BRIEF INTEGRATIVE THERAPY COMES OF AGE: A Commentary

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I have always maintained that brief therapy is therapy only more so: it is human nature to try make every moment count when confronted with finiteness. While we all know that our lives are time-limited, so to speak, we most often live as if we were immortal until our attention is rudely drawn to matters being otherwise. Often traditional -- read non-brief-- therapy proceeds as if time did not exist. Brief therapy "pulls" for full engagement and mindfulness of time. There is no reason to hold back or bide one's time: the condensed course almost mandates that therapists be disciplined, pragmatic, non-grandiose and hard-working moment-to-moment. In graduate school, some supervisors, kindly seeking to re-assure neophytes, would say, "there's always next session." The ethos of brief therapy is otherwise: " work as if there were no next session."

What seems clear after reading the four papers that comprise this special issue on brief integrative psychotherapy is the fact that focal problems can be rapidly resolved and that the essential nature of treatment is integrative is just that - a fact that is solidly established.

Brief integrative therapy has been around for a sufficiently long time to have acquired its own stereotypes - which these authors blow out of the water. The four papers in this issue go against received wisdom in many ways. There is a refreshing absence of the macho and hubris that so often characterized the tone of the earlier writings in the field: these authors are confident therapists in possession of effective techniques; the therapeutic results of their respective methods allows them to speak for themselves. That not every one can be cured, that there are treatment failures, that brief therapy “is not considered to be the final or definitive intervention” (Levenson, p. 21), that at some future point even those successfully treated may need further treatment -- such is merely the way things are, and no cause for defensiveness.

None of the authors focuses on the time limit itself as a central *technique* of acceleration. While the treatments are brief, effectiveness does not fundamentally come from the time limit, though that is an undeniably powerful factor. There is no devotion to brevity for the sake of brevity, no devotion to being brief at all costs. The devotion is to the welfare of the patient, and to efficacy. For instance, as part of standard procedure, in the last session of the initially planned twelve, James McCullough evaluates and rediagnoses the patient; treatment is terminated only if the patient is better. Magnavita & Carlson, who do a masterful job in their review of the rationale for selecting different approaches and different time frames with different patients, advocate intensive treatment “in as short a time frame as the patient can tolerate” (p. 21). And they are explicit about patient characteristics which affect tolerance differentially. Anchin achieves remarkable results with his patient in 12 sessions. However, the very depth and effectiveness of that treatment deepen the patient's trust and courage in such a way that he becomes actively motivated to take on old fears and shames and explore the life-long avoidances which have shaped his whole character. At the point in the treatment where Anchin's account stops, patient and therapist are on the brink of taking on matters from the dark night of the soul, matters where outcome goals are existentially -- and not only functionally-- defined. Finally, Levenson, in the event of an unsuccessful course of TLDP (Time Limited Dynamic Psychotherapy), urges that the therapist “weigh the possible benefits of alternative therapies, another course of TLDP, a different therapist, nonprofessional alternatives, and so on” (p. 21). We’ve come a long way, baby.

Just as the issue of the time limit is not a red flag, neither is the issue of integration. Turf battles seem of little relevance here; that different approaches have something to offer one another is patently obvious and needs no particular acknowledgment. If something out there has something useful to contribute, as my 12 year old daughter says, "bring it on." The effort at integration evident in these papers is not only across orientations; the clinical/research barrier is also seamlessly crossed in both directions. Rosenzweig (1936) recognized long ago that what therapists think matter and what actually seems to account for therapeutic results can be two different things. While that will probably always be true to some degree, we have become somewhat more savvy. Our models, in great part because they are specifically informed by research into psychotherapy process, outcome and effectiveness-- are coming to reflect more and more the complicated nature of what makes for effective therapy. There is increasing resonance between what we think matters, and thus what we do, and what actually matters.

I also maintain that the very nature of the therapeutic action of any treatment that works is integrative. Only theories are pure and unimodal. People are messy and multimodal, complex and chaotic systems. Thus, change as an organic process is invariably complex and multifaceted. The repertoires of interventions of all the models represented here bespeak multiple influences. Treatment methods may be pure (though they are surely not in this group of papers), but treatment effects are never pure. Theoretical purity is characteristic of an early phase in the development of a treatment model; through the maintenance of a clean and narrow focus, a highly specialized expertise can develop. This pure version -- be it of behavior therapy, or psychoanalysis, or body-focused therapy-- has passion and zeal. Singleness of purpose illuminates its one corner of the human experience in a very different way than obtains when matters are approached from a more complex and layered perspective. With purity, the illusion of having uncovered "the truth" can more comfortably be maintained. The next phase in the growth of a therapeutic approach is narcissistic injury. Invariably, complexity enters, limitations are encountered, results look less dramatic, parameters have to be introduced, and reality once again proves to be humbling. There is the realization that one does not have a monopoly on "truth." In the third phase, equilibrium is regained as maturity emerges: there is quiet confidence born of experience in the place of passionate certainty driven by conviction. These papers are all definitely of the third phase: brief integrative therapy has come of age.

In the rest of this commentary, rather than engaging in a detailed critique of each paper, I will instead comment on aspects of each papers which were startling and thought-provoking to me. Then I will try to articulate the set of common factors that emerges from these works, a set that I imagine these authors would endorse. I introduce a distinction between *unitary* and *dialectical* common factors. Finally, I end my comments with some reflections on a dichotomy that is not yet a dialectic, as the authors are on one side or the other of what is not yet even a clearly identified divide. I name the divide and muse on some questions the dichotomy raises.

ONE AT A TIME

Magnavita and Carlson: Short-Term Restructuring Psychotherapy (STRP)

STRP, the approach that Magnavita and Carlson describe, is a latter day, third phase avatar of ISTDP (Intensive Short Term Dynamic Psychotherapy), the highly confrontational STDP (short-term dynamic psychotherapy) method developed by Habib Davanloo (1990). As someone intimately familiar with that world (like Magnavita, I too, did intensive training with Davanloo in a previous life), I was astonished at

the breathtakingly integrative and even-handed tone of Magnavita and Carlson's paper. Every step of the way, a wonderful array of models of therapy and schools of thought are carefully considered. One of the strongest aspects of this paper is the thoroughness of the review of the contributions of different models that address similar concerns, thus revealing convergence where one least expects it. To have Kernberg's object relations perspective (1976) mentioned in the same paragraph as behaviorally-inspired interventions is truly refreshing.

