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### A programmatic study of short-term psychodynamic psychotherapy: Assessment, process, outcome, and training

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## EARLY CAREER AWARD

# A programmatic study of short-term psychodynamic psychotherapy: Assessment, process, outcome, and training

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### Abstract

The author reviews findings from his research program on short-term psychodynamic psychotherapy. A hybrid model of psychotherapy research is outlined that integrates efficacy and effectiveness methodology to examine interrelated issues regarding (a) psychological assessment, (b) psychotherapy process, (c) treatment outcome, and (d) training of graduate clinicians. The integration of applied clinical research initiatives into a doctoral training program, clinical implications, and directions for future research are also presented.

When asked by the editors to reflect on my intellectual journey in psychotherapy research, I am invariably drawn to two studies that appeared near the end of my graduate training. The first, by the Task Force on Promotion and Dissemination of Psychological Procedures (1995), discussed empirically validated psychological treatments, and the second, by Seligman (1995), focused on the effectiveness of psychotherapy. Like many psychologists who actually see patients, my initial reaction to the Division 12 task force report was generally negative. Nevertheless, I recognized that empirical evaluation of treatment change was both a responsible and a useful endeavor. My reaction to Seligman's article, on the other hand, included a deep appreciation that someone had clearly articulated the differences, strengths, and weakness of both efficacy and effectiveness research paradigms. What I learned from Seligman's original (1995) and follow-up (1996) articles was that both of the efficacy and effectiveness perspectives, which respectively focus on experimental control and clinical utility, complement one another, eliminate alternative hypotheses, and thereby answer vital questions regarding the validity of psychotherapy. Therefore, it seemed to me that a methodology of psychotherapy research

integrating aspects of both effectiveness and efficacy design was urgently needed, and it has been the implementation of this work that defined my early career focus.

### A Hybrid Model of Psychotherapy Research

The treatment research program I subsequently developed attempts to integrate the rigor of efficacy methods within the external validity of an effectiveness model, examining interrelated issues of psychological assessment, clinical process, and treatment outcomes of psychodynamic psychotherapy (Adelphi University Psychotherapy Project; Hilsenroth, 2002). Specifically, this treatment program integrates the assessment and technique training components of an efficacy model within an effectiveness design (Seligman, 1995, 1996). Incorporation of these efficacy features in a naturalistic treatment setting allows for the measurement of therapist activity in a less rigidly specified treatment procedure, one that is closer to real-world service delivery. In related terminology developed by the American Psychological Association's task force on describing the scientific evidence for treatment guidelines, the current model attempts to incorporate design

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features from the treatment efficacy dimension while ultimately pursuing the clinical utility dimension (Stricker et al., 1999).

Several procedural aspects were put in place to capitalize on both effectiveness and efficacy aspects of this hybrid model. To increase generalizability, this program, unlike those from an efficacy model, includes all patients regardless of comorbidity (i.e., Axis II), and there is no arbitrary time limit on the treatment. Although this program uses treatment manuals for intensive training in technique, they are used to aid, inform, and guide the treatment rather than prescribe it. Therapists are thus encouraged to provide the interventions in an optimally responsive (Stiles, Honos-Webb, & Surko, 1998) manner instead of producing a high volume of specific techniques within a predetermined session framework. This program, therefore, more closely approximates a naturalistic examination of patient change during psychodynamic psychotherapy as delivered in the community.

This desire to organize research initiatives that can inform applied clinical practice emanates from the mentoring I received during my undergraduate, graduate, as well as internship training and provided me with preparation in how to organize a comprehensive psychological assessment protocol.<sup>1</sup> These experiences demonstrated to me that a

multimethod approach to assessment is essential for accurate diagnosis, treatment planning, and evaluation of change (Leary, 1957; Rapaport, Gill, & Schafer, 1968; Strupp, 1996). This approach assumes that individuals are multidimensional beings who vary from one another and, from time to time, in the way they view themselves (self-perception), the way others view them (social perception), and how underlying dynamics influence their behavior (motivation, fantasy, ideals). Assessment from this model seeks a complex understanding of an individual rather than focusing on just one facet of behavior. It allows for problems of comorbidity, a range of severity levels, symptom overlap, complexity, and change in relation to therapeutic intervention.

Outcomes in this program are thus evaluated from three perspectives: patient (self-report and free response), therapist, and external raters (by means of videotape). Measures include well-normed questionnaires evaluating psychiatric symptoms, social and interpersonal functioning, dynamic personality characteristics, operationalized behavioral criteria, and survey material. This array of measures assesses changes across a broad range of domains, including productivity at work, quality of interpersonal relations, improvement on the presenting problem, satisfaction with treatment, and

Table I. Adelphi University: Psychodynamic Psychotherapy Treatment Team Assessment Schedule

	Session no.		
Intake assessment	3	9/15/27/36/64	21/52/76/Final
	Patient		
Self-report		Self-report	Self-report
Rorschach	Session process	Session process	Session process
EM protocol	Therapeutic alliance	Therapeutic alliance	Therapeutic alliance
Session process			
Therapeutic alliance			
	Therapist		
Semistructured	Psychodynamic		Psychodynamic
Clinical interview	Q sort and ratings	DSM-IV multiaxial	Q sort and ratings
DSM-IV multiaxial	DSM-IV multiaxial	Session process	DSM-IV multiaxial
Session process	Session process	Therapeutic alliance	Session process
Therapeutic alliance	Therapeutic alliance		Therapeutic alliance
	External rater (videotape)		
	Psychodynamic		Psychodynamic
DSM-IV multiaxial	Q sort and ratings	DSM-IV multiaxial	Q sort and ratings
Session process	DSM-IV multiaxial	Session process	DSM-IV multiaxial
Therapeutic alliance	Session process	Therapeutic alliance	Session process
	Therapeutic alliance		Therapeutic alliance

Note. EM = early memory; DSM-IV = *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; American Psychiatric Association, 1994).

