Distinctive Features of Short-Term Psychodynamic-Interpersonal Psychotherapy: A Review of the Comparative Psychotherapy Process Literature

Matthew D. Blagys and Mark J. Hilsenroth
University of Arkansas

The present article is a review of the comparative psychotherapy process literature. It is an effort to delineate techniques and processes that distinguish two prominent forms of treatment. Seven interventions stood out as distinguishing psychodynamic-interpersonal therapy from cognitive-behavioral treatment: (1) a focus on affect and the expression of patients' emotions; (2) an exploration of patients' attempts to avoid topics or engage in activities that hinder the progress of therapy; (3) the identification of patterns in patients' actions, thoughts, feelings, experiences, and relationships; (4) an emphasis on past experiences; (5) a focus on a patients' interpersonal experiences; (6) an emphasis on the therapeutic relationship; and (7) an exploration of patients' wishes, dreams, or fantasies. A better understanding of the specific techniques and processes that distinguish psychodynamic-interpersonal from cognitive-behavioral therapy can facilitate process-outcome research, aid in the training and teaching of psychodynamic-interpersonal psychotherapy, and provide psychodynamic-interpersonal therapists with a guide for session activity.

Key words: **psychotherapy process, psychodynamic-interpersonal, cognitive-behavioral, therapist activity.** ***[Clin Psychol Sci Prac 7:167–188, 2000]***

Alternative psychological treatments employ diverse techniques, processes, activities, and interventions in an attempt to facilitate patient change (Ablon & Jones, 1998; Jones & Pulos, 1993). Psychodynamic-interpersonal and cognitive-behavioral treatments propose different mechanisms of change and implement techniques that are sometimes contradictory and incompatible. For example, cognitive-behavioral therapists often make explicit suggestions for in-session or outside-of-session activities, while psychodynamic-interpersonal therapists are hesitant to make specific suggestions because of their potential implications (Jones & Pulos, 1993). Fairburn, Jones, Peveler, Hope, and O'Connor (1993) and Fairburn et al. (1995) compared the long-term effects of three treatments for bulimia nervosa (interpersonal, behavioral, and cognitive-behavioral). The authors illustrated that interpersonal and cognitive-behavioral therapy were superior to a strictly behavioral treatment for bulimia nervosa at a 12-month follow-up. In addition, Fairburn et al. (1993) reported that while cognitive-behavioral therapy was superior to interpersonal therapy in certain areas of functioning at the end of treatment, these differences disappeared during follow-up. The results of this study suggest that the effects of interpersonal therapy may not be immediate or fully manifested at the conclusion of active treatment and that interpersonal therapy employs a different mechanism of change than cognitive-behavioral therapy. Perhaps there is simply "more than one path to the mountain top." Different treatments may contain their own effective means and ingredients for accomplishing the goal of patient improvement. Specifically, Fairburn et al. (1993) proposed that changes in patients' relationships occur first in interpersonal therapy, translating in time to changes in patients' eating habits and attitudes toward their body shape and weight. In contrast, cognitive-behavioral therapy was believed to act more directly on patients' symptoms of bulimia nervosa, while a decrease in the level of general psychiatric distress and improve-

Address correspondence to Matthew D. Blagys, M.A., Department of Psychology, University of Arkansas, 316 Memorial Hall, Fayetteville, Arkansas 72701. Electronic mail may be sent to mblagys@comp.uark.edu.

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ment in social functioning were seen as secondary effects. The authors appropriately note that the equivalent long-term effects of interpersonal and cognitive-behavioral therapy through the use of different mechanisms of change warrants further comparison of the modality specific differences between these treatments and their relation to outcome.

Empirical documentation of theoretically derived differences between psychodynamic-interpersonal and cognitive-behavioral psychotherapy is an important area of research for three reasons.[1] First, once the distinctive elements of psychodynamic-interpersonal psychotherapy are identified, researchers can begin to distinguish more clearly between common and specific factors and can better determine the relationship between these treatment processes and outcome (Gunderson & Gabbard, 1999). Identifying the processes that distinguish psychodynamic-interpersonal from cognitive-behavioral treatments will allow researchers to better evaluate their effectiveness. Second, identifying distinctive processes can aid in the training and teaching of psychodynamic-interpersonal psychotherapy. Supervisors of this approach will be able to use this review as a training tool, helping psychodynamic-interpersonal therapists develop skills that are distinctive to the treatment. Lastly, the identification of distinctive elements of psychodynamic-interpersonal psychotherapy can provide therapists of this orientation with a guide for session activity, clearly specifying techniques and process to be emphasized in treatment.

Luborsky, Barber, and Crits-Christoph (1990) reviewed literature on several theoretically important mechanisms in the process of change in dynamic psychotherapy. These key features included an emphasis on the therapeutic relationship (transference), patients' interpersonal interactions (with current and historical figures), and a recognition of patterns or themes in patients' functioning. In addition, the authors pointed to the importance of interpretations and the development of an understanding of unconscious wishes (insight) in facilitating the change process.

The present review represents a further attempt to define psychodynamic-interpersonal therapy in terms of techniques, processes, activities, and interventions that distinguish it from cognitive-behavioral therapy. Other reviews of psychodynamic treatment process such as those by Luborsky et al. (1990) and Henry, Strupp, Schacht, and Gaston (1994) focused on principles theoretically believed to be important elements in the process of change. The present review is different in that the techniques discussed were selected on the basis of both theoretical and empirical evidence of their distinctiveness. To be included in the current review, techniques and processes had to consistently and significantly differentiate psychodynamic-interpersonal from cognitive-behavioral therapy in at least two studies, in at least two different research labs.

To obtain the articles used in this review, a computer search of the entire PsycLIT database was conducted to reveal studies comparing the processes and techniques of short-term, psychodynamically oriented therapy and cognitive-behavioral treatment. Reference sections of articles were also investigated in an attempt to retrieve related articles that may have been missed in the computer literature search. Only studies that compared the interventions of psychodynamic (PD), psychodynamic-interpersonal (PI), or interpersonal (IP) psychotherapy with those of cognitive (C), behavioral (B), or cognitive-behavioral (CB) approaches to therapy were included in this study.[2] For the sake of brevity, articles examining the techniques and processes of only one particular form of treatment were omitted from this review. Also, outcome studies were omitted unless therapist activity variables were specifically reported. Only those studies that provided an empirical comparison of the interventions used in the previously noted modes of treatment were included in our review.

In the following sections of this article, we examine research on the seven focus areas consistently found to differentiate PI from CB therapy (listed according to the amount of evidence that the technique or process distinguishes PI from CB therapy): (1) a focus on affect and the expression of patients' emotions; (2) an exploration of patients' attempts to avoid topics or engage in activities that hinder the progress of therapy; (3) the identification of patterns in patients' actions, thoughts, feelings, experiences, and relationships; (4) an emphasis on past experiences; (5) a focus on patients' interpersonal experiences; (6) an emphasis on the therapeutic relationship; and (7) an exploration of patients' wishes, dreams, or fantasies. Organizing the findings of the comparative psychotherapy process literature in this format covers some of the hypothesized core mechanisms of change in PI treatments.

LITERATURE REVIEW

Focus on Affect and the Expression of Patients' Emotion

The prevailing view among psychotherapists is that patients' emotions and feelings are an important clinical phenomenon (Clarke, 1989; Wiser & Goldfried, 1993). Theoretically, PI therapy focuses on the evocation and expression of a patient's emotions in an attempt expose more unconscious issues (Fenichel, 1945; Freud, 1905; Glover, 1955; Greenson, 1967). This discharge of energy and emotion, or "catharsis," is believed to be an important part of the change process in therapy (Freud, 1905). Intellectual insight gained by a patient during therapy is not sufficient for bringing about personality change and symptom improvement. Rather, it is essential that the patient achieve emotional insight, finding a way to express, understand, and be comfortable with his or her intense feelings (Alexander, 1961, 1963; Alexander & French, 1946; Freud, 1905; Wachtel, 1993). Through experiencing, being exposed to, and releasing emotion, a patient gains mastery over his or her repressed wishes, desires, fears, or anxieties. In contrast to PI therapy, CB treatment attempts to control, manage, reduce, moderate or explain affect in order to decrease stress and convey a more reality-based sense of self (Barlow, 1993; Beck, 1976; Beck, Rush, Shaw, & Emery, 1979; Goldfried & Davidson, 1994; Mahoney, 1974, 1988; Meichenbaum, 1977; Messer, 1986; Wiser & Goldfried, 1993).

After reviewing the comparative psychotherapy process literature, it appears that PI and CB therapy do differ quantitatively and qualitatively in their focus on patients' feelings (see Table 1). PI therapy focuses more frequently (quantitative) on patients' emotions and encourages patients to express their feelings instead of managing or controlling them (qualitative). Using the Psychotherapy Process Q-set (PQS; Jones, 1985), a 100-item instrument assessing therapist-patient interactions, Jones and Pulos (1993) found differences between PD and CB therapy sessions in their respective emphasis on patients' affect. PD sessions were described as emphasizing a patient's feelings in order to help him or her experience them more deeply, drawing attention to feelings regarded by patients as uncomfortable (e.g., anger, envy, or excitement), and being sensitive to patients' feelings significantly more than CB therapy sessions. PD therapy sessions were also characterized by linking patients' feelings to situations or behaviors of the past and by focusing on patients' feelings of guilt significantly more than CB sessions. Ablon and Jones (1998) also investigated psychotherapy process using the PQS. In this study, experts in PD and CB treatments rated Q-set items as to how characteristic each item was of the principles and activities ideally found in their respective therapy. The results largely replicated the findings of the earlier Jones and Pulos (1993) study in that experts rated PD treatment as being characteristically represented by an emphasis on feelings regarded by patients as uncomfortable, linking patients' feelings to situations or behaviors of the past, and being sensitive to patients' feelings.

Ablon and Jones (1999) investigated psychotherapy process in the National Institute of Mental Health (NIMH)-sponsored Treatment of Depression Collaborative Research Program (TDCRP) using the PQS. In this study comparing IP and CB therapy, the authors found the Q-set items "Therapist is sensitive to patient's feelings, attuned to patient, empathic" and "Patient has a cathartic experience" to be significantly more characteristic of IP therapy than CB treatment. A focus on feelings regarded by a patient as unacceptable and on helping a patient experience his or her feelings more deeply were also found to be significantly more characteristic of IP than CB therapy.

