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Treatment Goals and Strategies of Cognitive-Behavioral and Psychodynamic Therapists: A Naturalistic Investigation[1]

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The therapeutic goals and strategies of cognitive-behavioral and psychodynamic practitioners were investigated. Fifteen therapists in each group responded to four case vignettes, all of which contained clear evidence of an Axis I disorder, but only two of which noted explicitly the presence of interpersonal difficulties. There were no between-group differences in commitment to resolving the presenting Axis I disorder, and both groups were equally committed to the use of behavioral strategies. Psychodynamic therapists indicated significantly greater interest in pursuing nonsymptomatic goals and exploratory strategies across all vignettes. Cognitive-behavioral and psychodynamic therapists were equally committed to the resolution of interpersonal problems when they were clearly defined in the vignettes, but the latter group was significantly more likely to endorse goals involving interpersonal change in the vignettes without evidence of explicit interpersonal difficulties.

KEY WORDS: psychotherapy integration; goals of psychotherapy; strategies of psychotherapy.

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INTRODUCTION

Efforts to integrate different models of psychotherapy often assume that the approaches in question employ different therapeutic procedures in the service of similar aims. For instance, attempting to foster integration by focusing on common clinical strategies, as proposed by Goldfried (1980), assumes that the changes targeted by such strategies are alike. Frank (1973), in his seminal work, argued that different therapeutic instigations, or "rituals," serve the same therapeutic functions, such as combating demoralization or increasing the individual's emotional arousal. It is by no means certain, however, that clinicians of all orientations pursue identical treatment goals. Theoretical and practical disagreements among therapists of different approaches may in part reflect different conceptualizations of the purposes and aims of psychotherapy.

While we are unaware of any empirical data regarding this issue, there is at least some indirect evidence in discussions about therapeutic goals that therapists of different persuasions may not be attempting to bring about similar outcomes. For instance, Gill (1984) defined the goal of psychoanalysis as "no less than the reconstruction of character" (p. 183). Strupp and Binder (1984) noted that "the primary purpose of the dynamic psychotherapist . . . is to provide a constructive experience in living . . . [so that the patient might] achieve greater productivity and greater enjoyment" (p. 135). Bugental (1987) characterized the goals of treatment as "aiding the patient to experience himself as larger and more potent in his life, and thus as having choice, where formerly he experienced compulsion. Symptom reduction or problem solution may or may not occur as such" (p. 9). Nichols (1986) noted that the primary goal of psychodynamic treatment is to promote insight and emotional experience which he defined as "experiencing, with emotion, hidden and private aspects of the self, in the context of a significant relationship" (p. 5).

On the other hand, Kazdin (1980) noted that one of the hallmarks of behavior therapy is "specificity in defining, treating, and measuring target problems in therapy" (p. 75). And in fact, in numerous empirically supported cognitive-behavioral approaches to psychotherapy the treatment goals are usually restricted to resolving the presenting symptoms. For instance, even in an article on integrative aspects of treatment for anxiety disorders, Marten and Barlow (1993), while emphasizing that attention to the interpersonal system of the patient with panic disorder and agoraphobia enhanced outcome, still made clear that the goal of treatment remained the elimination of panic attacks and avoidance. Clinically significant change, they argued, is produced by "disorder-driven treatment strategies [that are] clearly and meaningfully tied to the targeted disorder" (p. 307).

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This assumption is consistent with other cognitive-behavioral therapies for Axis I disorders such as Fairburn and his colleagues' approach to the treatment of bulimia nervosa (Fairburn, 1985; Fairburn, Marcus, & Wilson, 1993). In this short-term therapy, the goal of treatment focuses mainly on reduction of binge eating and purging; other goals such as altering overvaluation of weight and shape and reducing restrained eating patterns are considered essential to bring about changes in symptomatology.

