DYNAMIC THERAPIES FOR PSYCHIATRIC DISORDERS

Supportive-Expressive *Dynamic Psychotherapy* of Depression:

A Time-Limited Version

Lester Luborsky • David Mark
Anita V. Hole • Carol Popp
Barbara Goldsmith • John Cacciola

Supportive-Expressive Dynamic Psychotherapy of Depression: A Time-Limited Version

Lester Luborsky, David Mark, Anita V. Hole,
Carol Popp, Barbara Goldsmith, and John Cacciola

e-Book 2015 International Psychotherapy Institute

From *Dynamic Therapies for Psychiatric Disorders (Axis I)* edited by Jacques P. Barber & Paul Crits-Christoph

Copyright © 1995 by Basic Books

All Rights Reserved

Created in the United States of America

Table of Contents

Supportive-Expressive Dynamic Psychotherapy of Depression: A Time-Limited Version

HISTORY AND DEVELOPMENT1

INCLUSION/EXCLUSION CRITERIA

DYNAMIC ISSUES IN DEPRESSED PATIENTS

TREATMENT GOALS

THEORY OF CHANGE

TECHNIQUES

CASE EXAMPLE

TRAINING

EMPIRICAL EVIDENCE FOR THE APPROACH

REFERENCES

Supportive-Expressive Dynamic Psychotherapy of Depression: A Time-Limited Version

**Lester Luborsky, David Mark, Anita V. Hole,
Carol Popp, Barbara Goldsmith, and John Cacciola**

HISTORY AND DEVELOPMENT[1]

The special form of psychoanalytic psychotherapy that we call supportive-expressive (SE) dynamic psychotherapy was only gradually shaped into its current form. It is an organized compendium of authoritative and representative accounts of psychoanalytic psychotherapy. Its concepts and techniques originated with Freud's recommendations for psychoanalytic psychotherapy (1912/1958, 1913/1958, 1914/1958) and his paper on depression (1917/1957). In the early 1940s these concepts and techniques were shaped to fit the framework of SE psychotherapy by Knight (1949), Gill (1951), and others at the Menninger Foundation, including Ekstein and Wallerstein (1958), who reshaped them into a guide for supervision.

Further organization into a manual was continued by Lester Luborsky after he left the Menninger Foundation in 1959 for the Department of Psychiatry at the University of Pennsylvania. He used the concepts and

techniques of SE dynamic psychotherapy in teaching the department's psychiatric residents and gradually formalized the principles into the general SE dynamic psychotherapy manual (Luborsky, 1976, eventually published in 1984). This progression toward manual making and manual use was at the start of the field's small revolution in practice (Luborsky & DeRubeis, 1984). Today many of the main forms of psychotherapy are developing or have developed their own manuals and measures of adherence to their manuals (Luborsky & Barber, 1993).

The present version of the SE dynamic psychotherapy manual for depression is an adaptation of the general manual (Luborsky, 1984). Some of its concepts and techniques came from experiences in a special form of supervision training in SE dynamic psychotherapy: each trainee gains experience both as a supervisor of his or her peers and as a recipient of supervision from peers (Luborsky, 1993). The first of these yearlong supervision groups was started in September 1987. Shortly thereafter, a similar group was launched at the Department of Psychiatry at the Toronto Women's Hospital (with weekly conference calls that included Drs. Lester Luborsky, Howard Book, Christine Dunbar, Harvey Golombek, Kas Tuters, and Anne Oakley). Further formative experiences came from the application of the manual to the patients in the project on SE dynamic psychotherapy for major depression and chronic depression (Luborsky et al., 1992; Luborsky, Diguer, DeRubeis, Cacciola, Schmidt, & Moras, 1994).

INCLUSION/EXCLUSION CRITERIA

The depressed patients to be treated with the guidance of this manual should be selected by assessments that verify that they fit the *DSM-IV* (APA, 1994) diagnoses of major depression or chronic depression or both. We will therefore use the main points of the *DSM-IV* criteria for these two diagnostic groups because they are the basis for selecting the appropriate patients and because the treatment techniques described in this manual were developed to help therapists deal with these patients' characteristics. The *DSM-IV* diagnostic criteria for major depression include a dysphoric mood or loss of interest or pleasure in the usual activities. The mood includes the symptoms of depression: sadness, hopelessness, and irritability. At least five of the following nine symptoms must be present: depressed mood most of the day; loss of interest or pleasure in most activities; weight or appetite loss; insomnia or hypersomnia; psychomotor agitation or retardation; loss of energy; feelings of worthlessness; slowed thinking; and recurrent thoughts of death. The essential *DSM-IV* diagnostic criteria for chronic depression include a depressed mood for no less than two years and at least two of the following: poor appetite, insomnia or hypersomnia, low energy, low self-esteem, poor concentration, or hopelessness. Details of the diagnostic criteria are given in *DSM-IV* (APA, 1994, pp. 327-344).

DYNAMIC ISSUES IN DEPRESSED PATIENTS

Nine dynamic issues in depressed patients are listed here approximately in order of importance, but they actually work together rather than separately. Some of them will be described more fully later in this chapter.

A sense of helplessness. In Freud's (1926/1959) general theory of symptom formation, it is the expected and remembered state of helplessness that sets off the symptom. Engel and Schmale (1967) further described the complex pre-symptom state as having two parts: (1) "giving-in" (helplessness), followed by (2) "given-in" (hopelessness). Helplessness followed by hopelessness is an especially difficult and central issue in depression; the other dynamic issues listed below feed into this one, as explained later in this chapter.

Vulnerability to disappointment and loss. This vulnerability is described most vividly in *Mourning and Melancholia* (Freud 1917/1957). Freud compares grief with depression. Grief is a response to an actual loss, while depression is a response to an internal loss. A patient's vulnerability is based on difficulty in coping with early childhood experiences of disappointment and loss, and both predispose the patient to later depression.

States of anger turned inward rather than directed outward. The concept of anger turned inward started with Freud (1917/1957) and was elaborated

on by others, including the scoring system for anger turned inward designed by Gottschalk and Gleser (1969). When anger is turned inward, it sets the stage for increased depression; turned outward, it sets the stage for reduced depression.

Vulnerability of the self-esteem. Self-esteem vulnerability is typically based on early injury to self-esteem (Bibring, 1953; Jacobson, 1971). Specific recurrent types of conflicts trigger impairments in self-esteem (as illustrated in the example of Mr. Quinn later in this chapter), which make the patient more vulnerable to depression.

Suicidal ideation and intention. This is a consequence of helplessness—and especially of hopelessness—about being able to deal with one's problems (e.g., Freud, 1926/1959; Beck, Weissman, Lester, & Trexler, 1974; Linehan, Armstrong, Suarez, Allman, & Heard, 1991).

Pessimistic explanatory style. The association of negative (pessimistic) explanatory style with vulnerability to depression has been shown by Seligman (1975). The pessimistic explanatory style for negative events involves three kinds of explanations: (1) it is me (internality); (2) it will always be me (stability); and (3) it is generally me (globality). The core of this style is explaining negative events by blaming oneself rather than external causes. Although the explanatory style concept did not come from the

dynamic tradition, it is compatible with it, and it is an important dynamic factor in setting the stage for depression.