Using a different measure of therapeutic process, Goldfried, Castonguay, Hayes, Drozd, and Shapiro (1997) and Goldfried, Raue, and Castonguay (1998) also found differences between PI and CB therapy in their respective emphasis on patients' emotion. In these studies, therapy sessions were rated using the Coding System of Therapeutic Focus (CSTF; Goldfried, Newman, & Hayes, 1989), a measure of in-session therapeutic process. In the Goldfried et al. (1997) study, PI therapists placed twice as much emphasis on emotion as CB therapists. Goldfried et al. (1998), however, found no significant main effect differentiating master PI from master CB therapists in their focus on patients' emotions. Rather, the authors reported that master PI therapists were more likely than master CB therapists to focus on patients' feelings during portions of sessions rated as most important (indicative of a more qualitative difference). The lack of differences between PI and CB therapy in the Goldfried et al. (1998) study could be due to several factors. First, the lack of differences may be attributed to the experience level of the therapists used in the study. Perhaps master/expert therapists are more likely than inexperienced therapists to focus on patients'

Table 1. Focus on affect in psychodynamic-interpersonal (PI) and cognitive-behavioral (CB) therapy

Study	Participants	Findings
Jones & Pulos (1993)	30 patients (20 women, 10 men) treated with brief psychodynamic (PD) therapy for various problems; 32 patients (25 women, 7 men) with a diagnosis of major depressive disorder treated with cognitive-behavioral therapy (CB) and tricyclic pharmacotherapy, alone and in combination	**PD Therapy** *PQS item 81:* "Therapist emphasizes patient's feelings in order to help him/her experience them more deeply." PD therapists ($M = 6.6$ out of 9.00) were rated significantly higher on this item than CB therapists ($M = 3.2$; $p < .001$). *PQS item 50:* "Therapist draws attention to feelings regarded by patient as unacceptable (e.g., anger, envy, or excitement)." PD therapists ($M = 6.2$) were rated significantly higher on this item than CB therapists ($M = 4.4$; $p < .001$). *PQS item 6:* "Therapist is sensitive to patient's feelings, attuned to patient; empathic." PD therapists ($M = 6.8$) were rated significantly higher on this item than CB therapists ($M = 5.9$; $p < .001$). *PQS item 92:* "Patient's feelings or perceptions are linked to situations or behavior of the past." PD therapist ($M = 6.8$) were rated significantly higher on this item than CB therapists ($M = 4.9$; $p < .001$). *PQS item 22:* "Therapist focuses on patient's feelings of guilt." PD therapists ($M = 5.4$) were rated significantly higher on this item than CB therapists ($M = 4.4$; $p < .001$).
Ablon & Jones (1998)	A panel of expert PD ($N = 11$) and CB ($N = 10$) therapists	**PD Therapy** *PQS item 6:* "Therapist is sensitive to the patient's feelings, attuned to the patient; empathic." This item was rated as highly characteristic of PD therapy (factor score = 1.46). *PQS item 50:* "Therapist draws attention to feelings regarded by the patient as uncomfortable (e.g., anger, envy, excitement)." This item was rated as highly characteristic of PD therapy (factor score = 1.17). *PQS item 92:* "Patient's feelings or perceptions are linked to situations or behaviors of the past." This item was rated as highly characteristic of PD therapy (factor score = 1.05). **CB Therapy** No PQS items regarding feeling, emotion, or affect were found to be characteristic of CB therapy.
Ablon & Jones (1999)	Outpatients (29 treated with CB treatment and 35 treated with interpersonal [IP] therapy) diagnosed with major depressive disorder	**IP Therapy** *PQS item 6:* "Therapist is sensitive to the patient's feelings, attuned to the patient; empathic." This item was rated as significantly more characteristic of interpersonal therapy ($M = 7.10$) than CB therapy ($M = 5.59$; $p \leq .001$). *PQS item 50:* "Therapist draws attention to feelings regarded by the patient as uncomfortable (e.g., anger, envy, excitement)." This item was rated as significantly more characteristic of interpersonal therapy ($M = 4.81$) than CB therapy ($M = 3.86$; $p \leq .001$). *PQS item 81:* "Therapist's emphasizes patient's feelings in order to help him/her experience them more deeply." Interpersonal therapists ($M = 6.16$) were rated significantly higher on this item than CB therapists ($M = 3.31$; $p \leq .001$). *PQS item 60:* "Patient has cathartic experience." This item was rated as significantly more characteristic of interpersonal ($M = 4.86$) than CB therapy ($M = 4.34$; $p \leq .001$). **CB Therapy** *PQS item 81:* "Therapist emphasizes patient's feelings to help him or her experience them more deeply." This item was rated as one of the least characteristic items of CB therapy ($M = 3.31$).
Goldfried et al. (1997)	57 patients (27 treated with psychodynamic-interpersonal therapy [PI], 30 treated with CB therapy) diagnosed with major depressive disorder	**PI Therapy** PI therapists ($M = 25.6$, $SD = 10.6$) placed twice as much emphasis on patients' emotion than CB therapists ($M = 11.8$, $SD = 5.6$; $p = .001$). **CB Therapy** No coding categories regarding patients' feelings were rated as significantly characteristic of CB therapy.
Goldfried et al. (1998)	36 patients (14 treated by master PI therapists, 22 by master CB therapists) presenting with anxiety, depression, or both	**PI and CB Therapy** Expert therapists of both orientations placed significantly more emphasis on patients' emotions during significant portions of sessions ($M = 20.6$, $SD = 11.3$) than in nonsignificant portions of sessions [$M = 16.7$, $SD = 12.5$; $F(1,34) = 8.98$; $p = .005$]. **PI Therapy** In significant portions of sessions, PI therapists were more likely to emphasize patients' emotion than they were during both the nonsignificant portions of their own sessions ($p < .001$) and the significant portions of the CB therapists' sessions ($p < .011$). **CB Therapy** No coding categories regarding patients' feelings were rated as significantly characteristic of CB therapy.

Table 1. *Continued*

Study	Participants	Findings
Wiser & Goldfried (1993)	30 patients with depressive or anxious symptomatology and interpersonal issues as a primary focus treated with CB therapy ($N = 17$ therapists) or PI therapy ($N = 13$ therapists)	**PI Therapy** Patients' peak experiencing scores were higher in significant portions of their sessions than in nonsignificant parts ($p = .04$). Portions designated by PI therapists as significant contained the client's highest points of emotional experiencing for that session. **CB Therapy** Although not significant, CB therapy patients' averaged peak experiencing ratings were lower in the significant portions of their sessions than their experiencing ratings in the nonsignificant portions of their sessions ($p = .07$). In CB sessions, portions of sessions designated by therapists as significant contained patients' lower experiencing states.
Luborsky et al. (1982)	Narcotic addicts in treatment with four supportive-expressive (SE) therapists and four CB therapists	**PD Therapy** Rated significantly higher ($M = 2.7$ out of 5.0) than CB therapists ($M = 2.1$; $p < .01$) on facilitating patient self-expression, and significantly higher ($M = 2.2$) than CB therapists ($M = 1.7$) on understanding patients' feelings and relationships.
Startup & Shapiro (1993)	Therapists and patients from the Second Sheffield Psychotherapy Project	**PI Therapy** Exploratory therapists ($M = 29.8$) were rated significantly higher than prescriptive therapists ($M = 5.3$; $p < .0001$) on the Exploratory Therapy (E) scale, which included items relating to the exploration of feelings, acknowledgment of affect, and acceptance of affect.
Hill et al. (1992)	180 patients from the National Institute of Mental Health Treatment of Depression Collaborative Research Project	**IP Therapy** IP therapists ($M = 2.02$ out of 7.0) were rated significantly higher than CB therapists ($M = 1.53$; $p < .01$) on the interpersonal therapy (IPT) scale, which included items related to a focus on feelings.
Goldsamt et al. (1992)	One patient seen in a 45-minute demonstration session by three master therapists (Beck, Meichenbaum, and Strupp)	**PD Therapy** No coding categories regarding a focus on the patient's feelings were found to be significantly more characteristic of PD therapy. **C Therapy** Beck focused more than both Meichenbaum ($\chi^2 = 5.50$; $p < .05$) and Strupp ($\chi^2 = 5.01$; $p < .05$) on physiological signs of the patient's emotions. **CBM Therapy** Meichenbaum placed more emphasis than both Beck ($\chi^2 = 4.58$; $p < .05$) and Strupp ($\chi^2 = 4.44$; $p < .05$) on the patient's feelings. Beck focused on the patient's physiological signs of emotion more than both Meichenbaum ($\chi^2 = 5.50$; $p < .05$) and Strupp ($\chi^2 = 5.01$; $p < .05$).

emotions. Second, the lack of differences found between PI and CB therapy in the Goldfried et al. (1998) article may be the result of the design/nature of the study and treatment being provided. In this study, patients were seen in a naturalistic setting as opposed to the Goldfried et al. (1997) study in which treatment was a controlled clinical trial. It is possible that when PI and CB therapists conduct treatment in a controlled clinical trial they are more likely to adhere to the prescribed protocols of a manual than when they deliver treatment in a natural setting, thus accounting for the lack of differences between the two approaches. In addition, the lack of differences could also be due to an interaction between therapists' experience level and the treatment setting (naturally occurring vs. controlled clinical trial). Expert therapists providing treatment in a natural setting may be less likely to follow the guidelines of a specific treatment manual than less experienced therapists providing treatment as part of a controlled clinical trial.

Using the Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1969), a measure of emotional involvement in the examination of personal issues, Wiser and Goldfried (1993) also found differences between PI and CB sessions in their emphasis of patients' emotional experiencing. The authors reported that PI therapists regarded portions of sessions high in affective experiencing as most important indicating an emphasis on the expression of feelings. Conversely, CB therapists viewed portions of sessions low in affective experiencing as most important indicating an emphasis on the control and reduction of emotions. These findings point to the qualitative difference between PI and CB therapy in their focus on patients' affect.

