COMMENTARY

Commenting on Process: Highlighting a Basic Psychotherapeutic Technique

Robert E. McGrath and Gillian J. Donovan
Fairleigh Dickinson University

This article explores the concept of commenting on process as a therapeutic technique. Commenting on process occurs when the therapist focuses attention on some aspect of the patient's in-session behavior. Many schools of therapy encourage discussion of the patient's behavior outside the therapy relationship, though they differ in the degree to which they emphasize such discussions. Discussion of behavior within therapy is particularly characteristic of dynamic theory, in which it has been conceptualized as one form of confrontation, and in interpersonal therapy, in which it is perceived as a core therapeutic technique. We propose that by distinguishing it from other forms of confrontation, and by highlighting the technique's focus on observable behavior, an argument can be made that commenting on process represents a potentially useful tool in any form of therapy. It also merits empirical evaluation concerning the extent to which such comments occur in practice and whether such comments can contribute to therapy outcomes. Common characteristics of comments on process are described. Finally, some guidelines are suggested for training students on how to improve their effectiveness at commenting on patient process.

Keywords: psychotherapy process, integrative psychotherapy, confrontation

When asked to describe their theoretical orientation, *integrative* or *eclectic* is consistently found to be the modal response among psychologists who provide psychotherapy (Norcross, Karpiak, & Santoro, 2005), with the former term preferred over the latter (Norcross, Karpiak, & Lister, 2005). These terms imply a willingness to use multiple theoretical perspectives and/or techniques derived from multiple theoretical perspectives in the service of optimal case formulation and patient care. Because the research on therapist orientation relies largely on self-report, the extent to which integration actually occurs in practice is uncertain. Even so, this self-reported preference has spurred interest in the identification of specific treatment components derived from different theoretical perspectives that are likely to advance the goals of treatment (Castonguay & Goldfried, 1994; Goldfried, 2010; Kazdin, 2009).

The search for empirically justified treatment components has been particularly vibrant in the context of the behavior therapies. Examples include the use of behavioral activation techniques to alleviate depression (Dimidjian, Barrera, Martell, Munoz, & Lewinsohn, 2011; Jacobson, Martell, & Dimidjian, 2001; Jacobson et al., 1996), exposure and response prevention for various anxiety problems (Abramowitz, 1997; Franklin, Abramowtiz, Kozak, Levitt, & Foa, 2000), remediation for cognitive deficits associated with schizophrenia (Medalia, Revheim, & Casey, 2002; Wykes et al., 2007), and mindfulness and acceptance to minimize the effects of potentially debilitating thoughts and feelings (Baer, Fischer, & Huss, 2005; Hayes, Luoma, Bond, Masuda, & Lillis, 2006).

Though efforts to validate psychodynamic therapies as a whole have been supportive (e.g., Leichsenring, Masuhr, Jaeger, Dally, & Streeck, 2010; Shedler, 2010), the task of isolating and evaluating potentially efficacious components

---

Robert E. McGrath and Gillian J. Donovan, School of Psychology, Fairleigh Dickinson University.

Correspondence concerning this article should be addressed to Robert E. McGrath, School of Psychology T-WH1-01, Fairleigh Dickinson University, Teaneck, NJ 07666. E-mail: mcgrath@fdu.edu

of dynamic treatment for use in an integrated framework is more problematic. There are at least three distinct features of dynamic therapy to consider as part of this analysis. One is the content of the discussion between therapist and patient. Blagys and Hilsenroth (2000) identified seven topics that are discussed more frequently in dynamic therapy than in other forms of therapy: affect and expression of emotion, attempts to avoid distressing thoughts and feelings, recurring themes and patterns, past experiences, interpersonal relations, the therapy relationship, and fantasy life. There is some research relevant to whether focusing on these issues in isolation from a general psychodynamic perspective can contribute to positive functioning, and what elements of discussions of these issues contribute most to change (e.g., Jakobsen, Hansen, Simonsen, & Gludd, 2011; Kring & Sloan, 2010). However, it is unclear to what extent addressing these issues in isolation from the context of dynamic therapy results in a change in the meaning of the intervention (Safran & Messer, 1997).

Alternatively, dynamic therapy can be described in terms of its therapeutic techniques. Traditional lists of techniques common to dynamic therapy include the use of silence, suggestions, questions and clarifications, encouragement of catharsis, confrontations, interpretations, reconstructions, and supportive interventions (e.g., Bibring, 1954; Langs, 1989). Again, these are used to varying degrees by therapists outside the dynamic perspective, particularly those such as the use of silence or encouragement of catharsis that are not common in everyday social interactions. Finally, dynamic therapy has been distinctive for its emphasis on understanding the therapeutic relationship as the foundation for effecting positive change, and the importance of factors such as empathy and the emotional bond between therapist and patient as contributors to the therapeutic relationship (e.g., Gelso & Carter, 1994). Of the three themes discussed so far, this has been the most widely accepted as a predictor of success in treatment (Norcross, 2011).

