Comparing Cognitive Behavior Therapy, Interpersonal Psychotherapy, and Psychodynamic Psychotherapy

Janis L. Cutler, M.D.

Adam Goldyne, M.D.

John C. Markowitz, M.D.

Michael J. Devlin, M.D.

Robert A. Glick, M.D.

The Residency Review Committee of the Accreditation Council for Graduate Medical Education now requires psychiatric residents to demonstrate "competency" in five forms of psychotherapy: brief, cognitive behavior, and supportive therapies; long-term psychodynamic therapy; and combined psychotherapy and pharmacotherapy (1). The field has been struggling with the implications of this graduation requirement since its promulgation in 2001 (2). During training, residents frequently choose a particular treatment for a particular patient based on their caseloads, training needs, and supervisory availability, with the rare opportunity to see how patients might respond to different psychotherapies. As a theoretical exercise, such an experience would clarify the differences and similarities among different psychotherapeutic orientations, including their theoretical assumptions, technical interventions (3), and the process of differential therapeutics that psychiatrists must undertake in evaluating patients and developing treatment plans (4, 5).

"A key technical difference in psychodynamic psychotherapy in contrast to cognitive behavior therapy and interpersonal psychotherapy is its emphasis on transference."

We simulate that experience by presenting a suitable patient to experts from the disciplines of cognitive behavior therapy, interpersonal psychotherapy, and long-term psychodynamic psychotherapy. Each expert will describe how his treatment might proceed. As we shall see, the treatments differ conceptually and technically. Other therapies, including time-limited brief dynamic therapy (which has its own conceptual basis and technical approach), are beyond the scope of this presentation.

Dr. Goldyne

Mr. A, a 24-year-old single man, came to the psychiatry resident evaluation clinic toward the end of his first year of law school. He was on academic probation and was referred by his dean, who feared that depression was impairing his studying. Mr. A had been a successful undergraduate, but upon beginning law school 6 months previously, he had developed "a procrastination problem." His class attendance was poor, and he often postponed studying to go to movies and to read "trashy novels." Cramming for examinations yielded worsening results as the year progressed. Mr. A felt increasingly depressed as he entered the spring term. For 6 weeks, he had had trouble concentrating, overslept, overate, and felt ashamed, fatigued, hopeless, and helpless. His enjoyment of movies and books declined, and he lost interest in sex. He had trouble leaving his dormitory room and felt too enervated to study. He never considered suicide.

Mr. A reported no psychiatric symptoms or treatment before law school. Specifically, he reported no previous major depressive, manic, or hypomanic episodes, or anxiety, psychotic, learning, or attention deficit hyperactivity disorders. Upon probing, he acknowledged an "underlying sadness" for as long as he could remember. He drank socially, reported using no recreational drugs, had no medical problems, and had never taken medication. He reported no family history of psychiatric illness.

Shortly after Mr. A's birth, his father had divorced his mother. His father soon remarried and had another child. His mother never remarried and had no other children. He lived with his mother in a small apartment in the Pacific Northwest. His father met him for dinner twice a year, keeping Mr. A's existence secret from his new family. "I was so sad not to have a dad, but my mom would say, 'Stop feeling sorry for yourself. I have problems, too.'"

When Mr. A was 10, his mother pursued vocational training in another city for 3 years, leaving him in the care of his grandmother and making him feel like an "orphan." After her return, they lived together until his graduation from a nearby university. Throughout that time, she "acted more like a needy girlfriend than a mother. It was all about how I was the man of her house, about how I could take care of her and not about her taking care of me."

Mr. A "goofed off" in elementary and high school. "I felt like nobody cared, so I didn't care....I never tried too hard." He described several incidents of cutting class as the only times that his father became involved in his upbringing, meeting with the principal, promising to "help me shape up, but he never followed through." Mr. A became a more serious student when, as a college undergraduate, he developed a mentorship relationship with a male professor: "It was the first caring relationship I ever had. We had a lot of long talks, and he made it about me, not all about him. He invited me to hang out with his wife and kid. I felt inspired to do my best." In-

deed, Mr. A thrived academically, served in student government, and was admitted to a competitive East Coast law school.

Mr. A reported developing an interest in girls and sex and beginning to masturbate as a high school freshman. In college, he experienced a "real romantic relationship" and first had sexual intercourse, which he described as "good, fulfilling, and frequent." The relationship ended as graduation approached, when his girlfriend "found another boyfriend and said she thought of me more as a brother than as a boyfriend."