Arnow (1996) suggested that one way to conceptualize different approaches to therapy is with respect to the relative specificity of the treatment goals. The dynamic therapies, he argued, tend toward more general goals, while the aims of behaviorally oriented therapies are more circumscribed. Goldfried and Castonguay (1993), in an assessment of cognitive-behavioral therapy, noted that its strengths include a focus on the attenuation of Axis I symptoms, while among its limitations is its relative inattention to complex intrapersonal and interpersonal problems. Similarly, Omer (1993) noted that the therapeutic focus of directive, behaviorally oriented therapies is "symptom-oriented" while that of the nondirective dynamic therapies is "person-oriented" (p. 284). In contrast to the often held assumption regarding similarity of aims among therapists of different orientations, it is possible that Wachtel (1987) was correct when he observed that protagonists of different psychotherapeutic models have "different ideas of what genuine or meaningful change really is" (p. 185).

Just as therapists may differ regarding the scope of treatment goals, consumers consult psychotherapists for a wide range of problems from the highly specific (e.g., "can you help me stop smoking?") to the more general (e.g., "I seem unable to sustain intimate relationships"). In an age of proliferating therapies, consumers have more choice than they had 40 years ago when psychoanalytic therapy enjoyed virtual hegemony; the vast array of psychotherapy approaches currently available may allow for a better match between patient and therapist. Psychoanalytic therapists may be seeing considerably fewer patients with phobic disorders whose goals for treatment are restricted to overcoming their phobia; and those with more enduring interpersonal problems, or disorders of the self (Wolfe, 1995) may be seeking out clinicians with an interpersonal, or dynamic orientation to treatment. Thus, it is possible that faced with the same patient, therapists of different orientations may conceptualize goals and strategies in similar fashion, but may be referring out to other practitioners those whom they believe would fail to benefit from the kind of therapy they offer. As one noted European psychoanalyst told the first author, "I used to see people with phobic disorders, but now I refer them out to behavior therapists" (Andre Haynal, personal communication, 1987). On the other hand, it has been frequently observed that what therapists do differs from what they

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say they do (Cyr & Lecomte, 1983), and it is conceivable that even when they identify strongly with theoretically distinct models, clinicians may incorporate goals and strategies from alternative paradigms.

The primary aim of this study was to learn more about the goals and therapeutic strategies pursued by therapists of two different orientations, namely, cognitive-behavioral (CBT) and psychodynamic, by asking each group to respond to a series of four case vignettes, all of which indicated a specific Axis I disorder, but only two containing clear evidence of interpersonal difficulties, or self disorders. The study extends present thinking regarding psychotherapy integration in two major ways. First, we lack empirical data about goal selection among therapists of different therapeutic persuasions. Given the same clinical information, how much agreement is there between cognitive-behavioral and dynamic therapists regarding the goals of treatment? Considering the critique of Goldfried and Castonguay (1993), does the level of agreement change if interpersonal problems are clearly present in the clinical material? That is, do CBT therapists recognize such problems and incorporate them into their therapeutic aims or do they focus solely on the obvious Axis I complaint? Similarly, despite the avowed focus of psychodynamic therapists on "person" or "self" oriented goals, do they demonstrate intention to devote therapeutic resources to the alleviation of Axis I symptoms?

Second, what strategies do therapists representing these orientations indicate they would employ? Do therapists identifying themselves as adherents of one model or the other really restrict themselves to those strategies associated with their own school of therapy or is psychotherapy integration proceeding at a pace that is quicker than we may be acknowledging?

Our hypotheses were as follows: (1) the goals of CBT therapists would focus more on symptomatic change than psychodynamic therapists; (2) the goals of psychodynamic therapists would focus more on nonsymptomatic change than CBT therapists; (3) CBT therapists would employ more directive strategies than psychodynamic therapists; and (4) psychodynamic therapists would employ more exploratory (i.e., insight-oriented) strategies than CBT therapists. We predicted that these differences would prevail whether or not evidence of interpersonal problems was present in the case material.