Commenting on Process

The purpose of this article is to draw attention to a specific technique that we will call *commenting on process*, defined as any incident in which the therapist chooses to note some aspect of the patient's in-session interpersonal behavior. Many schools of therapy acknowledge the potential therapeutic value of discussing the patient's behavior in their daily lives, particularly schools with a strong behavioral or interpersonal component. In contrast, the recognition of commenting on patient process in the therapy is largely peculiar to dynamic and interpersonal approaches. Because commenting on process originated in the context of dynamic therapy, the dynamic perspective on the concept will receive particular attention to provide a context for understanding its application in other treatment approaches.

This article is similar in focus to Frank's (2002) discussion of working with *enactments*, though our definition of process differs from his concept of enactment in several ways. Frank includes behavior both in and out of the therapy, whereas we are limiting ourselves to behavior in the therapy. In addition, Frank is interested in behaviors reflective of "psychodynamics," whereas our goal is to discuss a technique for addressing any aspect of an individual's behavior and interpersonal style.

Beyond the dynamic perspective, commenting on within-session process has been most closely associated with interpersonal psychotherapy. In particular, Kiesler (1988) discussed the role of the patient's evoking messages (communications through their behavior) and the therapist's impact messages (emotional, cognitive, behavioral, and fantasy reactions to the evoking message) in the therapy. He argued that impact messages initially tend to be complementary to the evoking message, meeting the desire expressed in the patient's message, and this response actually contributes to the therapeutic relationship. Over time, though, the therapist must start responding to unhealthy evoking messages with therapeutic metacommunications—communications about the evoking message.

Our goal is to address this topic in a manner that will be particularly accessible to therapists who do not espouse a specifically dynamic or interpersonal approach to therapy, and who do not accept the investigation of core psychodynamic issues or interpersonal style as the essential goal of psychotherapy. Focal issues for this presentation include a conceptual framework for the technique, the potential viability of com-

ments on process as a contributor to positive therapy outcomes in any form of psychotherapy, and a discussion of training issues.

Comments on process in therapy can be characterized on at least six dimensions:

1. The therapist may choose to comment on the behavior as soon as the patient emits it in the therapy room, or the therapist may defer discussion until a later time. An informed choice requires the therapist to generate a hypothesis about the patient's readiness to consider the meaning or purpose of the behavior, and the therapist's judgment of his or her own readiness to manage the discussion effectively, come what may. The latter issue will be discussed further as part of training.

2. The process may be one the therapist hypothesizes is stylistic to the patient, or functionally related to other behaviors perceived as stylistic, so that the comment is intended to identify a general factor potentially influencing the patient's interpersonal relationships. The therapist may instead identify it as a unique reaction to the therapist or the present situation, potentially suggesting some deviation from the patient's normal behavioral patterns that merits exploration.

3. If it is perceived as a stylistic element, that process may not have been previously labeled in the course of the treatment, in which case the technique is primarily intended to advance the patient's self-understanding; or it may represent a new example of some previously highlighted patient tendency, in which case the comment is intended to solidify or enhance prior learning.

4. If it is a deviation from the patient's normal behavioral patterns, this is likely to occur because of some unstated emotional reaction to what is going on at the moment. There are a number of possible causes, with anxiety, anger, and boredom among the most common.

5. The therapist may choose among several options for expanding upon the comment. Options include describing the therapist's reaction to the behavior (e.g., Kasper, Hill, & Kivlighan, 2008), leaving it to the patient to reflect on the therapist's com-

ment, providing an interpretation, and/or asking the patient to self-reflect on his or her thoughts or feelings prior to the behavior. The therapist must also decide whether to focus on the implications of the behavior for the therapeutic relationship, the relationships in the patient's daily life, or both. An informed choice on these issues would require a sense of which response is most likely to advance the discussion.

6. The therapist's style of presentation is also a potentially important moderator of the value of the comment. For example, Kiesler (1988) noted the potential for such communications to be perceived negatively and highlighted the importance of a supportive presentation that invites exploration.

Are Process Comments Psychotherapeutic?

Process Comments as a Dynamic Technique

In dynamic therapy, comments on process can advance discussion of at least five of the seven aforementioned topics listed by Blagys and Hilsenroth (2000):

1. The comment may provoke a discussion that helps the patient identify previously unidentified emotional states. The self-labeling of an emotional state can then contribute to the enhancement of emotional expression.

2. In some instances, the process may prove to serve as a means of avoiding distressing thoughts and feelings.

3. When identified as a stylistic element of the person's interpersonal style, the comment can provide the basis for identifying recurring themes or patterns.

4. Comments on behavior toward the therapist can provide insight into more general difficulties or strengths in interpersonal relationships.

5. If handled effectively, the comment can deepen the relationship between the therapist and patient, and thereby contribute to the therapeutic alliance.

Comments on process can also lead to discussions of the remaining two issues—past experiences and exploration of fantasy life—though the relationship is less direct than it is for the first five topics.