<sup>1</sup>I warmly thank Edwin Wagner, Len Handler, Drew Westen and Mark Blais for this important guidance.

global well-being. As evident in Table I, these measures are administered longitudinally: before beginning treatment, at standardized points during the treatment, and at termination. At the end of treatment, patients complete an exit evaluation. Thus, measures of clinical assessment and psychotherapy process can be evaluated in relation to outcome. Additionally, this program is distinctive in that it is one of the first to examine the effects of a psychological assessment process itself on the ensuing treatment.

### Psychological Assessment

Pretreatment assessment in this program consists of four steps, including three meetings between the clinician and patient and a patient appointment to complete a battery of self-report measures. The three meetings, all of which are videotaped, include (a) a semistructured diagnostic interview and early memory (EM) protocol (Fowler, Hilsenroth, & Handler, 1995), (b) interview follow-up and administration of the Rorschach (Exner, 1993), and (c) a collaborative feedback session. The assessment and feedback are organized according to a therapeutic model of assessment (TMA; Finn & Tonsager, 1997; Fischer, 1994) that contains a broad focus beyond the scope of a basic information-gathering (IG) assessment. Finally, in all cases, the clinician who carried out the psychological assessment was also the clinician who conducted the formal psychotherapy sessions, consistent with the belief (further discussed later) that the psychological assessment process itself (i.e., collaborative exploration in the relational present) provides an important synergistic effect with the subsequent psychotherapy.

### Therapeutic Model of Assessment

TMA (Finn & Tonsager, 1997; Fischer, 1994) is a multimethod assessment with a focus on collaboration, alliance building, and discussion of factors contributing to the maintenance of life problems. In a TMA, psychological test measures are viewed as “opportunities for dialogue between assessors and clients about clients’ characteristic ways of responding to usual problem situations and tools for enhancing assessors’ empathy about clients’ subjective experience” (Finn & Tonsager, 1997, p. 378; Fischer, 1994). Further, in TMA, assessors are committed to “(a) developing and maintaining empathic connections with clients, (b) working collaboratively with clients to define individualized assessment goals, and (c) sharing and exploring assessment results with clients” (Finn & Tonsager, 1997, p. 378). By expanding the focus of assessment,

both patient and clinician gain knowledge about treatment issues that promote a more involved interaction during the assessment phase of treatment.

In preparation for the collaborative feedback session, all clinicians receive a minimum of 1.5 hr of individual supervision to develop a comprehensive outline of the feedback information. The goal of the collaborative feedback session is to help the patient find new ways of thinking and feeling about self and others and to apply them to current problems in living. Patients are initially given feedback related to presenting complaints and symptoms (ego-syntonic) and are then presented with information that is progressively more discrepant from their self-concepts. Next, clinician and patient explore prominent inter- and intrapersonal themes from the testing results. Specifically, the cyclical relational themes are explored to foster the development of the patient’s core conflictual relational theme (CCRT; Book, 1998; Luborsky, 1984). The CCRT is a statement of the patient’s wish, an expected, imagined, or actual response from another, and a subsequent response from self. The response from self includes both the actions and behaviors as well as the feelings and affect associated with this response. One practical example of a CCRT interpretation that was developed in the session process with a depressed patient is as follows:

In that moment you described wanting a deeper connection and more support from your mother, but instead experienced her as rejecting and neglectful toward you. This led you to withdraw from her, feeling sad, hopeless that she will ever be concerned about your needs and also . . . even “*a little angry*” (emphasis on patient’s words).

An initial CCRT interpretation is given during the feedback session (see also Malan, 1979), and the exploration of these relational themes helps the clinician focus on collaboration, alliance building, examination of factors contributing to the maintenance of life problems (often relational), and potential solutions. During this exploration, the clinician often expands the patient’s understanding of relational themes, increasing the patient’s self-understanding and helping him or her feel understood. This facilitates an empathic connection between clinician and patient while helping the clinician work collaboratively with the patient to cultivate the therapeutic alliance.

Next, patient and clinician review a Socialization Interview (SI) developed by Luborsky (1984). The SI reviews what to expect in psychodynamic psychotherapy and outlines both the patient’s and the

clinician's roles. It emphasizes that the clinician will try to understand the patient and work collaboratively toward actualizing treatment goals, notes that the patient may become aware of issues that were not known before the start of psychotherapy, and outlines potential reactions (both positive and negative) to this new insight (Luborsky, 1984). It is believed that the SI enhances the patient's understanding of psychotherapy and highlights the relational focus of the therapeutic process. Finally, the clinician and patient work together to develop treatment goals and a treatment frame (i.e., scheduling session times, frequency of sessions, and payment plan). Immediately after the collaborative feedback session, patients and clinicians complete measures typically used for evaluating the psychotherapy process to examine interactions during the assessment. Patients are informed both verbally by the clinician and in writing on these forms that these ratings will not be made available to their clinician.

### **Therapeutic Process and Alliance During Psychological Assessment and Across Treatment**

Because psychological assessment is often the gateway to psychotherapy, it is an important area for examination. Although a substantial amount of research has examined the process of psychotherapy sessions, it is surprising how little process research has been conducted on the psychological assessment phase of treatment. The use of TMA in this program lends itself to empirically testable questions concerning the interaction of therapeutic process and alliance during psychological assessment. For instance, what impact would this approach to assessment have on termination rates in comparison with the more standard IG approach? How would the more collaborative focus impact patients' experience of the assessment process and therapeutic alliance? Furthermore, how would such experiences impact the subsequent psychotherapy?