Mr. A connected his recent procrastination and depression to several interpersonal stressors. First, since beginning law school, he had endured frequent needy phone calls from his mother, complaining about how lonely she was without him and "begging" him to move back home and take care of her "like a good son should." Second, since his move, his college mentor had failed to respond to his frequent communications as he had hoped: "He sends short answers once every few weeks. I know his wife just had another child, but it feels like he dropped the ball. It seems like the guiding light I had in college is gone." Third, he was increasingly frustrated by his relationships with male peers, feeling taken advantage of when his accommodations went unreciprocated.

Finally, Mr. A was distressed by his relationship with a fellow law student, whom he had dated for about a month. "She told me she couldn't handle a relationship and broke up with me. But she keeps calling me, wanting my support, wanting to hang out, but not to date....It seems like the only time she flirts with me now is when I might be interested in someone else....The whole thing is torture, but I can't seem to stop hanging out with her."

Upon his mental status examination, Mr. A was a neatly dressed, thin Caucasian man who appeared to be his stated age. He reported feeling "very depressed" and gazed downward with a constricted, morose affect. His speech had a normal rate and rhythm, and his thought process was coherent, but he answered open-ended questions in an overly detailed, intellectualized manner that had a complaining quality. His cognitive examination was unremarkable. He reported no psychotic symptoms and suicidal thoughts.

Based on a provisional diagnosis of major depressive disorder and on Mr. A's initial request for medication, I wrote a prescription for sertraline after the first session. During his evaluation, Mr. A was exceptionally deferential, readily acquiescing to my scheduling needs, calling me "doctor," frequently soliciting my opinion, and responding to every intervention with ready agreement. By contrast, he arrived more than 15 minutes late to all but the first evaluation appointment, saying, "I apologize," upon entering the room. In response to initial inquiries about his overly inclusive style of speech and about his tardiness, he smirked in a manner seemingly both defiant and contrite and lamented about his difficulties with "organizing time" and "getting to the point," speculating that "maybe it's a brain malfunction." By the second session, 3 days after the first, he appeared much less depressed and reported feeling better, in part because he had obtained permission to remain in school. He reported having thrown away his prescription and asked for psychotherapeutic treatment.

Mr. A was given a DSM-IV multiaxial diagnosis: axis I—major depressive disorder, single episode, moderate; rule out dysthymic disorder; axis II—personality disorder not otherwise specified with dependent and self-defeating traits; axis III—none; axis IV—moderate difficulties in academic functioning and in multiple relationships; axis V—score on the Global Assessment of Functioning Scale: current=55, highest in the past year=65.

Dr. Devlin

Initial tasks in working with Mr. A would be to agree on the goals of treatment; to collaboratively develop a cognitively informed model of his illness, which includes understanding the relationship among thoughts, feelings, and behaviors; and to orient him to cognitive behavior therapy procedures, including the basic structure of sessions and the importance of between-session homework (6–9).

Mr. A's procrastination seems to be a behavior that occurs in response to a set of feelings, which in turn relates to underlying automatic thoughts. A useful homework assignment might be for him to begin to map the behavior, e.g., explore the patterns of his procrastination and school avoidance. Although his overall impression may be that he takes no pleasure in anything related to schoolwork, this is unlikely to be true. If he were to keep a pleasure/mastery log, periodically rating the degree to which he experiences interest or pleasure in school-related tasks, including routine or less threatening tasks, and the degree to which he accomplishes school-related goals, including minimal goals such as simply getting himself to class, meaningful patterns might emerge. For example, Mr. A may find that particular classes or professors present more difficulty than others or that attending class with friends makes the experience more pleasurable. In any case, Mr. A may begin to move from regarding himself as "a procrastinator" or "a failure" to someone who has difficulties getting work done in some situations and performs adequately in others. A follow-up assignment might then be to zero in on moments when he chooses to avoid schoolwork, e.g., decides not to go to class and to write down as clearly as possible what he is feeling (e.g., shame, sadness, hopelessness, anxiety) and thinking (e.g., "I am a failure," "I am going to be expelled," "They made a mistake in admitting me and now they are finding out"). Although it might be difficult at the outset for Mr. A to name the feelings he experiences when procrastinating and to articulate the thoughts connected to these feelings, he would make a start on this in sessions and develop his skills in this area.