Comments on process can also contribute to the therapeutic relationship. Because comments on process are not generally a part of normal social interaction, commenting on patient behavior in the session can signal that the therapist is particularly attuned to the patient's communications, whether verbal or nonverbal; is willing to violate social conventions to achieve a more thorough understanding of the patient; and/or intends to correct the problem when the patient and therapist are not completely attuned. This last point is particularly important. Review of therapy transcripts with student therapists sometimes reveals an interesting pattern in which the patient raises a topic; the student therapist, for whatever reason, fails to respond to the topic and changes the topic; but the patient raises the topic again a few minutes later. This dance sometimes repeats three or four times before the student comes into attunement with the patient. Similarly, it is not uncommon for patients to verbally accept a therapist's explanation of some phenomenon, but by their tone of voice, narrowing of their eyes, and purse of their lips indicate their continuing reservations. The astute therapist who is sensitive to these signs of empathic lapse can use them to spur further dialogue.

Increasingly, dynamic theorists have moved beyond discussing the therapeutic alliance as a basis for patient change, to analyzing the therapy itself as a dyadic structure between patient and therapist (e.g., Frank, 1999), an approach that has allowed the convergence of dynamic and interpersonal themes (Wachtel, 2007). If, in the context of a comment on process, the therapist reveals his or her personal reaction to the patient's behavior, or if the therapist acknowledges his or her interpersonal style is impacting on the patient in a negative way, the therapist is acknowledging the dyadic quality of the therapy relationship, and creates a context in which the therapist and patient can collaboratively examine the dyad and see how it can be strengthened.

Process Comments as an Integrative Technique

At least two factors may undermine the technique's popularity outside the context of dynamic therapy. First, it was already noted that dynamic techniques vary in the degree to which they are used in normal interactions. As will be discussed later, effective commenting on process in particular requires interpersonal skills that are not commonly required in ordinary settings. If the therapist is not trained in a model that explicitly values such comments, those skills may not be sufficiently developed.

Second, descriptions of dynamic therapy often treat commenting on process as an aspect of the more general technique of confrontation. A confrontation occurs whenever the patient's attention is drawn to something the patient has previously overlooked. This can include a behavior in or out of therapy, a thought or feeling, inconsistencies of any kind, and/or illogical reasoning (Langs, 1989; Shechtman & Yanov, 2001). Confrontation is not commonly advocated as a therapeutic technique outside the context of dynamic therapy, with several factors potentially contributing to its neglect. The word implies the presence of conflict between patient and therapist, though this implication is not inherent to its use in reference to a therapeutic technique. As noted earlier, confrontations such as comments on process can be presented in a supportive manner. Second, it potentially implies a focus on the patient's failings rather than potential for growth. Most relevant to the current discussion, confrontation is a very broad concept. It encompasses a variety of verbal interventions by the therapist, making it difficult to develop a training model that would specifically improve therapists' use of confrontations. Finally, it is the focus on patient behavior that is most likely to make commenting on process palatable to advocates of other forms of therapy. That focus is lost when commenting on process is not distinguished from other forms of confrontation, such as speculations about the patient's emotional state.

Despite their limited discussion outside the dynamic framework, we propose that comments on process could prove to be useful in any form of treatment. This is particularly true for any therapy that focuses on improving the patient's style of interacting with others, on enhancement

of social skills in particular, or on behavior change. It can thus be considered a technique relevant to dynamic, behavioral, cognitive–behavioral, systems-based, interpersonal, or integrative models of treatment. Even individuals trained primarily in psychotherapy models that emphasize empirically supported principles of treatment can potentially see the technique's value if it is presented in the context of research having to do with the influence of relatively subtle interpersonal behaviors on relationships, such as the study of personal and relationship factors in therapy (Castonguay & Beutler, 2006), microaggression (Sue et al., 2007) and marital interactions during conflict (Gottman & Levenson, 2000), and various investigations into interpersonal aspects of psychopathology (e.g., Constantino et al., 2012; Salzer, Pincus, Winkelbach, Leichsenring, & Leibing, 2011). In addition, the effect of specific therapy process variables on therapy outcome has become a research topic of some importance in recent years (e.g., Barber & DeRubeis, 2001; Crits-Christoph, Connolly Gibbons, & Hearon, 2006).

The following sample is provided to demonstrate how commenting on process might occur in a cognitive–behavioral treatment. In this case, the therapist ("T") and patient ("P") are working on alleviating the patient's social anxiety.

> T: You've told me that meeting a new stranger is very uncomfortable for you. What are the thoughts going through your head when you're having a conversation with someone you don't know very well?
>
> P: Well, I keep thinking, "You sound stupid, you're probably boring her. It looks like she's losing interest" . . . things like that. And then I lose track of what I'm saying because I'm distracted by my thoughts.
>
> T: OK, so that's one area we could work on, losing focus on what you're saying. What else is going on in these moments?
>
> P: Um, I start to sweat and that's embarrassing.
>
> T: OK, so that might be something else distracting you. Can I suggest something else? I've noticed that whenever we talk, you sometimes don't make eye contact with me for a long time. And I'm not sure if you're bored talking to me or are thinking of something else. Do you think that might be happening in your conversations with other people as well?
>
> P: I don't really know, no one's ever told me that before. I'm certainly not bored.

