein (1975a, 1975b), on the other hand, linked anxiety to fear of death in the infant if the primary caregiver cannot be

evoked on demand. This anxiety is connected to a sense of being persecuted by other people and a lack of confidence in one's ability to sustain or repair relationships. When these internalized representations of self and others are carried over and activated later in life, relationships can be undermined. The emphasis in brief SE treatment of GAD on the meaning of separation from the therapist (termination) as a process that activates relationship conflicts involving attachment and loss of others is borrowed from the object relations view of separation conflict.

Although psychodynamic theorists have speculated on the origins and treatment of chronic anxiety from a variety of theoretical perspectives ranging from classic psychoanalytic to object relational to self-psychology, the treatment approach described here is more closely aligned with the interpersonal view. This orientation not only reflects the biases and experiences of the authors but is also influenced by the emerging research evidence for the importance of attachment and interpersonal issues in GAD. This literature is reviewed in the discussion of dynamic issues with GAD patients later in the chapter. Most notable in the emerging evidence is the high prevalence of past traumatic events in the history of GAD patients and the suggestive evidence for insecure attachment patterns. This research raises the possibility of the usefulness of brief dynamic therapies with GAD patients, particularly those that treat stress or trauma response syndromes and their maladaptive coping/defensive styles (Horowitz, 1986), as well as

those that examine core conflictual interpersonal patterns (Luborsky, 1984). Our approach, then, attempts to integrate the emerging research information on GAD with the clinical psychodynamic writing of Horowitz (1986) and Luborsky (1984) on brief dynamic therapy.

INCLUSION/EXCLUSION CRITERIA

We have recently crafted inclusion/exclusion criteria for the evaluation of our treatment as part of a planned comparative study including SE, cognitive therapy, medication, and pill placebo treatment conditions. Ultimately, the inclusion/exclusion criteria that would be employed in deciding whether to administer this treatment in a clinical context might differ from our research criteria. Until further data document the usefulness of the treatment with other inclusion/exclusion criteria, however, we prefer to advocate the use of this treatment only when these narrow criteria apply.

Inclusion criteria are (1) the patient meets *DSM-IV* criteria for a primary diagnosis of generalized anxiety disorder, and (2) the patient is age 18-69.

Exclusion criteria are (1) the presence of any acute, unstable, or severe Axis III medical disorder that might interfere with the successful completion of the 16 weeks of treatment; (2) any *current or past* history of schizophrenic disorder, bipolar disorder, or Cluster "A" Axis II personality disorder (schizoid, schizotypal, or paranoid); (3) any history *in the past 12 months* of

panic disorder with or without agoraphobia, alcohol or substance dependence or abuse, eating disorder, borderline personality disorder, or obsessive-compulsive disorder.

DYNAMIC ISSUES IN GAD

As previously mentioned, our application of an interpersonally oriented dynamic treatment to the diagnosis of GAD is partially based on emerging empirical evidence on the nature of GAD. This includes the data reported by Borkovec, Robinson, Pruzinsky, & DePree (1983) showing that worry (the central feature of GAD) is associated with high levels of interpersonal concerns. This link is also apparent in the high level of co-morbidity between GAD and social phobia (Brown & Barlow, 1992).

Research has also begun to shed light on the possible origins of the interpersonal issues in GAD. Lichtenstein and Cassidy (1991) performed a study in which GAD subjects were asked to recall memories of the nature of their attachment to primary caregivers in childhood. GAD subjects were found to be significantly more insecurely attached than non-GAD subjects. This was manifested in terms of more enmeshment/role reversal (i.e., the need to protect, but fear of losing, the primary caregiver) and greater preoccupying anger and oscillating feelings toward the caregiver. GAD subjects also felt significantly more rejected as children by the primary

caregiver than did non-GAD subjects.

In addition to interpersonal issues, GAD has also been linked to a history of past traumatic events. Borkovec (1994) reports on the results of three questionnaire studies involving over 1,000 subjects. In these studies, subjects meeting GAD criteria were found to have had significantly more past traumatic events compared with non-GAD subjects. Subjects meeting the full criteria for GAD also reported more frequent traumatic events than subjects meeting only some of the criteria. Similar results were found for a measure of the frequency of intrusive thoughts (one of the symptoms found in reaction to traumatic events) about traumatic events over the past week. Further analysis of the types of past traumas (Molina, Roemer, Borkovec, & Posa, 1992) has revealed interesting differences between GAD and non-GAD subjects. The vast majority of the traumas (80%) of non-GAD subjects were related to the death of a significant other and/or illness or injury involving self or others. The traumas of non-GAD subjects were rarely physical or sexual assault, emotional events involving friends or family, or miscellaneous traumas. (The percentage of traumas were distributed relatively evenly [6-8%] across these latter categories.) In contrast, GAD subjects characterized only 50% of their traumas as death, injury, or illness, but 21% were physical or sexual assault, 17% involved emotional events, and 11% fell in the miscellaneous category. These percentages describe the distribution of types of traumas in the experience of non-GAD subjects and GAD subjects

separately. Comparing the actual frequency of each type of trauma in the two groups is more revealing: GAD subjects report trauma involving death, illness, or injury at a rate one and a half times greater than that of non-GAD subjects, and traumas related to assault, emotional events, and miscellaneous traumas at rates four to six times greater.

Borkovec (1994) has further compared the data on past traumas with data obtained from interview studies on the content of current worries of treatment-seeking GAD patients and nontreatment-seeking GAD subjects. Although GAD subjects have higher rates of trauma related to death, illness, or injury than do non-GAD subjects, GAD patients and subjects rarely worry about these events (3% for patients and 0% for subjects). Non-GAD subjects, however, worry about these concerns at a much higher rate (25%). Borkovec speculates that these data suggest that GAD subjects/patients avoid thinking about those past events they consider traumatic. A study by Roemer, Borkovec, Posa, and Lyonfields (1991) that examines the function of worry is consistent with this hypothesis. The authors report that worrying appears to distract GAD subjects from more disturbing emotional contents ("Worrying about most of the things I worry about is a way to distract myself from worrying about even more emotional things, things that I don't want to think about"). In psychodynamic terms, worrying appears to serve a defensive function.

To summarize: The emerging research literature on GAD and worry suggests that GAD is linked to both an insecure/conflicted attachment in childhood and to a history of past traumas. It is not clear at this point whether these are two independent paths to GAD or whether they interact (i.e., specific traumas occurring to a person with insecure/conflicted attachment patterns produces the symptoms of GAD). GAD patients and subjects also display a characteristic defensive pattern of avoiding thinking about difficult emotional issues and events by worrying about other issues. It should also be acknowledged that the data are tentative and do not demonstrate causality. Nevertheless, the emerging data are consistent with a psychodynamic/interpersonal perspective on GAD that emphasizes attachment patterns and cognitive/emotional processing of past traumatic events.

In brief, our model of GAD follows from the above research finding and hypothesizes that a set of dangerous or traumatic experiences, which can occur at any phase of life, leads to a set of basic assumptions about oneself and other people, especially about one's ability to successfully obtain what one needs in life and in relationships. With GAD, these beliefs might center on the certainty of obtaining love, security, stability, or protection from others. These concerns at times are connected with feelings of fear so strong and troubling that the patient is actively motivated to not think about his or her concerns. That is to say, coping or defensive processes kick in that lead GAD

patients to become overly cognitively concerned ("worried") with certain current events in their lives as a way to avoid thinking about the more difficult emotional issues. The more difficult emotional issues, however, continue to be "alive," both consciously and unconsciously, and are manifested in repetitive, maladaptive relationship patterns. These self-defeating patterns are cyclical, meaning that they end up re-creating the same sort of perceived circumstances that originally generated the fear (e.g., expectation of losing a loved one).

