Clinical Conversations: Brief Psychotherapy Training and HIV
Domenic Ali, LCSW

Most psychotherapists early in their training are more preoccupied with how to do therapy than how to understand it. Hence, the never-ending questions from these clinicians-in-training: "What do I say exactly?" and "How do I decide which approach to take?" or "How am I supposed to come up with a case formulation from these guidelines?"

Current clinical theory either answers these questions in unsatisfying ways or remains oddly silent about them. Over the past five years, the Brief Psychotherapy Traineeship at the UCSF AIDS Health Project has come to revisit these questions and the issues they raise. To find a more satisfactory answer to the central question, "How do you do therapy?" the program reflects on the most significant self-generated obstacle to learning to do therapy—performance anxiety—and uses these reflections to develop an organizing metaphor to lessen that anxiety. This article describes this metaphor and how it evolved from the process of teaching trainees to conduct time-limited therapy with HIV-positive individuals.

Performance Anxiety

Teaching brief psychotherapy usually entails working with clinical trainees who have diverse life experiences. This is especially true in an urban community mental health setting such as the AIDS Health Project. The typical trainee we accept into the program attends a local clinical graduate school and comes to the traineeship having developed through this schooling his or her own theoretical orientation for conducting psychotherapy. Despite these differences, however, all trainees must adapt their existing therapeutic orientation and achieve competence in conducting brief therapy with a broad cohort of HIV-positive clients who present at AHP with a wide range of clinical issues.

It is well known, and hardly surprising, that no matter which theory of psychotherapy they have been taught, all trainees have a significant amount of performance anxiety when first learning to practice therapy. Trainees are asked to do the equivalent of a solo musical performance in front of an audience while, to extend the metaphor, they are still learning to play. To mitigate the anxiety that naturally accompanies this learning process, trainees benefit from a treatment model that both guides their actions in session—that is, helps them choose and carry out interventions—and also provides them comfort as they face the many uncertain moments during the course of any session.

The need for comfort and support is especially important, because performance anxiety builds over time. If not effectively relieved, this anxiety impacts the quality of therapy trainees are capable of providing in the present and how quickly they can improve over time. When a trainee can remain relaxed and focused, and quickly return to this relaxed state in response to the inevitable anxiety, both therapy and the learning process can proceed relatively unencumbered.

Brief therapy models, like all psychotherapeutic models, are based on an organizing metaphor. The ideal metaphor offers a compelling image or analogy that describes the way a particular type of psychotherapy unfolds and the relationship between therapist and client under that model. The effectiveness of a model is directly related to how well this metaphor captures the phenomenon it is modeling in relatively simple terms without overly distorting this phenomenon. The four most common organizing metaphors used in psychotherapeutic teaching
Editorial: Conversation and Care
Robert Marks, Editor

Counseling is at the heart of HIV care. Prevention, testing, coping, adherence, living with HIV—all often rely on a successful counseling relationship between provider and client. At the same time, HIV care has always relied on and, in an era of diminished funding, increasingly demands the efforts of volunteers and the application of “brief psychotherapy.”

Agencies are faced with the challenge of training therapists effectively and quickly to ensure both quantity and quality of service. This issue of FOCUS offers one approach to conceiving and imparting psychotherapy to trainees.

Domenic Ali harnesses the metaphor of the “clinical conversation” to help psychotherapy interns both understand the nature of the clinical relationship between therapist and client and gauge the success of the therapeutic interaction to respond to a client’s concerns. The conversation is an apt metaphor because as Ali notes, it is an activity with which we are all familiar, and it describes the essential nature of the counseling relationship.

Also in this issue, Robert Holm, a psychotherapist who learned brief therapy under Ali’s tutelage, discusses his own experience applying the metaphor as an intern and extends the metaphor as a way of understanding the difficulties some gay men bring into therapy. He suggests that because of societal homophobia, gay adolescents have missed the opportunity to participate in the fundamental conversations that other adolescents experience and which facilitate entry into a healthy adulthood. I suspect that the absence of the types of psychologically necessary conversations that Holm describes may occur among members of other groups of people who have been marginalized.