> T: You might be completely unaware of it, and that's another thing we can work on.

The therapist points out a behavior the patient is exhibiting in session, and raises it in order to bring it to the patient's attention and possibly link it to public behavior. As the therapy is focused on social skill development, the therapist uses the session as a data sample of the patient's social skills, while acknowledging that it might be unique to the therapy session. Raising it as an issue also allows adding it to other targets of treatment if the patient subsequently identifies it as a general issue in interpersonal situations.

Among dynamic techniques, confrontation—including comments on process—is particularly consistent with an active role for the therapist in therapy. The potential impacts of commenting on process in particular that are reasonably of interest to therapists of any school would include the following:

1. Enhanced self-reflection: Through commenting on process, the therapist communicates to the patient the expectation of greater self-observation of, and self-reflection on, behavior. As previously mentioned, a particularly important topic for such self-reflection to emerge from comments on process would be interpersonal issues, their triggers, and the identification and labeling of internal states, feelings, or beliefs that are influencing behavior in and/or outside the therapy without the patient's full awareness. An important clinical judgment that the therapist needs to make is whether and/or under what circumstances a process comment may enhance the patient's awareness—whether of interpersonal behavior or internal states—in a therapeutic way.

2. Improved functioning: Comments on process have the potential to enhance several components of personal functioning that have been found to be generally related to better outcomes in therapy, including emotional expressiveness (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Greenberg, 2008) and improved interpersonal functioning (Cuijpers, van Straten, Andersson, & van Oppen, 2008). For example, self-reflection on process can help

the patient identify previously unlabeled emotional reactions to certain types of interpersonal situations, with the goal of improving the patient's response to similar situations in the future. It is important to note that the unique contribution of commenting on process to these outcomes is untested and represents a worthwhile topic for future research.

3. Addressing resistance and anxiety: Any intervention by the therapist that encourages change can generate anxiety, hostility, and even active resistance. Sensitivity to negative reactions to calls for change and commenting on these observed reactions are important tools for maximizing the likelihood of successful intervention.

4. Addressing disengagement: The patient who changes the topic suddenly or responds in an unexpected way to input from the therapist can be expressing disengagement from the therapy. This disengagement is not necessarily resistance. It can instead reflect a failure of the therapist to present material in a way that the patient finds compelling or even intelligible, a failure to recognize which issues are most pressing to the patient at the moment, or some other lapse of judgment by the therapist (which could call for some evaluation of the therapist's own process).

5. Enhanced communication: Pointing out unstated negative reactions can also provide the groundwork for educating the patient about the value in therapy of verbalizing feelings toward the therapy, whether positive or negative. By encouraging the patient to identify the feelings underlying some behavioral response, and by responding to those feelings in a nondefensive way, permission is provided for the patient to be more open in the future. For example, a cognitive–behavioral therapist can be sensitive to whether a patient becomes argumentative or evasive whenever the therapist suggests using a chart to track a target behavior. Commenting on the pattern potentially provides the basis for exploring reasons the patient is resistant to charting, which may, for example, result in the therapist providing a more detailed justification for charting, modifying the charting procedure with the pa-

tient's wishes in mind, or implementing other changes that may be needed in the charting procedure to enhance the likelihood of compliance. This intervention can potentially improve the likelihood the patient will continue treatment, by improving the patient's sense of collaboration in the treatment plan, reducing patient concerns such as that charting is infantilizing, and/or revealing the therapist's openness to discussing negative reactions to assignments. Encouraging the patient to generalize this learning outside the therapy can also potentially contribute to the general quality of interpersonal relationships, particularly relationships that have traditionally had conflictual elements.

In a therapy that emphasizes interpersonal issues, a pattern of opposition when the therapist suggests charting a target behavior could also lead to examination and discussion of how the patient generally deals with authority, perceived demands from others, or various other aspects of their interpersonal difficulties.

It is important to note there may be differences across practitioners of different schools in how they handle the patient's response to the process comment. For example, either a dynamic or cognitive–behavioral therapist in the course of the session might explore the logic of some belief held by the patient, such as that attempts at self-advancement will inevitably end in failure. Whether this collaborative exploration is being pursued by a dynamic or cognitive–behavioral therapist, sensitivity to process in the course of this exploration could lead either to note that the discussion is associated with increased fidgeting, reduced eye contact, shifting around in the seat, and slightly longer pauses in the patient. Commenting on this process might result in the patient admitting she feels judged or that she feels her beliefs have been belittled. How the therapist responds could prove to be a choice point that distinguishes styles of therapy. The dynamic therapist would be more likely to explore whether feeling belittled is a theme for the patient and historical instances of feeling belittled. The cognitive–behavioral therapist may instead focus on educating the patient in a nonauthoritarian manner on the value of challenging one's

beliefs. Whether one approach is superior to another is debatable, and the answer may well depend on the patient, on which approach feels more comfortable to the therapist, and which approach is more pertinent to the goals of treatment.