One of our first studies from this project (Ackerman, Hilsenroth, Baity, & Blagys, 2000) found that patients in the TMA group were significantly less likely to terminate before the initiation of formal treatment relative to those in an IG assessment group (13% vs. 33%). In addition, measures typically used for evaluation of psychotherapy process (Session Evaluation Questionnaire [SEQ; Stiles & Snow, 1984] and Combined Alliance Short Form [Hatcher, 1999; Hatcher & Barends, 1996]) indicated that patient experience of the collaborative feedback session was significantly related to therapeutic alliance. Of particular interest was the finding that patients who rated their experience of

the feedback session higher on the SEQ Depth index (e.g., viewed the session as more powerful, valuable, deep, full, and special) reported a more positive overall experience of the assessment feedback and also rated the therapeutic relationship more positively. It is clear from these findings that patients value an extended assessment when they feel more engaged in the process and have the opportunity to gain a deeper understanding of prominent conflicts in their lives. It was not the length or smoothness of the assessment process but rather the depth of the process and the manner of using assessment information that was most important to patients.

A subsequent study examined the longitudinal relationship between patient and therapist alliance during psychological assessment with alliance ratings in early and late treatment sessions (Hilsenroth, Peters, & Ackerman, 2004). In addition, the therapeutic alliance of patients who took part in the TMA was compared with those receiving the standard IG model (i.e., assessment as usual). The TMA group reported high levels of alliance at all three measurement points (assessment feedback, early and late); these alliance scores were as high or higher during the psychological assessment process as at other points in their treatment. This indicates that maintaining the same clinician for assessment and psychotherapy does not impair the therapeutic relationship. Second, patient and therapist alliance, measured at the assessment phase of treatment, was positively related to alliance at both early and late stages of treatment. Third, the collaborative patient-therapist interactions developed during TMA led to significantly greater levels of therapeutic alliance compared with that for patients in a standard IG model of assessment.

These findings demonstrate that patient- and therapist-rated alliances developed during a TMA persist across the course of psychotherapy. This is consistent with other emerging research demonstrating that early patient-therapist interactions have a lasting impact on treatment process (Huber, Henrich, & Brandl, 2005; Rumpold et al., 2005; Sexton, Littauer, Sexton, & Tommeras, 2005; Svensson & Hansson, 1999; Tryon, 1990). A better understanding of treatment relationships may help to identify ways in which a collaborative assessment facilitates the development of stronger, more positive alliances throughout the course of psychotherapy. This increased understanding of the connection between assessment and alliance throughout treatment may help guide clinical work as well as the training and supervision of therapists. These findings, therefore, have implications for applied practice and suggest that cultivation of the therapeutic relationship, as early as

possible in treatment (i.e., initial interview or psychological assessment), may provide patients with a secure foundation to stimulate therapeutic progress.

### Process

To assess psychotherapy process, patients and therapists complete a standard set of measures immediately after the collaborative feedback session and after selected therapy sessions throughout the treatment as well as an exit evaluation (see Table I). Each member of the dyad completes these process questionnaires concurrently and immediately after the same session. In addition, patients are informed both verbally and in writing that their therapist will not have access to any of their responses. Videotaped psychotherapy sessions are also coded on a number of process dimensions. Although several areas of psychotherapy process have been explored, a significant focus has been on therapeutic alliance, therapist technique, and their interaction.

### Therapeutic Alliance

Contemporary psychotherapy research has emphasized the importance of the technical and relational aspects of therapeutic alliance. Decades of research have consistently found a significant, although modest, relationship between alliance with therapy process and outcome (Horvath, 2001; Martin, Garske, & Davis, 2000; Norcross, 2002). During our investigation of process and therapeutic alliance in the collaborative feedback session, we examined therapist interventions that demonstrated a direct relationship with alliance. This culminated in two separate reviews integrating information from several empirical studies (Ackerman & Hilsenroth, 2001, 2003). The studies covered in these reviews suggest that therapists' use of techniques from a range of psychotherapy orientations (e.g., cognitive-

behavioral [CB], experiential, interpersonal, family therapy, psychodynamic) may influence the therapeutic alliance in both positive and negative ways. Table II summarizes therapist techniques identified in these reviews that were reported to be important in the development and maintenance of a strong alliance or, conversely, related to lower levels of, or even to deterioration in, the alliance.

Therapist techniques found to contribute positively to the alliance could generally be categorized as supportive, exploratory, experiential-affective, and engaged. Research indicated that therapist techniques that specifically convey support, understanding, and affirmation and note adaptive changes across treatment were significantly related to higher alliance. Higher alliance was also related to therapist techniques that increased a patient's understanding of the problems that brought him or her to treatment through greater exploration and in-depth (i.e., full, special, powerful) discussion of these topics as well as accurate, high-quality, case-specific interpretations, not simply quantity. Techniques that maintained focus on the patient's in-session subjective experience (i.e., reflection) and affect or that facilitated the expression of these emotions were also related to higher alliance. Finally, a more active and engaged stance by the therapist was important in a positive therapeutic relationship.