I also suspect that the value of this metaphor extends beyond psychotherapy into other types of counseling relationships, where it can offer a range of providers a sense of whether they have established the rapport essential to a positive helping relationship and whether they are uncovering the concerns that are most important to clients or patients.

In these venues, sensitivity to “thematically rich” conversation may be particularly important to people—including but not limited to many gay men—who have felt marginalized in their lives. Even in medical settings, outcomes improve when health care providers sustain thematically rich conversations with patients, whose chief concerns may hide in between the lines of the doctor-patient patter.

today are adaptation, self-organizing feedback loops, transference, and encounter, which are respectively associated with cognitive/behavioral, family systems, psychodynamic, and existential psychotherapies. While these metaphors are reasonably helpful to experienced therapists, they provide inadequate comfort and support to trainees. In response, the AHP Brief Psychotherapy Traineeship has developed another metaphor to help therapists-in-training.

Conversation as an Organizing Metaphor

In searching for such an organizing metaphor, it became clear that one factor is common to all psychotherapeutic approaches: a conversation between therapist and client.2 To conceive of therapy as a form of conversation is a most natural place of departure in understanding the practice of time-limited therapy. Almost everyone knows how to have a conversation: learning how to practice therapy is just learning how to make use of a special kind of conversation. It is, of course, deceptive to say “just,” because establishing, identifying, and maintaining these “special” conversations is difficult to do well.

One of the values of the conversation metaphor is that it leaves no trainee empty-handed at the beginning of his or her training process. We all know how the tools of conversation—both words and non-verbal expressions—can comfort, encourage, confront, and eventually help us develop and maintain a flourishing life in the face of difficult and demoralizing circumstances. As social animals, these tools and the communication they facilitate are as much a natural part of us as our flesh and blood.

Pointing out to a trainee that he or she has a natural talent when it comes to one of the most central tasks in doing therapy—to establish and maintain a conversation that is helpful to another—goes a long way toward generating a realistic sense of competence that can serve as the basis for professional development. It provides the foundation for the specialized skills needed for the more complex conversations required by therapy and allows the trainee to do so with an increasingly wide range of people and presenting issues.

The metaphor of conversation also can help when trainees encounter those uncer-
tain moments that are not only part of every therapy, but frequently some of the most important parts of therapy. It is imperative during such challenging moments for trainee and client to find their way back to the center of the client’s issue and the interpersonal exchange of therapy, rather than to the trainee’s performance anxiety and the defensive responses that usually arise from this. Once familiar with the metaphor, a trainee can instead visualize the clinical conversation with reasonable ease and make use of his or her feeling states to guide the way towards these conversations and through the “uncertain” moments. Most trainees are exquisitely adept at using their feeling states to inform them if they are on the right track, that is, if the conversation “feels” genuine and collaborative rather than inauthentic and discordant.

Features of Clinical Conversations

Clinical conversations emerge from discussions between therapists and clients as they make an effort to be attuned to each other. This distinction between discussion and conversation is subtle but important to recognize, and can be identified by a subjectively felt shift in the quality of interpersonal engagement. Each trainee describes this qualitative shift differently, with a commonly understood depiction being a relatively sudden sense of calm elation for the trainee, accompanied by an increased interest in what the client is talking about. This shift almost always feels as if something is happening to the trainee, rather than as if the trainee is making this happen.

In such moments, the topic of discussion is experienced by both parties as vital, and there is a sense of shared agency between therapist and client, which is best described as a cooperative dance with the lead swaying effortlessly back and forth between the participants. Most experienced therapists can easily identify these types of moments and their potential value to the therapeutic work at hand. For trainees, the best way to clarify this subtle distinction between a conversation and a discussion is by “pointing” to it when it occurs (this “pointing” is possible because trainees audiotape their sessions and use them in supervision as part of their learning process).