Poor capacity to recognize the state of depression. Patients sometimes lose sight of the fact of being depressed; once they become depressed, the state seems natural and is not recognized as an altered state.

Poor capacity to notice events that trigger depression. For some depressed patients, the depression appears to them to come on of itself; they see little or no causal association with external or associated internal events. As a result, they are deficient in awareness and appreciation of the significance of the external events that trigger their depression.

Inclination to expect negative responses from self and others. Depressed patients often expect negative responses from self or others. But as therapy progresses satisfactorily, patients tend to move toward more positive expectations of self and others (Crits-Christoph & Luborsky, 1990, chap. 9). The shift is partly attributable to a decrease in helplessness and hopelessness and partly to a shift toward a more positive explanatory style for negative events. A similar shift is found in relation to positive outcomes of psychotherapy: More improved patients show a shift toward more positive outcomes and fewer negative outcomes in their relationship narratives.

It is much easier to see the interrelation of these nine dynamic issues in

discussing concrete examples, such as the relationship narrative of Mr. Quinn. That narrative starts with a thought about talking to a woman: he was "just talking to her," and then there was a shift to depression. But in the course of reviewing the thought in the narrative, he was able to fill in what happened before the shift in depression: he thought, "A guy like me could be with her, or [she could be with] a stronger guy. If it's me, then I'm not strong enough. That's what bothered me." Mr. Quinn's readiness to become helpless—dynamic issue number 1—is obvious (although it appears to be out of his awareness): helplessness is his response to a thought that he will fail in comparison with the stronger guy. The thought that he will lose out in competition is part of dynamic issue number 2: vulnerability to disappointment and loss. Dynamic issue number 3, anger, is not evident here. Dynamic issue number 4, vulnerability to self-esteem loss, is very obvious in this example; for this patient, losing out is interpreted as a sign of his failure and lowers his self-esteem. Dynamic issue number 5, suicidal ideation and intention, does not characterize this patient. Dynamic issue number 6, pessimistic explanatory style, is clearly evident: Mr. Quinn explains to himself that he will lose out in a conflict with a stronger guy, that is, his pessimistic explanatory style is based on his deficiency and is therefore an internal explanation. We know from other evidence that this explanation is stable for him and that he thinks it will always be and is generally true. Dynamic issues number 7 and 8 are evident for this patient: at first, he recognizes that the

thought made him "a little tight," but he does not attend to that feeling as related to the shift in depressive tone. Its meaning comes out after he is questioned; the therapist then makes a significant intervention by pointing out the event that triggered the shift toward depression (dynamic issue number 8). Dynamic issue number 9, an inclination to expect negative responds from self and others, is plain in this instance: Mr. Quinn thinks the stronger guy will win out, and he thinks his experience of losing out is based on his own weakness.

TREATMENT GOALS

The general goals for SE dynamic psychotherapy with depressed patients (Luborsky, 1984) include the following three, which amount to a condensed framework for the essential tasks of SE dynamic treatment:

1. To establish a relationship of rapport and trust—the supportive component of SE dynamic treatment. Paying attention to the patient's expressed goals is very important in establishing rapport and trust and leads to a helpful therapeutic alliance.

2. To use rapport and trust to develop an atmosphere in which patients can express what they are thinking and learn to understand what they have expressed—the expressive component of SE dynamic treatment. Understanding can be increased by interpretations that are focused on the central relationship pattern and the conflicts within it.

3. To facilitate maintenance of the gains of the therapy during the treatment period and after its termination.

The process of setting specific goals is especially useful for short-term psychotherapy because of the time limit and because coming to an agreement about goals can rapidly strengthen the alliance, as reviewed by Luborsky (1984). These goals need to be agreed on during the beginning phase of the treatment, especially in the first and second sessions. Goals are to be set in terms of what the patient wants as well as in terms of what can be reasonably accomplished. Usually one of the main goals of these patients is to be relieved of their depression.

THEORY OF CHANGE

The theory of change in SE dynamic psychotherapy explains the onset as well as the overcoming of the patient's symptoms of depression. The theory of how a depressive episode is formed can be derived from Freud's general theory of symptom formation (1926/1959). The symptom forms because the patient evaluates a situation as dangerous; the danger is the recognition of an expected situation of helplessness. The patient then evaluates his or her strength in relation to the magnitude of the danger. The symptom appears as a way to cope with the expected helplessness and the potential anxiety generated by the danger situation. Mr. Quinn's case illustrates this theory: The danger in the situation is that his wish for success

with the girl entails expected competition with a man whom he sees as stronger. The symptom of depression forms when Mr. Quinn expects to fail in that competition and feels helpless to cope with the conflict. For the symptom of depression to form, certain specific vulnerabilities are also involved, as summarized in the listing of the nine dynamic issues.

Four factors are responsible for overcoming the symptoms of depression:

1. The establishment of an alliance, which increases the patient's sense of strength in coping with problems, making symptom formation less likely.

2. The development of self-understanding through (a) more knowledge of the existence of the main relationship patterns and (b) more knowledge of the context of the symptom within the pattern.

3. The development of higher morale about coping and better ways of coping with the conflicts in problem situations.

4. The growth of greater ability to maintain the gains derived from helping relationships. This comes about through the relationship with the therapist by internalization of that relationship and by acquisition of therapy-derived tools for coping with future problems.

TECHNIQUES

Before going into the details of technique, we believe it would be valuable to state the four basic tasks of SE dynamic psychotherapy:

1. Attend to forming an alliance by listening to the patient's goals, coming to an agreement about the main goals, and establishing rapport and trust. These supportive elements begin to take root at the start of the treatment but always go through some ups and downs during the treatment.

2. Formulate the basic relationship pattern by means of the core conflictual relationship theme (CCRT) method. Focus interpretations on aspects of the CCRT so as to nurture the patient's growing awareness of the pattern.

3. Help the patient come to a generally higher morale and acquire ways of coping and mastering the conflicts in the CCRT.

4. Attend to the meanings of separation from the treatment so that they will not interfere with the patient's retention of the gains.

These four specific techniques relate to the general goals of SE dynamic psychotherapy. What distinguishes this adaptation of the general manual for depression is its focus on relieving the depression and on dealing with the associated dynamic issues of depression.

Methods of Introducing the Psychotherapy

This section is partly adapted from Orne and Wender's (1968) preparation interview for psychotherapy. The main points of this introduction can also be presented to the patient as part of the initial evaluation before the psychotherapy.

In the first session, the therapist should ask the patient to describe the main problems and the circumstances surrounding them. This discussion helps to develop an alliance and to focus the work of the psychotherapy, and it also provides the therapist with necessary information about the presenting complaint and its circumstances.

Also in the first session, the therapist should explain the nature of the psychotherapy in these terms: "You are about to start psychotherapy for your depression and other problems. It will help you to know how psychotherapy works. The basic plan is that you will tell what you have to tell about yourself, about events, and about the treatment. I will listen and respond whenever it is likely to be helpful.

"You will gradually get to know your typical pattern of relating to others, to yourself, and to the problems within the pattern connected with your depression.

"You should know that treatment has its ups and downs in terms of the difficulty or ease of making progress. At times it will develop easily, and at

times it will feel stalled. These stalled times may be difficult for you, but they can be the most profitable times of all. One way out of them is to tell me how you feel about the treatment so that we can both problem-solve the difficulty.