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METHOD

Participants

Therapists well known in their community for their theoretical orientation, either CBT or psychodynamic, were asked to participate in a study

about "treatment goals and strategies in psychotherapy." We deliberately chose therapists with a commitment to one or the other of these orientations and avoided asking therapists we knew to be more eclectic. Therapists were also asked to identify their orientation in a questionnaire accompanying the request, and all confirmed our *a priori* categorization of them as either psychodynamic or CBT. Thirty therapists, blind to our hypotheses, took part in the study (15 who identified themselves as cognitive-behavioral and 15 who labeled themselves as psychodynamic).

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Procedure

All participating therapists were given a series of four case vignettes and asked to list (1) their therapeutic goals, and (2) the strategies they would use in implementing those goals. Two vignettes described patients with clear symptoms of obsessive-compulsive disorder, and two described patients with obvious symptoms of bulmia nervosa.

Two distinct disorders were described in the clinical vignettes so that the findings would not be restricted to one type of psychological problem. We chose these disorders for two reasons. One is that both authors have treated a reasonable number of patients with these disorders; we hoped our experience would enable us to construct believable clinical vignettes. Another reason is that for each of these syndromes established CBT treatments are available (e.g., Fairburn, 1985; Fairburn *et al.*, 1993; Steketee & Foa, 1985; Steketee, 1993) to address the symptoms and there also exists a substantial dynamic literature on these disorders (e.g., Salzman, 1980; Sifneos, 1966; Tobin, 1993) outlining a different conceptualization and treatment approach.

The vignettes were balanced for gender and for the specific presence of interpersonal problems. For each disorder one patient was male and one was female. In addition, two of the vignettes, one for each disorder, contained material indicating clear evidence of interpersonal problems, while the other two did not. The material related to interpersonal problems included relationship difficulties experienced with parents during childhood, problems in current interpersonal functioning (e.g., social isolation), and potential problems forming a workable therapeutic alliance. Below is one of the vignettes of a patient with bulimia nervosa and no obvious evidence of interpersonal difficulties:

> The patient is a 35 year old female with a 15 year history of bulimia nervosa. She is married with three children. She is 5'3" and her weight is 135 lbs. Apart from pregnancies, there has been relatively little fluctuation in weight during the course of the disorder. She is approximately 15 lbs. heavier than she was when she was

> married at age 21. Symptoms include self-induced vomiting two to three times daily; sometimes she purges after a normal meal, sometimes after a snack that she considers too large. She always purges after bingeing. She frequently skips meals in an effort to keep her caloric intake as low as possible. She has numerous "food rules" including strictures against eating sweets of any kind; if she "gives in" and eats any sweets "it turns into a binge." She reports being obsessed with how many calories she is ingesting, and with worries about gaining more weight. She weighs herself several times daily. She finds herself constantly comparing herself unfavorably to other women whom she considers more attractive and with better figures. She used to attend an exercise class but stopped because she found it too upsetting to be in a leotard "in a room with mirrors all around." She does not use laxatives. She has never exercised excessively. She reported having been concerned about her weight for as long as she could remember, though she had never been overweight. She was unable to link the onset of the disorder with any particular stress or conflict, noting only that her eating style had become more restrained as she went through her adolescence. She is the oldest of three children. She has two younger brothers, who she notes are "tall and thin." She reports being close to her mother, who she notes is "naturally skinny." Her father died 10 years ago. There is no history of eating disorders, obesity, alcoholism or mental illness in any immediate family member. She reports that her marriage is stable, and that she is enjoying motherhood. Upon presentation, she is well-groomed, friendly and open.

