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LANCE P. LONGO, M.D.
Milwaukee, Wis.

Defining the Core Processes of Psychotherapy

TO THE EDITOR: Janis L. Cutler, M.D., et al. (1) presented an excellent clinical case conference comparing approaches to the treatment of an individual using three different types of psychotherapy (cognitive behavior therapy, interpersonal psychotherapy, and psychodynamic therapy). Dr. Cutler commented that cognitive behavior therapy and interpersonal psychotherapists "do not believe it necessary to explore or interpret transference" (p. 1572). We would disagree with this statement with regard to cognitive behavior therapy. As cognitive behavior therapy supervisors training psychiatry residents, we often find that supervisees and psychodynamic therapy supervisors have the perception that transference is not examined in cognitive behavior therapy. In our opinion, this is one of the major misconceptions of cognitive behavior therapy that has been identified by various experts (2–5).

Although the word "transference" is not part of the jargon of cognitive behavior therapy, examination of the cognitions related to the therapist with respect to past significant relationships is an integral part of the assessment and treatment in cognitive behavior therapy. Developing a cognitive behavior therapy case conceptualization of patients is recommended for treating every patient with cognitive behavior therapy (3); cognitive behavior therapists examine the thoughts, feelings, and behaviors related to a wide range of situations (including reactions to the therapist) and relevant childhood experiences to understand the underlying core beliefs and conditional assumptions of each patient. In addition, Beck et al. (5) stated that a cognitive therapist must be

> particularly sensitive to…the patient's hypersensitivity to any action or statement that might be construed as rejection, indifference or discouragement. The patient's exaggerated responses or misinterpretations may provide valuable insights but the therapist must be alert to their occurrence and prepare the framework for using these distorted reactions constructively.

We believe that it is important to underscore that transference issues are examined carefully, in an upfront fashion, in cognitive behavior therapy and must be an integral component of the complete management of every patient undergoing cognitive behavior therapy.

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JITENDER SAREEN, M.D., F.R.C.P.C.
KURT SKAKUM, M.D., F.R.C.P.C.
Winnipeg, Man., Canada

TO THE EDITOR: The informative clinical case conference by Dr. Cutler et al. arrived at the brink of psychotherapy's current challenges but failed to take the next step into the heart of the matter. After concise descriptions of cognitive behavior therapy, psychodynamic, and interpersonal therapy by proponents of each approach, Dr. Cutler and colleagues synthesized similarities and distinctions among the three. They noted their many shared features, including the critical importance of the therapeutic alliance, and found a primary distinction in the emphasis psychodynamic psychotherapy places upon transference, which cognitive behavior therapy and interpersonal psychotherapy do not share. They noted that "common factors" account for most outcomes. Technique is important but accounts for only about 15% of outcome, with 55% of patient change attributable to patient variables (1). Dr. Cutler et al. correctly believe that there may be prescriptive approaches for specific patient characteristics, citing investigators who found that cognitive therapy works better for patients with less impaired cognitive skills, whereas interpersonal therapy works better for patients who have some social skills. There is a growing body of process research suggesting that therapists must customize their approaches to patients (2). The patient's assets and deficits are the most substantial determinants of outcome, with the therapist's skills and abilities—regardless of theoretical school—secondarily influencing outcome. The strength of the working alliance follows these key variables as a tertiary influence (3). Like the child who saw that the pompous emperor really had no clothes, process research is revealing that the schools of therapy are illusory. It is finally telling us the naked truth that patient and therapist variables are the primary keys to outcome. Findings like these compel us to describe psychotherapy as it is, by using our expanding knowledge of the human brain to describe the neural circuits of psychotherapy based upon their fundamental processes: engagement, broadening self-awareness, pattern search, change, termination, resistance, transference, and countertransference. I hope Dr. Cutler and her colleagues will build upon these neurobiological discoveries to help define psychotherapy as it is.

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BERNARD D. BEITMAN, M.D.
Columbia, Mo.

Dr. Cutler and Colleagues Reply

TO THE EDITOR: We are pleased to see continuing interest in psychotherapies among readers of the *Journal*.

