Problem-Treatment-Outcome Congruence: A Principle Whose Time Has Come

Hans H. Strupp, Thomas E. Schacht, and William P. Henry

1. Introduction

There is clearly no need to preach to readers of this book about the importance of process research; however, in keeping with the views of many colleagues we firmly believe that process research must be closely tied to research on therapeutic outcomes. The reasons are obvious: for one thing, outcome, in our view, is a more or less arbitrary way station; secondly, process research will remain in limbo unless concerted efforts are made to link process to outcome.

Our research group at Vanderbilt University has endeavored for a number of years to combine research on process and outcome. We have done it in a particular way: beginning with the Vanderbilt I study (Strupp and Hadley 1979), we have systematically employed various process measures (notably the Vanderbilt Psychotherapy Process Scale and the Vanderbilt Negative Indicators Scale) and studied various indices in relation to outcome measures (Gomes-Schwartz 1978; Sachs 1983). We have found it particularly useful – and recommend the approach to others – to proceed with process research in the context of a reasonably controlled outcome study. In the Vanderbilt I study, for example, we used two experimental groups and two control groups. Having defined a patient population and followed out an experimental design, we learned a great deal by studying intensively individual patient-therapist dyads. Specifically, we focused attention on "high" and "low" changers treated by the same professional therapist (Strupp 1980a, 1980b, 1980d). We remain firmly convinced that scientific understanding of the variables instrumental in therapeutic change will be best advanced through intensive study of individual dyads. Traditional group comparisons, in our view, can be invaluable because they help to define and demarcate a controlled context; however, to bring greater magnification to bear on the patient-therapist transactions which are, after all, the place where therapeutic change ultimately is located, we must turn to process research. As we said, we have a predilection for the kind of process research we have briefly sketched.

2. Why Time-limited Dynamic Psychotherapy?

There are several reasons for our research group's interest in time-limited dynamic psychotherapy:

1. From the standpoint of the researcher, short-term therapy provides practical and realistic opportunities for intensive study of the therapeutic process and outcome under reasonably controlled conditions, and with the hope that a particular research project can be completed in a tolerable period of time. As we know, adequate experimental controls are extremely difficult to implement in open-ended forms of psychoanalytic psychotherapy, especially in analyses that may last for many years. The researcher concerned with time-limited forms of therapy must, of course, assume that the basic dynamics of long-term therapy are observable in the shorter forms as well, and that contemporary time-limited psychotherapy is not the kind of inferior therapy it was once considered to be. The salient point is that the study of time-limited therapy affords research economies not otherwise obtainable.

2. From a clinical standpoint, there are great potential advantages that accrue to both patient and therapist when therapeutic progress is monitored at specific periods of time, say every six months. This procedure begins to question the practice of patient and therapist embarking on a journey without direction or goals. Thus, periodic assessment can aid in keeping patient and therapist "on course" (Strupp and Binder 1984).

3. It has long been known that most psychotherapies are, in fact, time-limited. Indeed the average patient seems to stay in therapy only for a few sessions (Garfield 1978). Apart from these considerations, modern clinical practice, notably in the United States, is being profoundly influenced by considerations of cost-effectiveness and accountability (Strupp 1986). Increasingly, psychotherapy is being compared to other treatment modalities (particularly drugs). Rightly or not, long-term therapy has come to be regarded as a costly and often risky investment of time, effort, and manpower. These developments are linked to the continuing dearth of hard empirical evidence supporting the traditional claims of radical personality reorganization in psychoanalysis. Although I, for one, continue to believe that under propitious circumstances long-term psychoanalytic psychotherapy can produce changes obtainable in no other way, the research literature does not provide very convincing evidence in support of this position.

3. The Dynamic Focus

At the 1984 SPR meeting, Schacht, Strupp and Henry (1984)[1] presented an overview of a method for assessing interpersonal problems and dynamic conflicts. We have since begun to use it in our new process and outcome study (known as Vanderbilt II). A brief description of this project follows:

[1]The following section is based on this paper.

The Vanderbilt II Project, currently underway, is an intensive five-year NIMH-funded study of the process and outcome of a particular form of time-limited dynamic psychotherapy (TLDP) (Strupp and Binder 1984).