"At times you will wish for me to give you advice. Actually, treatment doesn't work that way. Your treatment works best when you, with my help, figure out what's in the way of your moving ahead. Then you will decide how to go. Figuring out how to solve problems will be helpful to you both in the treatment and long thereafter."

Although treatment arrangements will have been discussed in the initial evaluation, the therapist should review them again, including the agreed-upon treatment duration (number of sessions), follow-up sessions, and arrangements for payment of the fee, missed sessions, and so on.

Special Principles of Technique

The techniques listed below are of two kinds: those for learning about each patient's specific thoughts and preconditions for depressive episodes, and those for dealing with the more general dynamic issues that are typical for depressed patients.

Helplessness and Hopelessness

States of helplessness and hopelessness are the most common conditions for depression, as explained by Freud's (1926/1959) theory and by Engel and Schmale's (1965) elaboration of the theory and confirmed by the studies in Luborsky (in press). The therapist can manage these states well by using two methods:

1. The therapist can point to the association of helplessness and hopelessness with the subsequent appearance of depression and say, when appropriate, "Your state of helplessness and hopelessness was followed by the depression as though it was one way for you to try to cope with the helplessness and hopelessness." Such a comment may help the patient to see the depression as a response to the helplessness and hopelessness, not just as an inevitable reaction to the situation.

2. The helplessness and hopelessness can be interpreted in relation to the specific context in which they appear (as described below).

Anger

Recurrent anger in depressed patients is common, according to Freud (1917/1957). His observation is further confirmed in a study of the relationship narratives of patients with major depression by Eckert, Luborsky, Barber, and Crits-Christoph (1990). Sometimes the anger takes indirect forms, such as assuming that the other person does not care,

distancing from the other person, breaking appointments, or chronic lateness.

Anger was recurrent with Ms. Smyth, the patient described later in our case illustration. A patient's anger may in turn ignite anger in the therapist; that potential for contagion is a common countertransference risk and must be dealt with by the therapist. One way a therapist can deal with it, as illustrated in Ms. Smyth's case, is to remain in an empathic position—understanding how the patient becomes angry as a result of the relationship conflicts in his or her central relationship pattern.

Suicidal Ideation and Intention

Hopelessness is sometimes an extreme response to helplessness in situations of danger (reported in Freud's [1926/1959] theory of symptom formation). The basic observation of an association between suicidal intention and hopelessness has been confirmed by the work of Beck and his associates by means of their Hopelessness Scale (1974). The very frequent association of hopelessness with suicidal ideation or intention has an important practical implication—relieving the hopelessness usually relieves the suicidal ideation or intention. The standard way to begin to lessen the hopelessness is to have the patient talk about the situations that led to it. Through this expressive process, the patient often becomes more able to think of ways to cope with hopelessness-inducing situations.

Another time-tested way of handling suicidal intentions is to evaluate their seriousness when the patient first brings up such thoughts and then, if they are serious, to make a pact with the patient in which the patient agrees not do anything self-hurting when the thoughts occur but instead will call the therapist. Patients who make such a pact usually abide by it. The contact, or the availability of contact, with the therapist is usually sufficient to overcome the suicidal intention. If it is not sufficient, it may be necessary to arrange for hospitalization or other protection.

A further source of information in evaluating the potential for suicide is a depression inventory, such as the Beck Depression Inventory (BDI), filled out by the patient before each session. The therapist should check the inventory before and after each session to stay aware of the patient's suicidal risk and level of depression.

A related method of handling suicide intentions or attempts is similar to the method for understanding and dealing with any self-destructive behavior: Find out from the patient whether the behavior was partly intended as a nonverbal message to the therapist. For example, the therapist can ask, "Did you mean for this behavior to give me the message that you were feeling hopeless?" If it was intended as a message, the therapist should try to work out an agreement with the patient to convey these messages in words rather than through self-destructive action. This kind of discussion with the patient

is especially valuable when such behaviors first start to be expressed in the treatment, rather than after the pattern has become habitual. This method was presented in a case discussion at the University of Pennsylvania by John Gunderson on January 15, 1989, on the treatment of suicidal behavior in borderline patients, but his recommendation appears to be generally useful. After such discussion and agreement, some patients are thereafter impressively able to describe their intentions to the therapist rather than show them through actions. The method works by transforming communication through behavior into communication through words.

Negative Explanatory Style

A specific depression-inducing factor has been identified for depressed patients by Seligman, Castellon, Cacciola, and Schulman's research. It is that negative (pessimistic) explanatory styles in response to negative events ("danger situations," in Freud's theory [1926/1959]) help to set off depression. In other words, a person who tends to explain negative events in an internal, stable, and global manner will be more vulnerable to depression than a person who is able to attribute negative events to external, unstable, and local factors. An especially clear illustration of negative explanatory style and its understanding in dynamic terms was provided by the patient Mr. Quinn, who had precipitous depressions during psychotherapy sessions (Luborsky, Singer, Hartke, Crits-Christoph, & Cohen, 1984, pp. 157-193;

Peterson, Luborsky, & Seligman, 1983); these sessions often followed interactions with other people that invoked both his negative explanatory style and his lowered self-esteem. The therapist's interventions reflected an SE dynamic therapist's attempts to make the patient aware of these aspects of the dynamic context for his depressions.

Poor Capacity to Recognize the State of Depression

Some patients find it difficult to recognize when they are depressed. Their depressed state may even feel like a normal state. Such a patient can usually be helped when the therapist simply points out the patient's state and then points to his or her belief that it is a normal state. This kind of feedback from the therapist can be sufficient to improve the recognition of depression. Recognition is sometimes much easier to achieve when it is pointed out at the point of a shift into depression rather than after the depression has continued for a while. Continual feedback to improve recognition of depression may be helpful for some patients.

Poor Capacity to Recognize Depression-Triggering Events

Some depressed patients are not inclined to notice the events that set off their depression, or if they do notice them, they forget them quickly. The events may be external, or they may be a specific kind of thought. For example, Mr. Quinn did not recognize his trigger events, even though they

became obvious to the therapist. These events were thoughts about interactions with others that he interpreted as lowering his self-esteem, as in this very apt example:

> Patient: I dreamt about her ... I don't remember anything remarkable and there was no sex, just talking or something like that (shift to depressed tone), so that made me a little tight.
>
> Therapist: What made you a little tight?
>
> Patient: Just the thought of her, I guess. Oh, I know what it was. You know, I've got it.
>
> Therapist: Uh-huh?
>
> Patient: It was that I said, well, a guy like me could be with her,
>
> or [she could be with] a stronger guy. If it's me, then I'm not strong enough. That's what bothered me.
>
> Therapist: You managed to notice the kind of thought that makes you tight and then discouraged and then depressed: You compare yourself to another man and decide you are not as strong and conclude something is wrong with you.

As in this example, it is often possible to make some patients more aware of their depression-triggering thoughts or events, so that (1) the thoughts or events become less potent at instigating depression, and (2) the thoughts or events become more readily recognized in terms of the core conflictual relationship theme that they show, a recognition that lessens the patient's helplessness in dealing with them.

