Supportive-Expressive (SE) Psychotherapy: An Update[a]

Falk Leichsenring* and Eric Leibing

Clinic of Tiefenbrunn and Clinic of Psychosomatics and Psychotherapy, University of Goettingen, Germany

Abstract: An updated review of Supportive-Expressive (SE) psychotherapy is presented. The concepts, techniques and research methods of SE therapy are described, and empirical evidence is reviewed. Articles on SE therapy published between 1970 and 2006 were identified by a computerized search using Pubmed, MEDLINE, PsycINFO and Current Contents. In November 2006, the search was updated using database-specific keywords. By this search, 92 individual studies or review articles on SE therapy were identified. In addition, text books and journal articles were used. Only publications referring to Luborsky´s concept of SE therapy were included. The information was extracted by two raters. Sixty-seven publications addressing SE therapy according to Luborsky were included. Articles refering to conceptual (clinical) contributions and empirical research on concepts, processes and efficacy of SE therapy were reviewed. Results were summarized by two raters. Empirical data are in general consistent with the concepts of SE therapy. At present, a limited number of randomized controlled trials providing evidence for the efficacy of SE therapy in specific psychiatric disorders is available. Further efficacy studies are required. With regard to processes of SE therapy, studies addressing the interactions among supportive-expressive interventions, patient´s level of functioning and outcome are recommended.

Keywords: Supportive-expressive psychotherapy, evidence, efficacy, review.

In the present article, an updated review of supportive-expressive (SE) psychotherapy [1] is given. Techniques, concepts and empirical evidence are presented. As will be shown below in more detail, SE therapy allows for the treatment of a wide range of psychiatric disorders.

In clinical practice, psychodynamic psychotherapy is one of the most commonly used methods of psychotherapy [2]. It is also one the most commonly used methods of personal therapy of mental health professionals [3]. However, psychodynamic psychotherapy has often been controversially discussed, especially with regard to the adequacy of empirical evidence. For example, short-term psychodynamic psychotherapy was judged as "probably efficacious" by the American Psychological Association's (APA) Task Force on Promotion and Dissemination of Psychological Procedures [4]. Updated reviews about the efficacy of psychodynamic psychotherapy in specific psychiatric disorders [5-7] as well as a meta-analysis of short-term psychodynamic psychotherapy [8] were recently presented. According to these reviews, there is a limited number of randomized controlled trials which provided evidence for the efficacy of psychodynamic psychotherapy in specific psychiatric disorders [5-7]. However, no two studies of independent research groups are available demonstrating efficacy of the same model of psychodynamic psychotherapy in the same psychiatric disorder [5,7]. This was the reason why short-term psychodynamic psychotherapy was judged as "probably efficacious" by the APA´s Task Force. At present, ten years later, this judgement still holds true [5,7].

*Address correspondence to this author at the Clinic of Psychosomatics and Psychotherapy, University of Goettingen, von Sieboldstr. 5, D-37075 Goettingen, Germany; Tel: +49-551-398186; Fax: +49-551-394592;
E-mail: fleichs@gwdg.de

[a]We thank Dr. Luborsky (University of Pennsylvania) for helpful comments.

The different models of psychodynamic psychotherapy were described and compared in several reviews [9-11]. According to empirical data, there are some models of psychodynamic psychotherapy for which two or more randomized controlled trials in specific (though different) psychiatric disorders are available [5,7]. These are the models of Luborsky, Shapiro and Firth, Malan and Horowitz [1,12-14]. This article will focus on Luborsky´s model of SE therapy. An updated review will be given for conceptual and clinical aspects (e.g. concept of conflict, techniques of SE therapy, disorder-specific treatment manuals) as well as for research on efficacy and processes of SE therapy.

METHOD

We collected articles on SE therapy that were published between 1970 and (May) 2006, carrying out a computerized search using MEDLINE, PsycINFO, and Current Contents. The following key words were used: supportive-expressive therapy, study, outcome, process, randomized controlled trial, efficacy. In November 2006, the search was updated using database-specific keywords. By this search, 92 individual studies or review articles on SE therapy were identified. In addition, text books and journal articles were reviewed. Only publications referring to Luborsky´s concept of SE therapy [1] were included. Studies focusing on other models of supportive-expressive therapy were excluded, e.g. studies of Spiegel´s model of supportive-expressive group therapy for patients with cancer [15]. The information was extracted by two raters. Seventy publications referring to concepts of Luborsky´s SE therapy were included. The articles identified were reviewed with regard to clinical contributions (e.g. Core Conflictual Relationship Theme, supportive and expressive interventions, treatment manuals), and research on outcome and processes (e.g. on helping alliance treatment fidelity, curative factors) of SE therapy.

1573-4005/07 $50.00+.00

SUPPORTIVE-EXPRESSIVE THERAPY: A SPECIFIC MODEL OF PSYCHODYNAMIC PSYCHOTHERAPY

Psychodynamic psychotherapies operate on a supportive-interpretive continuum [1,16-21]. The concept of a supportive-interpretive (or supportive-expressive) continuum of psychodynamic interventions is empirically based on the data of the Psychotherapy Research Project of the Menninger Foundation [1,21-23]. Based on his work at the Menninger Foundation, Luborsky developed a specific model of psychodynamic psychotherapy including both supportive and expressive Interventions (SE therapy) [1] With regard to supportive interventions, the establishment of a helping alliance is regarded as a central component [1]. In SE therapy, expressive interventions are defined to enhance the patient´s cognitive and emotional understanding of his or her present symptoms and of the underlying "Core Conflictual Relationship Theme" (CCRT) [1,24-28]. The concept of the CCRT will be presented below more in detail. For both supportive and expressive interventions, Luborsky has formulated a number of principles [1, p. 82-8, p.121, 94-141]. Meanwhile, manual-guided adaptations of SE therapy for a variety of specific psychiatric disorders are available including for depression, generalized anxiety disorder, bulimia nervosa, specific personality disorders or opiate and cocaine dependence [16,29-34]. Disorder-specific specifications of supportive and expressive interventions were described in the respective treatment manuals [16,30-35]. For example, a secure therapeutic alliance is regarded as particularly important in specific psychiatric disorders, e.g. in generalized anxiety disorder [16] or social phobia [36]. The interventions characteristic of SE therapy have been operationalized both by treatment manuals and by rating scales for adherence and competence [1,37-39]. In addition, a psychodynamic concept of psychopathology has been specified, the "Core Conflictual Relationship Theme" [1,24,25,40] (CCRT). Empirical research on supportive and expressive interventions as well as on the CCRT method will be reviewed below. SE therapy can be carried out both as a short-term and as a long-term treatment. Short-term treatments tend to be from 6 to 25 sessions [1]. Long-term treatment ranges from a few months to several years [1,17,18,32]. Differences to classical psychoanalysis, e.g. a more active stance will be described below. In the following, the concept and method of the CCRT will be described more in detail.