The TLDP approach was developed from principles and techniques of modern psychodynamic, interpersonal, and communications theories, and from results of previous research. The elements of TLDP are conceptually integrated around core interpersonal principles, such as understanding and using the therapeutic relationship as a technical parameter rather than simply as a nonspecific or common factor. TLDP addresses therapeutic problems in terms of the concept of self-sustaining interpersonal systems. These are patterns of repetitive interpersonal transaction and experience organized in a self-sustaining "vicious circle" (cf. Wachtel 1982) or, in cybernetic terms, a positive feedback cycle. This way of characterizing problems may be contrasted with alternate approaches that define problems in term of symptoms (such as anxiety, depression, obsessions, fears) or in terms of behavioral excesses or deficits (of assertiveness, aggression, social ability, self-regulation skills, etc.).

The treatment process in TLDP is articulated to the foregoing model of psychological problems. That is, therapeutic work in TLDP focuses on the recurrence of problematic patterns of interpersonal transaction within the patient-therapist relationship. According to TLDP's working hypotheses, change occurs when this reenactment is uncovered and examined, and when the patient explores behavioral and experiential alternatives that disrupt self-sustaining vicious circles.

Although we have gained a good deal of experience with the approach we call "Dynamic Focus", we are still at an early stage of development. In the following we shall describe major concepts underlying our work on the Dynamic Focus and provide a brief example. We have also published a detailed description to which interested persons are referred: "The Dynamic Focus," Chapter 5 (Schacht, Binder, and Strupp 1984).

The Dynamic Focus[2] is an individualized process and outcome measure. It addresses the problem of gathering and organizing therapeutically relevant information. Of even greater importance, we seek to incorporate this information systematically into our form of time-limited dynamic psychotherapy (TLDP) which is central to the Vanderbilt II study (Strupp and Binder 1984). In other words, the Dynamic Focus is designed to (1) identify the patient's central "problem"; (2) guide the therapist's interventions; and (3) facilitate the study of the therapeutic process.

The TLDP Focus is grounded in two principles:

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[2]We have recently come to prefer the term Cyclical Maladaptive Pattern (CMP). Other researchers who are currently using similar concepts include Luborsky (1984) "Core Conflictual Relationship Theme"; Malan (1976a) "Dynamic Focus"; Mann (1973) "Central Issue"; Teller and Dahl (1981a, 1986; Dahl, this volume) "Frames."

1. For the kinds of problems treated by TLDP, the primary arena for construing life experience is *interpersonal*. Consonant with the thinking of Harry Stack Sullivan and more recent exponents of the interpersonal schools, we hold that issues become evident in therapy primarily through the role they play in patient's transactions with significant others and, more immediately, with the therapist. The latter emphasis we share with such authors as Gill (1982) who point to the analysis of the transference in the here-and-now as the most fruitful focus for psychotherapy.

2. The primary psychological mode of construing life experience, for the therapeutic operations central to TLDP, is *narration* the telling of a story to oneself and others. Because patients are typically unaware of the underlying scripts, they live them out as if they represented absolute truths rather than being simply versions of reality. Knowledge of a life story is acquired in the course of attempting to tell it (narration). Narration is thus a process of discovery, a kind of investigation. By retelling or renarrating one's life story in therapy, one gains a new understanding of its meaning and significance. This process, of course, is greatly aided by the therapist's gradual understanding and interpretations addressed to the emerging script or scenario.

The Dynamic Focus contains four structural elements which express, in schematized fashion, the following fundamental categories of action:

1. *Acts of self*. These may include all domains of human action, such as affects and motive (e.g. "I feel affectionate towards my mother" or "I wish my wife would pay more attention to me"); perceiving situations (e.g. "I sensed we were in a competition together"); cognitions (e.g. "I can't stop thinking about how ugly and inferior I am when I meet someone attractive"); or overt behaviors (e.g. "I can't refrain from avoiding eye-contact with my boss when I'm angry with him"). Acts of self include both private actions and public actions (e.g. feeling affectionate as well as displaying affection), and may vary in the degree to which they are accessible to awareness.

2. *Expectations about others' reactions*. These are imagined reactions of others to one's own actions and may be conscious, preconscious, or unconscious. To achieve a transactional understanding, these should be articulated in specific relation to some acts of self. Statements in this category should emphasize imagined anticipation of others' behavior. Expectations about others' reaction often take a form such as: "If I speak up, I imagine that she will disapprove of me" or "If I ask her out she will just laugh at me."