While any two people can have such moments together, a number of additional features further define a “clinical conversation.” First, it is centered on concerns causing a client discomfort and, over the course of therapy, there is increasing disclosure by the client of experiences that have felt painful or shameful. Second, the clinician tends to make an effort to actively model authentic engagement in these moments, probably more so than he or she does in life outside the session. Finally, because there is a clear distinction of roles in the room—that of a healer and that of a sufferer—the therapist must be aware of the resulting power differential and how he or she will use it in an ethical way to benefit the client.

Another set of characteristics signals to trainees that they are engaged in an authentic clinical conversation. Among these characteristics are: deep relaxation and focused attention on the part of the therapist during which stimuli outside the interpersonal...
interaction recede; a relative increase in the eloquence of the verbal exchanges; a cognitive process that is best described as a state of “hyper-flexible clarity,” characterized, for example, by the ability of either party to clearly state his or her thoughts while also being able to easily revise these thoughts without sacrificing overall coherence of the discussion; an emotional tone of dispassionate yet active involvement; and the recall of events from previous sessions with surprising clarity. While identifying these subjective characteristics is possible for all trainees, it is precisely this subjectivity that can easily result in a trainee misidentifying these experiences. Some, such as verbal eloquence and recalling events from previous sessions in great detail, however, can also be identified by other observers. This quality can be turned into a method of confirmation in group supervision, during which a trainee might ask other participants to judge the extent to which a segment of an audiotaped session demonstrates the characteristics of a conversation. Identifying these characteristics in each other’s work becomes easier for trainees over the course of the year as they help each other improve their conversation skills.

Clinical conversations can also be described in more objective terms, but thinking in these terms tends to hinder an inexperienced trainee by interfering with his or her intuitive sense of the process. For more experienced clinicians, however, this objective viewpoint can enrich their understanding and improve their use of the therapeutic process to facilitate resolution of the client’s presenting issue.

The Value of the Conversation

It seems intuitively true that a clinical conversation—as defined by these characteristics—would lead to greater engagement and better therapeutic outcomes. To test this assumption, the AHP Brief Psychotherapy Traineeship conducted a small pilot study of 25 completed therapy cases, sorting them into three groups: those in which authentic conversations were rarely established; those in which conversations were regularly established but were thematically simple; and, those in which conversations were both regularly established and thematically rich.

The clinical improvement in each therapy (as measured by the Outcome Questionnaire-45 [OQ-45], a well-researched psychotherapeutic outcome instrument) showed a clear association between the presence of clinical conversations during the therapy and clinical improvement. When no clinical conversations were established, none of the clients improved; when thematically simple conversations were established, 65 percent of clients improved; and when thematically rich conversations were established, 85 percent of clients improved.

While this analysis is limited by the size of the study and the lack of a formal coding system that would allow others to verify the reliability of the identified clinical conversations, it nonetheless suggests that maintaining a thematically rich clinical conversation about a client’s presenting issue leads to meaningful change.

Conclusion

It remains to be seen whether the metaphor of conversation can accurately capture the clinical process in all its richness and subtlety, and speed the learning process for therapists-in-training. Adopting conversation as an organizing metaphor for a time-limited therapy model, however, helps mitigate performance anxiety among trainees, freeing them to learn the practice of therapy, and perhaps most importantly, apparently leading to improved outcomes for clients.

Clearinghouse: Psychotherapy

References

In teaching new therapists to conduct brief psychotherapy with HIV-positive clients, the UCSF AIDS Health Project has adopted the metaphor of the “clinical conversation.” As a practicing therapist for more than five years and one who has conducted brief therapy at the AIDS Health Project for about 18 months, I have found this metaphor useful not only for its original purpose—developing my own clinical skills—but also as a means to conceptualize the distress of many of my gay male clients.