The anxiety in GAD, then, is hypothesized to consist of multiple components. At its most basic level, the anxiety stems from the fear of not obtaining what one needs in relationships and in life. This anxiety in GAD patients would be reflected in the response of self-component of the CCRT. This basic fear in itself can generate ongoing worry. As described above, however, much of the worry component of GAD is hypothesized to be an additional defensive response. Other symptoms of GAD—for example, somatic symptoms—can also be a defensive response as well as simply a part of the physiology of the fear response. Lastly, it is acknowledged that life presents difficult or traumatic experiences that may add very real anxiety to the mix of fears and defenses that are being brought by patients to their current relationships from past experiences.

Despite the evidence that GAD patients may share common elements of

exposure to traumatic events and/or insecure attachments in childhood, we do not hypothesize one specific CCRT to be evident in all GAD patients. One reason for this is that "trauma" and "insecure attachment" are broad concepts that leave room for various types and severities of specific experiences that shape the exact nature of the interpersonal themes manifested later. In addition, aspects of each patient's past and current social world modify the expression of the effects of the traumas and childhood experiences. For example, one person with a history of an insecure attachment in childhood, if currently in a stable relationship, might display the following CCRT:

Wish: to be taken care of

Response from other (RO): does not protect or nurture

Response of self (RS): fear of losing the relationship; anxiety

A patient who also has a history of insecure attachment in childhood, if not currently in a stable relationship, might display this CCRT:

Wish: to have someone to trust and rely on

RO: not trustworthy

RS: anxious and depressed

Thus, early development events and circumstances are modified by later sets of experiences and current circumstances. The fact that beliefs

about oneself and others may be modified in the context of new or current relationships provides the opportunity for psychotherapy—a relationship with a caring and insightful therapist—to change such beliefs.

It should be clear that our model does not restrict the development of GAD to early childhood events. Trauma and conflicted relationships can occur at any phase of life. A sustained period of insecure attachment during childhood is likely to set up rather powerful expectations about others as one moves into early adulthood. If one has experienced successful, positive relationships early in life, it is less likely that new traumas or conflicted relationships will generate a severe or lasting impact.

TREATMENT GOALS

One of the first tasks in our 16-session treatment for GAD is setting goals. The therapist, however, does not arrive at final goals at the beginning of the first session. Instead, the therapist begins treatment, after introductions, by asking a general question such as, "Tell me what's going on." The intent is to elicit relevant material before formulating goals. Ideally, preliminary goals would be set at the end of the first session, but in some cases a second session is needed to obtain more information or to establish more of a therapeutic alliance before setting goals.

Typically, patients' goals relate to symptom reduction and sometimes to

self-esteem or interpersonal changes. GAD patients in particular are prone to focus on symptoms, especially somatic anxiety symptoms. If a patient is staying only at the level of symptoms, the therapist needs to directly inquire about the rest of the patient's life: "O.K., now that you've given me an idea about the symptoms that you've been having, it would help me to know more about you." The therapist follows up by asking questions about family, work, love relationships, and so on. In addition, the therapist elicits information about relationship themes by asking the patient to describe his or her interactions with other people.

After obtaining relevant information, the therapist attempts to weave symptom reduction goals with goals related to increased self-esteem or interpersonal confidence. Goals are specified using the patient's own language as much as possible. In addition, the goals have to be appropriate for a short-term treatment. This means that they should not extend to major, comprehensive personality change but rather need to be focal in nature. For example, the therapist says, "It's clear that we both agree that an important goal of this treatment would be to help you with your anxiety symptoms. You've also talked about the uncertainty and confusion you feel in regard to where to go with your relationship with your girlfriend. That's clearly an ongoing stress in your life and something you would like to work on, as it may be playing a role in raising your general nervousness. As a first step, it sounds as if you are saying that it would be useful to sort out all the different feelings

that you are having about her. Once you are clearer on all the feelings, and what those feelings are about, it might be easier to figure out where you want to go with the relationship. So why don't we set as the first goal, trying to understand more about your different feelings and how they might relate to your anxiety?"

As treatment develops, goals are referred to periodically to monitor progress, as described by Luborsky (1984, pp. 62-63). In addition, goals may change over time. For example, goals can change if treatment has succeeded in lowering the patient's defenses either by greater comfort in the relationship with the therapist over time through the provision of a secure environment or by direct interpretation of defenses. Once defenses are lower, the patient is likely to have greater access to more troubling conflicts and fears. Additional goals can be added to treatment, but they have to be appropriate for the amount of treatment time remaining.

Whereas the patient's and therapist's goals may not be the same at the beginning of the first session, the task of these sessions is to develop a collaborative relationship so that the final goals are mutually arrived at. In addition, over treatment the therapist will, if possible, attempt to add a goal (if it is not one of the original agreed-upon goals) relating to greater mastery over the patient's CCRT. For example, the therapist says, "We have been seeing over and over again how you are caught in this cycle of wanting to be

close to others but not trusting them and then feeling you must distance yourself from the relationship; I wonder if we can add as a goal of our therapy to help you understand this pattern better and perhaps begin to look at new ways you could handle these situations."

THEORY OF CHANGE

Our theory of change is one that hypothesizes a number of factors that can be responsible for positive outcome. The complexity of dynamic therapy is that the relative salience of each of these factors to a given patient varies as a function of the nature of the patient's interpersonal patterns and characterological style. We also acknowledge that the position of these factors into categories is somewhat arbitrary; in fact, the factors often interact and overlap.

In Luborsky's (1984, chap. 2) description of the theory of change for generic SE treatment, he specifies the three main psychological changes that occur in the patient: (1) an increased understanding of the CCRT and the relation of the symptoms to the CCRT, leading to a greater mastery over negative expressions of the CCRT; (2) an increased sense of having an ally in the struggle to break out of the self-defeating CCRT pattern; and (3) an internalization of the therapist as a helpful person together with acquisition of the tools of therapy (i.e., self-exploration) so that the gains of treatment

persist after termination. Luborsky (1984) describes each of these changes in detail and also articulates the patient's and therapist's roles in bringing them about. Below we expand on Luborsky's discussion of these changes in terms of their relative importance in the treatment of GAD patients and in terms of empirical support for them. We also discuss additional concepts based on our work with GAD patients.

Change in the CCRT

Changes in the patient's CCRT are hypothesized to be the primary determinant of a successful treatment. Crits-Christoph and Luborsky (1990) showed that pre- to post-treatment changes in CCRT wish, response from other, and response of self-components correlated significantly with changes in symptomatology and general functioning. Significantly, the mean changes in the pervasiveness of the CCRT components were relatively small across patients in this study. However, apparently even small changes in the CCRT pattern can be associated with symptom reduction. This study did not provide information on the causal sequence of CCRT and symptomatic changes, and therefore we must provide the caveat that symptom change may cause CCRT change, or that another variable may cause change in both. Nevertheless, the empirical evidence thus far is consistent with the importance of CCRT changes.

From our empirical-psychodynamic point of view, relief of presenting symptoms is very important but not generally the sole definition of a successful treatment. Some degree of change in the CCRT is also necessary for a successful treatment. Symptom relief should not, of course, be devalued; it is likely to have extraordinary importance to the patient and is the first level marker of a successful treatment. However, our theory is that symptom change without change in the CCRT is likely to be associated with a higher rate of relapse and recurrence of the symptoms after treatment has terminated.