In a similar fashion, we could target his depressive symptoms, including sadness, a loss of interest in activities, and isolation. Mr. A most likely believes that nothing can bring him pleasure and that he is better off staying alone in his room. Yet his experience, if he systematically monitors it, will probably contradict this assumption. Behavioral experimentation will allow Mr. A to find out whether, in fact, the prediction that activity will be entirely devoid of pleasure is or is not borne out. Once Mr. A is engaging in more activities outside his dorm room, he will be in a better position to undertake the cognitive work of

systematically monitoring his feelings and thoughts in various circumstances, making the thought-feeling-behavior connection, identifying cognitive distortions, and challenging and reformulating dysfunctional thoughts. Thus, self-monitoring, behavioral activation, and cognitive restructuring are techniques that can be applied to both Mr. A's procrastination problem and his underlying depression (9).

Mr. A's relationships with women, particularly the woman he dated in law school, and with male peers, as well as his sense of himself as an adult man, seem to reflect his axis II psychopathology and can also be addressed within a cognitive behavior framework. Although the relevant behaviors may be less obvious, they are nonetheless present. For example, Mr. A's statement, "I can't seem to stop hanging out with her," represents a set of choices to, at particular points in time, spend time with her and not to seek out the company of other women. Just as with depressive symptoms and procrastination, it would be useful for Mr. A to monitor these choices, in part as a way of raising his level of consciousness of the choices he is making and increasing his sense of agency. It would further be useful for Mr. A to "tune in" to his feelings and thoughts as he thinks of or interacts with the woman over the course of the week.

With time, a fuller conceptual model can be constructed that would include not only the day-to-day automatic thoughts that influence Mr. A's moods and behaviors but also the core beliefs that serve as the filter through which Mr. A experiences the world and interprets his experiences and the compensatory strategies that he has developed to keep dysphoric feelings at bay. For example, Mr. A's presumably humiliating experience of exclusion from his father's life and further humiliation by his mother ("Stop feeling sorry for yourself") could well have led to a core belief that he is inadequate and unworthy. In order to fend off feelings of shame and despair, he developed a strategy of obtaining the approval of male authority figures, effectively "borrowing" self-esteem from these relationships. However, when the relationship is disrupted, Mr. A's dysphoric feelings return and he decompensates. As Mr. A becomes more consciously aware of his core beliefs, he will become more aware of how their activation influences his processing of the here and now. To give a hypothetical example, when Mr. A is disappointed by getting a grade of B on a test, his feelings (intense shame) and thoughts ("I knew I wouldn't be able to make it at a good law school"; "Dr. Devlin will be disappointed in me") reflect the core belief much more than they reflect the realities of the situation. If Mr. A's processing of this particular situation remains unchallenged, it will in turn strengthen the core belief of inadequacy, laying the groundwork for further such interpretations as Mr. A goes through his week. With continued work, however, Mr. A will become skilled in identifying and challenging his automatic thoughts, in understanding the origins of his core beliefs, in appreciating both how his core beliefs/compensatory strategies may work for him (e.g., believing himself to be inadequate may serve to obviate anxiety associated with seeing himself as an adult man) as well as how they hold him back, and, ultimately, in systematically testing and gradually altering the core beliefs themselves.

This brief discussion inevitably simplifies both the conceptualization of Mr. A's problems and the nature of his work in treatment. For example, his response to male authority figures is not always deferential. His early interactions with Dr. Goldyne, e.g., arriving late, summarily throwing away his prescription, suggest that other feelings and thoughts are coming into play. Perhaps these reflect other core beliefs or perhaps they reflect alternative compensatory strategies stemming from the same core belief. In any case, though, the model outlined will be a useful framework for Mr. A to understand his responses to various situations, to systematically modify his beliefs, and to attempt new approaches to problems that may provide experiences that disconfirm his previous assumptions. Although the interpretation of transference is not a central tool of cognitive therapy, automatic thoughts and feelings related to interactions with the therapist are very much within the scope of exploration and may provide valuable opportunities for testing and modifying dysfunctional automatic thoughts.