UNDERSTANDING OF SYMPTOMS, CONFLICTS AND TRANSFERENCE IN SE THERAPY: THE CORE CONFLICTUAL RELATIONSHIP THEME (CCRT)

In psychodynamic psychotherapy psychiatric symptoms are regarded as determined by both biological and psychological factors [1,17,41]. With regard to their psychological aspects, psychiatric symptoms are conceptualized as the consequence of unresolved conflicts or of impairments in ego-functions (for the concept of ego-functions see, for example, Bellak, Hurvich and Gediman [42]. The psychodynamic concept of conflict was noted by Luborsky as a "Core Conflictual Relationship Theme" (CCRT) [1,24,28,40]. A CCRT consists of three components: a wish (W: "I wish that person X …"), a response from the other (RO: "But person X will…") and a response from the self (RS: "Thus, I will..."). In this scheme, response from the self (RS) represents the patient´s symptoms. For a patient with a social phobia, for example, the CCRT may be described in the following way [43]: "I wish to be at the center of the attention and to be affirmed by others (W). However, the others will disapprove of me (RO). I feel ashamed and get afraid of exposing myself, so I have decided to avoid exposing myself (RO, symptoms of social phobia)". The therapist´s task is to identify the individual patient´s specific CCRT that is associated with his or her present symptoms. The CCRT is used as the focus to which the therapist directs his or her interventions. Focusing on the respective CCRT is an essential and integral part of the disorder-specific manuals of SE therapy [16,30-35]. The CCRT represents a transference potential, a scheme including central wishes, anticipated reactions of others and from the self ("I wish that..., but the others will... So I will...") that will be reproduced repeatedly like a theme and variations of a theme in spite of its self-hurtful nature [1]. - Freud referred to the transference potentials as relationship "stereotype plates" [44]. The concept and method of CCRT is a useful instrument not only in psychotherapy research, but also in everyday clinical practice [40]. It allows for both to operationalize the concept of transference and to formulate a therapeutic focus. The emphasis that psychodynamic psychotherapy puts on the relational aspects of transference is a key technical difference to cognitive-behavioral therapies [45]. In SE therapy and in psychodynamic psychotherapy in general, transference is regarded as a primary source of understanding and therapeutic change [1,18]. Recent studies using the CCRT method will be reviewed below.

EMPIRICAL EVIDENCES

1. Evidence for Efficacy

The computerized search yielded five randomized controlled trials of SE therapy [30,46-51] and one randomized controlled feasibility study [52]. In these studies the following psychiatric disorders were treated: opiate dependence [49-51], cocaine dependence [46,47], bulimia nervosa [30], personality disorders [48] and generalized anxiety disorder [52]. In the treatment of opiate addiction, SE therapy and cognitive-behavioral therapy (CBT) each of them combined with drug counseling were equally effective and both superior to drug counseling alone [49]. The pre-post effect sizes in target problems (drug-related outcome measures) at 7-month follow-up were 0.97 for SE therapy, 0.81 for CBT and 0.07 for drug counseling alone.* By subgroup analyses the effects of SE therapy in patients with comorbid antisocial personality disorder with and without a concomitant depression were examined [53]. Further subgroup analyses showed that patients with high symptom severity made little progress with drug counseling alone, but made considerable progress when SE therapy or CBT were added to drug counseling [54]. The efficacy of SE therapy in patients with opiate addiction was corroborated in another randomized controlled trial [50]. In that study, SE therapy combined with drug counseling was superior to drug counseling alone in the treatment of opiate addiction [50]. However, in a randomized controlled trial studying the treatment of cocaine dependence, SE therapy combined with group drug counseling,

*Effect sizes were assessed by the authors (FL & EL) on the basis of the data published by the authors of the studies. In the following, effect sizes assessed by us are marked with an asterisc.