The fact that even small changes in the CCRT can be important justifies engaging in brief 16-session therapy, in which major changes in relationship patterns can rarely occur. Thus, our model does not subscribe to the theory that interpersonal conflicts are "rooted out" in a brief course of therapy. Rather, the theory is that conflictual interpersonal themes are activated in the context of relationships and events occurring during a particular developmental phase of the patient's life (e.g., graduating from college, getting married, starting a career, etc.). A brief course of treatment serves to identify underlying CCRT patterns, their current developmental or relationship manifestations, and the maladaptive coping responses that hinder successful life adjustment. Additionally, the course of treatment helps the patient work through new expectations of self and others—thus starting the process of changing the CCRT. After termination, if the patient has successfully learned

the self-exploration tools of therapy, he or she continues to engage in self-exploration, make efforts to master the CCRT, and exhibit new behaviors. The extent to which the patient continues the process of therapy after termination is hypothesized to be associated with the maintenance of the treatment gains and the prevention of symptomatic relapses and recurrences.

A variety of types of changes in the CCRT would be expected in a successful treatment. Of central importance is movement toward less self-defeating responses of self and more new coping responses. We would also hope to see less rigid projection of assumed responses from others into new or evolving interpersonal relationships. Although it is not expected that wishes will change much in a brief treatment, with some patients a modification of wishes that are inappropriate to certain interpersonal contexts would be expected. Alternatively, change might be marked by successfully choosing new relationships that allow for appropriate expression of the CCRT wish(es).

Changes in the CCRT are thought to happen as a result of increasing self-understanding of the CCRT and, as described below, through the forging of a positive therapeutic alliance. Insight, or self-understanding, is actually a complex phenomenon consisting of multiple elements or meanings. At the first level, self-understanding refers to an uncovering of feelings or patterns that have been largely out of awareness (i.e., a de-repression). Although it is

probably rare for a patient to have no memory of a traumatic event and then suddenly during psychotherapy to have a complete lifting of repression with full access to the event, it is more common for a patient in treatment to gain access to difficult memories and feelings that may in fact have occasionally intruded into consciousness and to begin breaking down the variety of defenses (e.g., the distracting worrying of GAD patients) constructed over time to avoid thinking about them. By interpreting the patient's defenses and resistances, the therapist hopes to help the patient confront the deeper fears, conflicts, and feelings directly rather than continue to avoid thinking about them.

In addition to uncovering warded-off feelings, insight can be discussed at the level of cognitive understanding about one's self. At the cognitive level, insight is equivalent to a learning or educational process. Although this level of insight is often criticized as superficial, our position is that cognitive learning is a necessary aspect of treatment. However, the context in which such learning takes place is of central importance. As with any type of learning, cognitive learning is facilitated when the patient is sufficiently motivated and adequate groundwork has been accomplished (i.e., learning basic information before learning more complex information). If statements about the patient's dynamic conflicts are presented before his or her defenses and/or resistances have been lowered, the likely consequence is an increase in the patient's anxiety and further activation of defenses. Learning one's

dynamics after defenses have been lowered and the emotions connected with the conflictual themes have been tapped is often referred to as "emotional insight." With GAD patients, the danger of staying too much at the cognitive level is great, since these patients suffer from excessive thought activity (i.e., worry) and may pick up on a piece of cognitive information presented in therapy and simply incorporate it into their worry system.

At another level, self-understanding can be thought of as a skill or tactic rather than only as an outcome. Learning the process of self-exploration is then one goal of our brief dynamic therapy. As mentioned, the acquisition of this skill is seen as important for carrying on the work of therapy after termination in order to reduce relapse and recurrence of symptoms.

The main way self-understanding is increased and self-exploration is encouraged, leading to subsequent changes in the CCRT, is through the therapist's interpretations of the CCRT pattern. Our research has shown that the therapist's accurate interpretation of the CCRT is correlated significantly with treatment outcome (Crits-Christoph, Cooper, & Luborsky, 1988). Based on this research finding, our SE for GAD treatment model places even more emphasis on the importance of accurate formulation of the CCRT and centering interpretive work on the CCRT throughout treatment. Accuracy of CCRT interpretation has also been found to be associated with the development of the therapeutic alliance over treatment (Crits-Christoph,

Barber, & Kurcias, 1993). Thus, accurate interpretations may have a direct effect on self-understanding as well as an indirect effect on outcome through the role that the alliance plays in facilitating positive outcome.

Therapeutic Alliance

Luborsky's (1984) second curative factor for SE treatment is an increased sense of having an ally in the struggle to overcome symptoms and problems. We stress the importance of a positive therapeutic alliance as a factor in the change process for two reasons. First, a positive therapeutic alliance has consistently been found to be associated with better treatment outcome across a large number of studies. (See the review by Horvath & Symonds, 1991.) Our view is that this impressive research evidence needs to be taken seriously in the development of new treatment methods.

The second reason the therapeutic alliance is important in the change process relates to our formulation of the dynamic issues with GAD patients. As discussed earlier, GAD patients are hypothesized to have insecure or conflicted attachment patterns. Thus, a secure, positive relationship provides a "corrective emotional experience" and is fundamental to effective treatment with GAD patients. With some GAD patients, anxiety is fueled by guilt (i.e., fear that you have done something wrong to someone else). A safe, positive relationship with the therapist can often help ease the feelings of guilt and

lessen anxiety.

Another way a positive alliance is theorized to affect the patient is that a secure, positive relationship with the therapist allows the patient to feel safe enough to approach his or her fears. By "approach" we mean several things, including both psychologically approaching fears and behaviorally approaching feared situations. For some patients, the safe context allows them to lower defenses and gain access to fears not normally thought about because of their troubling nature. Other patients may be more aware of their fears but reluctant to disclose them given the possible negative reaction from others. At the behavioral level, the safe, positive relationship with the therapist encourages patients to actually approach feared situations, particularly interpersonal situations. Thus, a patient who is afraid of discussing some difficult issues in a relationship for fear of losing the relationship might be more likely to do so once he or she has had a positive experience in disclosing and discussing such fears with the therapist. From a psychodynamic point of view, this process is not simply one of desensitization but a cognitive process of changing internal representations of others and their expected responses.

The safety provided by a positive therapeutic alliance not only allows the patient to approach fears but subsequently also supports the patient's growth in trying new behaviors. The separation-individuation concept of the

object relations theorists is particularly relevant here. We assume that everyone experiences a basic desire to become independent and try new things, but that in order to do so a secure, positive attachment must be present first. The therapist also has to be aware of the danger of becoming overly involved with the patient so that fears of engulfment and losing one's identity are not activated and treatment consequently undermined.

A positive therapeutic alliance is also hypothesized to provide a context in which interpretive or expressive interventions are more likely to be heard, understood, and productively pursued by patients. The positive alliance conveys the sense that patient and therapist are working collaboratively, rather than a sense that the therapist comes up with explanations of the patient's behavior that the patient may hear as critical or condescending. In this way, the alliance sets the stage for the operation of other change mechanisms.

New Behaviors

Although the psychodynamic perspective emphasizes the steps necessary to gain understanding of the maladaptive problematic relationship patterns in order to provide the opportunity for the patient to grow in new positive directions, we also acknowledge the role of successfully engaging in new behaviors for encouraging further change and solidifying existing

change. Taking steps to adopt new, positive behaviors is particularly important for patients suffering from GAD or any other disorder that involves anxiety and/or avoidance. The therapist, therefore, should encourage such new behaviors, particularly if progress has been made on the preliminary steps of lowering defenses and understanding the CCRT patterns.

