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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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