CBT combined with group drug counseling and group drug counseling alone, were equally effective, but they were inferior to individual drug counseling alone [47][b]. SE therapy and CBT both combined with group drug counseling achieved large within group effect sizes [55, p. 40, 67], in target problems (drug-related outcome measures) both at the end of treatment and at 12-month follow-up (SE therapy: 1.43, 1.86; CBT: 1.57, 1.87)[c]. Individual drug counseling yielded the largest effect sizes (2.00, 2.14)* The difference between SE Therapy and CBT both combined with group drug counseling on the one hand and group drug counseling on the other hand was small (d=0.15)*. The hypothesis that psychotherapy is superior to drug conseling on associated features of drug- dependence was not corroborated [46]. Reduction in cocaine abuse was associated with an average 40% decrease in HIV risk across all treatments [56]. Individual and group drug counseling were associated with an equal or even greater reduction in HIV risk than the other treatment conditions. In another randomized controlled trial, SE therapy was compared with CBT in the treatment of bulimia nervosa [30]. With regard to target symptoms of bulimia nervosa (bulimic episodes, self-induced vomiting) SE therapy and CBT were equally effective [30]. The between group differences for target symptoms were not significant corresponding to a between group effect size of 0.24 in favor of CBT*, which is a small effect [55, p. 40, 67]. However, CBT was superior to SE therapy in some specific measures of psychopathology [30]. In another randomized controlled trial, SE therapy was compared to nonmanulized community-delivered psychodynamic therapy in patients with personality disorders [48]. The latter treatment was carried out by experienced psychodynamic clinicians. Both treatments were equally effective and achieved a significant decrease in the prevalence of patients fulfilling criteria for personality disorder diagnosis, personality disorder severity and psychiatric symptoms. In both treatments the global level of functioning also improved significantly. During the follow-up period, patients who received SE therapy made significantly fewer visits to the involved community mental health centers than the patients who received nonmanualized community-delivered psychodynamic therapy. For SE therapy the authors reported a large within group effect size for target symptoms (total number of DSM-IV axis II criteria) at follow-up (0.99) compared to 0.61 for the nonmanualized community-delivered psychodynamic therapy. For the general severity of psychiatric symptoms and global level of functioning, effect sizes of 0.72 and 0.64, respectively were reported for SE therapy (nonmanualized community-delivered psychodynamic therapy: 0.87, 0.59). These effect sizes of SE therapy correspond by and large to those reported in a recent meta-analysis of short-term psychodynamic therapy [8]. That meta-analysis included four studies of SE therapy [30,46,47,49,50]. In a randomized controlled feasibility study of generalized anxiety disorder, SE therapy was equally effective as supportive therapy with regard to continuous measures of anxiety, but significantly superior on symptomatic remission rates (46% *vs.* 12%) [52]. However, the sample sizes were relatively small (N=15 *vs.* N=16), and the study was not sufficiently powered to detect possible further differences between the treatments. A randomized controlled trial comparing SE therapy with medication and placebo in the treatment of major depression is presently being carried out (Dr. Barber, personal communication 2006-11-14). In another ongoing randomized controlled trial, SE therapy is being compared to CBT in the treatment of generalized anxiety disorder [57].

In several open trials SE therapy yielded significant improvements and large pre-post effect sizes* in target problems between 0.89 and 2.85 in patients with major depression, patients with major depression and a concomitant personality disorder or patients with chronic depression [58,59], generalized anxiety disorder [60], or avoidant and obsessive-compulsive personality disorder [35][d].

To sum up, there is evidence for the efficacy of SE therapy, but presently it is limited and further studies are required.

2. Evidence for the Concept and Method of the CCRT

Luborsky and his colleagues developed specific methods to assess the CCRT from the patients narratives about his or her interpersonal experiences. For these methods, sufficient reliability has been demonstrated [1,24,25,27,28,40,61,62]. Comparisons between the CCRT method and other methods of psychodynamic formulation were presented, for example, by Perry, Luborsky, Silberschatz and Popp [63]. In Germany, a modification of CCRT categories was presented [64]. A self-report questionnaire for the assessment of the CCRT showing acceptable psychometric properties was developed by Barber and colleagues [65-67]. Consistent with the theory of SE therapy, empirical studies have provided evidence that changes in symptom distress can be significantly predicted from changes in specific CCRT components [62,68,69]. Changes in the wish and in (negative) response of self significantly predicted change in symptoms [68]. As the RS component of the CCRT represents the patient´s symptoms, a correlation with outcome is to be expected. The correlations were 0.41 and 0.40, respectively with initial levels of CCRT, symptom measures partialed out. Changes in overall mental health were only significantly correlated with changes in (negative) response of self (r=-0.53). These correlations correspond to a medium to large effect size [55, p.80] explaining between 16% and 28% of variance in outcome. However, even after successful therapy, the CCRT tends to remain recognizable [68]. The pattern of transference as assessed by the CCRT is still evident (i.e. is not resolved), but under better control and mastery [62]. Whereas the patient´s wishes remained relatively consistent during treatment, changes were found in the response from the self and in the response from the other components of the CCRT. Negative responses from the self and from the others were reduced, positive responses from the others increased [68]. Furthermore, the patients´ self-understanding (operationalized as the convergence between patients' statements about themselves with their independently established CCRT) was found to be significantly associated with outcome [62,69].

[b]We thank Dr. Crits-Christoph for providing the data to calculate effect sizes.

[c]The difference between SE therapy and CBT both combined with group drug counseling on the one hand and group drug counseling on the other hand corresponds to a small effect size (d=0.15)*.

[d]We thank Dr. Barber for providing the data to calculate effect sizes for his study on personality disorders.

The concept and method of the CCRT has considerably stimulated research on psychodynamic aspects of psychiatric disorders. For example, several studies investigated CCRT patterns in specific diagnostic groups [70-73] in dreams and waking narratives [74], or examined the relationship of CCRT to psychopathology [75,76] or to patterns of attachment [77]. Recently, the CCRT method was applied in a non-clinical context to study the relationship between God and people in the Bible [78,79]. Further research should address if changes in the CCRT are specific to SE therapy or if they occur and are linked to outcome in other forms of psychotherapy as well (e.g. CBT or interpersonal therapy).

3. Evidence for the Concept and Method of Helping Alliance

Methods for the reliable assessment of the helping alliance have been developed including both the patient and the therapist perspective [80]. Consistent with assumptions of SE therapy, empirical studies have shown that the helping alliance significantly contributes to therapeutic success [27,62,69,80-83]. However, although the impact of the helping alliance on outcome is significant, it seems to be smaller than expected, and to be also dependent on patient group, treatment models and time of assessment [27,82,84-86]. In a study of SE therapy in patients with cocaine dependence, however, no correlation of the alliance to drug-related outcome of psychodynamic psychotherapy was found [84]. Furthermore, the assumption that accurate interpretations have their greatest impact in the context of a positive helping alliance was not corroborated by empirical data [87]. In a recent review, the alliance-outcome correlation was reported to range from 0.22 to 0.29 [86]. However, that review did not only include studies of SE therapy but also of other forms of SE psychotherapy. Thus, the results reported do not specifically refer to SE therapy. Future studies should address the interaction between the helping alliance, diagnostic group, treatment models, time of assessment and outcome, rather than the impact of single predictors alone [27,82,84-86]. Studies designed in that way will help to answer the question, whether the helping alliance is in itself a curative factor or whether it serves as the basis necessary for other therapeutic elements to become beneficial [86]. Future studies should also control for the methodological problem of a possible confounding between initial symptom improvement and helping alliance as well as between helping alliance and dispositional factors of patients and therapists [27]. In a methodologically careful study controlling for improvements in symptoms, the helping alliance predicted outcome in depressive symptoms beyond in-treatment change in symptoms [82]. Although only in SE therapy giving support has a prominent place in the treatment manuals, comparisons between SE therapy, CBT and other manual-guided treatments showed that other treatments used support to the same extent [39,88,89]. Giving support seems to be a common curative factor in psychotherapy. Meanwhile, the concept of a helping alliance originally developed in a psychodynamic context is studied in other forms of psychotherapy as well [85,86]. How therapists can be trained to develop a helping alliance with the patient is an important question in psychotherapeutic training [86].