TECHNIQUES

The major techniques for our SE treatment of GAD are the same as those described in Luborsky (1984, chaps. 5-9), and the reader is referred to the generic manual for a discussion of them. Our discussion here will focus on those techniques that are most applicable to brief SE and those that we emphasize in the treatment of GAD in particular.

Brief SE Techniques

Although Luborsky (1984) has a short section on time-limited SE, our experience with the 16-session format in the treatment of GAD patients has helped us map out the application of brief SE in more detail. We can now characterize the therapist's predominant tasks during four phases of treatment.

Early Phase

In the early phase of treatment, the therapist and patient set goals, as described earlier in this chapter. The early phase can be generally specified as Sessions 1 to 5. The therapist's most important task during the early phase is to build a positive therapeutic alliance, using the supportive interventions described by Luborsky (1984, chap. 6) with the aim of building trust.

The therapist's second major task during the early phase is to formulate and interpret a preliminary CCRT. To obtain the material for formulating the CCRT, the therapist encourages the patient to talk about his or her interactions with other people. Specific incidents with other people, "relationship episodes," are the most useful way of obtaining relevant CCRT information. The therapist needs to learn to help develop the patient's narratives, as advocated by Mark and Faude (chapter 10). In a brief therapy, we do not have the luxury of assuming that after the lifting of resistances, relevant material will naturally flow. According to Mark and Faude, the process of learning to develop narratives is best learned through reviewing tapes of sessions with the supervisor.

If negative transference issues emerge during the early phase, the therapist should empathize with the patient's feelings as much as possible in order to continue to build the alliance. Patients with an additional Axis II diagnosis are especially likely to display negative transference reactions in the early phase of treatment. The therapist's goal is to manage the Axis II

issues so as to keep the patient engaged in treatment but as much as possible to return to working on the anxiety and worry problems. The therapist should address Axis II defenses in an empathetic way, always maintaining, however, the goal of being in touch with the CCRT feelings and issues. As mentioned, severe Axis II patients (e.g., borderline) are not accepted in this treatment.

Middle Phase

The middle phase of treatment can be generally defined as Sessions 6 to 11. During this phase, the therapist refines the CCRT formulation using information from further relationship episodes told by the patient. It is usually during the middle phase that the patient feels safer in treatment, defenses have lowered somewhat, and more memories and experiences are recalled and discussed. Thus, the therapist now has the opportunity to relate the CCRT pattern to earlier relationships and to illustrate to the patient the extent to which the same patterns are appearing in a variety of relationships in the patient's life, including potentially the relationship with the therapist. This is the process of "working through."

Sometimes a therapist feels caught if a patient brings up new and very serious issues in the middle of the 16-session treatment. For example, given the high level of past traumas found in GAD patients, it is not uncommon for a GAD patient to disclose an incident of abuse or other trauma halfway through

the treatment. We have found that in most cases the incident can be talked about in therapy and used for understanding the patient's symptoms, defenses, and interpersonal conflicts. Thus, our view differs from that of some in the psychoanalytic camp who believe it is inherently counter-therapeutic to explore such material in a brief treatment. If necessary, of course, the patient can be referred for additional treatment if he or she begins to deteriorate once very traumatic experiences are brought up.

Termination Phase

The termination phase, approximately Sessions 12 to 16, is of central importance in our brief SE treatment for GAD. Although our treatment does not go quite as far as Mann's (1973) brief therapy— which makes the termination issues of overriding importance for almost the entire length of treatment—we nonetheless believe that the termination phase is critical. As Luborsky (1984) indicates, the termination phase is often characterized by a resurgence of symptoms as the patient's CCRT is activated in anticipation of the loss of the therapist. The loss of the therapist is meaningful not only in terms of the real loss of an important person in the patient's life but also, more specifically, in terms of anticipation of not obtaining the CCRT wish in relationships (e.g., wishes for support, nurturance, love, closeness, acceptance, etc.). The therapist must interpret the upcoming termination in terms of the link to the CCRT pattern and begin work on termination issues

no later than Session 14, and preferably as early as Session 12, whether or not the patient is making explicit references to termination. Not uncommonly, a therapist will collude with a patient to not discuss the upcoming termination because other topics seem more pressing, when in fact both participants are having difficulty facing the feelings related to termination. If left undiscussed, the termination issues often explode in the last or next-to-last session, with both parties feeling there is not enough time to deal with the feelings and issues that come up. With supervision, however, therapists learn after one or two training cases to address termination issues early enough and to be less apprehensive about the termination feelings that arise. The goal of the therapist in our brief SE treatment is to have patients end treatment with a clear educational understanding of their CCRT. As discussed earlier, this is not to say that an intellectual insight is the only task of therapy or the only requirement for self-understanding to be useful. If the patient is to achieve this educational understanding of the CCRT, the therapist needs to summarize, during the termination phase, what has been learned about the CCRT. Such a summary should be clear and succinct, and the therapist should encourage the patient to express his or her own understanding of the CCRT.

Booster Phase

The final phase of treatment is the booster phase, which was designed on an experimental basis as part of our research project. However, our

experience thus far in using booster sessions has been positive, and we can now recommend their use as part of our clinical treatment package. The booster sessions are scheduled at a rate of one per month over three months. The therapist's task during the booster phase is to monitor and reinforce the improvements the patient has made, encourage and support internalization of the treatment and the therapist (i.e., the patient doing the work of therapy on his or her own), and, if necessary, interpreting relapse in terms of the CCRT and the loss of the therapist. If during the booster phase a serious setback or relapse occurs, the patient is, of course, referred for appropriate treatment.

From a psychodynamic point of view, there is a concern that booster sessions "water down" the termination process, but we have not found this to be the case. The 16th session is still experienced as the final regular session and the cessation of the regular therapy work. Thus, our perception and the sense we have obtained from patients is that the positive aspects of these booster sessions outweigh any potential interference with the termination process. The booster sessions, however, should not be scheduled more often than once a month; more frequent booster sessions would likely cause more disruption in the termination process.

Technical Issues Specific to GAD

Beyond the modification of standard SE for its use in a 16-session format, other technical issues are specifically relevant to the application of SE to GAD patients. One issue has been mentioned already: the emphasis on supportive techniques to facilitate the therapeutic alliance and create a safe context for exploration. Although it is, of course, the larger goal of our treatment to reduce the patient's anxiety symptoms, we should note that some mild amount of anxiety (as an affect) actually contributes to therapeutic progress by providing continued motivation for working actively in treatment. Thus, it is not the therapist's goal to support the patient to the extent that anxiety is removed completely in the sessions.

CCRT Interpretation

In carrying out the main technical agenda for SE therapy, interpretation of the CCRT, several points should be emphasized in the treatment of GAD patients. First, our experience with GAD patients suggests that they not uncommonly display a primitive wish (e.g., "I want to feel safe") that surfaces early in treatment when they are in the most regressed state and overwhelmed by symptoms and feeling helpless. The therapist has to first bring this wish to the surface in the context of the alliance ("You want that in other relationships but are not getting it. How about here?"). Once the primitive wish is conscious and somewhat gratified by the alliance, the patient, after a few sessions, is motivated to move on to more mature wishes

("Well, the world is an unsafe place. I can be safe here, but out there I have to deal with the world as an adult"). The patient then begins to bring his or her more adult CCRT wishes to relationships, and the therapist focuses the interpretive work in that direction.

The therapist also needs to consistently link the CCRT wishes to the response of self. This link is important in first establishing the relation of the wishes to the anxiety feelings and symptoms. In addition, certain RSs are self-defeating and perpetuate a cyclical maladaptive pattern. For example, if the patient's wish is to be close to others but the RS is to distance from others after anticipating rejection, the therapist should not only interpret the CCRT wishes and responses from other and of self but should also point out the self-defeating nature of the RS. The focus on the RSs, whether the affect (anxiety) or the self-defeating behavior, also lays the groundwork for developing new RSs and new behaviors as therapy progresses.