Schema therapy, a modification of cognitive therapy (10), may be a particularly useful framework for Mr. A's treatment, as it would help him to develop his awareness of higher-level core beliefs or schemas that govern his cognitive, affective, and behavioral responses to various circumstances. In addition to Mr. A's defectiveness/shame schema, the case history also suggests that schemas of abandonment/instability (based on his abandonment by both his father and, later, his mother) and mistrust/abuse (stemming from threatening interactions with his mother) may be important.

Dr. Markowitz

Mr. A's life seems replete with the interpersonal difficulties around which interpersonal psychotherapists organize treatment (11). In early sessions, while building a therapeutic alliance, I would explore his affective responses to separations and rejections in the context of obtaining an "interpersonal inventory." Just how does Mr. A feel and respond when his roommate doesn't reciprocate a favor, his mother distorts their relationship to meet her own needs, or his ex-girlfriend teases him with illusory romance? Did Mr. A express disappointment or anger when his college mentor failed to call back? Did he tell his roommate or ex-girlfriend when he was frustrated or hurt by their behavior? We anticipate that Mr. A is sensitized to rejection, expects it, and feels it keenly; takes a passive, unassertive stance; is loathe to confront others when they don't meet his needs; and has difficulty effectively expressing his frustration. This overly "deferential" approach is enacted in the therapeutic evaluation as well. I would normalize and emphasize the appropriateness of expressing his needs and feelings to significant others, helping Mr. A to negotiate relationships more effectively.

Having defined the diagnosis and its interpersonal context, I would present Mr. A with a formulation that links the mood episode to an interpersonal crisis. For example:

> As we've established, you are suffering from an episode of major depression, which is a painful but treatable illness and not your fault. From what you've told me, your symptoms of depression seem to have arisen when your college professor was inattentive and you felt abandoned and overwhelmed by the prospect of dealing with law school on your own. Coming to terms with losses can be hard, especially when you've had as many dislocations as you've already had. We call these kinds of life changes *role transitions,* and they *are* hard to deal with, but there are ways to do so. I suggest that we work for the next 12 weeks on solving your law school role transition; as you gain greater comfort in your situation there, not only will that improve your life, but your mood symptoms should improve as well.

The formulation is a simplifying fiction, a plausible construct that organizes the patient to focus in treatment on an interpersonal life problem. An alternative focus for Mr. A might be a role dispute with his mother or ex-girlfriend. Once Mr. A agrees on a focus, the therapist sets a time limit totaling 12 or 16 weekly sessions, gives Mr. A "the sick role" to excuse him from what depression prevents him doing, and focuses him on difficulties in his current interpersonal relationships. What outcomes would make him happier? What options has he to achieve those goals? Who is giving him a hard time? Where can he get social support?

Once we agree on a focus, interpersonal psychotherapy enters its middle phase (12), in which each session begins with a simple question: "How have things been since we last met?" This requests an interval report and elicits either a mood or recent event. If Mr. A reports feeling depressed, I ask whether anything happened during the week that evoked that mood. If he reports an event ("I came to class late and a teacher said something critical"), I ask how this affected his mood. Mr. A soon learns to link feelings to life situations. Moreover, the elicitation of an affectively charged, recent life event—e.g., another rejection by his ex-girlfriend—provides an ideal substrate for psychotherapy. The discussion is concretely grounded, emotionally focused, and practical rather than abstract, intellectualized, and detached.

I then ask Mr. A to reconstruct the recent event. "How did it happen? What did you want to happen? What did you say? What did he say? How did you feel then? Then what did you say?" When things go well, I reinforce helpful social skills and link their use to improved mood. When encounters go sour, I offer sympathy, and then help Mr. A to explore alternative options for handling such situations and to role play them so that the next encounter goes better. The treatment concentrates on using feelings to understand social situations and on employing social skills to handle them well.

I would take a relaxed, friendly, encouraging, and supportive stance. If Mr. A struggles in his schoolwork or comes late to psychotherapy sessions, I would tend to blame the depressive symptoms (as documented on rating scales), relieving Mr. A of guilty self-criticism for those symptoms. Interpersonal psychotherapy provides and encourages psychoeducation about depression and treatment options; the more Mr. A knows about depression, the less pessimistic he should be about the hopelessness of his situation. Indeed, hopelessness is underscored as a particularly dangerous, convincing, yet illusory symptom of the syndrome. The treatment focus is on current outside relationships, not on the remote past or the therapeutic dyad. The therapist is a friendly ally. Thus, I might tacitly recognize Mr. A's quick improvement after the first evaluatory session as a response to engagement in treatment with a new potential father figure and anticipate his forthcoming sensitivity to termination of the relationship but would focus on these feelings in situations outside the office rather than interpreting transference.