4. Evidence for Adherence and Competence (Treatment Fidelity)

For SE therapy, reliable methods to assess the therapist´s adherence to the treatment manual and the competent delivery of supportive and expressive interventions were developed [39,62,88]. By these scales, blinded raters successfully discriminated SE therapy from other forms of psychotherapy, such as CBT or interpersonal therapy [1,29,37-39,90]. The effects of training in SE therapy, CBT and drug counseling were studied by Crits-Christoph *et al.* [91]. According to the results, training in manual-guided treatments did not have a negative impact on the therapeutic alliance. Furthermore, differences concerning learning trends were found between SE therapy and CBT. In another study, therapist characteristics in training effects were assessed [92]. Higher competence ratings before training, for example, were associated with greater change in competence for SE therapy. For CBT therapists, more years of experience were associated with greater change in competence.

5. Supportive-Expressive Therapy Compared to Other Models of Psychodynamic Therapy

In several studies SE therapy was compared to other models of psychodynamic therapy with regard to therapist behaviour. In a study by Piper *et al.* [93], which used a model of psychodynamic psychotherapy based on recommendations by Malan and Strupp and Binder [13,94], therapists were less active and used more transference interpretations compared to the results reported by Connolly *et al.* [95] for SE therapy. The two studies used a comparable coding system for therapists´ interventions. In an earlier study [1,81], therapist´s behavior was compared for the Penn-VA study [39], the Yale Study [96] and for the Temple study [97]. Compared to the psychoanalytically oriented therapies of the Temple study, the therapists in the Penn-VA study who applied SE therapy used fewer interpretations (and clarifications). The latter result refers to interpretations (and clarifications) in general, not specifically to transference interpretations. Interpersonal therapy (IPT) applied in the Yale study was reported by Luborsky [1] to fall between the profiles of SE therapy and CBT. However, future studies are required to assess the relation of SE therapy and IPT more precisely. This issue will be discussed below. In the generic manual of SE therapy, transference interpretations are regarded as especially effective [1,62]. However, there is some evidence that not much emphasis is put on transference interpretations in the practice of SE therapy [27,95]. In a study of short-term SE therapy in patients with major depression, more emphasis was put on interpretations of the patient´s maladaptive interpersonal patterns as experienced in current relationships outside therapy than on the interpretation of transference [95]. The majority of therapists´ interventions were clarifications and questions. Furthermore, the therapists were quite active, speaking about half of the time [95]. The authors concluded from their data, that both the active stance of the therapists and the relatively infrequent use of transference interpretations is a major difference between SE therapy and classical psychoanalysis [95]. In that study, however, the early sessions 2, 3 and 4 were examined. Transference interpretations may be more frequent in later sessions when transference is more consistent. For this reason, future

studies of transference interpretation should include both later sessions as well as longer treatments. Furthermore, different psychiatric disorders should be included to see if the results possibly depend on the disorder (e.g. depressive disorder). To sum up, these results provide some evidence that SE therapy is situated more towards the supportive pole of the supportive-expressive continuum than some other models of psychodynamic psychotherapy, e.g. Malan or Strupp and Binder [13,94] and classical psychoanalysis. Future research should address the complex interactions among supportive or expressive interventions, patient´s level of functioning, and outcome.

6. Curative Factors: Evidence for Associations of SE Interventions With Outcome

In several studies [81,87] the impact of the interventions applied in SE therapy on treatment outcome was examined. Consistent with the assumptions of SE therapy, the accuracy of the therapist´s interpretations of the patient´s CCRT proved to be a significant predictor of therapeutic outcome [27,62,81,87]. This was true for the accuracy on the wish plus the response-from-other components of the CCRT, but not for accuracy on the response-from-self component [87]. These data suggest that the focus on the interpersonal components of the CCRT (wish and response from other) contributes to outcome. The correlations ranged from 0.30 to 0.46 [81,87] corresponding to medium (0.30) to large (0.50) effect sizes explaining between 9% and 25% of variance of outcome [55]. Furthermore, there is evidence that the competent delivery of expressive interventions is a significant predictor (r=-0.53) of outcome in SE therapy [37]. However, this did not apply to the competent delivery of supportive interventions [37]. Furthermore, the frequency of supportive or expressive techniques (adherence) was not related to outcome [27,37]. These findings suggest that specific techniques of SE therapy as contrasted to nonspecific factors account for a significant and substantial proportion of the variance in outcome of SE therapy [27,37]. These results also suggest that therapeutic competence should be included as an important therapist variable in psychotherapy research [37].