Conversely, therapist interventions found to have negative effects on the alliance were at extreme ends of particular technical continua. For instance, overstructuring and managing therapy in an inflexible manner as well as failure to structure the treatment in an organized or coherent manner were both negatively related to alliance. Also, therapist behaviors involving either talking too much about superficial information not related to key treatment issues, or self-disclosure of his or her own emotional conflicts (vs. self-involving exploration of therapist's in-session process; see Teyber & McClure, 2000), or

Table II. Summary of Therapist Techniques Found to Be Significantly Related to Therapeutic Alliance

Techniques positively related to alliance	Techniques negatively related to alliance
Supportive	Overstructuring the therapy
Understanding	Managing treatment in inflexible manner
Affirming	Failure to structure the therapy
Noting past therapy success	
Exploration	Superficial interventions
Depth	Inappropriate self-disclosure
Accurate interpretation	Inappropriate use of silence
Attend to patient's experience	Unyielding transference interpretations
Reflection	
Facilitate expression of affect	
Active	Belittling

Source: Ackerman and Hilsenroth, 2001, 2003.

talking too little through the misuse of extended silence or withdrawal from the in-session process were detrimental to alliance. The use of transference interpretations (patient–therapist–past other) in a sustained, high-volume, and unremitting manner was detrimental to the alliance, particularly for patients with Axis II disorders or poor relational functioning (see Ogrodniczuk & Piper, 1999). However, it is important to note that continued focus on the transference relationship (i.e., linking patient, therapist, and past others from an intrapsychic distortion, unidirectional theoretical perspective) is not the same as exploring the here-and-now (Strupp & Binder, 1984) in-session process, including thoughts and feelings about the treatment relationship (i.e., exploring patient–therapist here-and-now interactions from a dyadic, interactive, relational theoretical perspective without directly linking to a past other; Safran & Muran, 2000; Wachtel, 1993). This is an important distinction that often muddies the water in research on transference interpretations. Various authors use different operational criteria of transference interpretations, with some limiting this definition only to the direct, immediate, and primary linkage of the current patient and therapist interaction with past others according to a more classical (i.e., causal) definition and others including any interpretations that mention the therapist and their experience or interactions with the patient regardless of any explicit connection to past relationships. Finally, communication of hostility or disrespect by the therapist toward the patient was found to be related to lower alliance.

We have also examined the relationships between therapist-rated alliance and therapist technique (Ackerman, Hilsenroth, & Knowles, 2005). Our findings suggest that therapist use of psychodynamic–interpersonal (PI) techniques early in treatment was related to both global and specific aspects of therapist-rated alliance late in treatment. These specific alliance aspects include the therapist’s perception of the patient collaborating in the exploration of salient themes, self-observing his or her own behaviors, and exploring his or her own contribution to problems, bond, and therapist confidence. Therefore, the use of expressive techniques early in treatment may enhance the therapist’s understanding of and confidence in the treatment process, which, in turn, facilitates the patient’s deepening engagement across psychotherapy. These findings also have important implications for training, to which I return later.

Confidence in the treatment process, from both patient and therapist perspectives, was also found to be the primary predictor of patient-rated improvement in a study examining different facets of

therapeutic alliance and their relationship with the effectiveness of psychotherapy (Clemence, Hilsenroth, Ackerman, Strassle, & Handler, 2005). Several significant relationships were demonstrated for patient and therapist alliance scores, but the convergence between patient and therapist Confident Collaboration subscales was the most highly related across all alliance scales examined. Taken together, these findings suggest that a forward-moving therapy includes the hopefulness of both participants. Therefore, when examining the factors involved in the therapeutic alliance and patient improvement, we must be mindful of the therapist’s level of confidence in treatment and the process in which they engage.

### **Therapist Technique**

One of the first challenges we faced when implementing this hybrid model of psychotherapy research was how to assess therapist technique or activity within a naturalistic setting. Although many instruments assess techniques and interventions for a variety of psychotherapies, these scales are most often directly linked to a specific manualized treatment. They are also relatively time consuming to implement (i.e., training) and labor intensive to rate. Therefore, their applicability and utility to more real-world therapies that (a) do not use any treatment manual, (b) do not use the manual for which the instrument was developed, or (c) use techniques from different theoretical orientations are largely unknown. The few measures available to assess therapist activity in a broad manner either suffer from weak psychometric properties or require an extensive amount of time for training and completion. It seemed apparent that there was a need for a brief, efficient, reliable measure of therapist technique that had general real-world applicability to a variety of treatments. Our approach to developing such a measure was to first examine empirical findings from applied clinical research (i.e., bottom-up) rather than solely theoretical predictions (i.e., top-down).

The scale we developed is based on two reviews of the comparative psychotherapy process literature (Blagys & Hilsenroth, 2000, 2002) that sought to identify core features used in PI (defined broadly to include psychodynamic, PI, and interpersonal therapies) and CB (defined broadly to include cognitive, CB, and behavioral therapies) treatment. These reviews identified 13 techniques that consistently and significantly distinguished PI and CB treatments (Table III). On the basis of the 13 core techniques identified from the empirical literature, we constructed the Comparative Psychotherapy Process Scale (CPPS; Hilsenroth, Blagys, Ackerman, Bonge,

Table III. Characteristic Features of Psychodynamic–Interpersonal (PI) and Cognitive–Behavioral (CB) Psychotherapy

Key features of PI psychotherapy	Key features of CB psychotherapy
Focus on affect and the expression of emotion	Emphasizes homework and outside-of-session activities
Exploration of attempts to avoid topics or engage in activities that may hinder the progress of therapy	Direction of session activity
Identification of patterns in actions, thoughts, feelings, experiences, and relationships	Teaching skills to cope with symptoms
Emphasis on past experiences	Focus on future experiences
Focus on interpersonal experiences	Provide information regarding treatment, disorder, or symptoms
Emphasis on the therapeutic relationship	Focus on cognitive experience, specifically illogical or irrational thoughts and belief systems
Exploration of wishes, dreams, or fantasies	

Source: Blagys and Hilsenroth, 2000, 2002.