Process Sensitivity as an Individual Differences Variable

The patient's trait capacity to comment on, or self-observe, his own interpersonal process merits consideration as a potential predictor of successful outcomes in treatment. In particular, the stylistic capacity to comment on one's own process is potentially predictive of the capacity to reflect objectively on the motivations behind one's behavioral choices and to learn from that reflection.

It is a hypothesis worth pursuing whether patients who demonstrate a greater capacity for recognizing their own interpersonal process will improve more in treatment, and whether this capacity makes a unique contribution over other skills like to be correlated with it, such as general mindfulness or intelligence. The ability to self-observe one's behavior is a key element of self-awareness expected to result in long-term change. The capacity to self-observe is particularly useful when it occurs simultaneously with the behavior rather than afterward, though even self-reflection after the fact allows for the possibility of correcting interpersonal errors (which is why therapist comments on process in the outside world is also a therapeutic tool). This capacity to self-observe is a skill that presumably can also be developed in therapy, though literature on this point in particular is absent.

It has been suggested that commenting on process as a technique can be conceptualized as a type of confrontation in the context of dynamic therapy. The capacity to comment on process as a person variable can similarly be seen as an essential aspect of various abilities that have been discussed in the psychotherapy literature. One is the psychodynamic concept of the observing or self-observing ego (Sterba, 1934), which can, in turn, be conceptualized as that component of the broader concept of mindfulness having to do with reflective observation of self and relationships (Horowitz, 2002). Another is mentalization, the capacity to understand the meaning of one's own and others'

behavior (Allen, Fonagy, & Bateman, 2008). Various authors have discussed the enhancement of abilities such as self-observation and mentalization as contributors to positive outcomes in psychotherapy (e.g., Allen et al.; Beitman & Soth, 2006). These concepts are broader in focus than commenting on process, in that they also encompass self-awareness about the emotional and motivational roots of the behavior. The extent to which one attends to one's own behavior can be seen as a necessary precursor to the self-exploration that contributes to improved self-awareness or mentalization skills.

Therapist Process Sensitivity

The potential contribution of the capacity to self-observe one's behavior to therapeutic outcomes should be considered as it applies to the therapist as well as the patient. It can be hypothesized that therapists more effective at commenting on their own process in the therapy, even if they choose not to reveal those self-observations to the patient, can be better therapists. This relationship can occur for several reasons. If commenting on patient process potentially contributes to improved emotional expression, interpersonal effectiveness, and ability to deal with conflict, then the therapist who is better at observing his or her own process should demonstrate similar characteristics. Therapists who are comfortable observing and exploring their own process are also likely to be more comfortable observing and exploring patient process.

Such self-evaluation on the part of the therapist is a major issue in psychodynamic therapy, but therapists of all orientations—and particularly those who are integrative in orientation—can recognize the effects that their behaviors, and their behavioral reactions to patient behaviors, can have on the patient. Sensitivity to personal process should enhance the therapist's capacity to avoid interpersonal errors with the patient, even if the patient's behavior tends to encourage those errors, and to self-correct when errors are made. Therapists who attempt to make objective evaluations of their behavior in a dyad can appreciate the difficulty of the very thing they frequently ask their patients to do.

Sensitivity to personal process is distinct from managing countertransference. Counter-

transference represents a reaction to the patient that may not emerge in the therapist's behavior. Furthermore, there can be some aspects of the therapist's interpersonal style that interfere with the therapeutic relationship but that are not usually discussed in the context of countertransference. Examples would include distracting behavioral mannerisms, or personal stylistic elements not specific to the patient. The capacity for the therapist to comment on his or her own process may minimize the likelihood of behaviors that reflect countertransferential issues.

Therapist self-reflection on process can also be distinguished from the concept of therapist self-awareness, which is also a broader term in its implications. For example, self-awareness can be used to refer to an excessive and anxiety-based self-focus on one's limitations as a therapist (Williams, 2008), in which self-reflection on process is intended to refer to dispassionate self-assessment of behavioral patterns.

Training to Comment

The final topic to be addressed here has to do with how to train therapists specifically in commenting on process. Several recommendations can be made about what would be required to ensure students achieve some level of competency in such comments.

First, we believe it is important to avoid communicating the message to students that they must more closely observe their own process in therapy. Direct instruction in closer self-observation can potentially undermine the therapeutic relationship (Fauth & Williams, 2005). It is hoped that with more experience commenting on patients' behavior, and experiences in which the comment advanced the treatment in some way or in which exploring the patient's behavior helped the student become more attuned to his or her own behavior, a greater capacity to self-comment would also emerge with minimal encouragement and without causing self-consciousness in the student. This approach is also more likely to be welcomed in an integrative framework than increased self-focusing.

Second, entry-level training should sensitize students to patient process. Because patient process is directly observable, taped materials could be developed, allowing students opportunities to identify patient process and to discuss

optimal responses. A combination of muted videotapes, which could be used to focus attention on patient behavior isolated from their overt communication; audiotapes, to focus attention on patient prosody in the absence of other behaviors; and standard videotapes might be particularly useful.