In response to the comments of Drs. Sareen and Skakum on the use of transference in cognitive behavior therapy, we agree that cognitive behavior therapists can productively explore the influence of early relationships on patients' core beliefs and the impact of these core beliefs on the cognitive and affective processing of interactions with the therapist. In fact, our cognitive behavior therapy formulation provides several examples in which the patient's experience of interactions with the therapist and the association of this experience to his longstanding core beliefs might enter into the work of treatment. Therapists of different orientations may use similar concepts and even similar techniques in service of very different interventions. Yet despite the frequent usefulness of extending cognitive work to the therapist-patient relationship, we believe the writers' claim that "transference issues…must be an integral component of the complete management of every patient undergoing cognitive behavior therapy" overstates the case. For example, the focus of treatment for a patient participating in short-term cognitive behavior therapy for panic disorder would likely be on the patient's interpretation of somatic states, and the patient's relationship with the therapist might never enter into the foreground of treatment. All therapists should heed the transference, but not all may interpret it. Nonetheless, Drs. Sareen and Skakum's comments usefully underscore the importance of the therapeutic relationship across treatment approaches and the usefulness of comparing how different psychotherapies manage it.

We disagree with Dr. Beitman's contention that "the schools of therapy are illusory." Common factors are important, patient and therapist factors count, but meaningful differences exist among psychotherapeutic approaches, as any good therapist knows. Although these differences may not always matter, they often may. We agree that all psychotherapeutic treatments involve the power of the interaction, implicitly the transference to authority, unconscious communications, and the wish for relief. Technique in practice is always flexible; for example, every effective psychodynamic treatment involves varied noninterpretive interventions that deepen the process and reveal resistances. Constructs like common factors and patient variables require greater precision and more research. The three psychotherapies our case conference described would not necessarily have yielded identical results. Process research can disentangle the useful from the extraneous in particular therapies, but only within the context of outcome research of defined psychotherapies; i.e., which processes may mediate treatment outcomes. Process research does not currently support the conclusion that no significant differences exist among various psychotherapies. Nor should Dr. Beitman's letter validate muddy eclecticism. Research may helpfully explore aspects of psychotherapy from neurobiological, process, and outcome vantage points, but it is surely premature to say that we should abandon 55% of our expectations to every patient's characteristics or that we can yet diagram the neurobiology of countertransference. We join Dr. Beitman in looking forward to the day when such a diagram may be possible.

JANIS L. CUTLER, M.D.
ADAM GOLDYNE, M.D.
JOHN C. MARKOWITZ, M.D.
MICHAEL J. DEVLIN, M.D.
ROBERT A. GLICK, M.D.
New York, N.Y.

A Simplistic Understanding of the Five-Factor Model

TO THE EDITOR: Jonathan Shedler, Ph.D., and Drew Westen, Ph.D. (1), argued that the five-factor model "omits key clinical constructs and may not capture the complexity of personality syndromes seen in clinical practice" (p. 1743). To demonstrate this, they constructed an abbreviated measure of the five-factor model using a small subset (30%) of the 200 items contained within the Shedler-Weston Assessment Procedure (SWAP-200). It was a foregone conclusion that the results of a factor analysis of 30% of the SWAP-200 items would not correspond to a factor analysis of the entire SWAP-200. In addition, one should ask whether their SWAP-200 items provided an adequate assessment of the five-factor model. They never attempted to validate their five-factor model measure, and a visual inspection of the items indicates inaccurate representation of the five-factor model. Finally, it is highly unlikely that their small set of SWAP-200 items would provide anything close to a reasonably comprehensive assessment of the five-factor model. In sum, there was little reason to expect that an incomplete and inadequate assessment of the five-factor model with a subset of the SWAP-200 would account for the variance within the entire SWAP-200.

Drs. Shedler and Westen suggested that the constructs assessed by the 12 SWAP-200 scales are outside of the realm of the five-factor model. They ignored many, many studies that indicated otherwise. For example, two other compelling dimensional models of personality disorder have been developed by Dr. Livesley (the Dimensional Assessment of Personality Pathology) and Dr. Clark (the Schedule for Nonadaptive and Adaptive Personality). A complete description of and references for these measures, as well as others, is provided by Widiger and Simonsen (2). The clinical constructs assessed by these scales include narcissism, identity problems, eccentric perceptions, affective lability, aggression, detachment, self-harm behaviors, and compulsivity that resemble closely the scales of the SWAP-200, and many studies have documented well that the constructs assessed by the Dimensional Assessment of Personality Pathology and the Schedule for Nonadaptive and Adaptive Personality are well within the realm of the five-factor model.

Drs. Shedler and Westen (1) derogatorily characterized the five-factor model as providing a simplistic lay description of personality. What was simplistic was their characterization of the five-factor model. The five-factor model is a rich dimensional model of general personality structure that has been used successfully in many areas of science and practice, in-