Following is a case vignette of a patient with obsessive-compulsive disorder and concomitant interpersonal difficulties:

> The patient is a 32 year old male, never married, living alone, working as an engineer. His presenting complaint is a persistent fear of germs and dirt with handwashing to avoid contamination. In general, whenever he comes in contact with anything that touches the floor, or with objects that might have been touched or handled by someone else whose hands might have touched the floor he experiences a compulsion to wash. He washes his hands for at least five minutes each time he comes in contact with something objectionable. Examples of his difficulties include washing after putting on or taking off his shoes, washing any item that touches the floor accidentally such as clothing or bedding, and an inability to touch a doorknob or handle money without washing. He fears contracting a fatal disease if he does not wash but he is unable to be specific about what sort of disease. He realizes these fears are irrational but feels powerless to control his anxiety when confronted with events that stimulate his fear of contamination. He fears that his ability to work is becoming compromised. He is socially isolated. He reported fears of having anyone come to his house out of concern that he might expose himself to contamination. He dated somewhat in college, and had several sexual encounters, but in recent years has dated only rarely and reported no relationships that endured beyond a few dates. The patient is the youngest of two children. He reported that both his parents were aloof. His father practiced corporal punishment. Often, his mother would send him to his room when she felt he had done something wrong, and his father would spank him with a belt when he came home. He believed his father would have been more understanding but "didn't want to rock the boat." One of his more bitter memories was of having his mother find a Playboy magazine under his bed when he was 13, and his father coming home and spanking him severely. On presentation, the patient was dressed neatly and appropriately. His manner was guarded, he made only intermittent eye contact, and once during the interview he said in a hostile way: "You know, I don't think you're getting how bad things really are for me."

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In order to verify that the presence or absence of interpersonal problems was explicit in each vignette, four Ph.D students in clinical psychology at Pennsylvania State University were asked to discriminate between those vignettes describing interpersonal difficulties and those that did not. There was 100% agreement among the raters that there were interpersonal problems in the two vignettes we intended and an absence of such material in the other two.

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Coding of Responses and Data Analysis

To test our hypotheses, a coding system containing the following four sections was constructed: (1) goals involving symptomatic change (e.g., elimination of obsessions; reducing binge/purge episodes); (2) goals involving nonsymptomatic or intrapsychic change (e.g., exploration of unresolved grief; increasing self-awareness); (3) directive strategies (e.g., self-monitoring of eating and purging episodes, exposure and response prevention); and (4) exploratory strategies (e.g., analysis of resistance, exploring inner conflicts).

Upon examining the returned questionnaires (before assigning them to coders), we found that the coding system did not adequately describe the range of responses. In an effort to be more comprehensive and to capture the data as accurately as possible, two additional categories were added. The first referred to goals involving interpersonal change not specifically associated with Axis I symptomatology or intrapsychic change (e.g., increase social support, improvement of social functioning). The second involved strategies not exclusively associated with cognitive-behavioral or psychodynamic psychotherapy, but which function to enhance the therapeutic relationship (e.g., expressing empathy).

One consequence of adding additional response categories was that more statistical tests were run than first anticipated. In addition to the analyses required to test our four original hypotheses, cognitive-behavioral and psychodynamic therapists' differences were tested regarding emphasis upon interpersonal change and relationship-enhancing strategies across the two types of vignettes (i.e., interpersonal and noninterpersonal). Thus, a high number of tests relative to the number of subjects were conducted (i.e., 12 chi-square analyses with 30 respondents). Nevertheless, as this study was exploratory, following Cohen's suggestion (1994) the alpha level was maintained at .05, increasing the probability of a Type I rather than a Type II error.

The therapists' responses were coded by two advanced graduate students in clinical psychology at Pennsylvania State University, who underwent 20 hours of training with the second author. Each goal and strategy category was coded as present or absent for each of the four vignettes.

Table I. Kappa Statistics for Each Response Category

Coding Item	Description	Kappa
Goal 1	Symptomatic Change	1.00
Goal 2	Intrapsychic Change	0.92
Goal 3	Interpersonal Change	0.95
Strategy 1	Directive/ Behavioral	0.97
Strategy 2	Exploratory/ Psychodynamic	0.95
Strategy 3	Developing Therapeutic Relationship	0.92

Thus, if a respondent listed four directive strategies and one exploratory strategy, both strategies were coded as present. We approached the data this way because there was considerable variability in the specificity and detail of responses (e.g., "dynamic psychotherapy" vs. "analysis of the transference, analysis of resistance, exploring the meaning of the symptom, linking interpretations to relationship history") and without knowing more about the meaning of these differences in this exploratory study, we decided this was the most prudent course.