Luborsky, Woody, McLellan, O'Brien, and Rosenzweig (1982) investigated similarities and differences

between manual-guided supportive-expressive psychodynamic psychotherapy (SE) and a CB treatment for drug abuse. In this study, SE therapists were found to facilitate patients' self-expression and to understand patients' feelings and relationships significantly more than CB therapists. In a study of therapist adherence to exploratory (PI) and prescriptive (CB) techniques in the Second Sheffield Psychotherapy Project, Startup and Shapiro (1993) reported that PI therapists scored significantly higher than CB therapists on items related to the exploration of feelings, acknowledgment of affect, and the acceptance of affect. Similarly, Hill, O'Grady, and Elkin (1992), in their study of adherence to IP and CB therapy in the TDCRP, reported that IP therapists were rated significantly higher than CB therapists on items related to a focus on feelings.

However, on a single-session, single-case basis, differences between PI, C, and CB master therapists' emphasis on patients' feelings were not as well defined. Goldsamt, Goldfried, Hayes, and Kerr (1992) used the CSTF to code a single session conducted by Beck (C), Meichenbaum (cognitive-behavior modification, CBM), and Strupp (PD) with the same patient. Surprisingly, Meichenbaum placed more emphasis than both Beck and Strupp on the patient's feelings. The authors reasoned that this could possibly be due to Meichenbaum spending a great deal of the session discussing the patient's anger and ways in which it could be controlled (qualitatively consistent with a CB approach). In addition, Beck emphasized the patient's physiological signs of emotion (physical status of the patient as it relates to his or her emotionality) significantly more than both Meichenbaum and Strupp. The authors suggested that this finding might be due to Beck's focus on the patient's initial anxiety regarding the session demonstration and may not represent a therapeutic component specific to cognitive therapy. Because of the single case, single session nature of this study, any generalizations made from its findings should be made with caution. As the authors noted, the observed therapeutic orientation differences may have been influenced by idiosyncratic patient characteristics, the order of the treatments provided, or the therapists themselves. However, we included this study in our review because useful and instructive differences emerged from the comparative analysis.

In summary, recent studies lend very strong support for the notion that PI therapy focuses more than CB therapy on the expression of patients emotions. Of the ten articles reviewed, nine reported PI therapy as emphasizing patients' affect significantly more than CB treatment, at least during significant parts of sessions. The one article reviewed that did not report the expected difference between master PD and CB therapists may attribute its contradictory results to the single-session, single-case design of the study. Perhaps with more patients or more sessions with the same patient (encompassing a wider range of affect), significant differences would have been revealed. The findings reviewed in this section also support the notion that PI therapy attempts to evoke the expression of patients' emotions while CB therapy attempts to control or reduce patients' feelings. The propensity of PI therapy to focus on affect not only conveys a greater emphasis on cathartic expression, but also a greater focus on emotional insight and a greater encouragement to identify, stay with, and/or accept emotion.

Exploration of Patients' Attempts to Avoid Topics or Engage in Activities That Hinder the Progress of Therapy

A second area in which PI and CB therapy differ is in their emphasis on hindrances to the progress of therapy. During the course of a session, a patient may purposely or unknowingly impede the progress of therapy in a variety of ways. He or she may avoid the discussion of important topics, shift the focus away from painful material, not complete assigned homework, or sit silently, unwilling to speak about a distressing issue, event, or feeling. A patient may also hamper the progress of therapy through such resistances to treatment as arriving late for scheduled therapy meetings or forgetting to pay his or her bill. Our review of theory suggests that PI therapy focuses on and explores such impediments to the progress of therapy (Book, 1998; Fenichel, 1945; Freud, 1905; Glover, 1955; Greenson, 1967; Luborsky, 1984; Strupp & Binder, 1984; Wachtel, 1993) in order to uncover and stimulate discussion on the (unconscious) meaning of these disturbances for treatment and the therapeutic relationship. CB therapy, however, appears to focus less on hindrances to the progress of therapy (Beck, 1976; Beck et al., 1979; Goldfried & Davidson, 1994; Meichenbaum, 1977) and does not ascribe any unconscious motivation to such patient resistance and noncompliance.

This theoretical difference between PI and CB therapy in their exploration of patients' resistance and noncompliance is supported by empirical process research (see Table 2). Jones and Pulos (1993) and Ablon and Jones (1998,

Table 2. Exploration of impediments to the progress of therapy in psychodynamic-interpersonal (PI) and cognitive-behavioral (CB) therapy

Study	Participants	Findings
Jones & Pulos (1993)	30 patients (20 women, 10 men) treated with brief PD therapy for various problems; 32 patients (25 women, 7 men) with a diagnosis of major depressive disorder treated with CB and tricyclic pharmacotherapy, alone and in combination	**PD Therapy** *PQS item 36:* "Therapist points out patient's use of defensive maneuvers (e.g., undoing, denial)." PD therapy ($M = 5.4$) was rated significantly higher than CB therapy ($M = 4.7$; $p < .001$) on this item. **CB Therapy** No PQS items regarding the exploration of impediments to therapy were found to be characteristic of CB therapy.
Ablon & Jones (1998)	A panel of expert PD ($N = 11$) and CB ($N = 10$) therapists	**PD Therapy** *PQS item 36:* "Therapist points out patient's use of defensive maneuvers (e.g., undoing, denial)." This item was rated as highly characteristic of PD therapy (factor score = 1.53). **CB Therapy** No PQS items regarding the exploration of impediments to therapy were found to be characteristic of CB therapy.
Ablon & Jones (1999)	Outpatients (29 treated with CB and 35 treated with IP therapy) diagnosed with major depressive disorder	**IP Therapy** *PQS item 36:* "Therapist points out patient's use of defensive maneuvers (e.g., undoing, denial)." Interpersonal therapy ($M = 4.92$) was rated significantly higher than CB therapy ($M = 3.84$; $p \leq .001$) on this item. **CB Therapy** NO PQS items regarding the exploration of impediments to therapy were found to be characteristic of CB therapy.
Goldfried et al. (1997)	57 patients (27 PI, 30 CB therapy) diagnosed with major depressive disorder	**PI Therapy** PI therapy focused significantly more than CB therapy on a patient's thoughts, feelings, or actions that interfere with the progress of therapy ($F = 23.36$; $p = .001$). **CB Therapy** No coding categories regarding a focus on the impediments to patient progress in treatment were found to be characteristic of CB therapy.
Goldfried et al. (1998)	36 patients (14 treated by master PI therapists, 22 by master CB therapists) presenting with anxiety, depression, or both	**PI and CB Therapy** Master therapists of both orientations were significantly more likely to identify ways patients may interfere with their progress in therapy during significant portions of sessions than in nonsignificant portions ($F = 6.37$; $p = .016$). **PI Therapy** No coding categories regarding a focus on the impediments to a patient's progress in therapy were found to be characteristic of PD therapy alone. **CB Therapy** No coding categories regarding a focus on the impediments to a patient's progress in therapy were found to be characteristic of CB therapy alone.
Gaston & Ring (1992)	16 depressed patients from a larger outcome study by Thompson et al. (1987) (10 treated with brief PD therapy; 6 treated with cognitive therapy)	**PD Therapy** PD therapists ($M = 0.82$, $SD = 0.58$) explored patients' problematic defenses significantly more than CB therapists ($M = 0.06$, $SD = 0.11$; $t = 8.30$; $p < .01$). **C Therapy** No coding categories regarding a focus on the impediments to a patient's progress in therapy were found to be characteristic of CB therapy alone.

1999) revealed that the PQS item "Therapist points out patient's use of defensive maneuvers (e.g., undoing, denial)" was rated as significantly more characteristic of PD and IP treatments than CB therapy. Similarly, Goldfried et al. (1997) reported that PI therapists explored how patients hinder the progress of therapy significantly more than CB therapists. Results from a study by Gaston and Ring (1992) using the Inventory of Therapeutic Strategies (ITS) also found that PD therapists explored patients' problematic defenses significantly more than CB therapists.

Goldfried et al. (1998), in their study using master therapists, failed to replicate a significant difference between PI and CB therapy in their emphasis of patients' interference with the progress of therapy. A main effect for session impact was found, however, in that master therapists of both orientations were significantly more likely to identify ways patients avoid making improvement during portions of sessions rated as most significant. This finding may possibly be attributed to the greater experience of the expert therapists in the Goldfried et al. (1998) study, the nature/design of the studies (controlled clinical trial vs. naturalistic setting), or an interaction between the two. Perhaps expert CB therapists are more likely than less

experienced CB therapists to view the exploration of a patient's hindrances to the progress of therapy as an important part of the therapeutic change process. Because of their greater experience, expert therapists may realize that a patient's resistance (such as not completing homework) may get worse/become stronger and reduce the effectiveness of treatment if left unattended.

Research provided in this section offers support to the notion that PI therapy focuses on impediments to the progress of therapy significantly more than CB treatment. Five of the six studies reviewed found that PI therapy was distinctive from CB treatment in its focus on patients' thoughts, actions, feelings, and defenses that hinder the progress of therapy. When between group differences were not found as in the Goldfried et al. (1998) study, a main effect for session impact was found such that master therapists of both orientations were more likely to focus on impediments to the progress of therapy during portions of sessions rated as most important rather than those portions deemed nonsignificant. As stated above, the lack of differences between PI and CB therapy observed in this study may be the result of the experience level of the therapists, the nature/design of the study (naturalistic setting as opposed to a controlled clinical trial), or an interaction between the two.

Identification of Patterns in Patients' Actions, Thoughts, Feelings, Experiences, and Relationships

Another area in which PI and CB therapy differ is in the emphasis each places on patients' repeated, similar experiences. Theory suggests that CB therapy attempts to identify similarities in a patient's problematic thoughts or beliefs (Barlow, 1993; Beck, 1976; Beck et al., 1979; Goldfried & Davidson, 1994; Mahoney, 1974, 1988; Meichenbaum, 1977). Once these thought patterns are identified, a CB therapist can begin to challenge and/or dispute these long-held beliefs in an attempt to provide the patient with alternative explanations and new perspectives. In addition to a focus on the identification of patterns in a patient's thoughts and beliefs, PI therapy appears to focus on the identification of patterns in a patient's relationships, feelings, and self-concept in order to bring core issues into the individual's conscious awareness (Book, 1998; Fenichel, 1945; Freud, 1905; Glover, 1955; Greenson, 1967; Luborsky, 1984; Strupp & Binder, 1984; Wachtel, 1993).