3. *Acts of others toward self*. These are observed acts of others that are viewed as occurring in specific relation to the acts of self. That is, these actions of others are performed in the patient's presence and appear (or are assumed) to be evoked by the patient's own actions. As above, "acts" may include all domains of human action, including both public and private actions. Acts of others are typically expressed in a form such as: "When I asked for the money he ignored me."

4. *Acts of self toward self (introject).* This category of actions refers to how one treats oneself (e.g. self-controlling, self-punishing, self-congratulating, self-destroying). These actions should be articulated in specific relation to the acts of self, expectations of others' reactions, and acts of others which comprise the remainder of the format. An introject prototypically takes this form: "When my husband praises me I feel guilty and remind myself of my shortcomings" or "When I get angry I just try to slow myself down and think things through. I give myself all the time I need."

The following example outlines a problematic interpersonal transaction pattern that was observed first in the patient's current relationship with her therapist, and later was narratively integrated with her childhood history and her current marriage.

> *Presenting problem.* The patient complains of depression and marital difficulties.
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> *Acts of self.* Frances assumes a passive interpersonal position in which she refrains from disclosing her inner self, avoids social contact by withdrawal or procrastination, defers and submits to other's wishes, and spends much time in private thinking and wondering rather than in active communication.
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> *Expectation of others' reactions.* Frances expects that other people will ignore or reject her. She validates this expectation with recollections of being ignored or rejected by her mother and by various significant others.
>
> *Observed reactions of others.* Others find Frances' passivity unappealing and do not spontaneously recognize her distress and come to her aid. However, Frances does not see this as an understandable reaction to her passivity, but instead interprets this as evidence that others are actively rejecting and ignoring her.
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> *Introject (how patient treats herself).* Frances views herself as helpless in a hopeless situation and neglects opportunities for change. Rather than endure the imagined negative reactions of others, she inhibits and controls herself and refrains from asserting her desires or complaints (hoping that this interpersonal passivity will make her mere presence more palatable to others).

4. The Dynamic Focus in Therapy and Research

The treatment process in TLDP is articulated to the foregoing model for understanding psychological problems. That is, therapeutic work in TLDP focuses on the recurrence of problematic patterns of interpersonal transaction in the patient-therapist relationship. According to our working hypothesis, change occurs when this reenactment is uncovered and examined, and when the patient explores

behavioral and experiential alternatives that disrupt self-sustaining vicious cycles.

As this cursory discussion illustrates, the Dynamic Focus in our usage deals with patterns of interpersonal transaction which are a common unit of analysis for:

(1) defining problems,

(2) conceptualizing the treatment process, and

(3) evaluating outcome.

There are, however, further implications for process and outcome research which we will examine now in somewhat greater detail.

5. Principle of P-T-O-Congruence

Schacht, Strupp and Henry (1984)[3] proposed a fundamental integrative principle which may aid in the design of intelligible studies of complex psychotherapeutic phenomena. This principle – which is perhaps so obvious that it has been too easily ignored – is called the Principle of Problem-Treatment-Outcome congruence ("P-T-O congruence", for short). *The principle of P-T-O Congruence proposes that the intelligibility of psychotherapy research is a function of the similarity, isomorphism, or congruence among how we conceptualize and measure the clinical problem (P), the processes of therapeutic change (T), and the clinical outcome (O).*

By this principle, measures of the problem, the change process, and the outcome should ideally be fully congruent. That is, therapeutic outcome should be characterized in the same form and units of analysis as the clinical problem; and, the language used to describe both the problem and the outcome should lend itself to formulation of cogent theoretical links among the problem, the intervention process, and the therapeutic outcome. It is proposed that psychotherapy research can accommodate eclecticism – whether in the therapies studied or in the research methods – in direct proportion to the achievement of P-T-O congruence.

Illustration. P-T-O congruence may be most clearly visible when its absence induces a sense that a train of reasoning or a research method has some logical or inferential weakness. A prototypic highly incongruent psychotherapy research design might appear as follows:

The example is of a comparative process and outcome study, in which Rational Emotive Therapy (Ellis 1970) and Interpersonal Therapy (Klerman, Weissman, Rounsaville, and Chevron 1984) are evaluated in the treatment of depression.