General Technical Principles of Interpretation: Selecting a Focus and Maintaining It

Use of the Core Conflictual Relationship Theme

Paying attention to the transference-related CCRT is a central technique of SE dynamic psychotherapy for selecting an interpretative focus (Luborsky & Crits-Christoph, 1990). The therapist listens for the redundant components across the narratives patients tell during the course of a session; the CCRT is formulated by recognizing the patient's combination of most redundant wishes, most redundant responses from others, and most redundant responses of self. The CCRT should be a prime candidate for the focus of interpretations because it reliably captures the main relationship conflicts that are evident in the transference, as illustrated in the case illustration of Ms. Smyth, in which a fuller description of the method is given.

Treatment Length and Degree of Focus

As a general principle, the shorter the time limit on the treatment, the more necessary it is to maintain a consistent therapeutic focus. In a 16-20-session treatment, the therapist should keep to the selected focus whenever it is appropriate.

Effects of Consistent Focus

Therapists in the early stages of learning SE dynamic psychotherapy

sometimes raise this question: "When the focus is chosen and the therapist stays focused on it with congruent interpretations throughout the treatment, will the patient and therapist find that it becomes boring?" Our experience is that a consistent focus is not usually a cause for boredom.

What happens instead is that the recurring association between the patient's experiences and the pattern provides more impetus for the patient's growth. Growth is stimulated because patients become more familiar with the shape of their own relationship pattern, and the conflicts within it, and therefore more capable of finding better ways to cope with some aspects of it. Specifically in relation to depression, when the signs of depression appear, patients will be able not only to recognize the state but to control it better by being better able to say to themselves, "I do not need to remain depressed; I can handle in other ways what is pushing me to become depressed."

Deciding Which Part of the CCRT to Interpret and How to Offer It

The CCRT is a complex theme, so it is not appropriate to present routinely the whole CCRT whenever an interpretation is needed. The therapist needs to have principles to guide his or her selection from the CCRT of the facets that are most appropriate for each interpretative occasion. Following are six experience-based principles (all are illustrated by the interpretation for the patient Ms. Simpson, described below):

1. Choose the aspect that fits best with what the patient is able to deal with at the moment and has been able to deal with in the past. A few trial interpretations may help to determine which aspects of the CCRT the patient seems best able to deal with.

2. Choose interpretations that include both the wish and the response from other. This principle is worthy of use because it has evidence to support its efficacy—a correlation has been found between use of such congruent interpretations and the outcome of treatment (Crits-Christoph, Cooper, & Luborsky, 1990).

3. Choose the aspect that fits best with the symptom that is most closely connected with the present suffering.

4. Choose the CCRT aspect that is most intense and most frequent.

5. Concentrate interpretations on the negative components. They are most in need of interpretation, for they tend to impede the treatment the most, as Freud's (1912/1958) principle of technique recommends and as is simply evident in our examples.

6. Choose a manner of offering interpretations that helps the alliance and steers around the resistance, such as "Let's look together at the part of your relationship pattern that might set off your depression" (other presentation modes are in Wachtel, 1993).

Pointing to the Symptom's Context of Relationship Conflict

With any patient who comes to treatment with a prominent symptom, such as depression, it is therapeutically valuable to find the specific context that is related to the manifestation of the symptom. When the symptom emerges directly in the session, the symptom-context method (Luborsky, in press) will help to locate the theme in its antecedents. The expressive techniques of the SE general manual (Luborsky, 1984, chap. 7) will routinely help the therapist to locate the specific context for each patient's symptom, as shown by the CCRT in this example.

Ms. Simpson was selected from a sample of 30 patients (Luborsky, Diguer, DeRubeis, & Schmidt, 1994) with major depression who were treated with time-limited, 16-session SE dynamic psychotherapy (Luborsky & Mark, 1991). She was a 26-year-old, single, white, graduate student who had started psychotherapy in a very depressed state with a *DSM-III-R* diagnosis of major depression. Her CCRT was based on the 10 pretreatment narratives she told as part of a Relationship Anecdotes Paradigm (RAP) interview (Luborsky, 1990b, chap. 7). RAP interviews are specifically designed to elicit relationship narratives. Within the 10 narratives elicited, the CCRT components that appear most frequently constitute the CCRT pattern that is the context for the emergence of the symptom of depression.

In the CCRT given below, the number in parentheses is the number of

narratives out of the 10 (typically half or more of the 10) in which the CCRT components appeared:

Wish 1:1 want to be respected (6)

Wish 2:1 want to be understood (5)

Response from other (RO):

Negative RO1: They are not understanding (5)

Response of self (RS):

Negative RSI: I feel unloved (5)

Negative RS2:1 feel not open (4)

Positive RS3:1 feel I am open (5)

Negative RS4:1 feel depressed (4)

The therapist in the course of treatment continually constructed clinical CCRT formulations as she listened to the patient. In the middle of the fourth session, the therapist responded to the patient's negative interactions with someone the patient depended on with this CCRT-based interpretation: "In these interactions, you clearly felt you couldn't get the respect and understanding you needed, and so you ended up feeling unloved and began to feel depressed."

In very brief treatments of patients with a main outstanding symptom such as depression, the therapist should especially concentrate on interpreting the links between the symptom and the rest of the relationship context in the CCRT, as illustrated in the example above and in the case illustration of Ms. Smyth. That recommendation also applies to longer treatments, but the concentration and correspondence of the interpretations may not need to be as extreme in longer treatments. (See the general SE manual [Luborsky, 1984, pp. 99ff], "Principle 1: understanding the symptoms in the context of relationships").

Eliciting More Concrete Elaborations of Experiences Before Interpreting Them

From time to time the patient refers to certain feeling states or certain events in an obviously incomplete way so that the therapist may have an experience of "looking through a looking-glass darkly." The therapist should try to see into these states or events more clearly and more fully. A good technique is to ask the patient to describe the experience again or tell more about it. Once a state or event has been pointed to by the therapist and the patient has had a chance to attend to it and re-present it, the therapist may find that it is time to interpret the meaning of the patient's experience. This technique will be familiar to experienced dynamic therapists, particularly the advice to give special attention to reexamining the experience of the patient before inferring its meaning. (The technique is more fully explained in Mark &

Faude [chapter 10].)

For example, a patient named Ms. Stanton described an experience of "feeling little, almost fainting, and having an adrenaline rush." The therapist asked her to repeat her description of the experience and to communicate more fully and concretely its content. The therapist subsequently understood it better and said, "So I hear you, you're feeling very little and helpless in relation to me, and that scares and depresses you."

At a later point, the therapist can interpret this same sequence of meanings in relation to other people in Ms. Stanton's life. With some patients, the concrete experiences can be easily reviewed, both in relation to others and in relation to the therapist. As with Ms. Stanton, the experiences that are most likely to be valuable to interpret for depressed patients are those connected with the dynamic theme of an association of helplessness and depression.

Dealing with the Meaning of the Time Limit

Beyond the general meanings of the time limit, patients need to come to terms with the meaning the time limit on the treatment period holds for them. The degree of concern about the limited time for the treatment has a time course. Concern is greatest in the first phase of treatment. As the treatment goes on, both the therapist and the patient accommodate to the

limit. Then apprehensions reemerge as the last phase approaches.