The proposed qualitative differences in identifying patterns in different domains of patients' functioning is supported by our review of the empirical comparative psychotherapy process research (see Table 3). Jones and Pulos (1993) and Ablon and Jones (1998, 1999) reported that the PQS item "Therapist identifies a recurrent theme in patient's experience or conduct" was characteristic of PD therapy. Furthermore, Jones and Pulos (1993) and Ablon and Jones (1999) reported that PD and IP therapy were rated significantly higher than CB treatment on the same PQS item. In addition, Startup and Shapiro (1993), in their treatment fidelity study, found that PI therapists scored significantly higher than CB therapists on items related to the identification of patterns in relationships.

Using the CSTF to code therapy sessions, Goldfried et al. (1997) also found differences between PI and CB therapy in their respective emphasis on patterns, similarities, and themes in a patient's life. In the intrapersonal domain, PI therapists placed significantly more therapeutic focus on similarities or recurrences within a patient's functioning and noted divergences or inconsistencies within a patient's functioning significantly more than CB therapists. PI therapists also highlighted patterns in a patient's interpersonal functioning repeated over time, settings, or people significantly more than therapists providing CB treatment. In a related study, Goldfried et al. (1998) reported that master PI therapists were significantly more likely than master CB therapists to identify general themes in a patient's life. In addition, master therapists from both orientations were more likely to emphasize how a patient's thoughts, feelings, and actions were part of larger, more general themes during portions of sessions rated as most important. This finding points to the importance of identifying patterns in patients' lives for more experienced PI and CB therapists and suggests that the identification of patterns appears to be an integral part of treatments delivered in either a manual-driven, controlled clinical trial or a naturalistic setting.

On a single-session, single-case basis, as in the study by Goldsamt et al. (1992), differences were found between master PD (Strupp), C (Beck), and CBM (Meichenbaum) therapists in their respective emphasis on themes and patterns in the patient's life. The authors reported that Strupp highlighted intrapersonal similarities (similarities occurring within the patient's functioning) significantly more than did either Beck or Meichenbaum. Strupp also placed significantly more emphasis than Beck on interpersonal patterns in the patient's life (interpersonal functioning repeated over time settings or people), but not more than

Table 3. Identification of patterns in psychodynamic-interpersonal (PI) and cognitive-behavioral (CB) therapy

Study	Participants	Findings
Jones & Pulos (1993)	30 patients (20 women, 10 men) treated with brief PD therapy for various problems; 32 patients (25 women, 7 men) with a diagnosis of major depressive disorder treated with CB and tricyclic pharmacotherapy, alone and in combination	**PD Therapy** *PQS item 62:* "Therapist identifies a recurrent theme in patient's experience." This item was rated as significantly more characteristic of PD ($M = 7.0$) than CB therapy ($M = 5.7$; $p < .001$). **CB Therapy** No PQS items regarding a focus on patterns and themes in a patient's life were found to be characteristic of CB therapy.
Ablon & Jones (1998)	A panel of expert PD ($N = 11$) and CB ($N = 10$) therapists	**PD Therapy** *PQS item 62:* "Therapist identifies a recurrent theme in patient's experience." This item was rated as highly characteristic of PD therapy (factor score = 0.95). **CB Therapy** No PQS items regarding a focus on patterns and themes in a patient's life were found to be characteristic of CB therapy.
Ablon & Jones (1999)	Outpatients (29 treated with CB and 35 treated with IP therapy) diagnosed with major depressive disorder	**Interpersonal Therapy** *PQS item 62:* "Therapist identifies a recurrent theme in patient's experience." This item was rated as significantly more characteristic of interpersonal ($M = 6.61$) than CB therapy ($M = 6.03$; $p \leq .01$). **CB Therapy** No PQS items regarding a focus on patterns and themes in a patient's life were found to be characteristic of CB therapy.
Startup & Shapiro (1993)	Therapists and patients from the Second Sheffield Psychotherapy Project	**PI Therapy** Exploratory therapists ($M = 29.8$) were rated significantly higher than prescriptive therapists ($M = 5.3$; $p < .0001$) on the Exploratory Therapy (E) scale, which included items related to the identification of patterns in relationships.
Goldfried et al. (1997)	57 patients (27 PI, 30 CB therapy) diagnosed with major depressive disorder	**PI Therapy** Focused significantly more on similarities or recurrences in a patient's intrapersonal functioning than CB therapists ($F = 3.96$; $p = .05$). PI therapists focused on divergences or inconsistencies within a patient's intrapersonal functioning ($F = 22.9$; $p = .001$) significantly more than CB therapists. PI therapists highlighted patients' interpersonal functioning repeated over time, settings, or people more than CB therapists ($F = 17.90$; $p = .001$). **CB Therapy** No coding categories regarding a focus on patterns and themes in a patient's life were found to be characteristic of CB therapy.
Goldfried et al. (1998)	36 patients (14 treated by master PI therapists, 22 by master CB therapists) presenting with anxiety, depression, or both	**PI and CB Therapy** Master therapists from both orientations were more likely to emphasize how a patient's thoughts, feelings, and actions were part of larger, general themes in a patient's life during significant portions of sessions than in nonsignificant portions of sessions ($F = 13.53$; $p = .001$). **PI Therapy** PI therapists were significantly more likely than CB therapists to identify general themes in a patient's life ($F = 8.40$; $p = .007$). Significant themes in a patient's life were more likely to be focused on during significant portions of PI than CB sessions ($p < .003$). Significant themes in a patient's life were more likely to be focused on during significant than nonsignificant portions of PI treatment ($p < .001$). **CB Therapy** No coding categories regarding a focus on themes and patterns in a patient's life were rated as significantly more characteristic of CB therapy.
Goldsamt et al. (1992)	One patient seen in a 45-minute demonstration session by three master therapists (Beck, Meichenbaum, and Strupp)	**PD Therapy** Strupp highlighted intrapersonal similarities and patterns significantly more than either Beck ($\chi^2 = 4.85$; $p < .05$) or Meichenbaum ($\chi^2 = 4.57$; $p < .05$). Strupp also placed significantly more emphasis on interpersonal patterns in the patient's life than Beck ($\chi^2 = 9.98$; $p < .01$), but not Meichenbaum ($\chi^2 = 1.51$; $p > .05$). **CB Therapy** No coding categories regarding a focus on patterns and themes in the patient's life were found to be characteristic of cognitive or behavioral therapy.
Stiles & Shapiro (1995)	39 patients receiving eight weekly sessions of either PI or CB followed by eight weekly sessions of the other treatment (Sheffield Psychotherapy Project)	**PD Therapy** Factor analysis revealed that an *interpreting* factor (eigenvalue = 2.57) distinguished PI from CB therapy.
Stiles et al. (1988)	33 patients receiving eight weekly sessions of either PI or CB followed by eight weekly sessions of the other treatment (Sheffield Psychotherapy Project)	**PI Therapy** Therapists used significantly more *interpretations* (explaining or labeling the other; judgment or evaluations of other's experience or behavior) when providing exploratory therapy ($M = 20.31$) than when they provided prescriptive therapy [$M = 14.31$; $F(1.37) = 47.63$; $p < .001$].

Table 3. *Continued*

Study	Participants	Findings
Stiles et al. (1989)	33 patients receiving eight weekly sessions of either PI or CB followed by eight weekly sessions of the other treatment (Sheffield Psychotherapy Project)	**PI Therapy** Therapists used significantly more *interpretations* (explaining or labeling the other; judgment or evaluations of other's experience or behavior) when providing exploratory therapy (M = 19.96) than when they provided prescriptive therapy (M = 13.96; $p < .01$).
Stiles & Sultan (1979)	Transcripts of sessions conducted by experts from different schools of therapy (Wolberg, PD; Ellis, CB)	**PD Therapy** Wolberg used four times as many interpretations (M = 24.0) than Ellis (M = 6.4).
Brunink & Schroeder (1979)	18 expert psychoanalytically oriented (PD), gestalt (G), and behavior (B) therapists	**PD and B Therapy:** Psychoanalytic (9.9% of therapist utterances) and behavior therapists (4.5% of therapist utterances) did not significantly differ in their use of interpretations.
Staples et al. (1975)	Three B and three PD therapists	**PD and CB Therapy** No significant quantitative differences were found between PD and CB therapy in their use of interpretations.
Luborsky et al. (1982)	Narcotic addicts in treatment with four supportive-expressive (SE) therapists and four CB therapists	**PD and CB Therapy** On the coding category "use of clarification and interpretation," the two approaches to therapy did not significantly differ.
Wiser & Goldfried (1996)	31 significant sessions from 13 PI and 18 CB therapists	**PI and CB Therapy** No differences were found between PI (M = 19.42) and CB (M = 19.06; $F < 1.0$) therapy in their use of interpretations.

Meichenbaum. While Strupp's greater emphasis of interpersonal patterns relative to Beck's was expected, Meichenbaum's focus on interpersonal themes was not. However, a major focus of Meichenbaum's CBM treatment is on intrapersonal dialogue and the thoughts and feelings that accompany this self-talk are evaluated to determine whether these thoughts occur in various situations in the patient's life (Goldsamt et al., 1992; Meichenbaum, 1977). This inquiry into the various situations in which a patient's thoughts interfere with his or her functioning may be viewed as an investigation of themes in the patient's life that are repeated over many different relationships, situations, or experiences. This focus in CBM could explain the similarity between Strupp and Meichenbaum's emphasis on the patient's interpersonal patterns.