Kappa statistics revealed a high rate of interrater agreement across all response categories (see Table I). All instances of disagreement were discussed by the coders and the consensus scores obtained were used in the data analyses.

RESULTS

Therapist Characteristics

There were no significant differences between the two groups of therapists regarding discipline or gender. As can be seen in Table II, however, psychodynamic therapists were significantly more experienced than the cognitive-behavioral therapists.

Treatment Goals

As Table III indicates, our first hypothesis, that cognitive-behavioral therapists would focus more on symptomatic change than psychodynamic

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Table II. Respondent Characteristics[a]

Group	Discipline (Frequency)			Chi-Square
	Ph.D.	M.D.	MSW	
CBT	14	0	1	
PI	10	4	1	
Total	24	4	2	4.67

Group	Gender (Frequency)		Chi-Square
	Female	Male	
CBT	7	8	
PI	10	5	
Total	17	13	1.22

Group	Years of Experience		*T*
	M	*SD*	
CBT	7.3	4.88	
PI	14.7	10.61	
Total	11.00	8.95	-2.45[b]

[a]CBT: cognitive-behavioral therapy; PI: psychodynamic therapy.
[b]$p < .05$.

therapists regardless of whether the clinical vignette contained evidence of interpersonal difficulties, was not confirmed. In fact, therapists of both persuasions expressed equal interest in helping patients to reduce their Axis I symptoms for the two types of vignettes.

Our second hypothesis, that psychodynamic therapists would endorse more nonsymptomatic goals (i.e., goals involving intrapsychic change) regardless of the type of vignette, was confirmed. As Table III shows, in both the vignettes containing evidence of interpersonal problems and those without any such evidence, the responses of psychodynamic therapists were significantly more likely to involve intrapsychic change.

We also tested whether our two groups of therapists differed with respect to the endorsement of interpersonally oriented goals among the two types of vignettes. As Table III also indicates, we found no between group differences for those vignettes with manifest interpersonal problems. That is, cognitive-behavioral and psychodynamic therapists were equally likely to list goals involving interpersonal change where evidence of such problems existed. However, for the vignettes that did not contain manifest evidence of interpersonal problems, psychodynamic therapists focused significantly more frequently on interpersonal change than did the cognitive-behavioral therapists.

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Table III. Goals of Treatment[a]

	Interpersonal Vignettes		
Goals	CBT	PI	Chi-Squares
Symptom reduction	30	25	0.45
Intrapsychic change	2	14	9.00[c]
Interpersonal change	23	21	0.09
	Noninterpersonal Vignettes		
Goals	CBT	PI	Chi-Squares
Symptom reduction	30	26	0.29
Intrapsychic change	3	13	6.25[b]
Interpersonal change	1	7	4.50[b]

[a]CBT: cognitive-behavioral therapy; PI: psychodynamic therapy.
[b]$p < .05$.
[c]$p < .01$.

Treatment Strategies

As Table IV indicates, our hypothesis that CBT therapists would employ more behavioral strategies than psychodynamic therapists was not supported by the data for both the interpersonal and noninterpersonal vignettes. While there were differences in the predicted direction, they did not reach significance. However, the hypothesis that psychodynamic therapists would endorse a greater number of exploratory strategies for both types of vignettes was confirmed.

Finally, as also indicated in Table IV, there were no significant differences between the two groups of therapists regarding the use of techniques to establish or maintain a therapeutic relationship for either type of vignette.