Types of restructuring: Magnavita and Carlson describe technical interventions for restructuring aspects of the personality. Beyond defense restructuring, which is the hallmark of the experiential STDPs, they also discuss affective, cognitive, and dyadic restructuring. In their world, the type of restructuring is largely determined by the level of disturbance of the patient. *Defense* and *affective restructuring* are used with patients with good ego strength; with such patients, the most rapid transformations of the personality can be attempted. *Cognitive restructuring* is used with patients with "fragile ego structure" and with those "who use the somatic channel (psychophysiological disorders)" (p. 39); its goal is to enhance these patients' capacity to tolerate affective experience without becoming disorganized, so that eventually they might be able to benefit from more challenging experiential affective work and its more radical results. Finally, *dyadic restructuring* is for the most disturbed of the patients who can be treated with STRP, those who suffer from what Magnavita and Carlson call "attachment disturbances." Given that their relational abilities are compromised, dyadic restructuring is undertaken to allow these patients the generic benefits of a therapeutic relationship before any other therapeutic work is attempted.

The addition of cognitive and dyadic restructuring expands the range of patients for whom this kind of ambitious treatment can prove beneficial. Moreover, through elaborating different types of restructuring and linking each with a different point on the spectrum of disturbances, Magnavita and Carlson contribute to the evolution of differential therapeutics.

The issue of aggression: In the process of writing this review, I decentered from my own engagement in the STDP world and its parochial schisms. As I did so, it occurred to me that ISTDP is the only therapy I know that makes active use of aggression --both the patient's and the therapist's-- as part of the process "getting there" to the "place" where deep change can take place. While other therapies use confrontational methods, Davanloo-influenced approaches, including STRP (e.g., Coughlin Della Selva, 1996; Kalpin, 1994; Magnavita 1997; Magnavita and Carlson in this issue), are unusual in how unapologetically they take on the dark side of human experience. Davanloo has been widely criticized as well as critiqued (e.g., Alpert, 1992; Fosha, 1992, 1995; Gustafson, 1986) precisely for this aspect of his work. Nonetheless, inasmuch as anger, rage and aggression are universal reactions and an ubiquitous source of problems, it behooves us to reflect further on this matter.

In part, anger is difficult because it disrupts the flow of relatedness, as it is ecologically meant to: its evolutionary function (Darwin, 1872) is to create a boundary against assault, invasion and territorial violations (of course, here *we* are talking about the psychic territory that is the self). The internal response of anger, and its translation into the assertiveness and strength that are its result when anger is adaptively used, bespeak a healthy self. Lack of access to anger -- the result of overregulation-- leaves the individual vulnerable to emotional exploitation, and out of touch with self experience. At the other extreme, unmetabolized expressions of anger and acted out rage --problems of underregulation-- result in devastating dysfunctions that wreak havoc as they rent the fabric of self, family and society[1]. Thus, the very essence of what makes ISTDP, and thus certain aspects of STRP, so difficult to master and practice --the aggression required can be viscerally and intuitively aversive to so many therapists-- may be precisely what is singularly valuable.

In its stance, ISTDP --and STRP as applied with certain patients-- reproduces the demand characteristics of situations that elicit aggression: the patient has to deal with threat and attack, though of course the therapeutic "attack" is against those aspects of the individual's functioning where her/his own best interests and adaptive responses are being betrayed and neglected. The highly confrontational approach iatrogenically "pulls" for the patient's anger and aggression; when they are elicited, ISTDP has specific techniques to facilitate their deep visceral experience, expression and working through. Those versed in ISTDP techniques have a rare expertise in the phenomenology and dynamics of anger, aggression and sadistic impulses, and are well versed in techniques that promote their transformation within the therapeutic relationship.

However demanding and uncomfortable this aspect of ISTDP and STRP may be for both therapist and patient, the questions it raises are profound: if the capacity for anger comes on line as the individual's sense of self becomes stronger in the context of a supportive and affirmative therapeutic relationship, is there anything lost if aggression and sadism are not fully experienced and explored within the therapeutic relationship itself? Is the assertiveness that emerges as a result of the building up of the self and its esteem different from the assertiveness that forms as one gains strength and confidence from fully engaging in battle? Is there something about the full experience of aggressive and sadistic impulses within oneself which gives access to regions of the self which otherwise remain uncharted? These are unsettling as well as unsettled questions, and Magnavita and Carlson give us the opportunity to engage them. As the illusion that "there's always next session" is not available in brief therapy, the consequences of both the road taken, and of the road not taken, have to be confronted.

James McCullough: Cognitive Behavioral Analysis System of Psychotherapy (CBASP) for chronic depression.

The world in which psychoanalysis and CBT represent disjunctive domains is not the world in which McCullough's Cognitive Behavioral Analysis System of Psychotherapy (CBASP) operates. Albeit choosing a Piagetian rather than a psychosexual or object-relations psychoanalytic language, nonetheless McCullough's model roots the chronically depressed patient's difficulties --the specific psychopathology his treatment model is designed to address-- in the infantile nature of the patient's way of being in the world. McCullough ranges freely with assumptions about points of fixation and regression, and the diagnostic value of transference and countertransference phenomena is at the center of his model.

Aside from being a (cognitive) analyst in his understanding of the patient, McCullough is a relationally oriented experientialist in what he thinks is most important in treatment. He seeks to promote a corrective emotional experience in the therapist-patient relationship, and he thinks the patient's *experience* of *relief moments* is crucial. Ultimately he views psychopathology as affective psychopathology, a view with which I could not more heartily agree (see Fosha, 2000a). I do, however, have a substantive quibble with him: While it is very good to see affect and emotion come to CBT, it is apparent that in McCullough's view, emotion is still suspect and viewed as essentially disruptive of cognition. This understanding of emotion fails to take into account recent (Damasio, 1994; Lazarus, 1991; LeDoux, 1996; Panksepp, 1998; Siegel, 1999) and not so recent (Darwin, 1972; Tomkins, 1962, 1963) work that strongly argues for the centrality of the information-processing function of emotion and its key role in promoting optimal adaptation. The view of emotion as disruptive is furthered by not distinguishing between adaptive --or core-- emotions, on one hand, and maladaptive or defensive/regressive emotions on the other (see Fosha, 2000, Greenberg & Paivio, 1997, and

Magnavita, 1997, among others, for extensive discussion of these issues), a highly relevant distinction in any emotion-centered clinical approach.