& Blais, 2005), which contains two subscales, CPPS-PI and CPPS-CB, that assess the degree to which a therapist uses these core techniques in PI and CB treatments, respectively. The CPPS is a brief descriptive measure consisting of 20 randomly ordered items rated on a 7-point Likert scale ranging from 0 (*not at all characteristic*) to 6 (*extremely characteristic*). Ten statements are characteristic of PI interventions and 10 are characteristic of CB interventions. The CPPS may be completed by a patient, therapist, or an external rater and is designed to assess therapist activity and techniques used during the therapeutic hour.

The reliability and validity of the CPPS are well established (Ackerman et al., 2005; Hilsenroth, Ackerman, & Blagys, 2001; Hilsenroth, Ackerman, Blagys, Baity, & Mooney, 2003; Hilsenroth et al., 2005; Hilsenroth, DeFife, Blagys, & Ackerman, 2006; Price, Hilsenroth, Callahan, Petretic-Jackson, & Bonge, 2004; Siefert, Hilsenroth, Weinberger, Blagys, & Ackerman, 2006; Thompson-Brenner & Westen, 2005a,b; Westen, Novotny, & Thompson-Brenner, 2004). We reported (Hilsenroth et al., 2005) on the excellent interrater reliability and internal consistency of the CPPS as well as results from six separate validity analyses conducted across several different contexts and samples demonstrating that (a) the CPPS-PI subscale was significantly related to extant scales of psychodynamic treatment activity; (b) the items and subscales distinguished between therapeutic modalities; (c) the CPPS differentiated the prototypic session characteristics of both PI and CB approaches by expert clinical training staff from these theoretical orientations; (d) the CPPS allowed naive (i.e., undergraduate) raters to distinguish the session characteristics of PI and CB treatments; (e) patients in psychodynamic psychotherapy reported significantly more PI than CB treatment techniques during their sessions; and (f) therapist and supervisor

ratings of both PI and CB treatment techniques were significantly related to one another.

The results of these studies suggest that the clinical utility of the CPPS extends into three overlapping domains. First, the CPPS identifies and operationally defines some of the central interventions in nonmanualized PI and CB therapy and, therefore, represents a potentially useful measure of therapist activity in real-world treatments that may be used in effectiveness studies conducted in naturalistic settings (i.e., private practice networks). In more controlled psychotherapy trials, the CPPS may be used to compare techniques both within and across various CB and PI therapies to distinguish specific or broad features of these treatments. Second, the CPPS can also be used as a teaching tool to aid students and trainees in learning about key treatment techniques of each therapeutic approach (see Hilsenroth et al., 2005). Supervisors can focus their educational efforts on these fundamental, orientation-specific activities and processes. In terms of clinical practice, the CPPS can provide the PI or CB therapist with a guide for session activity as well as a means to monitor their own use of salient techniques from each orientation. Finally, the CPPS may be useful in the integration of PI and CB approaches. By operationally defining some key features of these two sets of treatments, clinicians can begin to evaluate the effectiveness of each set of activities alone or in combination and attempt to incorporate these procedures into their treatment repertoire.

### Outcome

When organizing this hybrid research design, I found that the phase model of change (Howard, Lueger, Maling, & Martinovich, 1993; Howard, Moras, Brill, Martinovich, & Lutz, 1996) provided a useful framework with which to consider outcome changes across different domains of functioning. This model

suggests various types of measures (i.e., subjective well-being, acute and chronic symptoms, interpersonal and social functioning, personality variables) to assess different outcomes as indicated when reassessment of patient functioning on each of these domains might occur. This model of recovery progresses from subjective well-being (in the first month of treatment) to symptom reduction (beginning at 2–3 months), followed by gains in interpersonal, occupational, social, and then characterological functioning (beginning at 4–6 months). These various domains of functioning were assessed from both clinician (i.e., therapist and external rater) and patient self-report. This model also predicts that improvement in subjectively experienced well-being precipitates a reduction in symptomatology and that both precede decreases in interpersonal, occupational, social, and characterological dysfunction.

Another concept that has greatly influenced my approach to examining treatment outcomes has been clinical significance methodology (Jacobson, Roberts, Berns, & McGlinchey, 1999), which involves assessing response to treatment at the individual patient level using two criteria: (a) A patient's scores on a given measure should move from a dysfunctional distribution to a functional distribution, and (b) such change in test scores should be of sufficient magnitude to be statistically reliable. As such, we strive to present results from our program in a practical manner, easily translated to applied practice. The calculation of reliable change index (RCI) scores in the clinical significance methodology allows for a more psychometrically conservative and conceptually digestible change score when conducting analyses and reporting findings. That is, for RCI, higher scores are directly related to greater amounts of change (as opposed to the use of residualized, regressed, or factor-derived change scores for which clear interpretation of results is sometimes left wanting). In addition, RCI scores can be adjusted to control for regression to the mean (Speer, 1992). We also calculate effect sizes, using Cohen's  $d$  (Cohen, 1988), for within- and between-group comparisons because they provide more clinically relevant information than  $p$  values and represent the amount of change based on standard deviation units (i.e.,  $d$  of 0.50 is equal to half a standard deviation unit of change on a given measure). Using both the phase model of change as well as a more clinically applied approach to data analysis has guided our outcome investigations on early treatment gains, adult survivors of childhood sexual abuse, and depression.