DISCUSSION

The hypotheses tested in this study involved assumptions that when compared with psychodynamic therapists, CBT therapists attend mainly to symptoms of specific Axis I disorders and prefer the use of directive techniques of intervention, and that the attention of psychodynamic therapists, by contrast, is focused more on intrapsychic difficulties and on the use of exploratory techniques. These hypotheses were not supported in some important instances and confirmed in others. Specifically, the data suggests that psychodynamic and CBT therapists are equally interested in the resolution of Axis I difficulties, but that in contrast to their CBT counterparts,

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Table IV. Treatment Strategies[a]

Strategies	Interpersonal Vignettes CBT	Interpersonal Vignettes PI	Chi-Squares
Behavioral techniques	30	21	1.56
Exploratory techniques	4	24	14.28[b]
Relationship techniques	2	6	2.00

Strategies	Noninterpersonal Vignettes CBT	Noninterpersonal Vignettes PI	Chi-Squares
Behavioral techniques	30	17	3.60
Exploratory techniques	1	22	18.38[b]
Relationship techniques	3	3	0

[a]CBT: cognitive-behavioral therapy; PI: psychodynamic therapy.
[b]$p < .01$.

psychodynamic therapists emphasized promoting intrapsychic change whether or not evidence of interpersonal problems were present in the case material. Both groups also reported equal willingness to use behavioral strategies. Exploratory techniques, however, were more frequently prescribed by psychodynamic therapists. Although not part of our hypotheses, CBT and psychodynamic therapists were found to be equally attuned to interpersonal difficulties when such material was evident in the case material. When interpersonal difficulties were not described in the vignettes, however, psychodynamic therapists were more inclined than CBT therapists to assume that such problems were present and worthy of therapeutic intervention. The two groups did not differ in their intention to use strategies aimed at facilitating the therapeutic relationship.

Among the study's most surprising findings was the lack of difference between cognitive-behavioral and psychodynamic therapists regarding stated commitment to symptom reduction. The initial hypothesis, that CBT therapists focus on the resolution of Axis I symptoms and psychodynamic therapists on more general, "person-oriented" goals appears to have been overly simplistic. Rather, the data suggests that the goals of psychodynamic therapists are more inclusive than those of CBT therapists. The cohort of psychodynamic therapists were interested in both resolving the presenting symptoms and addressing more general issues such as an "increased understanding of family of origin issues" and to "help patient work through issues of loss and neglect." While some might suggest that psychodynamic formulations posit that attending to such issues is necessary to resolve presenting symptoms, we would argue that while this may be true, goals involving intrapsychic change are also directed beyond symptom reduction and reflect commitment to a broader therapeutic agenda. This is consistent

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with the views of McGlashan and Miller (1982), who divided the goals of psychoanalysis and psychoanalytic psychotherapy into nine clusters, most of which involved "general mental health and emotional maturity" (p. 378). They noted further that most psychoanalytic writers subscribe to the view that more than symptom attenuation should take place in the treatment.

Evidence that behavioral strategies were endorsed about equally by each group was puzzling. While one might argue that psychoanalysts alone are wedded to a neutral stance proscribing behavioral intervention (e.g., Schafer, 1983), those with a more broadly defined psychodynamic orientation—such as the therapists in this study—are likely to have been strongly influenced by analytic technique. For instance, in a text on psychodynamic psychotherapy, Kolb (1986) was extremely cautious about "suggestion," which he defined as "the use of interpersonal influence (an authoritative therapist, a dependent patient) to substitute for or overcome critical, rational thought" (p. 58). He concluded that suggestion "cannot do much to further the ends of psychodynamic psychotherapy, and can do much to confuse it" (p. 76).