Maladaptive Patterns

The AIDS Health Project uses the clinical conversation metaphor to help teach a specific psychodynamic approach to brief therapy that focuses on how clients relate to other people. This approach assumes that a client has unwittingly developed over time a self-perpetuating, maladaptive pattern of relating to others, and that this pattern underlies the client’s presenting issues. The therapist’s job is to use the clinical relationship to facilitate for the client a new experience of relating, allowing the client to break the old pattern and thereby resolve the presenting issues.1–3 In conducting therapy with HIV-positive gay men, I have repeatedly noticed two distinct maladaptive patterns.

In the first pattern, the client may present with a mild to moderate long-term depression, be nervously preoccupied with himself, and have difficulty identifying his feelings. The client has learned to display a competent persona (or, as it is often labeled, a “false self”)4 to the outside world and to repress his true feelings of sadness, loneliness, or desperation. Other people in the client’s life accept his outward persona at face value, missing the feelings underneath. The client, not realizing that others cannot see his true self, deduces that his true self is somehow shameful. In response, he redoubles his efforts to appear competent, and the cycle repeats.

In the second pattern, the client exhibits a pronounced defensiveness that serves to ward off internalized shame. He may attempt to explain or justify every thought, feeling, or action, as if he were defending a criminal in court; guard himself against perceived attacks on his gay identity or sexual choices, taking offense at the first sign of criticism; or refuse to disclose thoughts or feelings in any meaningful depth. In response, other people may feel pushed away, attacked, or manipulated; when they withdraw or retaliate, the client reexperiences his warded-off shame and again goes on the defensive.

The clinical conversation metaphor has offered me a way to understand how these two maladaptive relational patterns may arise for gay male clients. In linking psychosocial development to conversation, the metaphor invites a unique interpretation of these patterns; namely, that they result from disruptions in conversational processes earlier in life.

The conversation metaphor invites the interpretation that two maladaptive patterns among gay men may result from disruptions in conversational processes earlier in life.
Conversations in Adolescence

The clinical conversation metaphor is rooted in verbal and nonverbal processes of interpersonal communication that occur naturally throughout life. According to Domenic Ali (see "Clinical Conversations: Brief Psychotherapy Training and HIV" page 1, in this issue of FOCUS), these processes, or "conversations," can "comfort, encourage, confront, and eventually help us develop and maintain a flourishing life." In short, these conversations can lead to maturity, or as Freud supposedly put it, to loving well and working well. I immediately think of adolescence—a time of increasing autonomy and self-determination, a time when sexuality awakens, and a time when parents begin to engage with their children as adults.

As adolescents mature, they must negotiate a more "adult" place for themselves in the world. They must give up the relatively passive, obedient position of the child and learn to exert their will in the manner of adults. They work toward this goal in part by separating from their parents and affiliating with peers. But adolescents still need conversational support from adults—empathy, recognition of their authentic thoughts and feelings, respect for their opinions—to successfully navigate the passage to adulthood. Supportive conversations with even a single caring adult in an adolescent’s life—a teacher, a neighbor, a coach—can make all the difference.5

For gay male adolescents, however, such conversations are largely foreclosed by the fear and homophobia that prevent the frank recognition of gay adolescent sexuality. Rather than encountering comfort or encouragement, gay male adolescents are more likely to face injunctions and censure—forms of communication usually reserved for disobedient children. Their families may reproach or reject them, their peers may ostracize them, social institutions may tacitly promote violence against them, and counteractive support from a caring adult may not be available.6 The message from virtually all quarters is unmistakable: your sexuality is repugnant, your feelings about it do not otherwise have facilitated this process, are forfeited or deferred to a later age.

Failed Strategies

The two maladaptive patterns described above can be viewed as attempts to circumvent the foreclosure of supportive conversations in adolescence, thereby reinitiating the stalled process of psychosocial development. In both cases, the client internalizes the homophobic notion that honest conversation about his true self, especially about his sexuality, is dangerous. He tries to neutralize the danger using one of two strategies: concealing his true self, or rigorously defending it. His hope, conscious or unconscious, is that at some point he can safely undertake or resume the conversations foreclosed to him. But both strategies ultimately fail because they leave no room in any conversation for the client’s authentic self.