It helps the patient to come to terms with the time limit to be reminded of the length of the treatment. The reminders should be given (a) by the initial evaluator before treatment, (b) by the therapist in the first session when arrangements are discussed, and (c) again by the therapist during later sessions when the termination is anticipated. Even with all of this informing, some patients tend to forget the time-limit arrangements.

Typical questions that patients ask in the process of coming to terms with the time limit include: "What if I'm not ready at the end of 20 weeks?"[2] and, "What if I need a few more sessions at the end?" Reassuring comments by the therapist and the initial evaluator often help to explain to the patient the 20-session treatment length: "We have found that this length of treatment generally provides enough benefit so that the gains can be maintained thereafter. We will also have a meeting with you six months after termination to see how you are doing."

Therapists also need to accommodate to the brief time limit. The therapist's concerns are reflected in such questions in the supervision as, "How can I treat such a severely ill person in such a short time?" and, "How can I make a strong enough bond in such a short time?"

Therapists' concerns usually decrease as they gain experience with the

short-term format, and their confidence increases as they perceive several assets of the short-term format:

1. The pretreatment agreed-upon time limit tends to limit the degree of the patient's regression. It may be that the containment of regression is mediated by the patient taking the attitude: "I need not worry so much about getting overinvolved in the treatment because there are clear limits to my contact with the therapist." In fact, as Mann (1973) has observed, few patients appear to be hurt by the short-term time-limited experience, and its counter-regressive effect may contribute to the benefit.

2. Therapists and patients soon see that worthwhile benefits are being derived from the treatment, and that realization limits their concern about the treatment's agreed-upon brevity.

3. The time limit itself may accelerate the patient's growth by a greenhouse effect—the growth-inducing atmosphere is stimulated by an urgency to move toward the goals in the allotted time. This greenhouse effect may also be fostered when the therapist consistently keeps the interpretative focus on the relationship conflicts that impede the patient's growth. It is as if the amount of needed change remains constant but must be fitted into the shorter time period. Thus, what is seen in time-limited therapy is not a truncated treatment but a complete treatment condensed into the shorter time. The therapist and patient appear to sense what needs to be accomplished, and their attempts to accomplish it are shaped by the time period.

Scheduling Sessions and Payment of Fees

The therapist (and the initial evaluator, if there is one) provides the patient with an orientation about fees and attendance. Both the evaluator and the therapist can tell the patient: "Try to settle on an appointment time that you can keep regularly. Try not to miss any of the 20 sessions that are scheduled." The patient may also be told: "If a problem comes up and you can't make a session, please let me know at least 24 hours in advance. I hold your session open for you. It is your session. In this kind of work, it is not possible for me to fill unplanned missed sessions, so I may charge you for such sessions. But with enough notice, it *may* be possible to change the time of a session, if the schedule permits." The fee becomes less of a potential problem when the arrangement with the patient is for payment at the beginning or end of each session rather than for a monthly bill.

The time duration of the treatment should be adhered to. If the patient wants to extend the spacing of the sessions, for example, to every other week, the therapist may say, "We might lose some of the continuity of the treatment. The treatment works best when a weekly schedule is maintained."

Dealing with Termination: The Interactive Collision of Attachment and Separation

The idea of termination generates concerns in all patients, especially those in short-term treatment (Luborsky, 1984, chap. 9). Their concerns

revolve around attachment and separation. The first part of the treatment shows the fears and satisfactions of making an attachment; the second part shows the fears and satisfactions of the impending separation.

In the middle or late-middle stage of the treatment, the patient increasingly senses the approach of separation; its approach often arouses the irrational fear that the termination will be a catastrophic loss. Typically accompanying this fear is a pre-termination loss of the therapy's gains. But then there is a usually successful method for dealing with such pre-termination loss. The therapist needs to help the patient examine the meanings of the upcoming termination. Often it is discovered that the patient not only fears the loss of the therapist but with it the loss of ability to use the tools acquired during the treatment. The patient then realizes that the tools are part of the patient and can be used when the therapist is not present. Then the gains tend to become reinstated.

This method is part of a broader principle for dealing with termination —the therapist should attend to what is needed to ensure the lasting quality of the patient's gains. The three sections below discuss some specific guides for dealing with special types of termination issues.

Continuation of Therapy Beyond the Time Limit

As part of the initial orientation, the evaluator and later the therapist

present this position about continuing the sessions beyond the agreed-upon limit: "Our intention is to provide 20 sessions. This amount of therapy is likely to help you. After that you will probably be able to manage without our regularly scheduled sessions. Your progress will be evaluated at the end of therapy, and your needs then reconsidered."

Not surprisingly, a few patients near the end of the 20 weeks express the wish to continue. It can be helpful to have the patient explain more about this wish. If there is no emergency or danger to the patient and the patient appears to have made gains, the therapist may respond by asking the patient to wait for about six months and then return to reevaluate the need for further therapy. The exact interval of waiting is to be decided by the therapist and patient. The therapist may explain this response to the patient in these terms: "Sometimes the benefits of the treatment require more time to become integrated and effective, and therefore you should wait before coming back" (as in Mann's [1973] procedure).

During the therapist's discussion of how the patient will manage after treatment, it can be useful to make the point that the agreed-upon 20-week period is a time to become familiar with the everyday use of the tools of self-management. During and after this period, the patient has an opportunity to apply them and so will be able to make further improvements even after the treatment.

If there really is not enough time to review the meaning of the patient's concerns about termination, the therapist may sometimes set up an extra session or two for this purpose. In our experience, this option is taken for only those few patients who the therapist believes need the extra time to work through the meaning of termination.

Patients may raise further questions and need clarification about the finite nature of the time limit. For example, "What does it mean that I can't see you after the 20 sessions are over?" The therapist can explain that termination of sessions is part of the mode of the short-term time-limited treatment that the therapist and patient planned at the onset. But if an additional session or two to work through the meaning of the termination is likely to be insufficient and the patient needs treatment immediately, the therapist can suggest a referral. Another alternative is for the therapist, after the six months, to continue with the patient for an additional period.

"Booster" Sessions

Another way to deal with additional sessions is to use a few "booster" sessions: planned, widely spaced sessions convened between the termination and the follow-up. Booster sessions have been used routinely at the Center for Cognitive Therapy and the Center for Dynamic Therapy at the University of Pennsylvania. If the follow-up period is six months, one session would be one

month later, and another would be scheduled for three months after termination. If the follow-up period is one year, the first booster session would be one month later, the second three months after that, and the third three months after that.

Booster sessions offer another important advantage to the treatment (Whisman, 1990): They can foster the sense of maintaining contact with the therapist and the therapy and therefore further the consolidation of the gains. Booster sessions appear to be generally valuable, especially for patients who have difficulty with internalizing the benefits of helpful relationships.

The plan for these booster sessions is best presented during the orientation before the start of treatment and again in the initial sessions. It is better to inform the patient at these times rather than at the end of treatment so that the plan for boosters will be understood as a part of the planned arrangements. If the patient is told only at the end, the booster sessions could be misconstrued as having other meanings, such as the therapist's need to hold on to the patient or the therapist's uncertainty about the durability of the benefits of the treatment.

The patient can be told, "These review sessions are part of the routine arrangement," and, "They will give us an opportunity to review the treatment during the follow-up period after it is completed." It is useful to distinguish

between "the treatment period" and "the follow-up period." By keeping that distinction clear, the patient will go through much of the process of termination by the end of the treatment period.