### **The Phase Model of Change and Short-Term Psychodynamic Psychotherapy**

An initial outcome investigation from this research program examined change according to the phase model (Howard et al., 1993, 1996) and assessed the domains of subjective well-being, symptomatic distress, and social–interpersonal functioning across the early stages of short-term psychodynamic psychotherapy (STPP; Hilsenroth et al., 2001). Consistent with the phase model, changes in these domains showed a differential response over the early course of treatment. In addition, changes in subjective well-being and symptomatic distress contributed unique variance to predicting changes in social–interpersonal functioning. It should also be noted that patients who entered STPP during this study demonstrated a substantially lower rate of premature termination than those entering psychotherapy at the same clinic but who were not in this treatment program (12% vs. 30%). Although much of the treatment provided in the phase model literature has been predominantly psychodynamic in nature (Howard et al., 1993; Kopta, Howard, Lowry, & Beutler, 1994; Lueger, Lutz, & Howard, 2000), our hybrid design makes this one of the first studies to examine the phase model of change while empirically evaluating treatment fidelity and credibility, both of which were found to be high.

### **Adult Survivors of Childhood Sexual Abuse and STPP**

Various therapeutic approaches have been used effectively in the treatment of adult patients with a history of childhood sexual abuse (CSA; Callahan, Price, & Hilsenroth, 2004; Price, Hilsenroth, Petretic-Jackson, & Bonge, 2001). Because the vast majority of outpatients present to treatment for reasons other than their abuse history and are not recruited for clinical trials of specialized interventions, the use of a naturalistic sample in the current program was an opportunity to evaluate the effectiveness of STPP on treatment-seeking adults who reported a history of CSA and presented with a variety of Axis I and II disorders. Thus, we were able to address limitations in the existing literature by including treatment-seeking individuals with comorbid diagnoses, measuring treatment adherence and satisfaction, and assessing general functioning, symptomatic distress, and the therapeutic alliance from multiple perspectives.

Results of pre–post treatment analyses indicated that STPP can be an effective treatment for this population (Price et al., 2004). Both patient and clinician ratings demonstrated significant improvements in symptomatic distress, interpersonal,

occupational, and social functioning. These results are similar to previous individual treatment outcome research with this population using various therapeutic approaches (Price et al., 2001). Also, ratings of CSA patients' dynamic personality change demonstrated that patients saw their relationships more positively, gained adaptive control over their aggressive impulses, and felt better about themselves at the end of treatment. Patients' self-reports of specific improvement areas during treatment revealed significant change in original symptoms, feelings about the self, taking control of one's life, tolerance of painful feelings, and overall change. The dramatic improvements observed in abuse survivors' self-esteem were especially notable, particularly considering the near-perfect convergence in clinician- and patient-rated effect size changes. In addition, a comparison of the CSA group with a nonabused clinical control group (non-CSA) revealed that CSA patients demonstrated a greater rate of improvement in positive feelings about themselves than non-CSA patients. Finally, there were no significant differences in patient and therapist alliance ratings between the CSA and the non-CSA groups. This supports an emerging literature that adult survivors of abuse are capable of establishing and maintaining a positive therapeutic alliance (Paivio & Patterson, 1999).

Of note, the CSA patients reported a high degree of satisfaction with treatment and a low rate of premature termination (14%). Thus, STPP appears to have provided a tolerable, engaging approach that allowed for expression of painful affect and exploration of interpersonal themes within a supportive therapeutic context for this sample consisting predominantly of patients with depressed mood and relational difficulties (Herman, 1992). The findings demonstrate that CSA survivors who present to treatment for reasons other than their abuse history responded positively to interventions that emphasized the expression of affect and exploration of relational patterns. These results have important implications for clinicians who will often see patients who present with a variety of problems and comorbid Axis I or II disorders rather than their abuse history or acute anxiety symptoms (e.g., panic attacks, posttraumatic stress disorder).

### **Treatment of Depression and STPP**

In an examination of depressed patients from this program, changes in the domains of depressive symptoms, global symptomatic distress, and interpersonal and social functioning showed substantial improvements and large statistical effects across the full course of treatment (Hilsenroth et al., 2003).

Also, changes in depressive symptoms evaluated at the individual patient level using clinical significance methodology revealed that almost all patients either demonstrated reliable change or scored within a functional (i.e., nonclinical) distribution. Likewise, the percentage of patients exhibiting clinically significant change in depression through the course of psychotherapy was quite high, whereas the treatment termination rate for these depressed patients was quite low (15%).

Changes in depressive symptoms were significantly related to therapist use of psychodynamic techniques; alternative treatment techniques were nonsignificant. This finding is especially important because it is the third study, from three independent research groups, that has found a direct link between psychodynamic interventions and changes in depressive symptoms during STPP (Barber, Crits-Christoph, & Luborsky, 1996; Gaston, Thompson, Gallagher, Cournoyer, & Gagnon, 1998). Furthermore, in this study, specific therapist interventions from the STPP treatment model directed toward achieving as well as maintaining session focus on the experiencing, expressing, and exploring of uncomfortable emotions were found to be most related to positive changes in depressive symptomatology. These results are quite consistent with the psychodynamic model of change (Blagys & Hilsenroth, 2000; Book, 1998; Fosha, 2002; Luborsky, 1984; Luborsky, Barber, & Crits-Christoph, 1990; Luborsky et al., 1995; Malan, 1979; McCullough et al., 2003; Strupp & Binder, 1984; Wachtel, 1993), wherein a supportive relationship is developed with the therapist that allows the patient to better tolerate the experience, expression, and integration of painful affect. When painful affect is engaged or avoided, interventions are focused "in the moment" (including issues related to the therapeutic relationship) for further experience, expression, and integration. This finding is consistent with the results of Diener and Hilsenroth's 2006 meta-analysis, which demonstrated a significant positive relationship between therapist affective focus and treatment outcome in psychodynamic psychotherapy as well as the increasing focus on the experiential and affective aspects of treatment in more contemporary STPP approaches (Fosha, 2002; McCullough et al., 2003).