DISCUSSION

SE therapy is a manual-guided form of psychodynamic psychotherapy that can be adapted to the treatment of specific psychiatric disorders. SE therapy differs from other forms of psychodynamic psychotherapy by its focus on the CCRT. For psychodynamically oriented therapists, such a clear formulation of the main transference pattern is very useful both in research and in everyday clinical practice. Furthermore, SE therapy allows for relatating the patient´s symptoms to his or her CCRT. Depending on the patient´s needs, more supportive or more expressive interventions can be applied. Thus, a broad spectrum of psychiatric disorders can be treated with SE therapy. Compared to classical psychoanalysis and other forms of psychodynamic psychotherapy, SE uses less (transference) interpretations and puts a greater focus on supportive elements. SE therapists adopt a more active stance than therapist in classical psychoanalysis [95]. Thus, SE therapy seems to be situated more towards the supportive pole of the supportive-expressive continuum than some other models of psychodynamic psychotherapy or classical psychoanalysis. Manuals for the treatment of depressive disorders, generalized anxiety disorder, bulimia nervosa, specific personality disorders or opiate and cocaine dependence are presently available. The manuals facilitate learning and training in this kind of psychodynamic therapy. According to the studies presented, reliable measures of conflict and transference (CCRT) are available. This is also true for adherence to the treatment manuals and for the competent use of the respective therapeutic techniques including the helping alliance. Empirical studies have provided evidence that SE therapy can be discriminated from other forms of psychotherapy. Further studies of SE therapy should use audio or video taping of treatment sessions in order to further investigate differences (and communalities) between different models of psychotherapy. It is an interesting question, if and how they "really" empirically differ: "Relying on brand names of therapy can be misleading" [98, p. 775]. Ablon and Jones compared the CBT and interpersonal therapies (IPT) as they were carried out in the NIMH treatment of depression study [99]. According to the results, both forms of therapy adhered most strongly to the ideal prototype of CBT. In addition, adherence to the CBT prototype yielded more positive correlations with outcome measures across both types of treatment. However, in another study, CBT and IPT could be successfully discriminated [100]. Thus, the results reported by Ablon and Jones may be specific to the NIMH treatment of depression study and may not be generalized to IPT and CBT in general. Further research on the processes of SE therapy should also address the question if changes in the CCRT are specific to SE therapy or also occur in other forms of psychotherapy, for example in CBT or IPT and if possible changes are associated with outcome. Future studies should also address the role of the helping alliance in order to clear up some of the open questions of research discussed so far.

At present, evidence for the efficacy of SE therapy is limited. Randomized controlled trials provided some evidence for the efficacy of SE therapy in specific psychiatric disorders (e.g. opiate abuse, bulimia nervosa). According to several open trials, SE therapy yielded significant improvements in depressive disorders, generalized anxiety disorder, and obsessive-compulsive and avoidant personality disorder. However, further randomized controlled trials of SE therapy in specific psychiatric disorders are required. According to the criteria suggested by the Task Force on Promotion and Dissemination of Psychological Procedures of the Division 12 (Clinical Psychology) of the American Psychological Association for the definition of empirically supported treatments [101,102]), at least two randomized controlled trials of independent research groups are required for a treatment to be recognized as efficacious in a specific psychiatric disorder. Thus, further randomized controlled trials of SE therapy are required, both for those psychiatric disorders for which one randomized controlled trial is already available, and also for psychiatric disorders for which no randomized controlled trials of SE therapy presently exist (e.g. panic disorder, post-traumatic stress disorder). At present, a large-scale multi-center study comparing SE therapy and CBT in the treatment of social phobia is being carried out in Germany. For this purpose, a manual specific to social phobia was developed [36]. This trial includes cost-

effectiveness analyses, studies on attachment, on neuroimaging and on genetic polymorphisms in social phobia[e].

REFERENCES

[1] Luborsky L. Principles of psychoanalytic psychotherapy. A manual for supportive expressive treatments. New York, Basic Books, 1984.

[2] Goisman RM, Warshaw, MG, Keller, MB. Psychosocial treatment prescriptions for generalized anxiety disorder, panic disorder, and social phobia, 1991-1996. Am J Psychiatry 1999; 156: 1819-1821.

[3] Norcross JC. The psychotherapist's own psychotherapy: educating and developing psychologists. Am Psychol 2005; 60: 840-850.

[4] Task Force on Promotion and Dissemination of Psychological Procedures Training and dissemination of empirically-validated psychological treatments: Report and recommendations. Clin Psychol 1995; 48: 3-23.

[5] Leichsenring F. The efficacy of psychodynamic psychotherapy in specific psychiatric disorders: an update. In: Ablon, S, Levy, R Ed, Evidence Based Psychodynamic Psychotherapy: Humana Press, in press.

[6] Fonagy P, Roth A, Higgitt A. Psychodynamic therapies, evidence-based practice and clinical wisdom. Bull Menninger Clin 2005; 69: 1-58

[7] Leichsenring F: Are psychoanalytic and psychodynamic psychotherapies effective?A review of empirical data. Int J Psychoanal 2005; 86: 1-26.

[8] Leichsenring F, Rabung S, Leibing E. The efficacy of short-term psychodynamic therapy in specific psychiatric disorders: a meta-analysis. Arch Gen Psychiatry 2004; 61: 1208-1216.

[9] Messer SB, Warren CS. Models of brief psychodynamic therapy. A comparative approach. New York, Guilford, 1995.

[10] Messer SB. What makes brief psychodynamic therapy time-efficien. Clin Psychol 2001; 8: 5-22.

[11] Barber JP, Crits-Christoph P. Comparison of the brief dynamic psychotherapies. In: Crits-Christoph P, Barber. J, E, Handbook of short-term dynamic psychotherapy. New York: Basic Books, 1991, 323-355.

[12] Horowitz M. Stress response syndromes. New York, Aronson, 1976.

[13] Malan DH. Towards the validation of dynamic psychotherapy: replication. New York, Plenum Medical Books, 1976.

[14] Shapiro DA, Firth JA. Exploratory therapy manual for the Sheffield Psychotherapy Project. SAPU Memo 733. Sheffield, England, University of Sheffield, 1985.

[15] Spiegel D, Bloom JR, Yalom, I. Group support for patients with metastatic cancer. A randomized outcome study. Arch Gen Psychiatry 1981; 38: 527-533.

[16] Crits-Christoph P, Crits-Christoph K, Wolf-Palacio D, Fichter M, Rudick D. Brief supportive-expressive psychodynamic therapy for generalized anxiety disorder. In: Barber JP, Crits-Christoph P, Ed., Dynamic therapies for psychiatric disorders. Axis I. New York: Basic Books, 1995, 43-83.

[17] Gabbard GO. Psychodynamic psychiatry in clinical practice, 3rd ed. Washington, DC: American Psychiatric Press, 2000.

