A Current Perspective on the Psychotherapies

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In years past a self-described "eclectic" psychotherapeutic approach often turned out to be a potpourri of different activities, fuzzy and unstructured. This approach was in contradistinction to the definition of eclectic, which means "choosing what appears to be the best from diverse sources, systems, or styles" (1). Because psychotherapy strategies for change were not as clearly elaborated as they are today, the "diverse sources" from which the eclectic therapist could choose were vague and undifferentiated. Today the definitions are much clearer.

Appreciating the clearer definitions, the residency review committee of the Accreditation Council for Graduate Medical Education now requires graduating psychiatric residents to be certified as competent in five psychotherapies: psychodynamic, cognitive, supportive, brief, and combined psychotherapy and psychopharmacology. Although some programs with limited resources or confidence in one or more areas may balk at the requirements, enforcement of these prerequisites ensures that today's graduate is familiar with the goals, methods, and treatment possibilities of each modality. Graduates will know the strategies and goals of the psychotherapies and have a truly informed eclecticism—that is, a knowledgeable integration of the several available psychotherapy tools.

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Which therapy to prescribe for whom?

No one would debate the proposition that supportive elements of psychotherapy should be a part of every patient's psychotherapy prescription. Developing a therapeutic relationship, putting patients at ease, responding empathically, and looking for ways to enhance patients' self-esteem are natural parts of all psychotherapies.

However, there is an ongoing debate about the relative value of the psychodynamic and cognitive-behavioral approaches. These treatments embrace quite distinctly different strategies, although both include the goal of symptom relief. In actual practice, an integration of psychodynamic and behavioral psychotherapies—both theoretical and in practice—may best serve the patient. Many clinicians have recognized for decades that a therapeutic interface exists between the two approaches (2).

Addressing this debate, the American Psychiatric Association's (APA's) committee on psychotherapy organized a clinical case conference at the 1988 APA annual meeting to discuss the two modalities in the psychological treatment of a man with a diagnosis of depression. The case was discussed by a distinguished psychiatrist experienced in cognitive-behavioral therapy and by an equally esteemed psychoanalytic psychiatrist. Both psychiatrists described the patient as a bright man in his late 20s who, after overcoming many external obstacles, was now completing graduate school and had two professional opportunities. He had a choice between taking a job in a small town at a prestigious university, with easily affordable housing and an opportunity to settle down and raise a family, and taking a job at a much less prestigious school in a large city. Struggling with these two options seemed to be a trigger throwing him, for the first time, into an agitated suicidal depression.

The two psychiatrists, despite their very different treatment approaches, gave remarkably similar case formulations. They both recognized the importance of the patient's early traumas of abuse and attachment as well as specific conflicts with his parents. In their clinical formulations they appreciated the patient's ambivalence and anxiety about raising a family and succeeding in a way his father never had as well as the loss of personal anonymity that would occur in a small town. Despite the similarities in the case formulation, their treatment approaches were completely different. The cognitive-behavioral psychiatrist would work with the patient to correct his conscious cognitive distortions, and the psychoanalyst would focus on the unconscious meaning of past experiences and how they affected and distorted the patient's current decision making. Both psychiatrists would explain to the patient their theoretical understanding of his suffering. Their explanations would be simple and would be put in the context of the man's current struggle. The explanations would serve to take the mystery out of the man's illness, empowering him to move forward with his decision and his life.

These presentations demonstrated to the audience that there is no single answer to the question of which psychotherapy to prescribe for whom.

Studying the psychotherapies

It is certainly very important to learn more about the psychotherapies. Support for understanding, clarify-

ing, and studying the different psychotherapeutic approaches is presented in a review article by Margison and associates (3). The authors dispute the notion that psychotherapies cannot be adequately studied and differentiated. Studies that have examined interventions, case formulation, treatment integrity, performance (including adherence to treatment techniques, competence, and skillfulness), treatment definitions, the therapeutic alliance, and routine outcome measurement have found that modern methods of measurement can support evidence-based practice for psychological treatment.