Another remarkable aspect of McCullough's work is his advocacy for the fundamental importance of diagnosis and the value of describing in detail the phenomenology and psychodynamics of the psychopathology and nature of resulting problems of the target population any treatment aims to affect. He begins his article by saying: "The psychopathology of the patient should determine…the type of psychotherapy administered." This is a crucial aspect of what allows McCullough to intervene so effectively within the extremely brief CBASP model of treatment that he practices.

If I may be pardoned for some political incorrectness of my own, I found his tone vis-a-vis his patients most politically incorrect, and I have to confess that I loved it. McCullough has been in the trenches with these difficult patients and his battle scars entitle him to tell it like it is. He calls a psychopathology a psychopathology and he is not one to mince words: "…treatment begins with a cognitive-emotional retarded adult child….. who…. functions, at least in the social-interpersonal arena, with the structural mindset of a 4-to-7 year old preoperational child" (p. 9). In this unsentimental view of the patient, there is a realness born of actual experience, which is invaluable. He has hit his head against many walls; his head is bloody but unbowed. Out of those experiences has come a treatment that works.

Transference/countertransference in CBASP. At the heart of McCullough's CBASP model is a transference/countertransference-based understanding of the patient and of the treatment process. McCullough's graphic description of the interpersonal pulls of the chronically depressive style is arresting and to the point: Depressive patients' game of "gotcha" with the therapist is their very resistance and recalcitrance to being helped, the unrelenting pessimism and negativity characteristic of these patients: "nothing you can do can help me," "nothing you can do will alter the miserable course of my life." These attitudes are tailor-made to "get" therapists where therapists are generically most vulnerable. The confrontation with the failure to make an impact reliably pulls for the anger of the frustrated and humiliated healer; with hands tied behind the back, the therapist is forced to watch the unremitting suffering of the other which s/he is helpless to relieve. The other interpersonal pull, this one engendered by the patient's passivity and seeming haplessness, is to take over and be in charge. But, as McCullough clearly says, to respond with anger and/or with taking control are lethal strategies with these patients, as they reproduce precisely the conditions that gave rise to their psychopathology in the first place. There is no quicker way to therapeutic defeat than giving in to these powerful interpersonal pulls.

McCullough's solution is to resist these pulls, and to relentlessly expose patients to their characteristic modes of engaging others. He focuses on the importance of the consequences of patients' customary ways of behaving, so as to be able to make the powerful point that the patient has agency in her/his life, and is not merely a victim of cruel fate. McCullough highlights the importance of the consequences of behavior. And it is here that the radical fringes of psychodynamic therapies that advocate the use of the therapist's self-disclosure and operant conditioning models come together most surprisingly. Both hold that the therapist's experience of the patient's interpersonal ways of being contains crucial information about the patient's interpersonal patterns and their consequences on others; with the feedback coming from the therapist's self disclosure of her/his reactions, corrections can be made. McCullough makes a major contribution in stressing the need to make this explicit, and then to work with it dyadically. Finally, he is eloquent in arguing for the importance of getting the patient to specifically acknowledge the therapist's impact. The stage is set for allowing situations that are different from the psychopathogenic ones to gain psychic reality. Once positive relational experiences gain experiential tangibility, they can be used to refute cognitions that regard misery and unhappiness as inevitable. (See

also Fosha, 2001, for a similar set of interventions based on a similar rationale, approached from a different theoretical framework).

The use of transference/countertransference: the patient's egocentrism and the therapist's loneliness. I found McCullough's emphasis on the loneliness of the short-term therapist profound, moving and courageous. He has the courage of personal emotional involvement, and with personal involvement comes pain, which makes it quite real. The experience of loneliness while in the presence of the patient brings with it another deep insight into the precise ways in which chronically depressive pathology interferes with these patients' capacity to be in the world. Chronically relying on egocentric logic, the chronically depressed adult lacks empathy for the other. And without access to empathy, what chance is there for satisfying mutuality?

McCullough promotes experience and makes extensive use of his countertransference in his assessment, including diagnostic assessment, of the patient. The therapist's loneliness guides the way. When the therapist no longer feels lonely in the interaction with the chronically depressed patient, the patient's recovery has taken root. Speak of integration!

McCullough's emphasis on the centrality of the chronically depressed adult patient's egocentrism --and resulting impairment in empathy and the capacity to be attuned to the other-- is resonant with the work of Tronick and Weinberg (1997) who study the infants of depressed caregivers by analyzing moment-to-moment mother-infant interactions. One of the interactional hallmarks of infants of depressed mothers is their hyperfocus on self-regulation at the expense of self-other regulation. This extremely early tendency to rely on self-regulation and withdraw from self-other and other-focused regulation appears to be an early marker for the development of depression later on in life, a marker present at a very early age. It would be very interesting to know McCullough's take on this work.

Hanna Levenson: Time Limited Dynamic Psychotherapy (TLDP)

Hanna Levenson's paper on TLDP is masterful, an extraordinary example of what I mean by the coming of age of brief integrative treatment. It is written with ease and breadth and thoroughness and self-assurance. It is a complete work. Because she knows precisely what she thinks, she can say it as succinctly -- parallel process evocation intended-- as the limitations of the form of this article require. In Levenson's paper, we move seamlessly from theory to therapy to theory of the therapy to supervision to training and finally to research. And that's only half the paper. In the second half, we see a master therapist at work, struggling, being real and eventually finding her way to transforming this patient so that she can like him, i.e., so that he could like himself, and so that others would like him and genuinely wish to be with him, which is the way out of the psychological conundrum he has created through his cyclical maladaptive strategies.

The relation of self to self. An important aspect of Levenson's contribution is her attention not only to the interpersonal relationship between self and other— the two-person psychological perspective being a fundamental aspect of TLDP—but also to the relation of self to self. "TLDP makes use of the relationship between patient and therapist to kindle fundamental changes in the way the person interacts with others and him or herself" (p. 2).