Once students flag behaviors meriting comment, further discussion should focus on the ways in which the behavior is noteworthy, either based on normative behavior or on prior behavior by the patient. The situation can also be characterized according to the dimensions identified earlier (e.g., comment immediately or delay comment, whether the behavior is stylistic or a unique event). From this analysis, a decision will emerge about how to address the behavior. Role-playing can be particularly helpful for alleviating the anxiety associated with commenting on process. The more a therapist delivers such comments, the more he or she can develop a style of delivery that is sensitive, empathic, and effective.

Third, training should recognize the difficulties inherent to commenting on process. The student who is trying to interpret the information being presented by the patient, while managing his or her own anxiety about being a therapist, while trying to implement a therapy plan, can be hard pressed to remain attuned to how the patient is behaving. Even if the student identifies some element of the patient's behavior that may warrant comment, a good deal of doubt can surround the decision about an appropriate response in situ. Immediately commenting on the process can be perceived as disruptive to the flow of "normal" conversation by the patient. Bringing attention to some element of the patient's behavior can also be perceived as judgmental. This is particularly true if patients have a history in which significant others commented on their behavior in a negative or hostile manner. The therapist must be emotionally prepared for any response the patient makes to the comment, including discounting it completely (e.g., "No, I'm not mad at you"). Incorporating self-revelation into the response to the process raises additional dangers. It is possible the patient will perceive the admission of a personal reaction to the patient's behavior as a sign of weakness (e.g., if the therapist admits to feelings of fear) or lack of empathy (if

the patient believes the therapist has misinterpreted the behavior).

It is important for students to recognize that these concerns are justified. In fact, the excessive use of comments on process in the therapy room can potentially create more, rather than less, distance in the therapeutic relationship (Piper, Azim, Joyce, & McCallum, 1991; Ryum, Stiles, Svartberg, & McCullough, 2010). The training should include discussion of the judicious use of comments; the expression of comments in a sensitive and empathic manner; and gauging the patient's behavioral response to the comment, the process in response to the comment on process.

Conclusions

During a brief period in the first author's early training as a therapist, he provided individual therapy to adolescents in an inpatient unit. One male patient often spoke to the therapist in a hostile and sarcastic way, and in reviewing audiotapes of the session, the therapist's supervisor noted that the author responded in a way that was also hostile. When the author indicated this response reflected real feelings of annoyance at the patient, the supervisor suggested that the author should wait until he was calmer before responding to the patient. Several weeks later, the patient again asked the author a question using a sarcastic tone, and in the pause that followed while the author collected himself, the patient added, "It's like talking to a wall." When the author asked the patient to elaborate, the patient pointed to the long pauses that were occurring before the author responded to the patient. The author then revealed the strategy and, for the first time, described the patient's sarcastic style of speaking. The patient was shocked and surprised, and his style of speaking changed almost immediately. Several weeks later, the author was able to comment that the patient's style had shifted from hostile to a little sad, and, for the first time, the patient discussed his longstanding feelings of depression.

We believe that comments on patient process represent a potentially powerful technique in therapy beyond the boundaries of the dynamic model from which they emerged. This is true because they can contribute to improving the patient's interpersonal functioning; to self-labeling of feelings and cognitions; to identifying resistance in the patient or some detachment between the patient and therapist; and to the strength of the relationship between patient and therapist. Unfortunately, discussions of this technique in the dynamic literature tend to consider it in combination with other types of confrontation that may not be considered as universally useful by therapists who prefer other theoretical orientations, with Frank (2002) representing a notable exception. Its focus on behavior, and on interpersonal behavior in particular, makes it a technique of interest even to practitioners of behavioral, interpersonal, or integrative forms of therapy.

Having presented a theoretical justification for the contribution commenting on process can make to therapy, there is little evidence available evaluating whether comments on process can meet standards for an empirically justified technique. Research is needed to evaluate whether comments on patient interpersonal behaviors enhance therapy relationships and outcomes, and whether various moderators (e.g., presence of a personality disorder, patient comfort with therapy) influence the degree to which the use of comments on process contribute to outcomes. Related issues of interest include an optimal use of commenting on process and mechanisms for enhancing the use of such comments by therapists. The first step in this process is the identification of the technique as a distinct element of treatment. In this article, we have attempted to justify greater attention to comments on process in discussions of effective psychotherapy.

References

Abramowitz, J. S. (1997). Effectiveness of psychological and pharmacological treatments for obsessive-compulsive disorder: A quantitative review. *Journal of Consulting and Clinical Psychology, 65,* 44–52. doi:10.1037/0022-006X.65.1.44

Allen, J. G., Fonagy, P., & Bateman, A. (2008). *Mentalizing in clinical practice.* Arlington, VA: American Psychiatric.

Baer, R. A., Fischer, S., & Huss, D. B. (2005). Mindfulness and acceptance in the treatment of disordered eating. *Journal of Rational-Emotive & Cognitive Behavior Therapy, 23,* 281–300. doi:10.1007/s10942-005-0015-9

Barber, J. P., & DeRubeis, R. J. (2001). Change in compensatory skills in cognitive therapy for de-

pression. *Journal of Psychotherapy Practice & Research, 10,* 8–13.