There is no formal homework in interpersonal psychotherapy, but the goal of treatment—the resolution of the interpersonal focus (e.g., role transition)—constitutes an overarching task, which Mr. A can approach at his own pace, prodded on by the time limit. I would encourage activity, both because of its antidepressant benefit and because it provides a laboratory for understanding interpersonal encounters and the emotions they provoke. During this brief treatment, Mr. A is likely to develop new social competence, have "success experiences" with significant others, and remit from his depressive episode. To document this, I would serially assess mood symptoms, administering the Hamilton Depression Rating Scale (13) every few weeks.

In the final weeks, the termination phase, I would emphasize Mr. A's improvement and *why* he has improved, citing his new capabilities in dealing with those around him. Patient, not therapist, gets the lion's share of credit for his gains. This helps to build Mr. A's sense of independence and capability to handle life without therapy. Termination is addressed as an interpersonal event—one to which Mr. A, with his separation sensitivity and atypical depressive symptoms, might be particularly sensitive—a bittersweet graduation and role transition from treatment. As this is Mr. A's first depressive episode, treatment might end if his symptoms remit, with the understanding that depression can recur and that he should seek treatment if it does. If Mr. A has residual symptoms or reveals a prior depressive episode or dysthymic disorder (14), we might agree on a course of continuation treatment to prevent recurrence (12). Since making accurate axis II diagnoses is difficult in the setting of major depression, I would attribute Mr. A's "dependent and self-defeating" behaviors to the depression rather than to his character, at least until his mood disorder has remitted.

Dr. Glick

From the start, I would convey an open-minded, nonjudgmental, and curious attitude about Mr. A and his problems (15, 16). I want him to recognize that the treatment works by seeking together to understand everything we can about the meanings of his feelings, thoughts, and behaviors. I assume that his problems reflect motivations and fears about which he is only partially aware. We will pay attention especially to the "here and now" experience in the therapeutic interaction to give us clues about how his mind works. For example, I might draw his attention to possible meanings of his lateness to sessions, as follows:

> You're quite polite but missed a big part of each session. And today you seem to be staying on the surface of things. Might you be avoiding painful or troubling feelings about yourself? Are you aware of how you're "getting in your own way"?

The purpose of this interpretation is to begin to increase Mr. A's self-reflection, to look at his behavior, especially in the therapy, as meaningful. Expanding his awareness and encouraging curiosity about himself, in the context of a nonjudgmental therapeutic relationship, will increase his tolerance for painful affects and his insight into what is creating his current problems and maladaptive behaviors. This insight, in turn, will provide greater flexibility and freedom of choice in his relationships and other areas of functioning.

Dr. Goldyne's immediate prescription of an antidepressant suggests an eagerness to cure Mr. A of his pain before understanding, which might reflect a wish to be a new and satisfyingly reparative paternal figure. Another possible countertransferential reaction would be to experience an urge to scold Mr. A as if he were a mischievous child. Mr. A's constellation of passivity, underlying aggression, and perhaps hidden contempt (as reflected in his smirking) might elicit such a response in many therapists. By anticipating and paying attention to such countertransferential responses, psychodynamic psychotherapy affords the therapist the opportunity to recognize and manage such responses, which reduces the therapist's risk of retaliatory acting out.

Throughout treatment, Mr. A's level of depression would be carefully monitored. For example, if his depression appeared to be returning, with impairment in his concentration contributing to his difficulties in completing his schoolwork, I would explore this with him, looking for further evidence of symptoms of depression. With each suggestion or intervention, I would be nonjudgmentally curious about his response. If Mr. A fears that I'm trying to diagnose depression in order to prescribe medication, I would ask about his feelings about medication and concerns about seeming needy and weak. I might ask him to consider his concerns with my opinion of him. He might acknowledge some fears of criticism or disappointment and recognize how he guards his reactions in the sessions.