One study showed that although analyzing psychotherapy at the level of the single intervention did not easily generalize to the more complex clinical skill, there is evidence that early training at this "skills-based" level can be effective in reducing undesirable types of behavior by the therapist—for example, the excessive use of closed-ended questions (4).

Case formulation, initially developed in relation to the psychodynamic approach, has been shown to be a reliable procedure (5,6). Explicit formulation techniques are included in schema-focused cognitive therapy. Having a clinical formulation that is shared with a patient can help maintain the therapeutic alliance during difficult reenactments. As to the question of which psychotherapy strategy should be used for whom, a significant finding was that more competent therapists (rated as such by their supervisors) were able to deviate appropriately from traditional technical recommendations with more difficult patients (7).

Integrating the psychotherapies

It is, of course, the more difficult patients who test our skills and who remind us of the importance of having a clinical formulation, of having a direction for our work with a patient, and of being thoughtful about our therapeutic technique. For this reason the APA's *Treatment Guideline for Patients With Borderline Personality Disorder* (8) spells out both the tasks of the patient and the tasks of the therapist. The tasks of the patient include self-reports of important issues, inner thoughts, dysfunctional behavior, and anticipated behavior. The clinician's role includes the provision of understanding, consistency, and empathic feedback and arranging a clear plan for the time and place for meetings and for handling emergencies. All of this may seem obvious, but it is a useful framework to have in mind to help you "keep your head" when, during the vagaries of transference and the eruption of countertransference, "all about you are losing theirs." The guideline also remarks on the importance of making treatment goals explicit—for example, symptom reduction, improved relationships, and improved performance in the workplace. The development of a therapeutic alliance and treatment framework is the foundation of the therapeutic work. However—and this is a big however—as I say to beginning residents, "These are the goals. This is what you, the therapist, need to know and remember that you are working to accomplish." With these patients, achieving a therapeutic alliance, a treatment framework, and a mutual understanding of the direction for change may proceed in fits of starts and stops, but it is important for the clinician to constantly have the overall framework in mind.

The same holds true for psychotherapeutic technique. Two types of psychotherapy—psychoanalytic psychodynamic psychotherapy and dialectic cognitive-behavioral psychotherapy—have proven efficacy in the treatment of borderline personality disorder in randomized controlled trials (9–11). Which do you use, when, and for whom? Borderline personality disorder is such a multifaceted illness that there is not one clear-cut answer. Each type of psychotherapy may be of value at different phases of the illness. Psychoanalytic interpretations that are given to provide normalization and understanding of a frightening reaction, in the context of supportive psychotherapy, can provide a grounding reality in an otherwise chaotic emotional state. Cognitive-behavioral techniques may be used to interrupt destructive behaviors. The encouragement in dialectical behavior therapy to be in touch with the feeling that provokes the impulse to cut or to engage in other self-harming behaviors may alert a patient, for the first time in his or her life, to the feelings behind the behavior. A psychodynamic exploration may provide insight into the previously unexplained origin of such a feeling, but it will be the clinician's imperative to appreciate when such an exploration is potentially reparative and when it will, instead, cause the patient to become regressively vulnerable.

Staying in the same room

In the early 1940s a major split occurred in the British Psychoanalytic Institute between the Kleinians and the Freudians. A British psychoanalyst described it to me. He said that all the psychoanalysts stayed in the same room, one group on one side, the other on the opposite, and a "middle group" in between. Although heated debates occurred and participants hurled vitriol at each other, they did, at least, remain in the same room. I don't know whether this outcome was a reflection of the British character or the fact that it was in the midst of World War II and there were no other rooms available! The important element is that the psychoanalysts all stayed within hearing distance of each other. Many of the splits within psychoanalysis have healed, and for the most part, the best of each school of thought has been integrated.

With the development of cognitive-behavioral therapy, a somewhat similar paradigm has developed: psychoanalytic theory versus learning theory. Fortunately, as each training program is forced to keep all five psychotherapies in the same room, the similarities, differences, goals, and techniques are becoming more familiar to all psychiatrists. There is great strength in having a clinical formulation and a therapeutic plan that fit the patient and in having the ability to deviate and use other means as the need emerges—as well as staying in the same room to discuss it. ♦

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