Beitman, B., & Soth, A. M. (2006). Activation of self-observation: A core process among the psychotherapies. *Journal of Psychotherapy Integration, 16,* 383–397. doi:10.1037/1053-0479.16.4 .383

Bibring, E. (1954). Psychoanalysis and the dynamic psychotherapies. *Journal of the American Psychoanalytic Association, 2,* 745–770. doi:10.1177/ 000306515400200412

Blagys, M. D., & Hilsenroth, M. J. (2000). Distinctive activities of short-term psychodynamic-interpersonal psychotherapy: A review of the comparative psychotherapy process literature. *Clinical Psychology: Science and Practice, 7,* 167–188. doi:10.1093/clipsy.7.2.167

Castonguay, L. G., & Beutler, L. E. (Eds.). (2006). *Principles of therapeutic change that work.* Oxford, UK: Oxford University Press.

Castonguay, L. G., & Goldfried, M. R. (1994). Psychotherapy integration: An idea whose time has come. *Applied & Preventive Psychology, 3,* 159–172. doi:10.1016/S0962-1849(05)80068-X

Castonguay, L. G., Goldfried, M. R., Wiser, S., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology, 64,* 497–504. doi: 10.1037/0022-006X.64.3.497

Constantino, M. J., Laws, H. B., Arnow, B. A., Klein, D. N., Rothbaum, B. O., & Manber, R. (2012). The relation between changes in patients' interpersonal impact messages and outcome in treatment for chronic depression. *Journal of Consulting and Clinical Psychology, 80,* 354–364. doi:10.1037/ a0028351

Crits-Christoph, P., Connolly Gibbons, M. B., & Hearon, B. (2006). Does the alliance cause good outcome? Recommendations for future research on the alliance. *Psychotherapy (Chicago, Ill.), 43,* 280–285. doi:10.1037/0033-3204.43.3.280

Cuijpers, P., van Straten, A., Andersson, G., & van Oppen, P. (2008). Psychotherapy for depression in adults: A meta-analysis of comparative outcome studies. *Journal of Consulting and Clinical Psychology, 76,* 909–922. doi:10.1037/a0013075

Dimidjian, S., Barrera, M., Jr., Martell, C., Munoz, R. F., & Lewinsohn, P. M. (2011). The origins and current status of behavioral activation treatments for depression. *Annual Review of Clinical Psychology, 7,* 1–38. doi:10.1146/annurev-clinpsy-032210-104535

Fauth, J., & Williams, E. N. (2005). The in-session self-awareness of therapist-trainees: Hindering or helpful? *Journal of Counseling Psychology, 52,* 443–447. doi:10.1037/0022-0167.52.3.443

Frank, K. A. (1999). *Psychoanalytic participation: Action, interaction, and integration.* Hillsdale, NJ: Analytic Press.

Frank, K. A. (2002). The "ins and outs" of enactment: A relational bridge for psychotherapy integration. *Journal of Psychotherapy Integration, 12,* 267–286. doi:10.1037/1053-0479.12.3.267

Franklin, M. E., Abramowitz, J. S., Kozak, M. J., Levitt, J. T., & Foa, E. B. (2000). Effectiveness of exposure and ritual prevention for obsessive-compulsive disorder: Randomized compared with nonrandomized samples. *Journal of Consulting and Clinical Psychology, 68,* 594–602. doi:10 .1037/0022-006X.68.4.594

Gelso, C. J., & Carter, J. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology, 41,* 296–306. doi:10.1037/0022-0167 .41.3.296

Goldfried, M. R. (2010). The future of psychotherapy integration: Closing the gap between research and practice. *Journal of Psychotherapy Integration, 20,* 386–396. doi:10.1037/a0022036

Gottman, J., & Levenson, R. W. (2000). The timing of divorce: Predicting when a couple will divorce over a 14-year period. *Journal of Marriage and the Family, 62,* 737–745. doi:10.1111/j.1741-3737 .2000.00737.x

Greenberg, L. (2008). Emotion and cognition in psychotherapy: The transforming power of affect. *Canadian Psychology/Psychologie canadienne, 49,* 49–59. doi:10.1037/0708-5591.49.1.49

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes, and outcomes. *Behaviour Research and Therapy, 44,* 1–25. doi: 10.1016/j.brat.2005.06.006

Horowitz, M. J. (2002). Self- and relational observation. *Journal of Psychotherapy Integration, 12,* 115–127. doi:10.1037/1053-0479.12.2.115

Jacobson, N. S., Dobson, K. S., Truax, P. A., Addis, M. E., Koerner, K., Gollan, J. K., . . . Prince, S. E. (1996). A component analysis of cognitive-behavioral treatment for depression. *Journal of Consulting and Clinical Psychology, 64,* 295–304. doi:10.1037/0022-006X.64.2.295