Resistances and Defenses

Little is said in the generic SE manual (Luborsky, 1984) about dealing with resistances and defenses. Mark (in press) elaborates on the handling of resistances and defenses in an SE treatment in some detail, and we borrow from his approach here. Although we have highlighted the nature of worry as a defense in GAD patients, it is not the approach of our treatment to elevate

the interpretation of or confrontation with this or other defenses to the level of the primary intervention strategy of the treatment. Thus, our treatment does not attempt to analyze defenses routinely or to confront defenses head-on along the lines of Davanloo (1980). Rather, our approach is to deal with defenses and resistances to the extent that they present obstacles to understanding of the CCRT.

Mark (in press) also offers a variety of techniques for dealing with defenses in SE treatment; the therapist should (1) attempt to have the patient tangle with realities, rather than arguing with the patient, (2) use questions rather than state truths, and (3) simply sidestep defenses when it is more important to respect the patient's assets.

We have also found that the therapist needs to be aware of resistances and defenses in formulating and interpreting the CCRT. At times a manifest response of self may disguise the underlying wish, i.e., the response of self is defensive to the underlying wish. If interpretation of the defense does not help, the therapist should move toward work on the wish to the extent that it provides a less threatening context in which the patient is less defensive.

Past Traumas

As noted previously, GAD patients have a high frequency of past traumas. It is not the focus of this treatment, however, to specifically search

for past traumas. We have found that patients tend to bring up such experiences if they appear relevant to the therapeutic issues being discussed and the CCRT. The therapist's task is to be empathic to the patient's experience of the traumatic event(s). If relevant, the therapist should also examine with the patient how the CCRT was exacerbated by the trauma. For example, if a patient with a wish to be nurtured and protected also experienced a trauma such as sexual abuse, the therapist needs to help the patient understand how the wish was frustrated and exacerbated by the trauma when the parents or other people were unable to help. The therapist can then proceed to explore what the patient would have wanted in response to the trauma (e.g., to have expressed anger; to have been able to elicit help instead of withdrawing; for others to have taken him or her seriously).

CASE EXAMPLE

The patient, a married male in his late thirties, responded to an ad offering psychotherapy treatment for sufferers of anxiety. David (not his real name) was a college graduate, the oldest of four siblings, and worked with his mother and sister in managing the family business.

He had been in psychotherapy treatment at three points in his life and was now seeking treatment for emotional distress that had been consuming him since his return to work after a recent vacation. Before the first session,

he was evaluated by the research team and found to qualify for a diagnosis of GAD as determined by a structured interview. In the first session, David wept frequently and uncontrollably but was able to link his distress to feeling out of control at work owing to conflict with a longtime employee. He complained of unceasing obsessive worry, difficulty concentrating and sleeping, and feelings of isolation and withdrawal from family and friends.

David related a family history that was marred by the tragic accidental death of his youngest sister. At the time of the tragedy, David was in his early twenties and trying to formulate his career goals and separate from his family of origin. He had decided he did not want to work in the family business and had begun working in another company. He had first experienced symptoms of anxiety and perfectionism as a teenager, around the time his father was stricken and somewhat disabled by a chronic illness. Despite the added responsibilities, David managed his symptoms, entered and completed college, and got married. After his sister died, however, his father's emotional health deteriorated, and it fell to David and his mother to run the family business. David reluctantly accepted the responsibility, hoping that it would be temporary. He ended up staying on, however, without ever feeling he had made a fully conscious decision to do so.

David described his current distress as having been precipitated by increasing difficulties with the problematic employee. He felt that this man

was incompetent, unmotivated, and manipulative and defied supervision. David felt trapped in feelings of powerlessness, inadequacy, and personal failure. He also felt panic and paralysis linked to constant dread of an impending catastrophe. These feelings intensified when he considered taking any action that might result in losing this employee. As the situation worsened, David withdrew emotionally from other people at work and from his family, convinced that any request for help would further prove his failure and/or also lead to "something bad happening." Later in therapy, he revealed an associated dread that his parents would die precipitously and admitted the need to check on them each Sunday to see if they were still alive. The treatment goals he and the therapist agreed on were to regain a sense of control, feel able to manage the work conflict, and experience a reduction in symptoms of anxiety and depression.

In the next section, we present portions of the transcript of an individual session to illustrate the therapist's techniques and the process of David's understanding and working through his CCRT wishes, including important changes in his responses of self. The therapist considered this session, number 11 out of 16, to be a pivotal point in the course of treatment, as David was increasingly integrating his understanding of the CCRT and his past with the present and was recognizing his ability to change rather than remain at the mercy of events outside of his control. The previous sessions had laid the groundwork for this session by exploring and encouraging David's expression

of affect and his feelings about the past. In addition, the therapist had made many interpretations linking his wishes as well as responses of self and responses from others to the feelings he was describing in his relationship episodes with others. Session 11 witnessed a dramatic change: David decided to give up his initial wish (as revealed in earlier sessions) to be taken care of. He also connected his symptoms and personality style of expressing the negative to the gratification of this more regressed wish through the role of victim. David further progressed in this session by expressing his desire to replace the regressive wish with one of taking responsibility for his life, making changes, and tackling the obstacles that had previously led to a perfectionistic, sometimes self-defeating or overly fearful need for control.

We begin with an exchange that occurred at the start of the session.

Patient: I started to interview for a new employee, what have you. You know, that kind of freaks me out from the standpoint of, what's going to happen? How am I going to deal with a conflict and all that? But I am not going to let that stand in the way of finding someone. Finding somebody will sort of pull, push me through the pipeline that I have to deal with.

Therapist: So you have some anxiety, but it's not an anxiety that stops you from doing what you have to do?

Patient: Trying not to. Trying to refocus, get focused, do something, stop sitting around. Not focus on being depressed, woe is me, because that's really not going to change anything. I mean, coming here and trying to figure out where it stems from might change it, but sitting at home lying in bed, reading, or whatever, and not going to work doesn't change anything. So.

Therapist: That sounds like somewhat of a change in your feelings. What do you think may have precipitated that change?

Patient: Um, I don't know. Deciding that I better do something about this. I can't keep telling myself: I'm depressed, I'm getting more depressed, I'm not getting any better. Only I'm going to get better. Either I am or I'm not going to get better. Only I'm going to correct the situation at work. Nobody is going to step in. My employee is not going to come to me tomorrow and say, "You know, I decided this conflict that we've had is really all my fault, and I'm going to work more hours now, and I really see your point of view and what happened, and let's go forward."

Therapist: Right.

Patient: You know, the chances of that are the same chances that you'll pay me—

Therapist: (laughs)

Patient: —to meet with me every month.

Therapist: Uh-huh.

Patient: Today was a bad day, all kinds of, you know, problems. You know, the poison that's going on. You know, it's kind of hard to take this, and where they're not really doing what they're supposed to do anymore. We're sort of all going through the pretense that everything is sort of okay, but it's really not. They know it's not, we know it's not. They'll say, you know, we're a bunch of assholes, and it's spreading. It's not just the one employee's war anymore. It's like the whole department. You know, they've all commiserated, so it's even gotten uglier than it once was. You know, it might have been a brush fire, now it's a seven-alarm. You know, the brother's now involved. Because, of course, it's his sister. So whose side is he going to take? He's not going to take the benevolent, caring employer's. He's going to take the asshole sister's who stopped talking to him because he did something wrong six months ago, a year ago.