Moreover, a client’s preoccupation with the dangers of the past may leave him vulnerable to immediate dangers. The client afraid to let his real self shine forth may be unable to act on his own behalf at crucial moments: to resist pressure to engage in unsafe sex, to terminate a sexual encounter that feels uncomfortable, to get away from a physically abusive partner. The defensive client may resist all attempts to examine his behavior, no matter how well intentioned the questions or how problematic or self-destructive the behavior. For either client to tell the whole truth about his feelings—regarding sex, condoms, HIV infection, barebacking, or any other topic—is to vulnerable to internalized homophobia and other forms of psychological harm, making the need for such conversations all the more critical and their absence all the more damaging. Lacking the support of adults, peers, or social institutions, gay male adolescents are left to devise alternative strategies for navigating toward adulthood; supportive conversations, which might otherwise have facilitated this process, are forfeited or deferred to a later age.

Comments and Submissions

We invite readers to send letters responding to articles published in FOCUS or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals. Send correspondence to rmarks@itsa.ucsf.edu or to Editor, FOCUS, UCSF AIDS Health Project, Box 0884, San Francisco, CA 94143-0884.
risk judgment, censure, and rejection all over again. As in adolescence, honest conversation about sexuality is perceived as too dangerous.

Just as the clinical conversation metaphor permits me to recognize this disruption, it provides the framework for reopening the possibility of honest conversation and its promise of comfort, encouragement, and support. For many gay male clients, the result can be, quite simply, a new experience of relating.

The Conversation as Dance

If the clinical conversation at its best is, as Ali suggests, an effortless dance, I often find it punctuated by long periods where I must lead the reluctant client to the dance floor, struggle to hear the beat of the music, and try not to step on the client's feet. This was the case with a former client, "John," an HIV-positive gay man in his forties who sought to stop his casual methamphetamine use.

John's maladaptive pattern generally fit with the first, "competent persona," pattern. He presented himself to others as "having it all together" and had told no one of his drug use. His competent persona worked like an automatic reflex: he would start to focus on authentic feelings in one session, and the false persona would snap right back the next. After several sessions of this, uncertain of where to go, I spoke plainly and from the heart one day, saying that I felt we were missing something important and that John himself seemed to be "lost" somehow. This touched something in John, who began crying and replied that he did not know how to find his lost self.

In retrospect, this was the first "moment" of clinical conversation in John's therapy. Our exchange in this session and in the two that followed had qualities of rich clinical conversations: they were vital, authentic, and clearly focused on John's healing. It soon became clear that John, who had been raised in a strict charismatic religious environment and taught that he had no hope of salvation as a gay man, saw participation in the clinical conversation as literally risking the abandonment of God. John struggled with fundamental questions about his place in the conversation: Could he really say what he was thinking? Would he be hurt? Was he even worthy of such a conversation? The clinical conversation became both the content and the process of the therapy—that is, both a way to understand John's distress and a way to begin working through it.

From that point on, I used those three sessions to help gauge our progress. When that familiar combination of vitality, authenticity, and clarity reappeared, I could guess that we were on the right path, and when it did not, I could infer that we were off the mark. John still struggled with his false persona, and there were some rocky patches where the intensity of our conversations made him want to quit therapy. But he continued to take emotional risks, examining his own intuitive sense of spirituality at odds with his religious upbringing, his use of speed as a way to rebel against his family, and his quixotic dream of one day being accepted by them. By our final session, he had stopped using speed and had begun to seek out new relationships and a new spiritual community.