With further exploration, other aspects of Mr. A's difficulties completing his schoolwork might emerge. For example, perhaps Mr. A avoids his work because he becomes anxious about his abilities when he tries to study. Perhaps he tries to manage his anxiety by mastering a superficial understanding of the material, avoiding challenging himself. In listening to the details of Mr. A's daily life, I would note these defensive patterns and, when appropriate, tactfully describe them to Mr. A. While it may be potentially upsetting to realize the degree to which he is "getting in his own way," Mr. A may also be relieved and empowered by this deeper understanding.

Mr. A's fears of rejection and of unacceptable unconscious anger at his parents seem to result in powerful unconscious self-punitive motives, vulnerable self-esteem, and intense wishes for attachment, acceptance, and approval from authority figures. Academic success allowed him to win love and support as a way to resolve temporarily his real and imagined internal and external conflicts; he was emotionally sustained only when able to please a supportive "father figure." He probably suffers from considerable anxiety, shame, and guilt in his relationship with his demanding, "needy" (and perhaps depressed) mother. Needing and being needed by a woman generates intense unconscious conflict, and he may give "signals" of his ambivalence to his girlfriend, prompting rejection. His defensive response is self-punitive with self-defeating behavior and emotions of self-hatred, hopelessness, and helplessness.

This initial formulation will guide me but will not be shared directly with Mr. A. Avoiding dry, intellectualized, and abstract theoretical discussions, I will pay attention to his depressive affects, his anxieties, and his self-punitive behaviors as he becomes engaged. Exploration of the transference will be the focus in order to address Mr. A's interpersonal difficulties by revealing underlying unconscious fantasies and internalized object relationships in a concrete and vivid manner. Tact and timing in the exploration of transference reactions will be paramount, as Mr. A is likely to want to attach to a strong and supportive therapist but also to have anxieties about the safety of the relationship. Mr. A's dramatic relief of symptoms and his discarding of the prescription are early transference clues, suggesting gratification of wishes to be cared for but not controlled. As our work continues, I will be interested in his reactions, for example, to my interest in his relationships with women. He might be uneasy to reveal his negative feelings about women and fears of how needy and guilt-provoking women can be. If he is late or misses a session after his feelings about women have come up, I would explore the possible connection. Such transference reactions can be tactfully used to demonstrate that he is having difficulty in the treatment relationship with certain painful thoughts. We might have an exchange like the following:

Mr. A: "I don't like complaining to you about my mother or my difficulties dating. I think that you are going to see me as a 'momma's boy' or a failure."

Dr. Glick: "You may be experiencing me as a judgmental rather than supportive man in your life. We have reasons to suspect that this has been part of the problem for you. You do not want me to see you as weak and a failure with women. Perhaps it is easier to have me see you as a failure in school."

Mr. A: "I don't like the feeling that I am competing with you. You will not like me if you feel that I am trying to compete."

Dr. Glick: "Maybe this is why it is easier for us to talk about how I can help you with academic problems than emotional problems. Perhaps you worry that I will reject and abandon you if I know more about your feelings and desires."

While my words might sound confrontational, my tone would remain concerned and empathic, and my stance would be collaborative: we are together trying to understand and change Mr. A's maladaptive patterns.

Dr. Cutler

In approaching this clinical scenario, the formulations of therapists from three distinct schools of psychotherapy are, in some ways, quite similar. Each therapist is concerned about Mr. A's depression and his increasingly maladaptive patterns of behavior (although his axis I disturbance seems of greater concern to the cognitive behavior and interpersonal psychotherapists than to the psychodynamic therapist). Each focuses on Mr. A's vulnerability to abandonment, his passivity, and his simultaneous expectation of and hypersensitivity to rejection. The cognitive and psychodynamic therapists share a focus on the influence of Mr. A's past on his present difficulties (which interpersonal psychotherapy does only in recognizing past patterns of interpersonal behavior), and they both express concern about Mr. A's apparently inadequate sense of himself as an adult man, whereas interpersonal psychotherapy tends to blame this inadequacy on the episode of mood disorder.