One way therapists identify themes and patterns is through interpretations (judgments or evaluations of patients' experiences). Traditional theory would suggest that PI therapists use more interpretations than CB therapists as they attempt to make patients aware of the various manifestations of a particular theme. Many investigations of therapist verbal behavior have revealed a greater use of interpretations in PI therapy than in CB treatment (Stiles & Shapiro, 1995; Stiles, Shapiro, & Firth-Cozens, 1988, 1989; Stiles & Sultan, 1979). Brunink and Schroeder (1979) also reported that PD therapists made twice as many interpretations as B therapists. However, this difference was not statistically significant.[3] Some studies have not found this presumed theoretical difference (Luborsky et al., 1982; Staples, Sloane, Whipple, Cristol, & Yorkston, 1975; Wiser & Goldfried, 1996). When the expected differences have not been found, researchers have suggested several explanations. First, Staples et al. (1975) and Luborsky et al. (1982) posited that despite a quantitative similarity, a qualitative difference existed in the content of the interpretations made by PD and CB therapists. PD therapists focused more on themes in a patient's feelings while CB therapists emphasized patterns in a patient's beliefs and behaviors. A second explanation, offered by Luborsky et al. (1982), suggests that the equal use of interpretations in PD and CB therapy could be due to the broadness of the coding category used in their study (it included "clarifications" that may be a more common therapeutic technique). In addition, Wiser and Goldfried (1996) indicated that their lack of significant differences could be due to variations in the interventions used by expert CB therapists during significant and "ordinary" portions of sessions. Lastly, Wiser and Goldfried (1996) suggested that the equal use of interpretations in PI and CB therapy could possibly be accounted for by the recent shift in CB therapy toward a more interpersonal concentration.

Research reviewed in this section strongly supports the contention that PI therapy focuses significantly more than

CB therapy on patterns in a patient's functioning (intrapersonal and interpersonal). Of the 15 studies reviewed, 12 reported a greater emphasis by PI than CB therapy on the identification of patterns in a patient's experiences. In the studies not reporting significant differences, researchers indicated that the types of interpretations made by PI and CB therapists may have been qualitatively different. Moreover, the equal use of interpretations in PI and CB treatments reported in three studies could be due to the broadness of the coding category used or the current trend in CB therapy toward an interpersonal concentration. Lastly, the lack of significant differences could be due to the experience of the therapists as noted by Wiser and Goldfried (1996). Perhaps expert CB therapists are more willing to deviate from their theoretical focus than less experienced CB therapists.

Emphasis on Past Experiences

A fourth area in which PI and CB therapy differ is in the importance each places on patients' past experiences. While there is a recent trend in PI treatment toward an increased emphasis on a patient's present life situation, traditional PI theory proposes that a patient's childhood experiences, past unresolved conflicts, and historical relationships significantly affect a person's present life situation (Fenichel, 1945; Freud, 1905; Glover, 1955; Greenson, 1967; Luborsky, 1984; Strupp & Binder, 1984; Wachtel, 1993). In contrast, while recent modifications to CB theory have begun to include and integrate a more developmental focus (Beck, 1991; Mahoney, 1988, 1991; Robins & Hayes, 1993), traditional theory suggests that CB therapy primarily emphasizes a patient's present thoughts and beliefs and the impact they have on his or her future functioning (Barlow, 1993; Beck, 1976; Beck et al., 1979; Goldfried & Davidson, 1994; Mahoney, 1988, 1991; Meichenbaum, 1977).

Empirical psychotherapy process research has borne out this theoretical conjecture (see Table 4). In the Jones and Pulos (1993) and Ablon and Jones (1998, 1999) studies, PD and IP therapy were found to be characterized by an emphasis on past experiences. The discussion of a patient's early childhood memories and the linking of a patient's feelings or perceptions to experiences of his or her past were rated as more characteristic of PD and IP than CB treatment. DeRubeis, Hollon, Evans, and Bemis (1982) also reported that linking a patient's current problems to experiences occurring during childhood or adolescence was related to a factor representing IP technique. In addition, the exploration of a patient's past for evidence of the loss of (or change in) an important relationship was also related to an IP technique factor and not to a factor assessing CB technique. Brunink and Schroeder (1979) also reported a greater emphasis on past experiences in PD than B therapy, however this difference was reported as not significant (see note 3).

Goldfried et al. (1997) reported that PI therapists were significantly more likely than CB therapists to emphasize a patient's preadult past (infancy through high school) and adult past (from high school to the beginning of therapy) experiences. In this study, PI therapists were concerned with identifying the origin of patients' difficulties (in the past) and understanding how they were manifested in their lifetime (past and present). CB therapists, on the other hand, were concerned with facilitating patients' coping with future encounters of problematic events and experiences. In the Goldfried et al. (1998) study using master therapists, however, the significantly greater emphasis on past events and experiences in PI treatment was not demonstrated. Rather, master therapists of both orientations emphasized a wider range of time frames, including preadult past and adult past, during portions of sessions rated as most important rather than those sections rated as ordinary. The lack of a significant main effect for therapeutic orientation, then, could be a reflection of the greater experience of the expert therapists in the Goldfried et al. (1998) study, the nature/design of the study, (controlled clinical trial vs. naturalistic setting), or an interaction between the two. Perhaps master CB therapists are more likely than less experienced CB therapists to emphasize a patient's historical experiences, perceiving this avenue of exploration as a meaningful part of the change process. Similarly, master PD therapists may be more likely to focus on a patient's current or future functioning. The significant clinical experience possessed by expert/master therapists may result in an expansion and diversification of therapists' skills and techniques. For example, expert PI therapists and/or therapists conducting treatment in a naturalistic setting may be more likely than less experienced PI clinicians and/or PI clinicians delivering treatment in a controlled clinical trial to focus on a patient's present life situation in addition to his or her past experiences. By broadening their focus, the patient may feel that the treatment is more effective as he or she sees changes occurring in more immediate areas of func-

Table 4. Emphasis of patients' past experiences in psychodynamic-interpersonal (PI) and cognitive-behavioral (CB) therapy

Study	Participants	Findings
Jones & Pulos (1993)	30 patients (20 women, 10 men) treated with brief PD therapy for various problems; 32 patients (25 women, 7 men) with a diagnosis of major depressive disorder treated with CB and tricyclic pharmacotherapy, alone and in combination	**PD Therapy** *PQS item 91:* "Memories or reconstructions of infancy and childhood are topics of discussion." PD therapy ($M = 6.3$) was rated significantly higher than CB therapy ($M = 4.5$; $p < .001$) on this item. *PQS item 92:* "Patient's feelings and perceptions are linked to situations or behavior of the past." PD therapy ($M = 6.8$) was rated significantly higher than CB therapy ($M = 4.9$; $p < .001$) on this item. **CB Therapy** No items regarding an emphasis on past experiences were found to be characteristic of CB therapy.
Ablon & Jones (1998)	A panel of expert PD ($N = 11$) and CB ($N = 10$) therapists	**PD Therapy** *PQS item 91:* "Memories or reconstructions of infancy and childhood are topics of discussion." This item was rated as highly characteristic of PD therapy (factor score = 1.08). *PQS item 92:* "Patient's feelings or perceptions are linked to situations or behavior of the past." This item was rated as highly characteristic of PD therapy (factor score = 1.05). **CB Therapy** No items regarding a focus on past experiences were found to be characteristic of CB therapy.
Ablon & Jones (1999)	Outpatients (29 treated with CB treatment and 35 treated with IP therapy) diagnosed with major depressive disorder	**IP Therapy** *PQS item 91:* "Memories or reconstructions of infancy and childhood are topics of discussion." Interpersonal therapy ($M = 5.18$) was rated significantly higher than CB therapy ($M = 3.83$; $p \leq .001$) on this item. *PQS item 92:* "Patient's feelings and perceptions are linked to situations or behavior of the past." Interpersonal therapy ($M = 5.69$) was rated significantly higher than CB therapy ($M = 4.17$; $p \leq .001$) on this item. **CB Therapy** No items regarding a focus on past experiences were found to be characteristic of CB therapy.
DeRubeis et al. (1982)	6 videotaped IP and CB therapy sessions	**IP Therapy** *Item 27:* "To what extent did the therapist explore the client's past for evidence of the loss of (or a change in) an important relationship?" 1 = not at all, 9 = major focus of the session. This item loaded negatively on a CB technique factor (factor loading = −.68) and loaded positively on an IP technique factor (factor loading = .37). *Item 6:* "To what extent did the therapist attempt to relate current problems to experiences occurring during the client's childhood or adolescence?" 1 = frequently, 9 = not at all. This item loaded negatively on the IP technique factor (−.57) and positively on the CB technique factor (.24).
Brunink & Schroeder (1979)	18 expert psychoanalytically oriented, gestalt, and behavior therapists	**PD and B Therapy** Psychoanalytic (11.4% of therapist utterances) and behaviorists (2.9% of therapist utterances) did not significantly differ in their focus on "there and then."
Goldfried et al. (1997)	57 patients (27 PI, 30 CB therapy) diagnosed with major depressive disorder	**PI Therapy** Significantly more likely than CB therapy to emphasize patients' preadult past experiences ($F = 14.85$; $p = .001$) and patients' adult past experiences ($F = 5.63$; $p = .021$). **CB Therapy** No items regarding a focus on past experiences were found to be characteristic of CB therapy.
Goldfried et al. (1998)	36 patients (14 treated by master PI therapists, 22 by master CB therapists) presenting with anxiety, depression, or both	**PI and CB Therapy** Both approaches to therapy emphasized a wider range of time frames including preadult past ($F = 5.80$; $p = .02$) and adult past ($F = 5.91$; $p = .02$) during significant portions of sessions than in nonsignificant portions of sessions. **PI Therapy** No significant differences were found between PI and CB therapy in their focus on a patient's past experiences.
Goldsamt et al. (1992)	One patient seen in a 45-minute demonstration session by three master therapists (Beck, Meichenbaum, and Strupp)	**PD Therapy** Strupp focused significantly more than Beck ($\chi^2 = 7.56$; $p < .01$) or Meichenbaum ($\chi^2 = 9.03$; $p < .01$) on the patient's preadult past. Strupp focused significantly more than Beck ($\chi^2 = 9.91$; $p < .01$) or Meichenbaum ($\chi^2 = 19.24$; $p < .001$) on the patient's adult past.

tioning. However, using expert therapists, Goldsamt et al. (1992) found the expected therapy orientation differences in time frame emphasis. Strupp placed more of an emphasis than Beck and Meichenbaum on experiences of the patient's preadult and adult past.

Research reviewed in this section lends strong support to the theoretical belief that a focus on past experiences is a distinctive element of PI treatment. Of the eight studies reviewed in this section, six showed a significantly greater emphasis of past events in PI therapy than in CB therapy. The two approaches appear to conceptualize a patient's present difficulties in qualitatively different ways. While PI therapy sees difficulties arising in a patient's present life situation as manifestations of past unresolved conflicts and experiences, CB treatment conceptualizes a patient's current dysfunctional life situation as leading to problematic experiences in his or her present and future. It will be interesting to see how future research in this area changes as PI therapies being to focus more on a patient's present life situation and CB therapies begin to integrate a more developmental focus into their treatments.