In a subsequent study of the effects of borderline pathology on STPP for depression (Hilsenroth, DeFife, Blake, & Cromer, in press), dynamic therapists were more active in their approach early in the treatment of comorbid depressed patients with borderline pathology, suggesting both specific activities or tasks for the patient to attempt outside of session as well as more actively initiating the therapeutic focus during the session. As such, these

dynamic therapists augmented their treatment with more active CB interventions early in therapy by purposefully shifting attention to provide direct and explicit aid to patients for improving behavior in their day-to-day living. It was also evident that by Session 9 therapist activity was related to an increased use of key dynamic interventions such as linking the patient's current feelings or perceptions to experiences of the past as well as addressing the patient's avoidance of important topics and shifts in mood. In effect, the therapists were providing a historical context in which to understand current functioning, maintaining an exploratory focus, and working with subsequent changes in affective reactions to this exploration. One therapist activity that occurred more frequently in the sessions of depressed patients with borderline pathology throughout the entire treatment process was an increased focus on similarities among the patient's relationships repeated over time, settings, or people. Thus, for these comorbid patients, therapists allocated even more time and attention to addressing cyclical maladaptive patterns of relating and how these prominent interpersonal themes became manifest in the patient's life.

### Training

Inherent in the organization of this program was my desire to integrate practice-based research into a clinical doctoral program. A number of previous authors have addressed this issue and expressed the desire for research on the direct relationship between training and the acquisition of specific clinical skills related to this training (Beutler & Kendall, 1995; Binder, 1999; Holloway & Neufeldt, 1995; Miller & Binder, 2002; Patton & Kivlighan, 1997; Stein & Lambert, 1995). Unfortunately, graduate trainees are an understudied group: In a 2002 summary of this issue, Miller and Binder concluded that empirical evaluations of clinical training are sparse and little is known about how graduate training actually occurs or its effectiveness. For those of us involved in graduate education, these issues are of vital importance.

The process of training and supervising graduate students enrolled in an American Psychological Association (APA)-approved clinical psychology doctorate program were a significant aspect of this research program. These graduate clinicians conducted both the psychological assessment and psychotherapy for each patient in the program. Each therapist received a minimum of 3.5 hr of supervision per week (i.e., 1.5 hr individually and 2 hr in a group treatment team meeting) on the therapeutic model, case conceptualization, process, interpreta-

tion, and clinical interventions. Also, clinicians had the option to attend an ongoing case conference (1.5 hr) of a training case (videotaped) provided by the clinical supervisor. All psychotherapy sessions were videotaped and reviewed weekly by the supervisor on the therapeutic model, case-relevant formulations, process, and techniques designed to facilitate the appropriate use of STPP interventions.

The didactic methods used in this supervision process were modeled after those first described in Henry, Schacht, Strupp, Butler, and Binder (1993) and further developed by Binder (1999). Individual and group supervision focused heavily on the review of videotaped case material and technical interventions designed to facilitate the appropriate use of STPP interventions. Interpersonal themes and processes were a key area of focus in the patient narrative material and therapist response. Selected patient-therapist interactions were evaluated with regard to the identification of, and response to, relevant case-specific formulations. Examination of these treatment vignettes was structured to provide specific and direct feedback to supervisees. The supervisory focus was applied equally (and at times more often) to trainee experiences, process, and interventions as to patient dynamics. Technical interventions were reviewed and rehearsed, with several alternative options often being explored (see Wachtel, 1993). Support, encouragement, and praise were actively provided to trainees; this positive feedback was consistently linked to specific treatment interventions or training experiences (i.e., practice interventions, case-relevant formulations) during the supervisory session.

Treatment was organized and informed (but not prescribed) by the technical guidelines delineated in several training texts (Book, 1998; Luborsky, 1984; McCullough et al., 2003; Strupp & Binder, 1984; Wachtel, 1993). Additional technical material specific to STPP treatment (Barber & Crits-Christoph, 1995; Malan, 1979) was actively integrated into the treatment depending on patient symptoms and diagnoses. Key features of the STPP treatment model were reviewed earlier in the discussion of findings based on Blagys and Hilsenroth (2000) and are listed in Table III. In addition to these areas of treatment focus, relational patterns, case presentations, and symptoms are conceptualized in the context of cyclical patterns. Treatment goals were first explored during the assessment period, and a formal treatment plan was reviewed with each patient early in treatment; this treatment plan was reviewed every 2 to 3 months for changes, additions, or deletions. When a termination date is set, this issue becomes a frequent area of intervention; issues related to termination are linked to key

interpersonal, affective, and thought patterns prominent in that patient's treatment.

### Effects of Training on Alliance

Because the therapeutic relationship has been found to have a consistent effect on psychotherapy outcomes, it is important to examine what effect, if any, structured approaches to training may have on this relationship (Norcross, 2002; Task Force on Empirically Supported Therapy Relationships, 2001). Over a decade ago, both Luborsky (1990) and Strupp, Butler, and Rosser (1988) asked whether or not the capacity to establish a helping relationship was trainable. Subsequent authors have also emphasized the need to examine the impact of supervision and training on graduate students' relational skills (Holloway & Neufeldt, 1995; Levenson & Strupp, 1999; Stein & Lambert, 1995; Strupp & Anderson, 1997). The impact of such training in relation to treatment alliances developed by graduate clinicians is of equal interest.