Although our methodology did not yield information about the match between specific therapeutic goals and strategies, it seems likely that psychodynamic therapists endorsed behavioral strategies for the specific purpose of ameliorating the Axis I symptoms presented in the vignettes. Looking at the data as a whole, among the only differences between the two groups of therapists were that the psychodynamic group more frequently endorsed goals involving intrapsychic change and the use of exploratory strategies than CBT therapists. It seems unlikely that psychodynamic therapists endorsed the use of behavioral strategies to promote intrapsychic, or nonsymptomatic change. A more plausible explanation is that the exploratory strategies were geared toward promoting insight and other nonsymptomatic goals; this would account for the relative absence of such strategies among the CBT therapists, who rarely endorsed goals involving intrapsychic change. Thus, the surprising endorsement of behavioral strategies among psychodynamic therapists may imply that they do not always view exploratory strategies as sufficient to resolve Axis I symptoms, or at least that they view behavioral strategies as effective and helpful in doing so. The data also suggest that those who identify themselves as psychodynamic in orientation are more integrative in their approach, that is, more willing to incorporate strategies from other models than are the CBT therapists.

The findings, however, do not suggest that the goals of CBT therapists are always restricted to symptomatic change. In those vignettes with clear evidence of interpersonal problems, CBT therapists endorsed goals addressing interpersonal change no less frequently than did their psychodynamic

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counterparts. Thus the criticism that CBT often fails to attend to critical interpersonal issues (Goldfried & Castonguay, 1993) may be overstated. On the other hand, our data suggests that psychodynamic therapists focus more on interpersonal issues than CBT therapists when such issues are not clearly stated in the case material. In those vignettes lacking manifest evidence of interpersonal problems, we found that psychodynamic therapists more frequently endorsed goals involving interpersonal change than CBT therapists. This finding should be interpreted cautiously since interpersonal goals were identified by psychodynamic therapists only 7 times (out of a possibility of 30) in noninterpersonal vignettes; in the same type of vignette, interpersonal changes were mentioned only once by CBT therapists.

The finding that the two groups did not differ in their endorsement of strategies designed to enhance the therapeutic relationship is consistent with the notion that the therapeutic alliance is among the factors common to many approaches to psychotherapy (Frank, 1973; Goldfried, 1980). There is now a considerable body of data indicating that the strength of the alliance is an important predictor of outcome in psychotherapy (Alexander & Luborsky, 1986; Gaston, 1990; Klee, Abeles, & Muller, 1990).

Taken together, these findings are mixed with regard to the frequently held assumption that therapists of different theoretical persuasions use different strategies in the service of the same goals. There is clearly more overlap than we anticipated in the aims of the two groups of respondents. But the psychodynamic therapists demonstrated a more ambitious therapeutic agenda, and endorsed a broader array of techniques. Where therapeutic goals overlapped between the two groups there appeared to be overlap even at the level of technique, but where the aims of psychodynamic therapists diverged from those of the CBT therapists, the strategies and techniques also diverged.

Several methodologic limitations in this study warrant mention. First, because we employed a nonrandomized and relatively small sample, our study should be considered exploratory. Second, there was a significant difference in years of clinical experience between the groups, with the psychodynamic therapists averaging nearly twice as many years in practice as the CBT therapists; this was accompanied by an apparently more eclectic bent. It is possible that as one practices for a longer period of time, though one continues to think of oneself as holding allegiance to one primary theoretical orientation, the demands of clinical practice push therapists toward greater eclecticism, including incorporating treatment strategies taken from other models. We might find that equally experienced CBT therapists would show more willingness to incorporate psychodynamic strategies than our less experienced cohort. A larger, randomized sample would hopefully

eliminate the differences in years of experience and provide more externally valid findings.

Finally, one must be cautious in making the leap from a therapist's response to a case vignette to actual behavior in therapy. While our hypothesis that psychodynamic therapists are less inclined than CBT therapists to pursue directive strategies was not supported by the data, we noticed that when dynamic therapists endorsed such strategies, their responses were less specific than those of the CBT therapists. For instance, the dynamic therapists more frequently described strategies such as "CBT techniques," or "behavioral therapy" as opposed to "exposure and response prevention," "challenge attitudes toward weight and shape" or "facilitate normalization of the patient's meal pattern," as the CBT therapists did. If the lack of specificity indicates that psychodynamic therapists are less knowledgeable about such strategies they may in fact either not be using them, or using them less effectively. On the other hand, their endorsement of these strategies suggests a belief in their efficacy.

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