Focus on a Patient's Interpersonal Experiences

Another area in which PI and CB therapy differ is in their focus on patients' interpersonal experiences. According to theory, PI therapy, with its concentration on patients' relationships, contains a marked interpersonal component (Book, 1998; Klerman, Weissman, Rounsaville, & Chevron, 1984; Luborsky, 1984; Strupp & Binder, 1984; Wachtel, 1993). In this view, a patient's problematic interpersonal relationships interfere with a person's ability to fulfill his or her basic needs and wishes (Strupp & Binder, 1984). Psychopathology is seen as the result of conflicts between individuals and current or historical figures in their lives (Klerman et al., 1984; Luborsky, 1984; Strupp & Binder, 1984). In contrast, CB therapy, with its emphasis on patients' illogical and irrational thoughts and beliefs, focuses more on patients' intrapersonal experiences (Barlow, 1993; Beck, 1976; Beck et al., 1979; Goldfried & Davidson, 1994; Mahoney, 1988, 1991; Meichenbaum, 1977). In this view, psychopathology is seen as the result of inefficient, ineffective, or illogical intrapersonal/cognitive functioning.

Comparative psychotherapy process research supports this theoretical difference between PI and CB therapy (see Table 5). Jones and Pulos (1993) reported that the PQS item "Patient's interpersonal relationships are a major theme" was rated as characteristic of PD treatment. Ablon and Jones (1999) revealed that this same PQS item was rated as characteristic of both IP and CB therapy. However, IP therapy was rated significantly higher than CB therapy on this item. Surprisingly, a focus on interpersonal relationships was not rated as characteristic of either PD or CB therapy in the Ablon and Jones (1998) study.

Kerr, Goldfried, Hayes, Castonguay, and Goldsamt (1992) also investigated differences between PI and CB therapy in the area of interpersonal focus. In this study, therapists of both orientations tended to have an interpersonal rather than intrapersonal focus. This finding is consistent with the interpersonal focus of PI therapy. However, the finding that CB therapists made more interpersonal than intrapersonal links was not expected as this is inconsistent with the central cognitive focus of CB sessions and suggests that CB therapists deviated in some fashion from what might be expected by theory (Kerr et al., 1992).

Goldfried et al. (1997) found that PI therapists were significantly more likely than CB therapists to emphasize patterns in a patient's interpersonal functioning repeated over time, settings, or people, to focus on the impact that another person's functioning had on a patient, and to focus on general interactions between a patient and another person. However, Goldfried et al. (1998), using master therapists, reported that CB therapy was significantly more likely than PI therapy to compare or contrast patients' functioning with that of others in an attempt to provide a context for helping the person identify adaptive or maladaptive behaviors, thoughts, and feelings. In addition, master therapists of both treatment approaches were significantly more likely to emphasize the impact that one component of a patient's functioning had on other components and to compare and contrast a patient's functioning to others during portions of sessions rated as most important. Furthermore, both PI and CB master therapists were significantly more likely to point out the impact that others had on the patient and to deal with general interactions between patients and others in portions of sessions rated as most important. The results of this study suggest that experienced therapists of both orientations rely heavily on an interpersonal focus, particularly during portions of sessions deemed by therapists to be significant. In addition to the experience level of the therapists providing treatment, the results of this study could be influenced by the nature of the treatment (naturalistic setting

Table 5. Focus on patients' interpersonal experiences in psychodynamic-interpersonal (PI) and cognitive-behavioral (CB) therapy

Study	Participants	Findings
Jones & Pulos (1993)	30 patients (20 women, 10 men) treated with brief PD therapy for various problems; 32 patients (25 women, 7 men) with a diagnosis of major depressive disorder treated with CB and tricyclic pharmacotherapy, alone and in combination	**PD Therapy** *PQS item 63:* "Patient's interpersonal relationships are a major theme discussed in session." This item was rated as highly characteristic of PD therapy ($M = 7.16$). **CB Therapy** No items regarding a focus on interpersonal relationships were rated as characteristic of CB therapy.
Ablon & Jones (1998)	A panel of expert PD ($N = 11$) and CB ($N = 10$) therapists	**PD and CB Therapy** No items regarding a focus on interpersonal relationships were rated as characteristic of PD or CB therapy.
Ablon & Jones (1999)	Outpatients (29 treated with CB and 35 treated with IP therapy) diagnosed with major depressive disorder	**IP Therapy** *PQS item 63:* "Patient's interpersonal relationships are a major theme discussed in session." This item was rated as significantly more characteristic of interpersonal therapy ($M = 8.06$) than CB therapy ($M = 6.77$; $p \leq .001$). **CB Therapy** *PQS item 63:* "Patient's interpersonal relationships are a major focus of discussion." This item was rated as highly characteristic of CB therapy ($M = 6.77$).
Kerr et al. (1992)	27 patients from Sheffield I project (13 receiving PI therapy, 14 receiving CB therapy) presenting with depression and/or anxiety	**PI Therapy** Made significantly more interpersonal than intrapersonal links in their therapy [$t(12) = 2.37$, $p < .05$]. **CB Therapy** Made more interpersonal than intrapersonal links in their therapy but this difference was not significant [$t(13) = 1.68$, $p < .15$].
Goldfried et al. (1997)	57 patients (27 PI, 30 CB therapy) diagnosed with major depressive disorder	**PI Therapy** PI therapists placed more emphasis than CB therapists on relational patterns repeated over time, settings, or people ($F = 17.90$, $p = .001$), the impact that others made on clients ($F = 11.40$, $p = .001$), and patients' general interpersonal relations ($F = 10.90$, $p = .002$). **CB Therapy** No differences between PI and CB therapy were found to favor CB therapy in the area of interpersonal focus.
Goldfried et al. (1998)	36 patients (14 treated by master PI therapists, 22 by master CB therapists) presenting with anxiety, depression, or both	**PI and CB Therapy** Both master PI and CB therapists were more likely to compare and contrast a patient's functioning to others ($F = 6.21$, $p = .018$), point to the impact that others made on a patient ($F = 15.80$, $p = .001$), and deal with a patient's interpersonal relations in general ($F = 5.45$, $p = .026$) during significant portions of PI and CB sessions than in nonsignificant portions. **PD Therapy** No coding items were found to be significantly more characteristic of PD therapy than CB therapy. **CB Therapy** Master CB therapists were more likely than master PI therapists to compare and contrast clients' functioning with the functioning of others ($F = 5.76$, $p = .02$).
Goldsamt et al. (1992)	One patient seen in a 45-minute demonstration session by three master therapists (Beck, Meichenbaum, and Strupp)	**PD Therapy** Strupp highlighted interpersonal patterns more than Beck ($\chi^2 = 9.98$, $p < .01$). Strupp ($\chi^2 = 15.52$, $p < .001$) and Meichenbaum ($\chi^2 = 10.49$, $p < .01$) focused significantly more than Beck on interpersonal consequences (self having an impact on others).
Silove et al. (1990)	81 subjects (38% receiving PD therapy, 28% cognitive therapy, 17% behavior therapy, and 7% CB therapy) seeking services for anxiety and depression	**PD Therapy** Patients who received PD therapy described their therapists as focusing more on their relationships (both early and current; $M = 22.4$, $SD = 7.6$) than patients receiving CB treatments described their therapists ($M = 12.4$, $SD = 4.2$; $F = 44.76$, $p < .01$).
Crits-Cristoph et al. (1999)	72 patients receiving either CB or IP therapy	**IP Therapy** IP therapy contained a greater number of narratives about interpersonal interactions than CB therapy ($r = .44$; $p < .001$).
Startup & Shapiro (1993)	Therapists and patients from the Second Sheffield Psychotherapy Project	**PI Therapy** Exploratory therapists ($M = 29.8$) were rated significantly higher than prescriptive therapists ($M = 5.3$; $p < .0001$) on the Exploratory Therapy (E) scale, which included items such as relating interpersonal change to therapy and identifying patterns in relationships.
DeRubeis et al. (1982)	6 videotaped IP and CB therapy sessions	**IP Therapy** *Item 1:* "To what extent did the content of the session focus on the client's interpersonal relationships?" 1 = not at all, 9 = totally. This item loaded positively on the IP technique factor (.90) and negatively on the CB technique factor (−.12).

Table 5. *Continued*

Study	Participants	Findings
Hill et al. (1992)	180 patients from the National Institute of Mental Health Treatment of Depression Collaborative Research Project	**IP Therapy** IP therapists (M = 2.02) were rated significantly higher than CB therapists (M = 1.53; $p < .01$) on the Interpersonal Therapy (IPT) scale, which included items measuring interpersonal rationale, interpersonal relationships and tendencies, changes in interpersonal functioning, interpersonal disputes, and interpersonal deficits.

vs. controlled clinical trial) or an interaction between therapist experience level and type of treatment (naturalistic setting vs. controlled clinical trial).

On a single-case, single-session basis, Goldsamt et al. (1992) identified differences between expert PI and CB therapists with regard to their respective emphasis on a patient's interpersonal interactions. Strupp was more likely than Beck to highlight the patient's interpersonal functioning repeated over time, settings, or people, and Beck focused less than either Meichenbaum or Strupp on the impact the patient's functioning had on other people. As the authors suggest, these findings are consistent with the basic tenets of the alternative treatment approaches.

Silove, Parker, and Manicavasagar (1990) also illustrated differences between PD and CB therapy in their emphasis on interpersonal functioning from a patient's perspective. The authors of this study had patients who had been treated with either CB or PD therapy attempt to discriminate between the two approaches. As would be expected, patients who received CB therapy found their therapists to emphasize the cognitive change of a patient's attitudes, while patients receiving PD treatments described their therapists as focusing more on relationships (both early and current). Most recently, a study by Crits-Christoph et al. (1999) investigated the use interpersonal narratives in IP and CB treatment. IP therapy contained a significantly greater number of interpersonal narratives than CB treatment, suggesting a greater emphasis of interpersonal experiences in IP than CB therapy.