1. First, patients are selected for inclusion in the study (a group comparison) via various "therapy-neutral" characteristics, such as DSM-III diagnosis, MMPI or

[3]The following section is based on this paper.

SCL-90 elevation, or scores on instruments such as the Beck Depression Inventory. A patient's scores on these various selection criteria essentially define the "problem" to which psychotherapy is to be addressed. The ostensible advantage of using a therapy-neutral common language for describing clinical problems is that such a language facilitates communication with colleagues. However, such neutral language also may insure that the problem is not defined in terms derived from the theories of behavior and change underlying the therapies being studied.

2. Second, consistent with the foregoing selection process, patients are treated for the problem of "depression," rather than for problems bearing a closer conceptual relationship to each treatment's underlying theoretical rationale. Thus, problems are not defined in terms of irrational beliefs or interpersonal deficits. Indeed, it is implicitly assumed that irrational beliefs or interpersonal deficits are important primarily as mediating variables which contribute to the etiology of the "real problem" of depression.

3. Third, evaluation of treatment process is primarily concerned with therapists' adherence to specified protocols, rather than with specifying how change occurs. "General" measures of treatment process may be employed (especially those emphasizing so-called "common factors" such as warmth and positive relationship). These general measures are conceptually distant from the way the problem and the treatment are characterized.

4. Finally, the battery of initial measures is repeated to characterize the therapy outcomes. Because the various individual measures have moved in different directions, (a common research finding) the investigator combines them statistically (factor analysis, effect-size calculations, etc.) to yield a composite outcome index. This composite index bears an uncertain conceptual relationship to anything that is directly observable or to any variables of specific theoretical importance. Little or no effort is made in the analyses to interpret the data from individual cases.

Further implications. The principle of P-T-O congruence implies that simply administering the same instrument pre- and post-treatment is not satisfactory, *unless* the instrument also articulates with the core dimension of the hypothesized therapeutic process. Frequently used pre- and post-measures such as MMPI elevations or SCL-90 symptom profiles typically provide only a pseudo-congruence. Such measures certainly have psychometric utility, especially for making comparisons to normative groups, but they lack heuristic value for the fundamental research task of understanding the nature of therapeutic change and the relationships between process and outcome. Ideal pre-post problem measures, in contrast, should carry some prescriptive implications for therapeutic action and appropriate therapeutic process. Such ideal measures are unlike DSM-III categories, for example, which appear to have little prescriptive value for psychotherapy in most cases.

In line with the foregoing, the principle of P-T-O congruence also implies that psychotherapy researchers should work toward refining representations of

psychological problems so that so-called patient-dispositional variables or patient-selection criteria are incorporated into the original problem statement, rather than treated as extraneous mediating influences requiring separate analyses. We should assign patients to treatments using selection measures that are congruent with how we characterize the problem, the outcome, and the corresponding intervention and change processes. We ought not ask how patient dispositional characteristics influence the relationship of process to outcome; rather, we should seek to incorporate important patient characteristics into the initial definition of the problem, and hence into the definition of the appropriate process and eventual outcome. In this view dispositional variables should become an integral part of how the problem is characterized, and diagnostic concepts should be periodically revised to include these criteria.

In our view, all other measurement considerations are dependent on the principle of P-T-O congruence. Whether a measurement approach is individualized, standardized, or even reliable becomes a secondary consideration, since with P-T-O congruence the value of these other measurement properties is severely diminished. Use of psychometrically inferior measures, even with P-T-O congruence, illustrates the principle of "garbage in/garbage out." Using a psychometrically superior measure *without* P-T-O congruence is equally undesirable – an instance of "gold in/garbage out."

To readers familiar with both literatures it should be apparent that, on the whole, researchers studying behavioral therapies have often been more successful than their psychodynamically oriented counterparts in approximating the requirements of P-T-O congruence. However, the principle itself militates against overzealous attempts to export this limited success from its natural theoretical context.