The relationship of self to self and *its* relationship to earlier patterns of relatedness with significant others is a major aspect of object relations theory (cf. Fairbairn, 1954; Guntrip, 1969), and of Lorna

Benjamin's circumplex model of interpersonal psychology (1997). Recent emphasis on self to self relatedness has emerged in the context of the explosion of interest in trauma and the new trauma treatments (Herman, 1982; Rothschild, 2000; Shapiro, 1995; van der Kolk, 1996). Issues of self-care, self-empathy, and self-compassion are only beginning to be recognized as an essential dimension along which the effectiveness of treatment ought to be evaluated. Traumatic interpersonal experiences acquire their psychotoxicity through their internalization: good, bad or ugly, attachment relationships become internalized in the psychic structure of the individual, reflected in the schemas that inform how the individual interacts with others (see Wachtel, 1987, 1997). But the internalization is also reflected in the individual's treatment of him or herself. We learn about how the patient was treated in the toxic relationship with the other by watching the individual's relationship with him or herself. In self-loathing, shame, guilt, self-punitiveness, self-neglect and/or destructiveness toward the self, we have a stark record of what the patient had to contend with in the relational past.

Therapeutic modalities emphasizing empathy (Alpert, 1992; Fosha, 2000; Jordan, 1991; Kohut, 1984; L. McCullough, 200; McCullough Vaillant, 1997) link the capacity to be compassionate toward others with the individual's ability to be compassionate toward the self. Empathy flows outward when self-empathy is restored. In this context, it is interesting to note that the turning point in Anchin's treatment of his patient Sid comes when the focus switches from difficulties in functioning in the interpersonal world –with boss, wife, etc.,-- to the relationship of self with self.

Through the therapist's empathy toward and affirmation of the patient's self, the patient's relationship to his/her own self can begin to change; the new experiences in the dyad stimulate self-to-self changes that eventually generate interpersonal changes. By drawing attention to this area, Levenson expands our awareness of yet another realm of experience, and thus yet another essential realm of therapeutic action.

A direction for future integration. It is interesting to consider the significant overlap between Levenson's TLDP and J. McCullough's CBASP. Both models are concerned with the short-term treatment of patients who are "hostile, negativistic, inflexible, mistrusting or otherwise highly resistant … [who uniformly had] poor outcomes. Their therapists became entrapped into reacting angrily; in general, they [the therapists] responded antitherapeutically to the patients' pervasive negativism and hostility" (Levenson, p. 1-2). Both authors discuss the need for the therapist to resist the interpersonal pull of the patient's typical interpersonal patterns; similarly both affirm the centrality of corrective emotional experiences with the therapist, what McCullough refers to as "relief moments" and Levenson as "new experiences." I thought that Levenson's treatment of Mr. Johnson could well work as an example of CBASP, and McCullough's treatment of his female patient might very well meet criteria for TLDP. Given that TLDP is rooted in the interpersonal/object relations dynamic tradition, and CBASP in the cognitive behavioral tradition, this cozy convergence gives one pause. The convergence, and *integrative* nature, of the clinical innovations we are witnessing here is fostered, I believe, by the push to maximal effectiveness inherent in all brief treatments. When the problems to be solved are the same, and so are the constraints imposed by the time limit, it is less surprising that the tools and solutions that emerge have much in common. As Levenson says "the brevity of the treatment promotes therapist pragmatism, flexibility and accountability" (p. 2).

I would like to see both authors go further. Because of the clinical experience they accrue as a result of their innovations -- experience with new phenomena elicited through the application of the new techniques-- these therapists are in a position to go back to their respective models and introduce innovations at the theoretical level so that the theory can do justice to the new frontiers the clinical practice is opening up. What would a CBT *theory* look like that would do justice to McCullough's

countertransference-based diagnostic and prognostic assessment, and his focus on relief moments? TLDP shows that thoroughly established patterns, dating back to childhood, can be transformed rapidly and that new self-transforming patterns can be come to be part of the individual's repertoire in a brief period of time. What would a change-focused object-relations model look like? Object relations theory has a powerful way of accounting for the tendency to repeat and thus, the continuity of patterns over time. However, the model does not yet adequately account for the mechanisms of corrective emotional experiences, nor for individuals' drive for new experiences in spite the templates of the past. Precisely because of their clinical and technical contributions, these clinicians are uniquely poised to make contributions at the theoretical level.

We need clinical theories that are as adept at explaining change processes (characteristic of the effective therapeutics) as they are at explaining stasis, resistance and stagnation (the hallmarks of psychopathological processes). This issue is explored in detail in two recent papers, one proposing a change-based metatherapeutic from within an affect-centered experiential-psychodynamic framework (Fosha, in press), the other examining the radical implications of infant-mother interaction research into moment-to-moment change processes for psychoanalytic clinical practice (Lachmann, 2001).

Levenson quotes Strupp and Binder, the creators of TLDP, as saying that their "purpose is [not] to construct a new theory of personality development…. Rather we have chosen interpersonal conceptions as a framework for the proposed form of psychotherapy because of their hypothesized relevance and utility" (Strupp & Binder (1984), in Levenson, p. 30.) "A new theory of personality development" based on the evolving clinical expertise would be an invaluable contribution, and would only enhance the "relevance and utility" of theory for practice. Such conceptual contributions would organically foster the development of integration at the level of theory. Levenson says that new experience leads to new understanding. Given the new experiences that constitute TLDP, the time is ripe to cultivate the emergence of the new understanding (theory) that naturally develops in the wake of such exciting new experience (clinical work).

Jack Anchin: Cybernetic Systems, Existential-Phenomenology, and Solution-Focused Narrative

While there are a myriad of points of insight and pearls of therapeutic wisdom in Jack Anchin's article, I will begin my discussion of the radical nature of this contribution by reflecting on its length and detail.