Startup and Shapiro (1993), in their treatment fidelity study, also noted differences between PI and CB therapy in their emphasis of a patient's interpersonal experiences. PI therapists scored significantly higher than CB therapists on items related to interpersonal change in therapy and a focus on patterns in relationships. In addition, DeRubeis et al. (1982) and Hill et al. (1992) reported that a focus on a patient's interpersonal relationships and tendencies (including past relationships), interpersonal rationale, interpersonal disputes, and interpersonal deficits were related to a factor describing IP technique and unrelated to a factor describing CB technique.

Research reviewed in this section offers strong support for the contention that an emphasis on a patient's interpersonal interactions is a distinctive feature of PI therapy. Of the 12 studies reviewed in this section, nine found patients' interpersonal functioning to be emphasized more in PI therapy than in CB treatment. Goldfried et al.'s (1998) contradictory finding that CB therapists were more likely than PD therapists to compare and contrast patients' functioning with that of others may possibly be attributed to the master therapists in the study, the nature of the treatment (controlled clinical trial vs. naturalistic setting), or an interaction between the two. By comparing and contrasting a person's functioning with that of others, a therapist can help the patient assess the adaptive or maladaptive quality of his or her thoughts, behaviors, and feelings and begin to identify problematic areas of functioning. As a whole, however, a focus on patients' interpersonal experiences appears to be a distinctive aspect of PI therapy.

Emphasis on the Therapeutic Relationship

One particular interpersonal relationship that may be a focus of discussion in treatment is the therapeutic relationship. PI and CB therapy also differ in the importance each treatment ascribes to the therapeutic relationship. While theory suggests that both PI and CB therapy view the therapeutic relationship and the therapeutic alliance as important, PI theory proposes that the therapeutic relationship is a vehicle or medium for the process of change (Kerr et al., 1992). The concept of transference is essential to this view of the therapeutic relationship (Book, 1998; Fenichel, 1945; Freud, 1905; Glover, 1955; Greenson, 1967; Luborsky, 1984; Strupp & Binder, 1984; Wachtel,

1993). From a classical psychoanalytic perspective, transference is conceptualized as arising when a patient unconsciously ascribes to the therapist qualities that are related to earlier figures or relationships in the patient's life (Freud, 1916/1943; Gill, 1954). In this view, the transference comes strictly from the patient's internal or fantasized world. The therapist does nothing to contribute to this process. More recently, however, contemporary psychodynamic theorists such as Gill (1982, 1984) have begun to conceptualize transference in a different way. In this alternative conceptualization, the patient's projections onto the therapist are not seen as an entirely internal phenomenon, but rather as having some basis in external reality. That is, the therapist plays a role in the facilitation of the transference experience as he or she is a participant in the interaction. While not all transactions between the patient and therapist are necessarily transferencial in nature, problematic relational patterns may emerge in the therapeutic relationship as the therapist uses this interaction to identify the patient's conflictual ways of dealing with significant others (Kerr et al., 1992). In CB theory, the patient and therapist are seen as "scientific collaborators" investigating and testing the validity of a patient's thoughts (Barlow, 1993; Beck, 1976; Beck et al., 1979; Goldfried & Davidson, 1994; Mahoney, 1988; Meichenbaum, 1977).

Recent empirical psychotherapy process research has supported this theoretical difference (see Table 6). Jones and Pulos (1993) and Ablon and Jones (1998, 1999) reported that the Q-set items "Therapist draws connections between the therapeutic relationship and other relationships" and "The therapy relationship is a focus of discussion" were rated as more characteristic of PD and IP than CB therapy. Research by Goldfried et al. (1997, 1998) reported that PI therapists were significantly more likely than CB therapists to focus on the therapeutic relationship and what was occurring within a session. The Goldfried et al. (1998) study, using master therapists, also noted a significant main effect for session portion such that master therapists from both orientations were more likely to focus discussion on the therapeutic relationship and what occurred within a session during portions of sessions rated as most important. DeRubeis et al. (1982), in their study of differences between CB and IP treatments of depression, found that the item "Did the therapist elicit feedback about the client's reactions to the therapy and/or the therapist as part of the closing portion of the session?" loaded positively on an IP technique factor and negatively on a CB technique factor.

In the Goldsamt et al. (1992) single-session, single-case study, no significant differences were noted between the master therapists' focus on the therapeutic relationship. While this finding was unexpected, the authors suggest that Strupp did not actively make use of transference in this session, choosing instead to learn about the patient. Before a therapist can make interpretations of transference and use the therapeutic interaction as a tool in treatment, the therapeutic relationship must develop over time. Perhaps the single-session design of this study was insufficient for establishing the relationship needed to cultivate transference from the patient. In addition, Gaston and Ring (1992), using the ITS, reported that PD and C therapy did not significantly differ in their respective focus on patients' problematic reactions toward therapists and reported an effect size of 0.43 for this comparison representing a small effect as defined by Cohen (1977). Rather, only a trend toward a greater emphasis of patients' problematic reactions toward the therapist in brief dynamic therapy was observed. Similarly, Brunink and Schroeder (1979) also reported a nonsignificant difference between PD and B therapists in their focus on the therapeutic relationship (see note 3).

The research reviewed in this section offers moderate support for the notion that focusing on the therapeutic relationship is a distinctive feature of PI therapy. Six of the nine articles reviewed here found a greater emphasis of the therapeutic relationship in PI therapy relative to CB treatment. The contradictory results reported by Goldsamt et al. (1992) could be due to the insufficient nature of the single-session design to allow the therapist to make use of the patient-therapist relationship. Perhaps with a greater number of sessions, Strupp may have made more use of the therapeutic relationship.

Exploration of Patients' Wishes, Dreams, or Fantasies

One final area in which PI and CB therapies differ is in their respective focus on patients' wishes, fantasies, and dreams. PI theory proposes that wishes, dreams, and fantasies give important clues into the workings of a patient's unconscious functioning (Fenichel, 1945; Freud, 1900, 1905, 1916/1943; Glover, 1955; Greenson, 1967). In contrast, CB therapy tends to be more reality based and problem/symptom focused, emphasizing a patient's present and conscious thoughts and beliefs (Barlow, 1993; Beck, 1976; Beck et al., 1979; Goldfried & Davidson, 1994; Mahoney, 1988; Meichenbaum, 1977).

Recent comparative psychotherapy process research

Table 6. Emphasis on the therapeutic relationship in psychodynamic-interpersonal (PI) and cognitive-behavioral (CB) therapy

Study	Participants	Findings
Jones & Pulos (1993)	30 patients (20 women, 10 men) treated with brief PD therapy for various problems; 32 patients (25 women, 7 men) with a diagnosis of major depressive disorder treated with CB and tricyclic pharmacotherapy, alone and in combination	**PD Therapy** *PQS item 100:* "Therapist draws connections between the therapeutic relationship and other relationships." PD therapy (M = 5.1) was rated significantly higher than CB therapy (M = 4.0; $p < .001$) on this item. *PQS item 98:* "The therapy relationship is a focus of discussion." PD therapy (M = 5.3) was rated significantly higher than CB therapy (M = 4.6; $p < .01$) on this item. **CB Therapy** No PQS items regarding the therapeutic relationship were found to be characteristic of CB therapy.
Ablon & Jones (1998)	A panel of expert PD (N = 11) and CB (N = 10) therapists	**PD Therapy** *PQS item 100:* "Therapist draws connections between the therapeutic relationship and other relationships." This item was rated as highly characteristic of PD therapy (factor score = 1.47). *PQS item 98:* "The therapy relationship is a focus of discussion." This item was rated as highly characteristic of PD therapy (factor score = 1.28). **CB Therapy** No PQS items regarding the therapeutic relationship were found to be characteristic of CB therapy.
Ablon & Jones (1999)	Outpatients (29 treated with CB and 35 treated with IP therapy) diagnosed with major depressive disorder	**IP Therapy** *PQS item 100:* "Therapist draws connections between the therapeutic relationship and other relationships." IP therapy (M = 4.44) was rated significantly higher than CB therapy (M = 3.66; $p \leq .001$) on this item. **Cognitive Therapy** No PQS items regarding the therapeutic relationship were found to be characteristic of CB therapy.
Goldfried et al. (1997)	57 patients (27 PI, 30 CB therapy) diagnosed with major depressive disorder	**PI and CB Therapy** Both approaches to therapy were found to place significantly more emphasis on what was occurring within the session during high-impact sessions than in low-impact sessions (F = 3.88, p = .05). **PI Therapy** PI therapists placed significantly more emphasis on the therapist in relation to the patient than CB therapists (F = 14.20; p = .001). **CB Therapy** No coding categories regarding an emphasis on the therapeutic relationship were found to be characteristic of CB therapy.
Goldfried et al. (1998)	36 patients (14 treated by master PI therapists, 22 by master CB therapists) presenting with anxiety, depression, or both	**PI and CB Therapy** Master therapists from both orientations were more likely to focus discussion on the therapist in relation to the patient during significant portions of sessions than in nonsignificant portions (F = 8.81; p = .005). Master therapists from both orientations were significantly more likely to focus discussion on what was occurring within the session during significant portions of sessions rather than nonsignificant sessions (F = 21.52, p = .001). **PI Therapy** PI therapists focused significantly more on the therapist in relation to the patient than CB therapists (F = 5.27; p = .028). **CB Therapy** No coding categories regarding a focus on the therapeutic relationship were found to be significantly characteristic to CB therapy alone.
DeRubeis et al. (1982)	6 videotaped IP and CB therapy sessions	**IP Therapy** *Item 20:* "Did the therapist elicit feedback about the client's reactions to the therapy and/or the therapists as part of the closing portion of the session?" This item loaded negatively on a CB technique factor (factor loading = −.60) and loaded positively on an IP technique factor (factor loading = .30).
Goldsamt et al. (1992)	One patient seen in a 45-minute demonstration session by three master therapists (Beck, Meichenbaum, and Strupp)	**PD Therapy** No coding categories regarding a focus on the therapeutic relationship were found to be significantly characteristic of PD therapy alone. **CB Therapy** Beck (χ^2 = 6.33; $p < .05$) and Meichenbaum (χ^2 = 3.95; $p < .05$) focused significantly more than Strupp (PD) on the in-session time frame.
Gaston & Ring (1992)	16 depressed patients from a larger outcome study by Thompson et al. (1987) (10 receiving brief PD therapy; 6 in cognitive therapy)	**PD and Cognitive Therapy** The two treatment approaches did not significantly differ in their respective focus on patients' problematic reactions toward therapists (t = 1.89; p = .06). A trend was observed, however, in that PD therapists focused more (M = .21) than CB therapists (M = .09) on patients' problematic reactions to the therapist.
Brunink & Schroeder (1979)	18 expert psychoanalytically oriented, gestalt, and behavior therapists	**PD and B Therapy** PD therapists (2.9% of therapist utterances) and B therapists (0.4% of therapist utterances) did not significantly differ in their focus in the therapist-client relationship.