To address these issues, we compared alliance ratings for graduate clinicians receiving structured clinical training in assessment and psychotherapy with a second group of graduate clinicians receiving unstructured supervision as usual under field conditions (Hilsenroth et al., 2002, 2004). The first area of training examined was the relatively new and different approach to psychological assessment: TMA (Finn & Tonsager, 1997; Fischer, 1994). The second area concerns the use of treatment manuals for STPP (Book, 1998; Luborsky, 1984; McCullough et al., 2003; Strupp & Binder, 1984). We examined the relationship of training in these specific skills to particular facets of the therapeutic alliance from both patient and therapist perspectives.

Both patient and therapist ratings of the therapeutic alliance demonstrated several significant differences between graduate clinicians receiving structured clinical training and those receiving unstructured supervision as usual. These significant differences that occurred in relation to total alliance scores, as well as particular facets of the therapeutic alliance (i.e., goals, tasks, and bonds), were consistent with the specific focus of training. Both the TMA and supportive-expressive dynamic psychotherapy focused heavily on collaboratively developing empathic connections through extensive feedback of assessment results as well as by examination and exploration of the therapeutic relationship. Training was supported by both statistically significant differences and clinically significant moderate effects for both patient and therapist ratings of the therapeutic bond. Even greater statistical and clinical differences (i.e., moderate to large effects)

were observed between these two groups concerning the goals and tasks aspects of therapeutic alliance. A significant aspect of the structured clinical training group was the focus on the individualized and collaborative identification of patient goals. This identification of the goals and tasks of treatment was further developed through a review of the socialization interview, identifying the roles and process of psychotherapy. In addition, during the course of the therapeutic assessment and STPP treatment, clinicians focused interventions explicitly on the relational aspects (past and present) that precipitate, maintain, and sustain problematic symptomatology and functioning. These findings highlight the benefit of explicit, formalized, and collaboratively developed goals early in the treatment process.

### Effects of Training on Technique

A second area we examined is the effect of manual-based structured clinical training for graduate clinicians on the development of STPP therapeutic techniques (Hilsenroth et al., 2006). That study examined the effects of structured training for graduate clinicians on the frequency of PI therapeutic techniques within and across two outpatient STPP cases. As predicted, graduate clinicians who received structured clinical training in STPP demonstrated significant increases in the use of dynamic techniques within and across these cases. Early into the second treatment case, these graduate clinicians were performing treatments that were considered in the characteristic range of the STPP model of intervention, explicitly and consistently identifying the affective and relational aspects (past and present) that precipitate and maintain symptomatology and functioning. These findings are consistent with previous research on the relationship between supervised training in STPP and increased use of PI techniques (Crits-Christoph et al., 1998; Henry, Strupp, Butler, Schacht, & Binder, 1993; Multon, Kivlighan, & Gold, 1996). In addition, large differences were observed between PI and CB techniques as well as no changes in CB interventions across the two STPP cases, consistent with the specificity of the training. These findings suggest that the increased use of PI techniques was related to the focused training rather than to nonspecific factors and are consistent with prior research demonstrating that more focused, intensive, and task-specific instructional methods are positively related to training effectiveness at various levels of experience (Burlingame, Fuhrman, Paul, & Ogles, 1989). Finally, when both training studies from our program are viewed together (Hilsenroth et al., 2006, is a

subsample of Hilsenroth, Ackerman, Clemence, Strassle, & Handler, 2002; Hilsenroth et al., 2004), the results are consistent with those of Crits-Christoph et al. (1998) and Multon et al. (1996), who demonstrated that structured clinical training did not deleteriously impact patient ratings of the therapeutic alliance.

Studies should continue to explore the relationship among therapeutic alliance, treatment techniques, and various aspects of structured clinical training, particularly with less experienced clinicians. The utility and validity of treatment manuals in applied settings (i.e., field supervision) are topics that are rarely addressed for most manual-based training and treatment programs (see Westen et al., 2004). Several authors have called for training in relational skills for graduate trainees, and perhaps the implementation of this type of training may gain momentum after the APA Division 29 task force review on the impact of the therapy relationship (Norcross, 2002; Task Force on Empirically Supported Therapy Relationships, 2001). Related to this issue, the two reviews by Ackerman and Hilsenroth (2001, 2003) also examined extant research on therapist personality characteristics that directly impact the therapeutic alliance. The empirical findings covered in these reviews indicate that therapists' personal attributes of warmth, openness, flexibility, respectfulness, trust, and interest were found to contribute positively to the alliance, whereas therapist attributes such as being rigid, uncertain, critical, distant, tense, and distracted were found to contribute negatively to the alliance. In fact, there have been both clinical and analogue training programs developed to help increase alliance, empathic accuracy, and helping skills with encouraging results (Crits-Christoph et al., 2006; Hill, 2004; Marangoni, Garcia, Ickes, & Teng, 1995). Although it may seem difficult to conceive of clinical training programs offering coursework on enhancing personal attributes of their students (beyond the suggestion that students engage in their own personal therapy), perhaps the time has come to do so more actively. At the very least, the empirical literature on therapist relational skills should be given more attention in the admission and training processes.

### Conclusion

I believe one of the most gratifying aspects of the programmatic research I have conducted thus far in my career is in relation to student involvement and success in these endeavors. Since my first semester as a faculty member in fall 1996, graduate students working with me on this project have been first author or coauthors on several peer-reviewed journal

articles, made conference presentations at national and international meetings, and won awards for their thesis and dissertation research. I feel confident that these projects have helped facilitate the training experiences as well as develop the professional identity of these students and will likewise help to establish them in their own careers. Although not meaning to diminish the findings from these research initiatives or the significant improvement in patient functioning, I believe that the students' first-hand experience of participating in an integrated applied clinical research process, as well as an increased sense of professional-efficacy, will ultimately prove to be this treatment program's greatest contribution as these students join the next generation of professionals providing care to others and conducting psychotherapy research.

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