Ode to length and detail. Some gestalt guru said that the world is a battle between the phobics and the addicts. Passionate and deeply involved himself, Anchin writes for the addicts. The idea of appealing to the lowest common denominator does not appear to occur to him. He does not condescend, he does not lower standards, he does not dumb down. He is not afraid of being smart, and he is not afraid of being intellectual. Anchin weaves together many different intellectual and clinical traditions, each with its own kind of history, wisdom and vision, and he seeks to do justice to each of their ways of knowing. Suffice it here to say that his review and integration of three therapeutic approaches -- the cybernetic systems, existential-phenomenology, and solution-focused narrative perspectives-- is splendid and informative. However, all the theory in Part I would not be as powerful without the detail of the case presented in part II. Anchin's work with Sid further brings his ideas to life. The highly detailed account of that treatment allows the therapist/reader to inhabit an actual therapy. And, as invariably happens with elaborated experiences, by deeply understanding something about another, we emerge with a deeper understanding of ourselves, in this case, of our own treatments and own ways of working.

Affirmation and slouching toward the future: What stands out about Anchin's clinical work is his unwaveringly affirmative stance with the patient: "I compliment and at times even literally stand up and applaud efforts and successes throughout this process" (p. 28). He does not appear to struggle with the patient's "pull" to engage in undesired patterns of interaction. (Since I will discuss this point in the last part of my comments, I will no more than name it here.)

An interesting turning point of Anchin's treatment of Sid occurs when the patient is better and has returned to professionally functioning after a long hiatus of withdrawal. The goal of the therapy has been met in 12 or so sessions. It is then that treatment deepens. "I want to deal with work, but I also want to work on all areas of my pain," says Sid. The therapist maintains, as he does throughout the treatment, a dual focus: he is positive, affirmative and purposive; and yet, he steadfastly maintains a focus on the patient's difficulties. The therapist's unwaveringly affirmative stance earns the patient's deep trust and short-circuits his resistance: it is the patient who takes hold of his maladaptive patterns, takes responsibility for them, mourns the enormous sacrifices to his own well-being that engaging in them has involved, and, his motivation high, bravely plunges forward to do hard, painful work. His self-esteem solidified by the interaction with the therapist, the patient has the strength to face unsavory things about himself with a non-judgmental therapeutic work ethic devoid of self-loathing and avoidance.

The teleological perspective. Anchin introduces a vocabulary to address an insufficiently represented aspect of motivation: teleological, purposive, progressive, future-oriented, these are all different ways to refer to the individual's active striving toward positive and desired ways of being. The teleological perspective holds that negative states, the very states that bring patients to us, contain within them the seeds of healing: "The underside of this distress [the individual's subjective pain] speaks to the patient's intensely urgent desire to experience more positive and subjectively satisfying ways of being-in-the-world" (p.2). From an information-processing point of view, the negative state tells you that the organism's aims are not being attained. This is reminiscent of Joffe and Sandler's definition of mental pain as involving " a discrepancy between the actual state of the self on one hand and a… state of well-being on the other" (1965, p. 396). In Anchin's words, "teleological meaning encompasses "change implications" embedded in the patient's pain" and "represents a potential solution to the problematic situation."

The teleological perspective has been largely absent from traditional psychodynamic approaches (Jungian theory being the exception). The clinical applications of such an approach are significant: the therapeutic process is not conceived of as involving getting rid of something bad, i.e., pathology, and installing something that was not there before, i.e., adaptive strategies. Rather, that which is desired is already present implicitly; the therapeutic task consists of facilitating the emergence of desirable ways of being, dealing piecemeal and locally with barriers that stand in the way of their realization. In this view, rather than needing to contend with resistance before the treatment can take hold, from the beginning, patient and therapist are on the same side. Resistance is not a basic motivational construct; it is construed as a local event to be handled in the clinical moment and used as a further opportunity to learn first-hand about what has stood in the way of the patient's ability to actualize her/his life agenda.

The patient's motivation for change, rooted in his distress, is taken for granted. It does not require heroic therapeutic measures to be rescued from underneath the weight of repetition compulsion. From within the teleological perspective, the therapist is merely assisting the patient, helping bring about what is clearly inherent in her/his distress. In Anchin's work with Sid, we see seamless integration in action. And it works.

ALL TOGETHER NOW: THE COMMON FACTORS

The list of common factors that emerges from brief integrative psychotherapy approaches differs somewhat from that emerging from approaches in which the temporal parameter is not front and center. The bar is set higher: we are looking not only at what makes treatment work, but at what makes treatment work quickly. If the common factors listed below contribute to therapeutic results in a condensed time frame, they will be effective, *a fortiori*, in treatments in which the temporal constraints are more relaxed. I will review what we glean from these authors about the common factors that seem to underlie effective and efficient treatment. My discussion makes a distinction between *unitary* common factors and *dialectical* (process, oscillating, dual-focus) common factors.

Unitary (or Qualitative) Common Factors

1. A collaborative therapeutic relationship

2. The patient's experience as the fundamental agent of change

3. Understanding of psychological processes in terms of schemas linking affect, cognition, and representations of self, other, and self-other relatedness

a. the dyadic nature of psychological functioning

b. alternating waves of experience and reflection

1. *For (brief) treatment to be effective, the therapeutic relationship needs to be collaborative*. It is not just being in a therapeutic relationship that matters, it is being in a *collaborative* therapeutic relationship. This is quite different from focusing on the therapist's warmth, empathy, understanding, and positive regard, and the patient's receptive experiences of feeling cared about and understood. The focus is on the collaborative activity of both members of the therapeutic dyad.

In the relatively early days of STDP, patients had to come with ready-made capacity for collaboration, e.g., Sifneos's (1987) criteria. No longer. Now, part of the therapeutic competence of brief treatment, evident in all four papers, is active techniques to foster collaboration by (a) using any glimmers of engagement that are present, and enlarging them, and by (b) deeply and rapidly identifying the patterns by which engagement is avoided and resisted, and intervening actively to transform those patterns. What is required of patients is that they have the *potential* for collaborative relatedness, and that they be willing to engage in an interaction with that as its goal.

The notion of collaboration also has implications for the therapist's stance, which must be such as maximally fosters collaboration even in the presence of other interpersonal trends. Aspects of the therapist's stance that contribute to a collaborative spirit include pragmatism, flexibility, willingness to emotionally engage, and an attitude that is non-authoritarian, non-omnipotent and respectful of the patient's competence.