Referral After Therapy

If the patient remains in a precarious state and the therapy has not altered his or her depression, the therapist should reevaluate the patient for referral to other treatments for depression, particularly pharmacological ones, either in combination with psychotherapy or alone.

For patients who are still very depressed by the beginning of the last month of treatment, some planning for referral might be begun at that time. Before communicating this intention to the patient, the therapist should keep in mind the possibility that the approach of termination may have an integrating effect and produce unexpected improvement, not just a plateau or a disintegrative effect. But when the therapist concludes that the patient is not likely to pull out of the depressed state during the remaining allotted sessions, the referral possibilities need to be discussed, whether for continuation of the same kind of treatment or for alternative treatments. (The choices for referral may be limited by the patient's finances; for example, because the patient sample in the study of major depression was mostly a low-income group, paying approximately $30 per session, the choices for

referral were limited.)

When a Patient Is Concerned About Not Receiving Medication

Sometimes an arrangement is made between the initial evaluator and the patient before the beginning of treatment to refrain from taking medications for depression, anxiety, or sleep disturbance, as in the major and chronic depression study (Luborsky et al., 1994). Despite the initial agreement, some patients remain concerned about this arrangement, especially in the current climate of controversy about which kinds of depression require antidepressant medications. The Elkin et al. (1989) study reinforces such concerns: although the patients in all treatments compared showed benefits, imipramine plus clinical management was generally best, but not by much, as compared with the two psychotherapies. The slight advantage for imipramine plus clinical management was for the most severe of the patients in this group.

The patient's question about medication needs to be discussed to be better understood. Such discussion tends to be helpful to the patient. Usually the patient is concerned that the psychological treatment by itself may not alleviate the depression. Such a concern should also be addressed directly by both the initial evaluator and the therapist. For example, "Our intention is to have the treatment progress without medications for depression, anxiety, or

sleep disturbance because we expect that these difficulties will be helped by the psychotherapy."

Deciding to Use Antidepressant Medication

If it becomes necessary, nevertheless, to use antidepressant, antianxiety, or sleep medication during the course of the treatment (as it was for 3 of the 30 patients in our major depression study), it is a good practice to use a highly experienced outside consultant for a separate opinion. The patient can then have an evaluative interview with the outside consultant before the medication is decided upon and begun.

The Initial Evaluator's Adjunctive Role

The functions assigned to the evaluator were useful to the treatment in our study of time-limited psychotherapy for major depression (Luborsky et al., 1994). Those functions include more than the selection of the patients; the evaluator also orients the patients to the nature of the treatment. It is worth noting that formal preparation for the treatment generally increases the benefits of psychotherapy—four of six studies have shown a significant added benefit from formal preparation (Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988).

The evaluator's role also goes beyond selection and initial orientation of

the patients. The five hours of contact with the evaluator during the initial assessment and the evaluator's part in the evaluations at termination and at follow-up mean to some patients that the evaluator is a resource person who can help with certain kinds of issues that appear even after the patient is launched in the therapy. For example, Mr. Johnson, a patient who was about halfway through a 16-session time-limited therapy for major depression, called the evaluator to say that he would not be able to continue coming to treatment because he no longer could afford it. The evaluator was able to help him by providing information about the fees and by encouraging him to review the issue with his therapist.

CASE EXAMPLE

The example of Ms. Smyth (SE17 in the major depression study) illustrates (1) how a helping alliance is formed, (2) how to use the relationship episodes in a session to derive the CCRT (Luborsky, 1990a, chap. 2), and (3) how to use the CCRT to focus the interpretations (Luborsky, 1990a).

Ms. Smyth was a 32-year-old single woman and recovering alcoholic who came for treatment for depression. Besides her long-term dysthymia (chronic depression), she had become severely depressed (major depression) when she flunked out of a training course. Her *DSM-III-R* diagnosis, based on

the initial evaluation, was major depression with dysthymia.

The therapy began inauspiciously when she showed up half an hour late and then said she was unable to schedule the next appointment. The therapist felt angry but contained her anger, using her awareness of it to understand and empathize with what Ms. Smyth was doing in the interaction with her. When Ms. Smyth said she was afraid of "sabotaging herself," the therapist replied that she thought she was correct to be afraid. Although Ms. Smyth continued to have difficulty keeping appointments, she nevertheless responded to the treatment remarkably well, much to the surprise of the therapist, who noted in her final report that she "had not expected that someone with such severe depression and who already was making full use of self-help via therapeutic groups, such as AA, could have resolved her depression without the use of psychopharmacology."

In the termination interview, Ms. Smyth said that she was feeling good and that "everything is a lot better." She was less pessimistic and more confident and hopeful. She felt she could take care of herself and no longer seemed as disorganized as she had been during the initial evaluation. She was working regularly in a clerical job, and she had set up a stable living arrangement with a female roommate.

At six months post-termination, she had remained free of depression.

Her BDI was 9. She had continued working full-time at the same job. She found she was pregnant by the man she had been seeing for the last five months of the treatment. She plans to be married, but her boyfriend is uncertain. She is angry and anxious but feels that she can handle whatever happens and knows that she will have the baby. She and her boyfriend have started weekly couples therapy and will continue it.

The helping relationship appeared to have been formed largely when the therapist communicated her intention to be helpful and caring about Ms. Smyth's best interests and concerns. This caring message was also conveyed to Ms. Smyth, however, in the therapist's interpretative focus on her maintenance of self-hurting relationships with a boyfriend and others who were painfully the opposite of caring and helpful. The therapist was surprised at Ms. Smyth's good response to the therapy, but it is not uncommon that a good alliance forms as a consequence of a therapist's correct interpretative focus.

An example is given in Table 2.1, which outlines Ms. Smyth's third session: (1) the four relationship episodes scored according to CCRT components; (2) the CCRT frequency, a summary of the scored relationship episodes, and (3) samples of accurate interpretations based on the CCRT. The therapist examined the relationship episodes with each of the four people who were the subject of Ms. Smyth's narratives. (The four relationship

episodes are listed but not given in full here.) Also listed are the wishes (W), responses from other (RO), and responses of self (RS). The overall CCRT is evident in all four relationship episodes.

The use of the CCRT to help show the relationship context in which depression appears is illustrated by two sample interpretations given at the bottom of Table 2.1. In each interpretation, special prominence is given to the symptom by including the associated relationship conflicts involved in its appearance. For example, the therapist said, "I see you get depressed after you deal with people who won't give you what you need." This is an "accurate" interpretation in the sense that it fits with the CCRT.

TABLE 2.1 Using the CCRT to Interpret Four Relationship Episodes in Session 3 of the Therapy of Ms. Smyth

CCRT Components in Each Episode			
The Other Person in the Relationship Episode (RE)	Wish(W)	Response from Other (RO)	Response of Self (RS)
RE1: Therapist	I want treatment (but have no money) (Wl)	Will not give treatment without money (ROl)	Unhappy and depressed (RSI)
RE2: Ex-employer	I want job and help (Wl)	replaces (fires) me (ROl)	Get helpless (RS2); discouragement and depression (RSI)
RE3: Brother	I want care (Wl)	Treats me badly	Get angry (RS3);

		(ROl)	discouragement and depression (RSI)	
RE4: Boyfriend	I want him to care (Wl)	Gives no support (ROl)	Crying, sad (RSI); anger (RS3)	
Number of Episodes with Each Component				
W1 (Getting Care and Support): 4	ROl (Rejects): 4	RS1 (Discouragement and Depression): 4	RS3 (Anger): 2	RS2 (Helplessness):1
Sample of "Accurate" Interpretations Based on the CCRT				
"I see you get depressed after you deal with people who won't give you what you need."				
"You could see me as one of those people."				