Therapist: Well, it sounds like what makes a difference is when you think that it's

got to be perfect, everything has got to be perfect, or it's a real blow to you.

Patient: Well, things are out of control. The problems freak me out still. And the answer isn't doing what we've been doing.

So I have to realize it's time to make changes.

Therapist: Mm-hm.

In the above exchange, David is directly revealing a desire to change his responses of self and implicitly revealing a change in his wish to be taken care of. He points out that focusing on his anxiety and depression and passively "lying in bed" or escaping by reading is not going to change anything. He adds, "Nobody is going to step in" (i.e., to take care of him). The therapist does not pursue his joking reference to her wish to pay him (and, by implication, take care of him completely) because David is focusing on more adaptive responses and the more mature wish to take care of things himself. When he describes how difficult and more complicated the situation has become ("now it's a seven-alarm,") the therapist attempts to interpret the increasingly difficult and emotionally defeating effects ("it's a real blow to you") of trying to maintain perfect control. Even though David responds somewhat defensively, stating that there are real problems he can't ignore, he continues with the positive RS, "I'm going to have to find an answer to that."

Immediately following this exchange, David continues to discuss his need to take care of the stresses and demands of his life and business.

Patient: I've got to change my way of dealing with people, my way of thinking about things. So, you know, the biggest thing is the realization that if I want my life to change, if I want to be more positive, if I want to have a personal life, I've got to do something about it. And not sort of go through being depressed and victimized. Because that's not really going to get me anything. On the other hand, you know, these problems still exist, so I still get depressed and anxious. I still get anxious about money and people hounding me to pay them and, you know, "Why if you're doing all the business can't you be current?" There's a \$10 million question. They should spend a day in my business and see how well we run it, and then they can understand.

Therapist: So there is a lot of stress even if you were not going to be overwhelmed by the fear of—

Patient: Dying. You die anyway.

Therapist: You die?

Patient: You get hit by lightning, and all of a sudden you're dead anyway.

Therapist: Mm-hm.

Patient: You've got to look at things to see a positive outcome of them. It's like building a house, right? If you don't see, if you don't plan in your mind how to build it, you can't physically build it. You die anyway. It's all how you want your life to be.

But I can't say that I'm still not dreadfully fearful of someone dying or something like that. But I didn't call my parents immediately to see if they're still alive and breathing, you know, to check their breathing. Because I guess on one level I realize what it is that I was doing, or am doing, and you know, I guess if you realize that, you can sort of stop doing it if you decide that you don't buy into it anymore.

Therapist: Mm-hm. It gives you more choices.

Patient: Right. Or become more responsible for your own outcome of things.

Therapist: It must be a relief to know that it's not really about what other people are doing to you, that it's something that you can change.

Patient: And stop buying into that, you know, these outside forces are what's causing it.

Therapist: Mm-hm. Exactly.

This is a good illustration of both the therapist and the patient combining expressive and supportive techniques and direction; they are clearly working together as a team. The therapist first highlights the effects of David's underlying unconscious fear, and he completes her sentence about what that fear is about. He then elaborates on his attempts to control death, noting that he can consciously decide to stop if he understands what underlying fear is motivating his behavior. Here the therapist has both helped to make the unconscious conscious—by leading David toward identifying the RS as fear of dying—and identified the RO—that they (his parents) will die. She also supportively empathizes with David when he expresses relief that outside stressors from other people are not causing him to have these feelings, that they are coming from within himself, and that he can therefore change his responses to these fears. Her statement is not only empathetic but also effectively supports David's ability to achieve his goals of feeling more in control, taking constructive action, and decreasing his anxiety.

This session is remarkable in that David is able to achieve his wish to take care of himself, as manifested in his leading the focus and content of the

session. Because of his focus on having more adaptive responses and working through difficult feelings and fears from the past, the therapist takes a supportive and clarifying approach in her interventions, rather than pushing David toward deeper expressive exploration and encouraging his regression. In a sense, she gratifies— perhaps unconsciously, since there is no mention of this transference in the material—his wish to take care of himself and elicit help and support from others for his efforts. Unlike those who take more conservative and open-ended analytic approaches, proponents of SE treatment do not view this facilitation of the alliance as detrimental so long as it is reviewed as an example of the CCRT wish within the relationship with the therapist before termination occurs.

The following exchange is a further example of the therapist and patient working through the more primitive wish and RSs associated with it by making a transition to a more modified adult-level wish.

Patient: Well, one of the things is a lot of stress. And (sigh) it's ... I think that there's part of me that wants someone else to take care of me.

Therapist: Mm-hm. Take care of you.

Patient: Well, wouldn't we all? I mean—

Therapist: Sure.

Patient: I think for part of me there's a warm comfortable feeling about being a victim and things not working out. And all of us being huddled in like a life raft and floating out in that storm after the ship sinks. Uh, you know, I don't

know where that comes from or what that's about. But there's a certain part of me that—

Therapist: Yeah.

Patient: —that buys into that. That that's a warm comfortable feeling. That [feeling] fights changing myself, reaching out, becoming competitive. Breaking out of that shell or whatever.

Therapist: I think the other side of this is that as a person who's taking over some of the responsibility for keeping that raft aloft, so to speak, it's almost as if part of you needs to succeed so that you could create that secure, childlike sort of haven. And when something feels like it's getting screwed up with that, it just messes up the feeling you have that you can create the security for yourself and the others. You know, that's the fear that you would have if you failed someone.

Patient: Yeah, and that things will get out of control.

Therapist: That's right.

Patient: And you die.

The therapist's intervention highlights for David that part of his perfectionism stems from wanting to take care of things so well that he will be able to re-create the security of his regressive avoidance, and that when he encounters realistic obstacles he feels like he has failed. David confirms and elaborates on this idea by identifying additional RSs—that he is out of control and anxious about dying. Later in the session, to facilitate further affective working through, the therapist comments on David's verbally unexpressed sadness, which she perceives in his eyes. She also attempts to explore its

roots.

Therapist: Mm-hm. What's making you sad?

Patient: Actually, I'm not sad. I don't know, am I sad?

Therapist: Well, you look sort of like you're filling up.

Patient: Um, talking about death, you know, that scares me. I get freaked out about it.

Therapist: Um-hm.

Patient: I really do.

Therapist: Can you stay with that?

Patient: Mm-hm. Just dying, saying "dying," makes me cry.

Therapist: Mm-hm.

Patient: It scares me. I don't know why.

Therapist: Mm. Hm. Does it help at all to be able to at least, you know, feel the feeling?

Patient: No. Because it doesn't seem to go anywhere, you know. It's just painful for a little bit, and I cry, then it stops, then I come back a week later and talk about it, and I'll cry again.

Therapist: It may be hard to let go.

Patient: Of the fear of dying?

Therapist: It's a real step forward that you're not completely running away from

those feelings of grief. Even though they may be painful.

Patient: Probably.

Therapist: If you could feel less worried about feeling depressed, maybe there's a good reason for your sadness. Maybe it's something you need to feel. Maybe there's not anything wrong with that. You know, it's accepting the depression.

Patient: Yeah, but you know, it gets old after a while.

Therapist: Nah. I think that the problem is, you keep pushing the feeling down.

Patient: Well, that could be true too.

Therapist: And that's why it feels frustrating, because it keeps coming back and you keep pushing it down.

Patient: Yeah, yeah, yeah. But you know, I've been sad and morose for so long I can't remember just having an out-of-hand good time and laughing.

Therapist: Well, you're probably going to lose the battle of pushing that sadness and grief away, because it's taking up so much energy. I don't think it's just the sadness that you've been feeling for a long time. I think that the battle over the sadness is so frustrating.