For example, psychodynamic researchers are sometimes criticized for failing to include behavioral measures, such as role-playing or in-vivo observations of target behaviors. These complaints ignore the fact that definitions of the form and content of problems vary across theories, and that a measure which enhances P-T-O congruence for a behavioral therapy may fail to adequately represent events of crucial interest to researchers working form an alternate theoretical base. P-T-O congruence is not a property of specific measures taken in isolation (although certain measures are undoubtedly more theory-relevant than others). Rather, P-T-O congruence is context-dependent; it is a property of the logical inter-articulation of measures across the domains of problems, treatment processes, and outcomes.

The research challenge in studying TLDP involves translating the conceptual integration (around principles of interpersonal dynamics) into a research method that, via P-T-O congruence, preserves an opportunity to map the conceptual integration onto subsequent empirical observations. In applying the principle of P-T-O congruence to the design of the Vanderbilt II project, the study clearly could not be limited to traditional measures of symptoms, traits, target complaints, goals, and so forth, since these are not "problems" in a form that TLDP purports to treat.

Therefore, the traditional battery of measures is being supplemented by efforts to develop additional procedures more conceptually consistent with the problems TLDP is designed to address. With respect to this more general end of enhancing P-T-O congruence, the following considerations emerge:

1. First, to articulate with TLDP's underlying theoretical premises, the measure should characterize a self-sustaining pattern of action and interaction, and it should reflect TLDP's emphasis on the interpersonal domain. To characterize patterns may require a measure on a different order from, say, a Likert scale or a frequency count of target-behaviors. The idea of measuring a pattern alters assumptions that characterize linear and numerically incremental models of change, as reflected in attempts to measure "more" or "less" of a trait, symptom, behavior, etc. Linear or incremental models typically assume that all change may be reduced to either positive or negative, and that outcome judgments may be arrayed correspondingly. In contrast, outcome in TLDP may also involve transforming a self-sustaining pattern of maladaptive action into a self-limiting or self-extinguishing pattern. This kind of transformation reflects a qualitative change in the organization of behavior that is difficult to express in terms of numerical increments with fixed relationships to judgments of "good" or "bad." More traditionally, a change in a transactional pattern might be characterized quantitatively as an altered conditional probability that, given certain precipitating events, the entire vicious cycle would be enacted. Again, however, judgment of whether this represents a positive or negative outcome cannot be reduced to a simple context-free numerical indicator without risk of conceptual distortion.

2. Second, because a transaction pattern unfolds over time, and because at any one time the pattern exists both as present behavior and as future potential, dynamic assessment is preferable to static assessment. A static assessment is made in cross-sectional fashion by simply "freezing the action" and applying a measure. Static assessment is commonly used to measure "levels" of various symptoms, traits, dispositions, etc. Most self-report questionnaires and observer ratings in current use involve static assessments. Dynamic assessments, in contrast, involve a dialectical interaction between assessment, trial intervention, and reassessment. The clinical wisdom of this approach to assessment is reflected in the various forms of trial therapies advocated as part of the patient-assessment process in most brief psychodynamic treatments. Dynamic assessment is most useful when we wish to identify a person's *potential* to learn or adapt, or when we wish to see how a complex transaction pattern unfolds over time. Cross-sectional measures cannot adequately describe the nature of problems that are conceived in this essentially longitudinal manner.

3. Third, because of the potential for idiosyncratic or highly patient-specific problems, measures should permit individualized assessment. However, while patients should be able to serve as their own standard for comparison it is also desirable to be able to make some group comparison.

6. Structural Analysis of Social Behavior

In applying the principle of P-T-O congruence to TLDP, it is immediately apparent that patterns of interpersonal transaction are a common unit of analysis for defining problems, conceptualizing the treatment process, and evaluating outcome. Hence, any model of interpersonal behavior that is capable of representing interpersonal transactions has the potential, in theory, to enhance the P-T-O congruence of research on TLDP. While other general models of interpersonal behavior might be applied to this task, we have elected to incorporate Lorna Benjamin's (1974) model for the Structural Analysis of Social Behavior (SASB). The SASB model is a detailed, conceptually rigorous, and psychometrically advanced descendant of Leary's (1957) original circumplex model. The SASB permits interpersonal behaviors or their intrapsychic analogues to be represented mathematically as points on one of three interrelated two-dimensional coordinate planes or "surfaces." Any interpersonal process or content may be described mathematically by locating it in one or more points on the SASB surfaces, according to highly reliable coding procedures developed by Benjamin, Giat, and Estroff (1981). Similarity, difference, and change may then be quantified by reference to the well-known mathematical properties of the interpersonal circumplex.