TRAINING

A good background for learning SE dynamic psychotherapy, as specified in this manual and in the general manual (Luborsky, 1984), is sufficient training and clinical experience in psychoanalysis or psychodynamic psychotherapy. Beyond clinical experience in dynamic therapies, supervision is needed for specific training in SE dynamic psychotherapy. The mainstay for this experience is the treatment of patients under supervision, along with reading and rereading this manual to learn the specific ways to maximize the curative factors in SE dynamic psychotherapy (Luborsky, 1993). It is not possible, of course, to learn to conduct this therapy just by reading the manual.

The supervision methods come in two formats: inpidual and group. The inpidual format consists of regular meetings with the supervisor to discuss the supervisee's tapes, which will have already been listened to by the supervisor. The group format is a newer method of training based on learning how to supervise and be supervised by other therapists who are part of a peer group of therapists (Luborsky, 1993). This training includes practice in CCRT scoring of sample cases as well as in using the CCRT in psychotherapy.

A major part of the supervision consists of evaluations of the therapist's adherence to the principles and techniques of the manual, in both clinical and clinical research applications. Several forms of training have been shown to improve adherence to the manual (Butler & Strupp, 1993; Luborsky & Barber, 1993). In one clinical research training system, independent judges experienced with the manual listen to the sessions and evaluate them on the degree of adherence to the recommendations of the manual (for two sessions early in training and two later in training). The adherence/competence scale is a 45-item scale developed by Barber and Crits-Christoph (1994). An earlier 4-item scale was used in Luborsky, McLellan, Woody, O'Brien, and Auerbach (1985). Experience with this adherence scale will allow trainers to set cutoffs for acceptable adherence.

EMPIRICAL EVIDENCE FOR THE APPROACH

Several kinds of empirical evidence for the efficacy of SE dynamic psychotherapy are available. Some of the evidence is from reviews of studies of outcomes of dynamic psychotherapy. This evidence probably applies to SE dynamic therapy, although most of the studies cover dynamic psychotherapy more generally. The earliest review is Luborsky (1987), which examines studies of dynamic psychotherapy versus other psychotherapies. Its conclusion is the usual one: There is no significant difference in outcome measures between dynamic psychotherapy and other psychotherapies. The same conclusion had been reported by a meta-analytic review of studies of all types of therapies (Smith, Glass, & Miller, 1980). An even more systematic meta-analytic review by Crits-Christoph (1992) also shows evidence for the efficacy of dynamic psychotherapy versus other psychotherapies. A larger meta-analysis of 13 comparative treatment studies of dynamic and other psychotherapies (Luborsky, Diguer, Luborsky, Singer, & Dickter, 1993) showed benefits from each treatment, as well as the usual nonsignificant difference between treatments.

Some of the evidence comes from studies specifically of SE dynamic psychotherapy, approximately as delineated in this manual. Two of the 13 dynamic psychotherapy studies reviewed in Luborsky et al. (1993) evaluated SE dynamic psychotherapy for the treatment of addiction; in both studies, significant and sizable treatment effects were shown (Woody et al., 1983; Woody, McLellan, Luborsky, & O'Brien, 1994). In the most recent study

(Luborsky, Diguer, DeRubeis, & Schmidt, 1994), SE dynamic psychotherapy was used to treat patients diagnosed with major depression or chronic depression. Results were significant, although the benefits were probably limited by the number of very seriously ill patients in the sample. Termination scores were very significantly better than intake scores on the BDI, the Hamilton Depression Scale, and the Global Assessment Scale. The benefits shown at termination were maintained at follow-up.

REFERENCES

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.

Barber, J. P., & Crits-Christoph, P. (1994, June). *Development of an adherence/competence rating scale for supportive-expressive dynamic psychotherapy.* Paper presented at the international meeting of the Society for Psychotherapy Research, York, England.

Beck, A. T., Weissman, H., Lester, D., & Trexler, L. (1974). The measurement of pessimism: The Hopelessness Scale. *Journal of Consulting and Clinical Psychology,* 42, 861-865.

Bibring, E. (1953). The mechanism of depression in affective disorders. In P. Greenacre (Ed.), *Affective disorders* (pp. 13-48). New York: International Universities Press.

Butler, S., & Strupp, H. (1993). Effects of training experienced dynamic therapists to use a psychotherapy manual. In N. Miller, L. Luborsky, J. P. Barber, & J. Docherty (Eds.), *Dynamic psychotherapy research: A handbook for clinical practice* (pp. 191-210). New York: Basic Books.

Crits-Christoph, P. (1992). The efficacy of brief dynamic psychotherapy: A meta-analysis. *American Journal of Psychiatry*, 149,151-158.

Crits-Christoph, P., Cooper, A., & Luborsky, L. (1990). The measurement of accuracy of interpretations. In L. Luborsky & P. Crits-Christoph, *Understanding transference: The CCRT method* (pp. 173-188). New York: Basic Books.

Crits-Christoph, P., & Luborsky, L. (1990). Changes in CCRT pervasiveness during psychotherapy. In L. Luborsky & P. Crits-Christoph, *Understanding transference: The CCRT method* (pp. 133-146). New York: Basic Books.

Eckert, R., Luborsky, L., Barber, J. P., & Crits-Christoph, P. (1990). The CCRT in patients with major depression. In L. Luborsky & P. Crits-Christoph, *Understanding transference: The CCRT method* (pp. 222-234). New York: Basic Books.

Ekstein, R., & Wallerstein, R. (1958). *The teaching and learning of psychotherapy.* New York: Basic Books.

Elkin, I., Shen, T., Watkins, J., Imber, S., Sotsky, S., Collins, J., Glass, D., Pilkonis, P., Leber, W., Docherty, J., Fiester, S., & Parloff, M. (1989). National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program: General effectiveness of treatments. *Archives of General Psychiatry,* 46, 971-983.

Engel, G., & Schmale, A. (1967). Psychoanalytic theory of somatic disorder: Conversion, specificity and the disease onset situation. *Journal of the American Psychoanalytic Association,* 15, 344-365.

Freud, S. (1958). Recommendations to physicians practicing psychoanalysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 111-120). London: Hogarth Press. (Original work published 1912)

Freud, S. (1958). On beginning the treatment (further recommendations on the technique of psycho-analysis). In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 121-144). London: Hogarth Press. (Original work published 1913)

Freud, S. (1958). Remembering, repeating and working through. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 145-156). London: Hogarth Press. (Original work published 1914)

Freud, S. (1957). *Mourning and melancholia.* In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 243-258). London: Hogarth Press. (Original work published 1917)

Freud, S. (1959). *Inhibitions, symptoms and anxiety.* In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 20, pp. 87-174). London: Hogarth Press. (Original work published 1926)

Gill, M. (1951). Ego psychology and psychotherapy. *Psychoanalytic Quarterly*, 20, 60-71.