[18] Gabbard GO. Long-term psychodynamic psychotherapy. Washington, DC, American Psychiatric Publishing, 2004.

[19] Gill MM. Ego psychology and psychotherapy. Psychoanal Q 1951; 20: 60-71.

[20] Henry WO, Strupp HH, Schacht TE, Gaston L. Psychodynamic approaches. In: Bergin, A.E. Garfield, S, Ed, Handbook of psychotherapy and behavior change, 4th ed. New York: Wiley, 1994, 467-508.

[21] Wallerstein RS. The Psychotherapy Research Project of the Menninger Foundation: An overview. J Consult Clin Psychol 1989; 57: 195-205.

[22] Shahar G, Blatt SJ. Benevolent interpersonal schemas facilitate therapeutic change: Further analysis of the Menninger psychotherapy research project. Psychother Res 2005; 15: 345-349.

[23] Wallerstein R, Robbins L. Concepts. In: Wallerstein R, Robins, L, Sargent, H, Luborsky, L, Ed, In: The Psychotherapy Research Project of the Menninger Foundation. Bull Menninger Clin 1956; 20: 239-262.

[24] Crits-Christoph P, Luborsky L, Dahl L, Popp C, Mellon J, Mark D. Clinicians can agree in assessing relationship patterns in psychotherapy. The Core Conflictual Relationship Theme method. Arch Gen Psychiatry 1988; 45: 1001-1004.

[25] Luborsky L. A guide to the CCRT method. In: Luborsky L, Crits-Christoph, P Ed, Understanding transference New York: Basic Books, 1990, 15-36.

[26] Luborsky L. The everyday clinical uses of the CCRT. In Luborsky L, Crits-Christoph, P, Ed, Understanding transference. New York: Basic Books, 1990, 211-221.

[27] Crits-Christoph P, Connolly B. Alliance and technique in short-term dynamic therapy. Clin Psychol Rev 1999; 6: 687-704.

[28] Eckert R, Luborsky L, Barber J, Crits-Christoph P. The narratives and CCRTs of patients with major depression. In: Luborsky L, Crits-Christoph, P, Ed, Understanding transference. New York: Basic Books, 1990, 222-234.

[29] Barber JP, Krakauer I, Calvo N, Badgio PC, Faude J. Measuring adherence and competence of dynamic therapists in the treatment of cocaine dependence. J Psychother Pract Res 1997; 6: 12-24.

[30] Garner DM, Rockert W, Davis R, Garner MV, Olmsted MP, Eagle M. Comparison of cognitive-behavioral and supportive-expressive therapy for bulimia nervosa. Am J Psychiatry 1993; 150: 37-46.

[31] Luborsky L, Woody GE, Hole AV, Velleco A. Supportive-expressive dynamic psychotherapy for treatment of opiate drug dependence. In: Barber J.P, Crits-Christoph, P, Ed, Dynamic therapies for psychiatric disorders. Axis I. New York: Basic Books, 1995; 131-160.

[32] Luborsky L, Mark D, Hole AV, Popp C, Goldsmith B, Cacciola J. Supportive-expressive psychotherapy of depression, a time-limited version. In: Barber JP, Crits-Christoph, P Ed, Dynamic therapies for psychiatric disorders. Axis I. New York: Basic Books, 1995; 13-42.

[33] Mark D, Faude J. Supportive-expressive therapy for cocaine abuse. In: Barber JP, Crits-Christoph, P Ed, Dynamic therapies for psychiatric disorders. Axis I. New York: Basic Books, 1995; 294-331.

[34] Mark DG, Barber JP, Crits-Christoph P. Supportive-expressive therapy for chronic depression. J Clin Psychol 2003; 59: 859-872.

[35] Barber P, Morse JQ, Krakauer ID, Chitams J, Crits-Christoph K. Change in obsessive compulsive and avoidant personality disorders following time-limited supportive-expressive therapy. Psychotherapy 1997; 34: 133-143.

[36] Leichsenring F, Beutel M, Leibing E. Psychodynamic psychotherapy for social phobia: a treatment manual based on supportive-expressive therapy. Bull Menninger Clin, in press.

[37] Barber J, Crits-Christoph P, Luborsky L. Effects of therapist adherence and competence on patient outcome in brief dynamic therapy. J Consult Clin Psychol 1996; 64: 619-622.

[38] Barber JP, Foltz C, Crits-Christoph P, Chittams J. Therapists´ adherence and competence and treatment discrimination in the NIDA Collaborative Cocaine Treatment Study. J Clin Psychol 2004; 60: 29-41.

[39] Luborsky L, Woody GE, McLellan AT, Rosenzweig J. Can independent judges recognize different psychotherapies? An experiment with manual-guided therapies. J Consult Clin Psychol 1982; 30: 49-62.

[40] Luborsky L. The everyday clinical uses of the CCRT. In: Luborsky L, Crits-Christoph, P Ed, Understanding transference. New York: Basic Books, 1990; 211-221.

[41] Miller LA, Taber KH, Gabbard GO, Hurley RA. Neural underpinnings of fear and ist modulation, Implications for anxiety disorders. J Neuropsychiatry Clin Neurosci 2005; 17: 1-5.

[42] Bellak L, Hurvich M, Gediman H. Ego functions in schizophrenics, neurotics, and normals. New York: Wiley, 1973.

[43] Gabbard GO. Psychodynamics of panic disorder and social phobia. Bull Menninger Clin 1992; 56: A3-A13.

[44] Freud S. The dynamics of transference. In: Strachey, J Ed, The standard edition. London: Hogarth Press and the Institute of Psychoanalysis, 1912, Vol. 12; 97-108.

[45] Cutler JL, Goldyne A, Markowitz JC, Devlin MJ, Glick RA. Comparing cognitive behavior therapy, interpersonal psychotherapy, and psychodynamic psychotherapy. Am J Psychiatry 2004; 161: 1567-1573.