Patient: Mm-hm. It's a battle. I don't know what the battle is.

Therapist: Well, you want to keep it away.

Patient: (sigh).

Therapist: For instance, your sister's death. That, plus something else.

Patient: Yeah. I don't know. I don't know. (26-second pause). But you think I just push it back and then it resurfaces again and I get depressed again?

Therapist: Mm-hm. You're fighting something. I don't know whether it's the mourning and grief.

Patient: I don't know either (55-second pause).

Therapist: What would happen if you let yourself feel it?

Patient: If I just let myself feel sad?

Therapist: Mm-hm.

Patient: No, I feel like I fall deeper and deeper. I just get consumed by it. Uh, it's like a whole self-destructive kind of path.

Therapist: Why do you feel so bad about feeling that way?

Patient: Pardon?

Therapist: Why do you feel so bad about grief, grieving?

Patient: Uh, not normally. I mean, you know, I've lost people, and I've grieved for them. You know, I lost my grandmother. It hurts, and I feel that sense of loss, but it isn't the same. I mean, I don't have an emotional triggering. When we talk about my sister dying, and dying and all that, I start to cry. I don't know what that's about, to be honest with you. I mean, the closest I have to figuring some kind of sense of it is that my sister died and all of a sudden, if I could have jumped back into my mother's womb, I would have. The closest thing to that, I guess, was going to work for them.

Therapist: What made you want to jump back into the womb? What were you feeling?

Patient: I don't know. What was I feeling? I don't know. I didn't want to go into my father's business. So for the life of me, I'm sitting here like six years later trying to figure out why I did what I did. And why I continued to be frustrated by it. Even if you make the wrong decision, after a while you say

to yourself, It was the wrong decision but this is what I did. And I have two alternatives. I could quit, or I could work it out.

Therapist: Mm-hm.

Patient: But you've got to let the past be the past.

Although the roots of the patient's difficulty accepting his sister's death and accepting his grief are not clear, he understands that his reaction of wanting to be taken care of, "to jump back into his mother's womb," certainly intensified after the death. He also perceives that, however this reaction affected his decision to work for his family, he must now try to take responsibility for his decision in the present. Unlike the goals of open-ended therapy, which would seek to completely understand the roots of David's anxious reaction to his sister's death, short-term SE treatment focuses on the process of understanding and on the beneficial effects of working through and making conscious the defenses, feelings, and wishes associated with the trauma that surface in the safe context of the therapeutic alliance.

The session ends with David directly confronting his fear of catastrophe should he meet head-on the challenge of taking care of himself and other people.

Therapist: Well, it's hard for you to take care of yourself and other people because you're afraid. Do you know why it is hard for you to—

Patient: Take care of other people?

Therapist: To take care of yourself?

Patient: I don't know.

Therapist: What are you afraid of would happen if you got things to be going well?

Patient: Well?

Therapist: Mm-hm.

Patient: I'd be afraid something would happen.

Therapist: Okay, some catastrophe.

Patient: Yeah, right.

Therapist: You raise your hopes, and then catastrophe—

Patient: Right. Like all of a sudden, things will be going well, and then I'll die. You know, it's like the person who ... they're on top of the world and, you know, something happens. But that's life. I mean, I understand, but you can't. You know, even the person that has cancer still goes out, still goes out dancing—well, hopefully. You know, they should still be able to go out and enjoy life. You know, my problem is, I'm so worried about that, you know, if something good were to happen, that it can only mean bad or disaster. That, you know, or looking for the next crisis, you know. I'm always visualizing a negative outcome.

Therapist: Mm-hm.

Patient: You know. And then Thursday they're going to be much better because this is the goal. This is where we're going to go. And yeah, we might have setbacks or something, you know, but that's not the end. You know, you're not going to die from a setback.

Therapist: Setbacks won't kill you.

Patient: The setbacks are what, like, create those anxiety trends.

Therapist: The setbacks are also part of life, they're not part of death.

The therapist's final comment is supportive. By implication, it reinforces all that David has said and provides hope that he can view obstacles with positive coping responses and thus fulfill his goal of enjoying life more and being less symptomatic.

In the next section, the rest of the treatment, in Sessions 12 through 16, is summarized with respect to the development and consolidation of treatment gains and the issue of termination. The therapist felt that Session 11 was pivotal because, in the remaining sessions, David continued taking action to deal with the work conflict. He interviewed applicants to replace the problematic employee and began to consider whether he would fire that employee or demote him to another less responsible position. He was also able to set limits on continued insubordination from the employee, who refused to cooperate in training his replacement. As suggested by the manual, the therapist had predicted that a setback would occur prior to termination. Prior to Session 15, David experienced a temporary regression when he felt that he had taken out his anger about the work situation on his parents and family. He felt "out of control" and worried whether this feeling indicated that he would fall apart after termination. The therapist reminded him of the expected setback and reframed it as an understandable anticipation of

ending.

Although David still felt stressed and anxious in the remaining treatment sessions, the anxiety lessened considerably and he was able to experience a much fuller range of affect and emotions. In Session 14, he mentioned how much better he was and that he was pleased that his sense of humor had returned. David continued to learn about his CCRT, recognizing that one of the ways he had avoided taking responsibility was to inappropriately ask those under his authority for advice. This RS was not only unhelpful to him, but it also undermined his ability to be an effective and credible authority figure.

The process of beginning to give up the more regressed wish to be taken care of was facilitated by David's deepening recognition that he longed for parental figures to depend on and give him advice. He explored his feeling that both his parents had been limited in their ability to take care of him this way, especially since the death of his sister. The therapist suggested that he was enacting his CCRT wishes with her as well. David thought that perhaps he was in some ways, but he had some difficulty accepting that the therapist was serving as a transitional parental figure. He agreed that he had needed her to take care of him, but he denied seeing her as "the father" who would support and encourage him to take care of himself and others. His denial of her in the fatherly role may have been influenced by his more conscious appreciation of

her feminine qualities.

In Session 12, David first mentioned that he was anxious about the upcoming termination, stating that he still feared that his depression and anxiety would come back. He spoke of his anticipated loss of the therapist and of her special role several times in the remaining sessions, sometimes while considering how he might be able to receive more support from other relationships, including that with his wife. He seemed to be accepting his loss of the therapist with good humor even as he admitted to anxiety about "what might happen" afterward. When the therapist asked in the final session whether he had started to feel that he could become his own parent, he said that although he knew he could do it, he would be very lonely. David also began to cry and appeared able to grieve the anticipated loss freely without pushing down the sadness. At the end of the session, he reported feeling very good about the therapy and his progress and was looking forward to the first scheduled monthly booster session.

TRAINING

We have been engaged in the training of therapists in our treatment model in order to have a group of skilled therapists available for efficacy studies on the treatment. We should note that not all of the rather elaborate steps we employ in the training of therapists in a research context may be

necessary for the training of therapists in a clinical context. However, until we have established the efficacy of the treatment under the high-quality conditions we attempt to achieve in research, it is not appropriate for us to speculate on the steps needed to train clinicians outside of a research context. If efficacy is established under high-quality, standardized conditions, further research will be needed on the training process per se in order to understand which ingredients are essential, how many training cases are indicated, what level of previous experience and background is necessary, what cutoff level of adherence/competence is required to certify a therapist as adequate, and what level and format of supervision is necessary to train therapists adequately.