2. *Therapy is essentially experiential. The necessary, though not sufficient, active therapeutic agent is the patient's experience.* The specific techniques of the four models described in this issue may be

different, but all seek to affect the patient's emotional experience, which is viewed as a crucial catalyst for transformation. As Frieda Fromm-Reichmann is said to have said, " What the patient needs is an experience, not an explanation." Specifically, there seems to be agreement that:

a) the patient must have an experience where the bodily (i.e., sensory, somatic, visceral, motoric) referents of psychological processed must be engaged

b) optimally, the patient should have a corrective emotional experience in the relationship with the therapist

c) the therapist's own emotional experience be engaged in the therapeutic process, as it is a very important source of data that is actively used with the patient and is dynamically linked with the patient's experience

A corollary of the experiential focus is this: *in general, work in the present; more specifically, work in the here-and-now of the therapeutic relationship*. The experiential immediacy of such a focus makes therapeutic work most effective. Working in the present allows change to happen more quickly; there is no assumption that one needs to work through the specific contents of childhood conflicts and uncover historical truths, though formative conflicts and historical truths are alive and well as ongoing processes, manifest in the patient's moment-to-moment current experience and functioning.

Therapy accesses, fosters, and co-creates experiences to which the patient previously had no access. This includes, but is not limited to, corrective emotional experiences. Emotional *experience*, be it of new or old patterns and material, unlocks psychological resources. It allows patients to look both at the antecedents and the consequences of their actions. It unlocks formerly unavailable memories and experiences. It offers opportunities for mastery. It leads to insight and perspective. It gives the patient hope.

3. *The organization of psychological processes (be they those involved in optimal functioning, pathology, or therapy) is best understood in terms of schemas where affect, cognition, and representations of self, other and their interaction are intertwined*. These schemas are translated into patterns of experience, behavior, and interaction (the environment, others, and the self). This is a *conceptual* common factor, a common factor of shared theoretical understanding. How we as therapists understand clinical process shapes and guides our clinical actions and our selection of interventions.

Psychopathological manifestations can be understood as organized by cognitive-affective schemas of *self and other engaged in a relationship.* While treatment is not past-focused as such, the roots of pathological patterns in early relationships is a source of deep understanding for both patient and therapist. This is now an invariant feature of how we all seem to understand pathology. The collection of elements comprising the schema, indeed the very notion of underlying schemas, speaks tomes about how far integration has come.

3a. The dyadic nature of psychological functioning. All the authors in this issue implicitly or explicitly subscribe to a two-person psychology: the therapeutic process is essentially understood as relational and interpersonal. It is not seen as a function of the patient, or of the patient's pathology. From within the interpersonal perspective, the therapeutic process is understood to evolve through and emerge from the interaction of both members of the therapeutic dyad.

3b. Minding the body, embodying the mind. Therapy involves alternating waves of experience and reflection. Reflection is not a simple cognitive function, but rather is a deeply integrative function

(Fonagy, 1997; Fonagy & Target, 1998), akin to mindfulness where the integration of emotional and cognitive processing is probably mediated through the prefrontal orbital cortex (Schore, 1996).

Experiential work potentiates new understanding, and is potentiated by it. Experience without reflection (or understanding) is hard to generalize, making more iffy the translation of in-session changes to out-of-session changes (Mahrer, 1999), which is, after all, the key to a positive outcome. On the other hand, reflection without experience is anemic, often lacking transformational staying power. Thus, for therapeutic experiences to have lasting results the patient must have an experience, must be aware of having (or having had) an experience, and must have a sense of how that experience fits in with the his or her personal narrative. Here, in the integration of experience and reflection, we encounter the cognitive-affective integration at the intrapsychic level.

Dialectical Common Factors: "I love you. You're perfect. Now Change"

a. Empathy vs. authenticity

b. Validation and acceptance vs. facing and challenging maladaptive patterns

c. Support vs. confrontation

d. The patient knows best vs. the therapist as expert

e. Corrective emotional experiences vs. cyclical transactional processes

f. Focusing on the exception to the rule vs. the maladaptive pattern

g. Focus on health, and the patient's resourcefulness, vs. focus on pathology and the patient's disturbance

h. focus on future (and the patient's progressive aims and strivings) vs. focus on the past (and reasons for patient's being the way he or she is)

The notion of a *dialectical* common factor identifies a factor which is relevant to therapy, where its two poles are in direct opposition, seemingly contradictory. But the apparent contradiction can be resolved at a different level, where in the two seemingly mutually exclusive positions can be interrelated. The new understanding that comes from their being woven together is deeper and more comprehensive than the understanding captured by either side of the dichotomy. Unlike the notion of a dichotomy, which reifies the opposition, the notion of a dialectic captures the idea that a thing and its opposite are mutually contradictory only at one level, but that the opposition can be resolved at a higher level. The idea of dialectical common factors resonates with the essence of what integration is about. It also resonates with the notion of restoring the coordination of affective states between dyadic partners whose attunement to each other is disrupted, which will be introduced and elaborated in the next section. Here, the notion of dialectical common factors represents integration at the level of the therapist's stance vis-a-vis the patient and the clinical material.

Anyone who has kids knows how impossible it is to strike a graceful balance, yet how crucial it is to

struggle to do so. It is no different with patients (except that the therapeutic encounter does eventually come to an end).

The conceptual and technical question becomes which side of the dialectic to lead with. Which side of the dialectic is most effective as a way of engaging the patient and engaging with the patient, so that both sides can ultimately be addressed? Does one lead with confrontation or empathy? Does one lead with validating the patient or with confronting him or her with painful and unsavory aspects of their way of engaging or behaving? How these, and other similar questions, are specifically answered is what differentiates therapeutic approaches and it remains for empirical research to demonstrate the superiority of leading with one side of the dialectic over the other. However, all the approaches represented in this issue, recognize the importance of addressing both sides of the dialectic.

While each of these dichotomies could be individually addressed and elaborated, in the spirit of brief therapy and of an understanding of aspects become manifest in the moment-to-moment process, I will choose just one dialectic - that involving empathy vs. authenticity- to explore in detail, hoping that this exploration will illuminate some of the clinical issues embedded in these factors.