[46] Crits-Christoph P, Siqueland L, McCalmont E, *et al*. Impact of psychosocial treatments on associated problems of cocaine-dependent patients. J Consult Clin Psychol 2001; 69: 825-830.

[e]www.controlled-trials.com/ISRCTN53517394

[47] Crits-Christoph P, Siqueland L, Blaine J, *et al*. Psychosocial treatments for cocaine dependence, National Institute on Drug Abuse Collaborative Cocaine Treatment Study. Arch Gen Psychiatry 1999; 56: 493-502.

[48] Vinnars B, Barber JP, Noren K, Gallop R, Weinryb RM. Manualized supportive-expressive psychotherapy versus nonmanualized community-delivered psychodynamic therapy for patients with personality disorders: bridging efficacy and effectiveness. Am J Psychiatry 2005; 162: 1933-1940.

[49] Woody GE, Luborsky L, McLellan AT, O´Brien CP. Corrections and revised analyses for psychotherapy in methadone maintenance patients. Arch Gen Psychiatry 1990; 47: 788-789.

[50] Woody GE, Luborsky L, McLellan AT, O´Brien CP. Psychotherapy in community methadone programs: a validation study. Am J Psychiatry 1995; 152: 1302-1308.

[51] Woody GE, Luborsky L, McLellan AT, *et al*. Psychotherapy for opiate addicts: Does it help? Arch Gen Psychiatry 1983; 40: 639-645.

[52] Crits-Christoph P, Connolly Gibbons MB, Narducci J, Schamberger M., Gallop R. Interpersonal problems and the outcome of interpersonally oriented psychodynamic treatment of GAD. Psychotherapy: Theory/Research/Practice/Training 2005; 42: 211-224.

[53] Woody GE, McLellan T, Luborsky L, O´Brien CP. Sociopathy and psychotherapy outcome. Arch Gen Psychiatry 985; 42: 1081-1086.

[54] Woody GE, McLellan AT, Luborsky L, *et al*. Psychiatric Severity as a Predictor of Benefits from Psychotherapy: The Penn-VA Study. Am J Psychiatry 1984; 141: 1172-1177.

[55] Cohen J. Statistical power analysis for the behavioral sciences. Hillsdale, Lawrence Erlbaum 1988.

[56] Woody GE, Gallop R, Luborsky L, *et al*. Cocaine Psychotherapy Study Group HIV risk reduction in the National Institute on Drug Abuse Cocaine Collaborative Treatment Study. J Acquir Immune Defic Syndr 2003; 33: 82-87.

[57] Leichsenring F, Winkelbach C, Leibing E. Psychoanalytisch orientierte Fokaltherapie der Generalisierten Angststörung – ein Manual [Psychoanalytically oriented focal therapy of generalized anxiety disorder - a manual]. Psychotherapeut 2005, 50, 258-346.

[58] Diguer L, Barber JP, Luborsky L. Three concomitants, personality disorders, psychiatric severity, and outcome of psychodynamic therapy of major depression. Am J Psychiatry 1993; 150: 1146-1248.

[59] Luborsky L, Diguer L, Cacciola J, Moras K, Schmidt K, deRubeis RJ. Factors in outcomes of short-term dynamic psychotherapy for chronic *vs*. non-chronic depression. J Psychother Pract Res 1996; 5: 152-159.

[60] Crits-Christoph P, Connolly MB, Azarian K, Crits-Christoph K, Shappell S. An open trial of brief supportive-expressive psychotherapy in the treatment of generalized anxiety disorder. Psychother 1996; 33: 418-430.

[61] Barber J, Crits-Christoph P, Luborsky L. A guide to the CCRT standard categories and their classification. In: Luborsky L, Crits-Christoph, P, Ed, Understanding transference. New York: Basic Books 1990; 37-50.

[62] Luborsky L, Barber J, Crits-Christoph P. Theory based research for understanding the process of dynamic psychotherapy. J Consult Clin Psychol 1990; 58: 281-287.

[63] Perry JC, Luborsky L, Silberschatz G, Popp C. An examination of three methods of psychodynamic formulation based on the same videotaped interview. Psychiatry 1989; 52: 302-323.

[64] Albani C, Pokorny D, Blaser G, *et al*. Reformulation of the Core Conflict Relationship Theme (CCRT) Categories: The CCRT-LU Category System. Psychother Res 2002; 12 319-338.

[65] Barber JP, Foltz C, Weinryb RM. The central relationship questionnaire: initial report. J Counsel Psychol 1998; 45: 131-142.

[66] Foltz C, Barber JP, Weinryb RM. Consistency of themes across interpersonal relationships. J Soc Clin Psychol 1999; 18: 204-222.

[67] Weinryb RM, Barber JP, Foltz C, Goransson SG, Gustavsson JP. The central relationship Questionnaire, CRQ. Psychometric properties in a Swedish sample and cross-cultural studies. J Psychother Pract Res 2000; 9: 201-212.

[68] Crits-Christoph P, Luborsky L Changes in CCRT pervasiveness during psychotherapy. In: Luborsky L, Crits-Christoph, P Ed, Understanding transference. New York: Basic Books, 1990, 133-146.

[69] Luborsky L, Crits-Christoph P, Mintz J, Auerbach A. Who will benefit from psychotherapy? Predicting therapeutic outcomes. New York, Basic Books, 1988.

[70] Benninghoven D, Schneider H, Strack M, Reich G, Cierpka M. Family representations in relationship episodes of patients with a diagnosis of bulimia nervosa. Psychol Psychotherapy 2003; 76: 323-336.

[71] Drapeau M, Perry JC. Childhood trauma and adult interpersonal functioning: a study using the Core Conflictual Relationship Theme Method (CCRT). Child Abuse Negl 2004 ; 28: 1049-1066.

[72] Drapeau M, de Roten Y, Korner AC. An exploratory study of child molesters' relationship patterns using the core conflictual relationship theme method. J Interpers Violence 2004; 19: 264-275.

[73] Lee CY, Liu SN, Chang CF, Wen JK. Change of core conflicts of schizophrenic patients who received brief psychodynamic psychotherapy: a pilot study in Taiwan. Chang Gung Med J 2000 ; 23: 458-466.