Jacobson, N. S., Martell, C. R., & Dimidjian, S. (2001). Behavioral activation treatment for depression: Returning to contextual roots. *Clinical Psychology: Science and Practice, 8,* 255–270. doi: 10.1093/clipsy.8.3.255

Jakobsen, J., Hansen, J., Simonsen, E., & Gluud, C. (2011). The effect of interpersonal psychotherapy and other psychodynamic therapies versus "treatment as usual" in patients with major depressive disorder. *PLoS ONE, 6,* e19044. doi:10.1371/ journal.pone.0019044

Kasper, L. B., Hill, C. E., & Kivlighan, D. M., Jr. (2008). Therapist immediacy in brief psychotherapy: Case study I. *Psychotherapy (Chicago, Ill.), 45,* 281–297. doi:10.1037/a0013305

Kazdin, A. E. (2009). Understanding how and why psychotherapy leads to change. *Psychotherapy Research, 19,* 418–428. doi:10.1080/10503300802448899

Kiesler, D. J. (1988). *Therapeutic metacommunication: Therapist impact disclosure as feedback in psychotherapy.* Palo Alto, CA: Consulting Psychologists Press.

Kring, A. M., & Sloan, D. M. (2010). *Emotion regulation and psychopathology: A transdiagnostic approach to etiology and treatment.* New York, NY: Guilford Press.

Langs, R. J. (1989). *Technique of psychoanalytic psychotherapy, Vol. 1. Initial contact, theoretical framework, understanding the patient's communications, the therapist's interventions.* New York, NY: Jason Aronson.

Leichsenring, F., Masuhr, O., Jaeger, U., Dally, A., & Streeck, U. (2010). The effectiveness of psychoanalytic-interactional psychotherapy in borderline personality disorder. *Bulletin of the Menninger Clinic, 74,* 206–218. doi:10.1521/bumc.2010.74.3.206

Medalia, A., Revheim, N., & Casey, M. (2002). Remediation of problem-solving skills in schizophrenia: Evidence of a persistent effect. *Schizophrenia Research, 57,* 165–171. doi:10.1016/S0920-9964(01)00293-6

Norcross, J. C. (Ed.). (2011). *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed.). New York, NY: Oxford University Press. doi:10.1093/acprof:oso/9780199737208.001.0001

Norcross, J. C., Karpiak, C. P., & Lister, K. M. (2005). What's an integrationist? A study of self-identified integrative and (occasionally) eclectic psychologists. *Journal of Clinical Psychology, 61,* 1587–1594. doi:10.1002/jclp.20203

Norcross, J. C., Karpiak, C. P., & Santoro, S. O. (2005). Clinical psychologists across the years: The division of clinical psychology from 1960 to 2003. *Journal of Clinical Psychology, 61,* 1467–1483. doi:10.1002/jclp.20135

Piper, W. E., Azim, H. F. A., Joyce, A. S., & McCallum, M. (1991). Transference interpretations, therapeutic alliance, and outcome in short-term individual psychotherapy. *Archives of General Psychiatry, 48,* 946–953. doi:10.1001/archpsyc.1991.01810340078010

Ryum, T., Stiles, T. C., Svartberg, M., & McCullough, L. (2010). The role of transference work, the therapeutic alliance, and their interaction in reducing interpersonal problems among psychotherapy patients with Cluster C personality disorders. *Psychotherapy (Chicago, Ill.), 47,* 442–453. doi:10.1037/a0021183

Safran, J. D., & Messer, S. B. (1997). Psychotherapy integration: A postmodern critique. *Clinical Psychology: Science and Practice, 4,* 140–152. doi:10.1111/j.1468-2850.1997.tb00106.x

Salzer, S., Pincus, A. L., Winkelbach, C., Leichsenring, F., & Leibing, E. (2011). Interpersonal subtypes and change of interpersonal problems in the treatment of patients with generalized anxiety disorder: A pilot study. *Psychotherapy (Chicago, Ill.), 48,* 304–310. doi:10.1037/a0022013

Shechtman, Z., & Yanov, H. (2001). Interpretives (confrontation, interpretation, and feedback) in preadolescent counseling groups. *Group Dynamics: Theory, Research, and Practice, 5,* 124–135. doi:10.1037/1089-2699.5.2.124

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist, 65,* 98–109. doi:10.1037/a0018378

Sterba, R. F. (1934). The fate of the ego in analytic therapy. *The International Journal of Psychoanalysis, 15,* 117–126.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62,* 271–286. doi:10.1037/0003-066X.62.4.271

Wachtel, P. L. (2007). *Relational theory and the practice of psychotherapy.* New York, NY: Guilford.

Williams, E. N. (2008). A psychotherapy researcher's perspective on therapist self-awareness and self-focused attention after a decade of research. *Psychotherapy Research, 18,* 139–146. doi:10.1080/10503300701691656

Wykes, T., Reeder, C., Landau, S., Everitt, B., Knapp, M., Patel, A., & Romeo, R. (2007). Cognitive remediation therapy in schizophrenia: A randomized controlled trial. *The British Journal of Psychiatry, 190,* 421–427. doi:10.1192/bjp.bp.106.026575