Empathy vs. authenticity. Empathy informs the stance of all these therapists, but all go beyond empathy and use their authentic experience to do so. All the approaches attempt to get to excluded areas of the patient's experience--warded off, defended against, selectively unattended to-- and bring it to the patient's attention. The therapist has access to excluded aspects of the patients' experience, in part through his or her own authentic experience of being with the patient. The processing of these excluded (because frightening, painful, unknown) areas of the patient's experience is essential to an integrated outcome. Empathy as a mode of interacting and of "just being there" with the patient has limits. This is why self-psychological treatments take so long. There needs to be a balance between assimilation-based empathy, which sees everything from the patient's point of view, and accommodation-based authenticity of the therapist's experience of the patient. In using the dynamic tension between the two, the patient's areas of emotional mastery can be expanded.

FOCUS ON DISTINCTIONS RATHER THAN COMMONALITIES

All the authors in this issue agree that for therapeutic results to stick, the patient must have an *experience*, and that, optimally, that experience should be a corrective emotional experience in the relationship with the therapist. There is, however, a divergence between Anchin's approach, on one hand, and those of Levenson, J. McCullough, and Magnavita & Carlson, on the other. It is a divergence which is not articulated by any of them, yet one which is significant: Does the corrective emotional experience *follow* the repetition of the maladaptive pattern with the therapist, or does the corrective emotional experience in the therapeutic relationship *pre-empt* the repetition, as a new, adaptive pattern is dyadically co-created from the start?

The notion of the corrective emotional experience comes from Alexander and French (1946):

...reexperiencing the old, unsettled conflict but with a new ending is the secret of every penetrating therapeutic result. Only the actual experience of a new solution in the transference situation or in his everyday life gives the patient the conviction that a new solution is *possible* and induces him to give up the old neurotic patterns" (p. 67, italics in the original).

Alexander and French emphasized that it wasn't insight into the repetition of the old conflict that was curative, but rather the *experience of the new solution*. Their search for ways to facilitate and accelerate the experience of the new solution led to technical innovations that made them key figures in the brief therapy movement.

Rapid detection of slouchings toward repetition. As we see in this issue, technical innovations aimed at short-circuiting the repetition scenario are among brief therapy's major contributions: Practitioners have become savvy at detecting slouchings toward repetition right off the bat, and effective in their attempts to offset them. Bob Dylan wisely recognized that "You have to pay to get out of / Going through these things twice." And paying to get out of going through these things twice is precisely what Levenson, McCullough, and Magnavita & Carlson work so hard to do, Levenson and McCullough by resisting the "pull" or "unhooking from" those maladaptive patterns (see also Safran & Muran, 2000), and Magnavita & Carlson through "restructuring" those patterns as soon as they make themselves known in the trial therapy. Their work promotes effectiveness and speed by *not* requiring that the patient fully engage in enactment of the maladaptive patterns before such patterns can be therapeutically addressed and transformed.

Leading with the corrective emotional experience. Another solution, however, is to forego the repetition of the old patterns altogether, and aim for the experience of the new solution from the get-go. I have called this "leading with the corrective emotional experience" (Fosha, 2000, p. 331). Anchin's work is representative of models that take this approach (see also Bohart & Tallman, 1999; Buber, 1965; Hubble, Duncan, & Miller, 1999; Fosha, 2000; Gendlin, 1996; Greenberg, Rice, & Elliott, 1993; Levine, 1997; Rothschild, 2000; Shapiro & Silk Forrest, 1997). It is here that Anchin's work stands apart from the other three models.

Instead of working to resist the patient's pull toward repetition, Anchin exerts his own "pull," and sets out to "hook" the patient into a new relationship. He leads with engagement and affirmation, and sets a tone of healing, support and informed hope. Enthusiastically greeting the patient, he stands up and applauds the patient, before the patient has a chance to sink into his or her seat. Before the enactment can gather any steam, the therapist has already gotten something else going. Through *his* therapeutic actions, Anchin begins the interaction with the patient in a new, adaptive mode.

Magnavita & Carlson, McCullough, and Levenson acknowledge the co-constructed aspects of the patient-therapist interaction. However, while they subscribe to a two-person psychology, in their models, the therapeutic interaction is patient-shaped and shaped by the patient's maladaptive tendencies. It is the patient --and his or her pathology-- who sets the tone and the therapist who responds. As Levenson says: “the TLDP perspective is that the behavior is *predominantly* shaped by the patient evoking patterns” (p. 17; italics in the original).

Beyond responsiveness: therapist initiative. The alternative represented here by Anchin's work involves a radical re-envisioning of the therapist's role as actively involving therapist action and initiative, in addition to responsiveness. In the radically dyadic view, *both* members of the dyad contribute and thus are responsible for shaping the therapeutic interaction, though their contributions need not be strictly symmetrical (Stern, 1985).

The transformational model of mutual influence. The transformational model of mutual influence articulated by Beebe and Lachmann (Beebe, Jaffe & Lachmann, 1992; Beebe & Lachmann, 1988, 1994; Lachmann & Beebe, 1992, 1996), informs the radically dyadic view and is in turn informed by research into moment-to-moment emotional communication between mothers and infants which promotes

optimal developmental outcomes in the children (Beebe & Lachmann,1994; Emde, 1988; Stern, 1985; Tronick, 1989, 1998). This model addresses the bi-directionality of the change process and the active role of both partners in the construction of the dyadic interaction and, ultimately, of the individual's psychic repertoire.

The relational origins of psychic structure. How do we conceptualize the process by which an individual's experiences with others transform his or her self? "From the beginning of life, the infant engages with the caretaker in an active construction of both the interpersonal and the subjective world" (Lachmann & Beebe, 1992, p. 139). The dyadic process of the construction of the self through experiences with significant others begins at birth and continues throughout the life cycle. *We are who we relate with.*

Relational patterns become internalized in schemas which organize and shape our ongoing behaviors. Through shaping expectations, perceptions, etc., these interactive cognitive-affective relational schemas become the inheritance of the individual, fashioning his or her contribution to ongoing interactions with others. The sense of self, the sense of the other, and the sense of the dynamic self-other interaction are all viewed as being "emergent dyadic phenomena" (Beebe, Jaffe, & Lachmann, 1992, p. 74), i.e., phenomena that cannot be explained by referring to just one person alone.

In understanding what determines the course and outcome of the treatment, the transformational model of mutual influence focuses not only on the patient "pulls" on the clinical encounter, but also on the contributions of the therapist and of the dyadic interaction to the process.