The rather rigorous criteria we have currently established in the research context evolved through our experience in training dynamic therapists for five separate pilot studies or clinical trials conducted at the Center for Psychotherapy Research at Penn. The training program consists of the following steps:

Careful Selection of Therapists

The selection process consists of obtaining a C. V. (or, in some studies, a formal application form), letters of recommendation (or verbal recommendations from other supervisors or therapists who may know the

applicant's work well), and two audiotaped sessions of the applicant's therapeutic work with patients. Ideally, these sessions would be with two different anxious patients.

Therapists selected have generally been at least several years post-terminal degree (PH.D., Psy.D., M.S.W., post-residency M.D.). In addition, most therapists chosen have had some post-degree supervised training in some form of dynamic therapy. They must also have a strong interest in learning brief dynamic therapy, as we have found that many if not most dynamically oriented therapists have negative attitudes about brief treatment. This interest in brief dynamic therapy would include having read some of the main clinical contributions to brief dynamic therapy (e.g., Mann, Sifneos).

The audiotapes are then rated by our senior supervisors using the Penn Adherence/Competence Scale for SE (PAS-SE) Therapy (Barber, Crits-Christoph, Luborsky, Crits-Christoph, & Smailis, 1992). Although this scale relates to SE therapy and the applicant's own approach to dynamic therapy may be somewhat different, one of the subscales of the PAS-SE measures general dynamic therapy skills, and the other scales (the Supportive and Expressive subscales) give us a general sense of whether the therapist's approach is compatible with our SE approach. We have found that the audiotape rating step is crucial for selecting dynamic therapists, since there are wide variations in technique and style among therapists who label

themselves "dynamically oriented." We commonly screen out therapists who (1) rely exclusively on supportive interventions and show no skill at expressive interventions, (2) have a poor ability to formulate patients' interpersonal-dynamic issues, and (3) use a highly idiosyncratic personal approach that, while perhaps dynamic in flavor, would need to be changed substantially to meet our criteria for implementation of SE for GAD.

Preliminary Orientation

The preliminary orientation of a therapist consists of first reading the generic SE manual and then reading our SE for GAD addendum. The therapist then meets with our senior supervisor to discuss questions and reactions to this material. An important part of this orientation is to discuss the therapist's preconceived notions about brief therapy. Most therapists express reservations about the degree of sustainable improvement that can be accomplished in brief therapy and also express concerns about "abandoning" patients. These concerns are addressed by indicating that many, but perhaps not all, patients do appear to benefit considerably from brief therapy. It is also explained that the goals of brief therapy differ from many of the goals of long-term therapy. The therapist is told that, in our experience and the experience of others, most patients actually appear to prefer a time-limited brief therapy format to an open-ended format. While feelings related to termination (both patients' and therapists') are difficult, working through such feelings is a

major part of the treatment model and successfully doing so can provide a unique and important experience for the patient. In addition, the therapist is told that if, upon clinical evaluation by our interviewers, a patient is found to be not in recovery, or to be in significant distress, an appropriate referral for additional alternative treatment is made at termination.

Training Cases

Our current standard is to have therapists learn the method on at least four training cases. Although this number may seem high by standards in the research literature, our experience is that dynamic therapy is difficult to learn to do well. The learning process with dynamic therapy comes not from the manual per se—the manual is a description of general principles rather than the sort of step-by-step session guide that might be found with some cognitive-behavioral treatments—but from the supervision process.

Supervision

Supervision is conducted on an individual basis with one hour of supervision for every two hours of therapy delivered. The supervisor listens to portions of audiotaped treatment sessions as much as possible. The supervision process is explicitly a teaching relationship. The treatment model and manual are referred to frequently in supervisor-supervisee discussion.

Concrete aids for learning are encouraged. For example, during supervision we make use of the CCRT Session Form. After selected sessions, the therapists are asked to complete a brief form that asks for their formulation of the patient's CCRT from the material presented in the session. This form then is discussed during supervision to teach the CCRT concept and to track the development of the therapist's understanding of the patient's CCRT over treatment. This method also helps to accomplish one of the main aims of the treatment model: to focus the therapist's interventions on the CCRT.

The explicit nature of the teaching of the model during supervision makes the training somewhat different from the not-uncommon mode of dynamic therapy supervision in which the therapist simply presents case material and the supervisor gives comments. We have found that when trained well, therapists have a clear understanding of the treatment model and recite principles learned in supervision frequently. Since many experienced dynamic therapists consider themselves expert clinicians already, it is important to select therapists who are open to a new learning experience. The supervisor, of course, while oriented to teaching trainees, is also aware of the clinical competencies that the therapist brings to the training program and is respectful of the stylistic and personality differences among therapists, as long as such differences do not hinder the effective implementation of the model.

In addition to ongoing individual supervision, we have found that group meetings of therapists and supervisors are useful. Such meetings provide another forum for discussion of the treatment model and of different therapists' experiences with patients and with learning the model. By providing another arena for intellectual exchange with colleagues, group meetings also often help to maintain therapists' morale and commitment to the model.

Adherence and Competence Monitoring, and Certification

Ongoing adherence/competence rating should be performed during the training period. Using the PAS-SE adapted for GAD, the supervisor should rate at least two sessions for each training case. In addition, it is useful to have an independent judge (an experienced SE therapist, supervisor, or tape rater) also rate each training case. These ratings serve several functions: provide structured feedback on the strengths and weaknesses of each trainee; show progress over the training period; and serve as the criterion for "certifying" each therapist as competent to perform SE therapy for GAD. We have not obtained enough research experience with the instrument to propose a cutoff score that meaningfully delineates "competent" from "non-competent" therapists. However, we have used a tentative criterion of an average item rating of 4 on the 1-7 scale that is used for rating the items of the PAS-SE.

EMPIRICAL EVIDENCE FOR THE APPROACH

An open trial of SE for GAD has been performed at the Center for Psychotherapy Research. The goals of this study were several-fold. The first goal was to develop and refine the treatment approach for GAD patients. Aspects of the treatment described in this chapter have emerged from our early experience working with GAD patients. A second goal was to gain several trained SE therapists for future comparative efficacy studies by evaluating their performance in treating GAD patients. Therapists therefore had audiotapes of their sessions rated for adherence to and competence in the SE approach. A third goal of the pilot study was to obtain preliminary efficacy data for the treatment approach. This preliminary data would help justify continuing with further research efforts to establish the efficacy of the treatment.

Three of the five trainees have consistently displayed high ratings of adherence and competence, as rated by their supervisor and an independent judge who rated tapes of their sessions. Using the PASSE (Barber et al., 1992) modified for use with GAD patients, all three of these therapists received an average item rating of 5.0 or greater on the 45-item instrument, indicating excellent application of the techniques. These three therapists each have a minimum of 10 years of post-degree experience. (Two are psychologists, and one is an M.S.W. who also had advanced psychoanalytic training.) Each of the

three therapists has treated (or have in treatment) a minimum of five GAD patients and continues to treat GAD patients on an ongoing basis, under supervision, in an extension of the GAD pilot study. Supervision is provided on an individual basis.

For the 11 patients completing treatment, scores on the Hamilton Anxiety Rating Scale decreased from 16 (SD = 6) to 5.8 (SD = 7) ($p < .005$). Scores on the Beck Anxiety Inventory also decreased considerably (intake mean = 26.2; termination mean = 6.5; $p < .001$). Those patients with initial Hamilton scores greater than 18 also showed marked improvement (mean initial scores = 20.8; termination mean = 8.4). Thus, there is good preliminary evidence that our SE treatment helps patients with GAD, and that we have a group of therapists who have been trained in the treatment manual and are certified as competent. These promising pilot results suggest that our SE treatment for GAD is ready to be tested in a full clinical trial in comparison with other treatments (e.g., medication, cognitive-behavioral therapy). Such a study is the next step in our research program.

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