SASB and P-T-O Congruence. SASB coded formulations of the focus can be applied to numerous research questions. Using the SASB as a common, theoretically cogent metric, it becomes possible to search meaningfully for relationships among *any* aspects of psychotherapy expressible in interpersonal terms – problem definition, treatment process, or outcome. Two closing examples will illustrate:

1. Congruence between problem definition and outcome measures can be enhanced by using the TLDP focus as an individualized measure of treatment outcome. A working hypothesis is that a successful therapy should be accompanied by changes in the patient's transaction patterns. Such changes may be characterized, quantified, and tracked with the dynamic focus/SASB combination. It is also possible, as Luborsky (1977) and Levine and Luborsky (1981) have suggested, that in a successful therapy a main transaction pattern does not always change. Rather, what may change is the patient's sense of mastery or control over the problematic transactional events. This latter possibility is addressed in two ways: first, via follow-up interviews, and second, via an experimental measure of interpersonal locus of control that is integrated with the SASB model, thereby permitting evaluation of the mastery dimension in relation to the specific interpersonal areas targeted by the focus formulation (Schacht and Henry 1983).

2. Congruence between the problem definition and the treatment process will be enhanced by using the focal narrative as a benchmark for raters of therapeutic process. The extent to which patient and therapist reenact the focal interpersonal pattern, as opposed to understanding it while resisting reenactment, may be estimated from direct SASB coding of the interpersonal process and content of critical sessions. Along a related line, since maintenance and effective pursuit of a focus are hypothesized to be a central aspect of TLDP technique, the focal formu-

lation will be used as the reference point for anchoring assessments of therapists' adherence to this technical guideline. By using the focus as a rating benchmark it thus becomes possible to evaluate an individualized aspect of the therapeutic process as well as the outcome. In contrast to homogeneous process "dimensions" like warmth, empathy, and so on, a therapist's adherence to a focus is a highly individualized aspect of the therapeutic process, and, consistent with the principle of P-T-O congruence, one that is closely articulated to the initial understanding of the problem.

7. Concluding Comments

Only modest progress has been made in the search for a common metric for evaluating psychotherapy outcomes. Unfortunately, there are no universally shared definitions of "mental health," and different psychotherapies disagree on conceptualizations of a patient's "problem" and preferred therapeutic interventions. We do great conceptual violence to psychotherapy research when we insist that, say, two different therapies, each based on very different ideas about the nature of psychological problems, be compared in terms of their effects on yet a third kind of problem that is defined in a way not consistent with a given form of therapy but rather in terms of descriptive diagnostic taxonomy such as DSM-III. Thus, researchers continue to employ measures that are derived from descriptive traditions but are unrelated to a theory of change. In short, current outcome measures often fail to capture unique and complex but also essential "clinical realities." To remedy these problems, there has been a widespread call for the development of change criteria specific to the individual patient. However, specificity and individualization are not panaceas, and they cannot compensate for the more fundamental problems we have mentioned. The Dynamic Focus approach is one attempt to come to grips with the basic issue of problem-treatment-outcome congruence and to facilitate study of the therapeutic process.

In the Vanderbilt II study we have begun to apply this approach. First, we are using a so-called Interpersonal Assessment Interview (IAI) which is designed to elicit, in a semi-structured form, the patient's narrative of his or her interpersonal difficulties. The assessment clinician seeks to obtain the pertinent information by focusing on the four action categories we have discussed (acts of self; expectations about others' reactions; acts of others toward self; and acts of self toward self (introject)). The next step is to construct a Dynamic Focus. To this end, two members of the research team study videotapes of the assessment interviews. We have found that in many cases it is relatively easy to distill a Dynamic Focus; however, there are other instances when the task is difficult if not impossible. It is our impression that the more difficult it is to identify a focus, the more difficult it is for the patient to form a viable therapeutic alliance. At the moment we are beginning quantitative analyses of the therapeutic process by means of SASB. We consider this a promising venture and also are encouraged by the work of colleagues represented in this volume. These approaches, we believe, hold considerable promise for the future of psychotherapy process research.