....[T]he manner in which the relatedness is constructed will bear the mark of both participants. Each influences the process through his own self regulatory range, as well as through specific contributions to the pattern of interaction." (Beebe, Jaffe, & Lachmann p. 76).

To further conceptualize the nature of therapist's contribution to the therapeutic process requires that we look at the confluence of two streams of influence. The therapist's own emotional and relational history that led him or her to be the person he or she is in the very moment we are focusing on is the first stream of influence. The second stream consists of the regulatory rules derived from the therapeutic framework within which the therapist is operating, i.e., the rules by which our perceptions, experience, and behavior as therapists are regulated. Any framework is really a system of rules of interaction, timing, and selection of when, how, and what to address, as well as an education of expectancies based on clinical experience. Not so incidentally, the articulation of models, such as the four represented here, is an attempt to contribute to the shaping of that second stream. Just as much as the patient's --and therapist's-- history of emotional relatedness is a major contribution to what happens in the therapy, so is the therapist's *model*.

There is a third source of influence, in addition to the contribution of the patient and the personality-based and model-based contribution of the therapist. It is the influence of the dyadic interaction itself, which acquires unique and characteristic properties of its own.

When these sources of influence come together, the moment-to-moment oscillation between them leads to a state transformation: there is the emergence of what I have called “core state” (Fosha, in press), a state in which intense, rapid, and mutative work readily and effortlessly takes place. In the core state, patient and therapist are “in the zone,” there is a “flow” (Czimentalyi, 1990) to the therapeutic process, and that “seemingly nebulous, yet creative process” (Anchin, personal communication, October, 2001) kicks into gear. It is as if the process acquires a mind of its own. “The miracle of successful psychotherapy occurs when patient and therapist meld their minds and their experiences” (Gold, 1996,

p. 214).

The developmental literature documents the specifics of the process by which all of these influences come together and thus how experience is *co-constructed* through the interaction of dyadic partners (Beebe & Lachmann, 1988, 1994; Beebe, Jaffe, & Lachmann, 1992; Emde, 1988; Gianino & Tronick, 1988; Lachmann & Beebe, 1992, 1996; Stern, 1985, 1998; Tronick, 1989, 1998), be they mother and child, therapist and patient, or partners in a relationship.

The dyadic regulation of relatedness is attained through the coordination of affective states (Fosha, 2001; Schore, 1996; Tronick, 1989, 1998). It involves a moment-to-moment process of *attunement* (being in sync as a result of matching affective states), *disruption* (the lapse attunement as a result of being in non-matching affective states), and *repair* (the reestablishment of coordination at a new level). In the new coordinated state, reached as a result of the repair of the disruption, a new level of dyadic integration is reached. The coordinated state has motivational properties; both partners experience pleasure on achieving coordination, strive to maintain it, and work hard to restore it when it is disrupted. Countless repetitions of the sequence of attunement, disruption, and repair lead to an affective competence, as the individual internalizes the affective, cognitive and relational coping strategies of the dyad (Beebe & Lachmann, 1988, 1994; Fosha, 2000, 2001; Tronick, 1989).

Tronick (1998) recently proposed that the adaptive function of mutual coordination is the "dyadic expansion of states of consciousness (p. 298)." Through mutual coordination, the more vulnerable members of dyads get access to capacities that are not quite theirs, but that *become* theirs through the interaction; thus, their functioning is enriched. Tronick and Weinberg (1997) give the example of a baby whose muscle development does not yet allow her to sit up on her own. The mother props up the baby in response to the infant's cries of frustration because she cannot control her posture. The propping up facilitates the infant's ability to communicate gesturally during social interaction - a complex action beyond the infant's own ability. There has been a *dyadic expansion* of the baby's capacities. This applies to the therapeutic realm as well. When patients arrive for therapy, their patterns reflect their history of dyadic interactions to date. The therapist's emotional presence and affective responsiveness are crucial in fostering a different learning process. It represents an opportunity for the dyadic expansion of the patient's emotional repertoire.

While both partners contribute to the transforming interaction, their contributions are neither equal nor equivalent: those in the caregiver *role*, be they parents or therapists, having a wider and more *flexible* repertoires, have more opportunities to affect the process (Fosha, 2000; Lachmann, 2001; Tronick, 1989). The therapist's experiences in the dyad are crucial to maintaining the open emotional dialogue, which, in turn, is crucial to the patient's therapeutic transformation.

Integration at the personal level. Just as the child becomes who he or she is through the interaction with his or her caregiver, who --while staying in the role of a caregiver-- is very much is engaged and interacting as him- or herself, so can the patient engaged in an interaction with a therapist. This requires the therapist be emotionally present and engaged, to go beyond responsiveness, and to step forward, weighing in with his or her own unique interpersonal contribution.

The foundations of such a metapsychology of therapeutics go back not to the original psychopathology, but to original health. They have their roots in the natural change processes which result in optimal development within the child/caregiver dyad. The implications of such a metapsychology are profound for theory (rooted in the change processes of optimal development, rather than in the stasis and stagnation-rooted processes of psychopathology), stance (active, and emotionally engaged, not hidden

and neutral), and technique (Fosha, in press; Lachmann, 2001).

It brings the ethos of integration right into the consultation room. Just like integration of therapeutic techniques, or of theoretical approaches, or of stances reflected in the dialectical common factors, the radically dyadic view of therapy holds that personal growth occurs through the *integration* of the best of what each contributor --here meaning each member of the therapeutic dyad, as well as the process itself-- has to offer. It is part patient-based, part therapist-based, and part miracle. So we end with a notion of integration within the person as a result of the therapeutic interaction.

As I said in the introduction, the dichotomy between a corrective emotional experience that *follows* the repetition, and a corrective emotional experience that *pre-empts* the repetition is not yet ready for dialectical common factor status. First, the differential contributions of each side need to be clearly delineated, and their clinical implications fully elaborated and pursued, so that both their advantages and their limitations can be clearly encountered. Only then, will we be in a position to determine whether, in this dichotomy, we have another dialectical common factor, in which the clinical oscillation between the two poles leads to an integration at a higher level, and thus to more comprehensive and effective clinical results.

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