Gottschalk, L., & Gleser, G. (1969). *The measurement of psychological states through the content analysis of verbal behavior.* Berkeley: University of California Press.

Jacobson, E. (1971). *Depression.* New York: International Universities Press.

Karasu, B. (1990). Toward a clinical model of psychotherapy for depression I: Systematic comparison of three psychotherapies. *American Journal of Psychiatry, 147,*133-147.

Knight, R. P. (1949). A critique of the present status of the psychotherapies. *Bulletin of the New York Academy of Medicine,* 25,100-114.

Linehan, M., Armstrong, H., Suarez, A., Allman, D., & Heard, H. (1991). Cognitive-behavioral treatment of chronically para-suicidal borderline patients. *Archives of General Psychiatry,* 48,1060-1064.

Luborsky, L. (1976). *A treatment manual for supportive-expressive (SE) psychoanalytically oriented psychotherapy.* Unpublished manuscript version of Luborsky (1984).

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive (SE) treatment.* New York: Basic Books.

Luborsky, L. (1987). *A review of comparative treatment studies of dynamic psychotherapies versus other psychotherapies.* Unpublished manuscript, University of Pennsylvania.

Luborsky, L. (1990a). A guide to the CCRT method. In L. Luborsky and P. Crits-Christoph, *Understanding transference: The CCRT method* (pp. 15-36). New York: Basic Books.

Luborsky, L. (1990b). The Relationship Anecdotes Paradigm (RAP) interview as a versatile source of narratives. In L. Luborsky & P. Crits-Christoph, *Understanding transference: The CCRT method* (pp. 102-113). New York: Basic Books.

Luborsky, L. (1993). How to maximize the curative factors in dynamic psychotherapy research. In N. Miller, L. Luborsky, J. P. Barber, & J. Docherty (Eds.), *Dynamic psychotherapy research: A handbook for clinical practice* (pp. 519-535). New York: Basic Books.

Luborsky, L. (in press). *The symptom-context method: Solving and resolving symptoms in psychotherapy.* Washington, DC: APA Books.

Luborsky L., & Barber, J. P. (1993). Benefits of adherence to psychotherapy manuals, and where to get them. In N. Miller, L. Luborsky, J. P. Barber, & J. Docherty (Eds.), *Dynamic psychotherapy research: A handbook for clinical practice* (pp. 211-226). New York: Basic Books.

Luborsky, L., Barber, J. P., Schmidt, K., Redei, E., Prystowsky, M., Levinson, A., Cacciola, J., Crivaro, A., & Schretzenmair, R. (1992, June). *Depression and immune-competence: Do they inversely interact during psychotherapy?* Paper presented at the meeting of the Society for Psychotherapy Research, Berkeley, CA.

Luborsky, L., & Crits-Christoph, P. (1990). *Understanding transference: The CCRT method.* New York: Basic Books.

Luborsky, L., Crits-Christoph, P., Mintz, J., & Auerbach, A. (1988). *Who will benefit from psychotherapy? Predicting therapeutic outcomes.* New York: Basic Books.

Luborsky, L., & DeRubeis, R. (1984). The use of psychotherapy treatment manuals: A small revolution in psychotherapy research style. *Clinical Psychology Review,* 4, 5-14.

Luborsky, L., Diguer, L., DeRubeis, R., Cacciola, J. Schmidt, K., & Moras, K. (1994, February). *The efficacy of dynamic psychotherapy for major depression versus for chronic depression.* Paper presented at the NIMH methodology conference on research on treatment of chronic and recurrent anxiety and mood disorders, Bethesda, MD.

Luborsky, L., Diguer, L., Luborsky, E., Singer, B., & Dickter, D. (1993). The efficacy of dynamic psychotherapies: Is it true that everyone has won so all shall have prizes? In N.

Miller, L. Luborsky, J. P. Barber, & J. Docherty (Eds.) *Psychodynamic treatment research: A guide for clinical practice* (pp. 497-518). New York: Basic Books.

Luborsky, L., & Mark, D. (1991). Short-term supportive-expressive psychoanalytic psychotherapy. In P. Crits-Christoph & J. P. Barber (Eds.), *Handbook of short-term dynamic psychotherapy* (pp. 110-136). New York: Basic Books.

Luborsky, L., McLellan, A. T., Woody, G. E., O'Brien, C. P., & Auerbach, A. (1985). Therapist success and its determinants. *Archives of General Psychiatry,* 42, 602-611.

Luborsky, L., Singer, B., Hartke, J., Crits-Christoph, P., & Cohen, M. (1984). Shifts in depressive state during psychotherapy: Which concepts of depression fit the context of Mr. Q's shifts? In L. N. Rice & L. S. Greenberg (Eds.), *Patterns of change* (pp. 157-193). New York: Guilford Press.

Mann, J. (1973). *Time-limited psychotherapy.* Cambridge, MA: Harvard University Press.

Mark, D., & Faude, J. (1995). Supportive-expressive therapy of cocaine abuse. In J. P. Barber & P. Crits-Christoph (Eds.), *Dynamic therapies for psychiatric disorders (axis I)* (pp. 294-331). New York: Basic Books.

Orne, M., & Wender, P. (1968). Anticipatory socialization of psychotherapy: Method and rationale. *American Journal of Psychiatry,* 124, 88-98.

Peterson, C., Luborsky, L., & Seligman, M. E. P. (1983). Attributions and depressive mood shifts: A case study using the symptom-context method. *Journal of Abnormal Psychology,* 92, 96-103.

Seligman, M. (1975). *Helplessness: On depression, development and death.* San Francisco: Freedman.

Seligman, M., Castellon, C., Cacciola, J., & Schulman, P. (1988). Explanatory style change during cognitive therapy for unipolar depression. *Journal of Abnormal Psychology,* 97,13-18.

Smith, M., Glass, E., & Miller, T. (1980). *The benefits of psychotherapy.* Baltimore: Johns Hopkins

University Press.

Wachtel, P. (1993). *Therapeutic communication: Principles and effective Practice.* New York: Guilford Press.

Whisman, M. A. (1990). The efficacy of booster maintenance sessions in behavior therapy: Review and methodological critique. *Clinical Psychology Review,* 10,155-170.

Woody, G., Luborsky, L., McLellan, A. T., O'Brien, C., Beck, A. T., Blaine, J., Herman, I., & Hole, A. V. (1983). Psychotherapy for opiate addicts: Does it help? *Archives of General Psychiatry,* 40, 639-645.

Woody, G., McLellan, A. T., Luborsky, L., & O'Brien, C. (1994, February). Psychotherapy for opiate addiction in three community programs. Paper presented at the meeting of the North American Society for Psychotherapy Research, Santa Fe, NM.

Notes

1 With thanks for the editors' shaping and for suggestions by the 1993-94 Psychotherapy Practicum participants: Dr. Brian Esch, Dr. Rajni Lad, and Ms. Suzanne Johnson.

2 Most of our experience with this manual was with a 16-session limit for major depression and a 20-session limit for most of the patients with chronic depression (Luborsky et al., 1994). We use these numbers in the text, although the short-term limit in other samples may be anywhere from 12 to 40 sessions.