[74] Popp CA, Diguer L, Luborsky L, *et al*. Repetitive relationship themes in waking narratives and dreams. J Consult Clin Psychol 1996; 64: 1073-1078.

[75] Cierpka M, Strack M, Benninghoven D, *et al*. Stereotypical relationship patterns and psychopathology. Psychother Psychosom 1998; 67: 241-248.

[76] Albani C, Benninghofen D, Blaser G, *et al*. On the connection between affective evaluation of recollected relationship experiences and the severity of the psychic impairment. Psychother Res 1999; 9: 452-467.

[77] Albani C, Blaser G, Korner A, *et al*. Connections between attachment prototypes and relationship patterns. Psychother Psychosom Med Psychol 2002; 52: T67-75.

[78] Popp C, Luborsky L, Descoteaux J, *et al*. Relationships between God and people in the Bible, Part II: The New Testament, with comparisons with the Torah. Psychiatry 2003; 66: 285-307.

[79] Popp CA, Luborsky L, Andrusyna TP, Cotsonis G, Seligman D. Relationships between God and people in the Bible: a core conflictual relationship theme study of the Pentateuch/Torah. Psychiatry 2002; 65: 179-196.

[80] Luborsky L, Crits-Christoph P, Alexander L, Marguolis M, Cohen M. Two helping aliance mehods for predicting outcomes of psychotherapy: a counting signs *vs*. a global rating method. J Nerv Ment Dis 1983; 171: 48-492.

[81] Luborsky L, McLellan AT, Woody G, O´Brian C, Auerbach A. Therapist´s success and its determinants. Arch Gen Psychiatry 1985; 42: 602-611.

[82] Barber JP, Connolly MB, Crits-Christoph P, Gladis L, Siqueland L. Alliance predicts patients´ outcome beyond in-treatment change in symptoms. J Consult Clin Psychol 2000; 68: 1027-1032.

[83] Summers RF, Barber JP. Therapeutic alliance as a measurable psychotherapy skill. Acad Psychiatry 2004; 28: 251-253.

[84] Barber JP, Luborsky L, Gallop R, *et al*. Therapeutic alliance as a predictor of outcome and retention in the National Institute on Drug Abuse Collaborative Cocaine Treatment Study. J Consult Clin Psychol 2001; 69: 119-124.171.

[85] Beutler L, Malik M, Alomohamed S, *et al*. Therapist variables. In: Lambert M Ed, Bergin and Garfield´s handbook of psychotherapy and behavior chang, 5th ed New York: Wiley, 2004, 227-306.

[86] Horvath, AO. The therapeutic relationship, Research and theory. An introduction to the special issue. Psychother Res 2005; 15: 3-7.

[87] Crits-Christoph P, Cooper A, Luborsky L. The accuracy of therapists´ interpretation and the outcome of dynamic therapy. J Consult Clin Psychol 1988; 56, 490-495.

[88] Barber J, Crits-Christoph P. Development of a therapist adherence and competence rating scale for supportive-expressive dynamic psychotherapy: a preliminary approach. Psychother Res 1996;6: 81-94.

[89] Barber JP, Stratt R, Halperin G, Connolly, MB. Supportive techniques. Are they found in different therapies? J Psychother Pract Res 2001; 10: 165- 166.

[90] Siqueland L, Crits-Christoph P, Barber JP, *et al*. What aspects of treatment matter to the patient in the treatment of cocaine dependence? J Subst Abuse Treat 2004; 27: 169-178.

[91] Crits-Christoph P, Siqueland L, Chittams J, *et al*. Training in cognitive, supportive-expressive, and drug counseling therapies for cocaine dependence. J Consult Clin Psychol 1998; 66: 484-492.

[92] Siqueland L, Crits-Christoph P, Barber JP *et al*. The role of therapist characteristics in training effects in cognitive, supportive-expressive, and drug counseling therapies for cocaine dependence. J Psychother Pract Res 2000; 9: 123-130.

[93] Piper WE, Azim HF, Joyce AS, *et al*. Transference interpretations, therapeutic alliance, and outcome in short-term individual psychotherapy. Arch Gen Psychiatry 1991; 48: 946-953.

[94] Strupp HH, Binder JL. Psychotherapy in a new key: a guide to time-limited dynamic psychotherapy. New York, Basic Books, 1984.

[95] Connolly MB, Crits-Christoph P, Shappell S, Barber JP, Luborsky L, Shaffer C. Relation of transference interpretation to outcome in the early sessions of brief supportive-expressive psychotherapy. Psychother Res 1998; 9: 485-495.

[96] Rounsaville BJ, Glazer W, Wilber CH, Weissman MM, Kleber HD. Short-term interpersonal psychotherapy in methadone-maintained opiate addicts. Arch Gen Psychiatry 1983; 140: 629-636.

[97] Sloane RB, Staples FR, Cristol AH, Yorkston NJ, Whipple K. Short-term analytically oriented psychotherapy versus behavior therapy. Am J Psychiat 1975; 132: 373-377.

[98] Ablon JS, Jones EE. Validity of controlled clinical trials of psychotherapy, findings from the NIMH Treatment of Depression Collaborative Research Program. Am J Psychiatry 2002; 159: 775-783.

[99] Elkin I, Shea T, Watkins J, *et al*. National institute of mental health treatment of depression collaborative research program, General effectiveness of treatments. Arch Gen Psychiatry 1989; 46: 971-982.

[100] DeRubeis RJ, Hollon SD, Evans MD, Bemis KM. Can psychotherapies for depression be discriminated? A systematic investigation of cognitive therapy and interpersonal therapy. J Consult Clin Psychol 1982; 50: 744-756.

[101] Chambless DL, Hollon SD. Defining empirically supported treatments. J Consult Clin Psychol 1998; 66: 7-18.

[102] Chambless DL, Ollendick TH. Empirically supported psychological interventions. Controversies and evidence. Annu Rev Psychol 2001; 52: 685-716.

Received: August 16, 2006 Revised: November 15, 2006 Accepted: November 16, 2006