Table 7. Exploration of patients' wishes, dreams, or fantasies in psychodynamic-interpersonal (PI) and cognitive-behavioral (CB) therapy

Study	Participants	Findings
Jones & Pulos (1993)	30 patients (20 women, 10 men) treated with brief PD therapy for various problems; 32 patients (25 women, 7 men) with a diagnosis of major depressive disorder treated with CB and tricyclic pharmacotherapy, alone and in combination	**PD Therapy** *PQS item 67:* "Therapist interprets warded off or unconscious wishes, feelings, or ideas." PD therapy ($M = 6.3$) was rated significantly higher than CB therapy ($M = 4.2$; $p < .001$) on this item. **CB Therapy** No PQS items regarding the interpretation and exploration of patients' wishes, dreams, or fantasies were found to be characteristic of CB therapy.
Ablon & Jones (1998)	A panel of expert PD ($N = 11$) and CB ($N = 10$) therapists	**PD Therapy** *PQS item 90:* "Patient's dreams or fantasies are discussed." This item received the highest factor score (1.71) on a factor labeled by the authors as psychodynamic technique. **CB Therapy** No PQS items regarding the interpretation and exploration of patients' wishes, dreams, or fantasies were found to be characteristic of CB therapy.
Goldfried et al. (1997)	57 patients (27 PI, 30 CB therapy) diagnosed with major depressive disorder	**PI and CB Therapy** No significant differences were found between PI therapists ($M = 12.6$) and CB therapists ($M = 10.5$; $F = 1.29$; $p = .26$) in terms of their focus on wishes.
Goldfried et al. (1998)	36 patients (14 treated by master PI therapists, 22 by master CB therapists) presenting with anxiety, depression, or both	**PI and CB Therapy** No significant differences were found between PI therapists ($M = 17.1$) and CB therapists ($M = 14.6$; $F < 1.0$) in their focus on wishes.
Goldsamt et al. (1992)	One patient seen in a 45-minute demonstration session by three master therapists (Beck, Meichenbaum, and Strupp)	**PD and B Therapy** Both Strupp ($\chi^2 = 7.61$; $p < .01$) and Meichenbaum ($\chi^2 = 5.28$; $p < .05$) focused significantly more than Beck on the patient's dreams, fantasies, or ideal figures.

has borne out this theoretical difference (see Table 7). Jones and Pulos (1993) and Ablon and Jones (1998) reported that a discussion and interpretation of patients' wishes, fantasies, and dreams was characteristic of PD and not CB therapy. Moreover, in the Ablon and Jones (1998) study using experts therapists as raters, the PQS item "Discussion of patients' dreams or fantasies" contributed most to a factor labeled by the authors as PD technique. Goldfried et al. (1997, 1998) also investigated PI and CB therapists' focus on wishes. The CSTF contains a coding category labeled "Intention" that was defined as a focus on a "patient's/client's future-oriented volition, such as wishes, desire, motivation, or need." In both the Goldfried et al. (1997) and the Goldfried et al. (1998) study using master therapists, no significant differences were found between PI and CB therapy in this category. The lack of significant differences between PI and CB therapy in terms of their focus on wishes in these studies could be due to the nature of the coding category. The "Intention" category specifically taps reasons and motives for future patient action. As discussed above, theory suggests that CB treatment emphasizes a patient's future functioning. This future focus may partly account for why CB therapists were rated so highly on this process dimension.

In the Goldsamt et al. (1992) single-session, single-case study, differences between treatment approaches were found in their respective emphasis of the patient's dreams. The authors reported that both Strupp and Meichenbaum focused more than Beck on the patient's dream, fantasy, or ideal figures. However, Strupp and Meichenbaum did not significantly differ in this domain. While offering some conditional support to the contention that PD therapy focuses more on dreams and fantasy than Beck's cognitive therapy, the single-session research design presents a limitation in terms of the generalizability of this study's findings to other patients. However, it is surprising that Strupp's PD therapy did not emphasize this area significantly more than Meichenbaum's CBM. No explanation for this finding was noted by the authors. Perhaps with a greater number of sessions, Strupp may have explored the patient's dreams and fantasies to a greater extent as theory would suggest.

The results of the literature reviewed in this section offer moderate support for the belief that an emphasis on patients' wishes, dreams, and fantasies is a distinctive aspect of PI therapy. PI therapy was found to emphasize a patient's dreams, wishes, or fantasies significantly more than CB therapy in three of the five studies reviewed in this section. In the two studies that did not report the presumed theoretical differences, the "Intention" coding category may be confounded with CB therapists propensity to focus on a patient's future functioning. While PI and CB therapy appear to differ in their emphasis of a patient's

Table 8. Summary of distinctive features of psychodynamic-interpersonal psychotherapy

1. Focus on affect and the expression of patients' emotion
2. Exploration of patients' attempts to avoid topics or engage in activities that hinder the progress of therapy
3. The identification of patterns in patients' actions, thoughts, feelings, experiences, and relationships
4. Emphasis on past experiences
5. Focus on patients' interpersonal experiences
6. Emphasis on the therapeutic relationship
7. Exploration of patients' wishes, dreams, or fantasies

wishes, dreams, or fantasies on a theoretical level, relatively few studies have actually compared the two approaches on this issue. More investigation of this topic is needed in the future before conclusions can be made with certainty.

CONCLUSIONS

This review was conducted to identify techniques and processes that distinguish PI from CB therapy. Seven activities and areas of focus empirically differentiated short-term, manualized PI therapy from CB treatment (see Table 8).

The empirically distinctive features of PI therapy identified in this article appear very similar to the suggested key curative factors in dynamic psychotherapy outlined by Luborsky et al. (1990). Their review included discussions of processes such as the therapeutic relationship, interpersonal interactions (with current and historical figures), patterns in patients' functioning, and unconscious wishes. That therapists delivering PI therapy are focusing significantly more than CB treatment on issues proposed by Luborsky et al. (1990) as theoretically essential to patient change in dynamic psychotherapy is encouraging. The overlap between the present review and that of Luborsky et al. (1990) suggests that PI therapists are adhering to techniques and processes theoretically believed to facilitate patient improvement in a psychodynamic model of change. However, because only limited process-outcome correlational research exists, further work is needed to expand on the relationship between distinctive psychodynamic treatment processes and outcome before definitive conclusions can be made as to their ability to facilitate patient change.

By providing empirical evidence of theoretically assumed differences between psychodynamic-interpersonal and cognitive-behavioral therapy, this review identifies a useful heuristic for future research on the effectiveness of these distinctive, specific techniques and processes. Researchers can more easily isolate, operationally define, and measure these variables in process-outcome research and will be better able to assess the effect of each element both alone and in combination with other common elements (such as the supportive techniques). Studies of the effectiveness of these distinctive variables for facilitating patient change will enable therapists to determine whether these interventions should be adhered to or avoided. In addition, future research on the relationship between process and outcome can aid in the determination of when and with whom the use of these techniques will be most effective.

The identification of the processes that distinguish PI from CB therapy can also aid in the training and teaching of psychodynamic-interpersonal psychotherapy. Supervisors of this treatment will be able to use this review as a training tool, helping new trainees and/or graduate students learn about the techniques and processes that are distinctive to the treatment approach. Teachers will also be able to point to this article as a clear illustration of empirically derived differences between two prominent treatment options. In addition, this review can provide PI therapists in any setting with a guide for session activity, specifying techniques and processes to be emphasized in treatment.

As suggested by the findings of Fairburn et al. (1993, 1995) that CB and IP therapy operate via different mechanisms and processes of change, there is a need for future research to investigate the effectiveness of treatment specific techniques. This review represents an initial step in this process. By understanding the contribution of distinctive, treatment-specific techniques and processes in addition to those factors common to alternative forms of treatment, psychotherapists may be better served in their attempts to facilitate patient improvement. Fitting together the distinctive, treatment-specific and common pieces of the psychotherapy puzzle represents the next challenging step in psychotherapy process and outcome research.

NOTES

1. This sentence was adapted from the comments of an anonymous reviewer of this manuscript. We thank Dr. Barlow and the five anonymous reviewers for their helpful comments and recommendations.

2. When describing the findings of a particular article, the

abbreviation used corresponds to the type of therapy described in the study. For example, PI is used when referring to the Goldfried et al. (1997) work, PD is used when discussing the findings of the Jones and Pulos (1993) study, and IP is used when reviewing the findings of Ablon and Jones (1999). At the close of a section, when the research in a content area is being summarized, the PI abbreviation is used as an aggregate term, describing the three types of therapy as a group. PI was chosen because that type of treatment purports to integrate PD and IP therapy and, hence, is a more conservative and neutral choice. The same rationale was maintained for using the CB abbreviation in the summary sections.

3. Rosenthal (1991) indicated that a group of seemingly discrepant findings can often be highly consistent in small sample studies if effect sizes are calculated. We attempted to calculate the more relevant statistical result of effect sizes for the differences between PD and B therapy in the use of interpretations. However, we found that Brunink and Schroeder (1979) did not report p values, t scores, standard deviations, or correlations for nonsignificant differences. Thus, we were unable to compute effect sizes. This issue is raised in our review when discussing differences between PD and B therapy in their focus on past experiences and the therapeutic relationship reported in the Brunink and Schroeder (1979) study.

ACKNOWLEDGMENTS

We thank Dr. Barlow and the five anonymous reviewers of the manuscript for their helpful comments, recommendations, and suggestions.

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Received August 3, 1999; revised December 14, 1999; accepted December 21, 1999.