Technically, the three therapies under consideration exhibit characteristics shared by many psychotherapies: the helping relationship established between patient and therapist, ascribing of meaning to the patient's difficulties, and enhancement of a sense of mastery within the setting of emotional arousal (17). Beyond these common ingredients to the specific techniques of each psychotherapy, the technical approaches of the cognitive behavior and interpersonal psychotherapists have more in common than those of the psychodynamic therapist. These practitioners of time-limited therapies emphasize linking feelings to thoughts (cognitive behavior therapy) and feelings to life events (interpersonal psychotherapy) in a fairly structured manner (particularly cognitive behavior therapy, which includes an agenda), rather than assuming a less directive stance of general curiosity about the patient's unconscious conflicts. Role playing, skill building (interpersonal psychotherapy and cognitive behavior therapy), and log keeping (cognitive behavior therapy) are important technical elements. Yet Dr. Devlin's description of the potentially maladaptive influence of "core beliefs" seems consistent with Dr. Glick's interest in the influence of "unconscious fantasy." A key technical difference of psychodynamic psychotherapy in contrast to cognitive behavior therapy and interpersonal psychotherapy is its emphasis on transference. Psychodynamic therapists view transference as a powerful tool in understanding the patient and eventually effecting change. Cognitive behavior and interpersonal psychotherapists do not believe it necessary to explore or interpret transference, and in fact, interpersonal psychotherapists tend to view interpretation of transference as an intervention that distracts the patient from outside relationships and risks therapeutic rupture.

The three therapies can also be contrasted by their demands on the psychotherapist. Interpersonal psychotherapy and cognitive behavior therapy require the therapist to be structured and supportive. Working as a psychodynamic psychotherapist requires a higher tolerance of ambiguity and the expectation of a deepening collaborative exploration.

Although some psychotherapy researchers present the somewhat nihilistic view that the common ingredients of psychotherapy are more potent than the specific (17, 18), many experts believe that these common ingredients are a necessary, but not in themselves always sufficient, foundation for other more specific interventions. Thus, for many patients, a clear recommendation may be indicated for a particular type of psychotherapy. For example, one landmark study (19), the first head-to-head comparison of cognitive behavior therapy and interpersonal psychotherapy, suggests that patients do best in cognitive behavior therapy when they have less impaired cognitive functioning and better in interpersonal psychotherapy when they have better (than minimal) social adjustment. Although one might think that the psychotherapy chosen should focus on the patient's deficits most in need of improvement, these data suggest choosing the psychotherapy that will best use the patient's strengths. Repeated randomized clinical trials have demonstrated the efficacy of cognitive behavior therapy, interpersonal psychotherapy, and pharmacotherapy for major depression. Clinical experience and naturalistic studies (20) suggest that psychodynamic psychotherapy may benefit patients with dysthymia, anxiety, and long-standing interpersonal difficulties. This latter assumption awaits confirmation by randomized controlled trials (21).

Which type of psychotherapy should be recommended to Mr. A? In his case, it may be that each of these treatments under consideration would be equally appropriate and effective and the choice is merely a matter of his preference. A brief summary of the approaches of each therapy (such as the first two paragraphs of this section, translated into nontechnical language) might be presented to

Mr. A so that he could make an informed choice. Combined pharmacotherapy and psychotherapy would be an additional alternative, although the premature prescription of medication before an evaluation is completed (as was done here) is not generally indicated.

Training in multiple psychotherapies is now a residency requirement. Competence in different psychotherapies may enrich and broaden the therapist's view of patients and of therapeutic possibilities. Appreciating the differences and commonalities will afford the clinician optimal flexibility. For example, as this case discussion illustrates, appreciation for the concept of transference might inform the cognitive behavior therapist's understanding of a patient's dysfunctional automatic thoughts and feelings, and an interpersonal psychotherapy perspective on empowering patients to feel in control over their relationships might inform a psychodynamic therapist's approach when a patient complains of being "stuck" in an unsatisfying relationship. Clinical competence, conviction, and consistency in a therapeutic approach seem to predict a more successful psychotherapeutic outcome (17, 18). Careful diagnostic evaluation that takes into account the problems, the motivations, and the circumstances of the patient will allow a psychiatrist to make effective choices about what might be most helpful to a particular patient.

Received March 23, 2004; revision received June 15, 2004; accepted June 30, 2004. From the Department of Psychiatry, New York State Psychiatric Institute, the College of Physicians and Surgeons of Columbia University; and Weill Medical College of Cornell University, New York. Address reprint requests to Dr. Cutler, New York State Psychiatric Institute, 1051 Riverside Dr., Number 125, New York, NY 10032; cutlerj@pi.cpmc.columbia.edu (e-mail).

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