The Learning Process

As I look back on my work with John and with other clients, I see that, like them, I have been learning to participate in conversation. Amidst all the theory and technique one acquires as a therapist—important and useful as these are—it is easy to forget how to simply be oneself. It is instructive for me to see that at many therapeutic moments of clinical conversation, like the one in which John cried for his lost self, I am not preoccupied with maladaptive patterns, or even with how to be a good therapist; I am simply one human being speaking to another. Thus, an essential lesson for me has been to ground my use of theory and technique in my own basic humanness and to trust that this is what will best foster clinical conversations in therapy.

I have also come to realize that for many gay men—who have never felt welcome to take part in conversation and were never meant to master its art—the very chance to enter authentically into conversation with another person can itself be therapeutic. For only in learning that our real selves are worthy of love and acceptance can we begin to flourish.
Recent Reports

Integrating Psychotherapy


The psychotherapy integrationist movement seeks to shift emphasis from theory toward efficacy, focusing, in particular, on the relationship between client and therapist, according to an overview of the movement. Integration of the four foundational schools of psychotherapy—psychoanalysis, cognitive behaviorism, humanism, and transpersonalism—traditionally considered mutually exclusive, takes advantage of the diversity of the schools by encouraging the incorporation of elements that can both be validated in the world at large and match the values of the individual therapist.

The movement arose from three motivations. First, the professional or economic imperative focuses on building psychotherapeutic models that are more effective and cost-efficient. Second, the evolutionary imperative recognizes the natural course of psychotherapy—like everything in life—toward change and integration. Finally, the exotic, the external, imperative acknowledges that psychotherapy must be based on real-world needs and must be tested in this broader context.

There are three kinds of integration: “constructive or classic integration,” which aims to construct a new approach that can be easily explained to clients and passed on to trainees; “complicit integration or emergence,” which emerges from fundamental therapeutic processes, for example, the therapeutic relationship, that are common to different schools of psychotherapy; and “contiguous integration,” which connects therapeutic theories to knowledge about and understanding of the outside world.

Integration efforts are diminishing the dominance of the four great theories. Ironically for integrationists, research showing that therapeutic efficacy has less to do with theoretical orientation than with the quality of the therapeutic relationship has diminished not only the role of the great theories but also the integrationist quest for a “grand theory.”

Monitoring Therapy Training


A study of therapists working with 56 depressed HIV-positive individuals found that “adherence monitors”—people who have been trained to analyze therapy sessions using a qualitative scale—can be consistent in their ratings of adherence to a particular treatment style and can validate the specificity, purity, and efficacy of the treatments that are delivered. There has been very little research on adherence of therapists to specific approaches.

Researchers recruited HIV-knowledgeable psychiatrists, psychologists, social workers, and psychiatric nurses with experience working with depression and trained them in four, 16-week depression interventions for people with HIV: interpersonal, cognitive-behavioral, and supportive psychotherapies, and supportive therapy with imipramine. Researchers assigned two audiotapes of each therapist’s session for evaluation by trained psychology graduate students. These monitors listened to two randomly selected, complete audiotapes for each therapist-subject dyad—one from an early session, one from a later session—and rated these tapes using the Collaborative Study Psychotherapy Rating Scale (CSPRS). Clients were mainly gay and bisexual White men who scored 15 or more on the Hamilton Rating Scale for Depression.

Not only were the therapists highly adherent to the type of therapy they provided, but also they were able to avoid using at the same time techniques from the other modalities. There was high reliability among monitors rating the same therapist’s audiotapes.

Next Month

For many people with HIV who are disabled, particularly those struggling with psychiatric disorders or addiction, housing can become the paramount issue. Yet, managing subsidized housing for this diverse group of people can be a huge challenge.

In the September issue of FOCUS, authors including Glenn Motola, PsyD, Director of HIV Services for Catholic Charities CYO in San Francisco, discuss the challenges for both providers working in these settings and clients living in them.
ABOUT UCSF AIDS HEALTH PROJECT PUBLICATIONS

The AIDS Health Project produces periodicals and books that blend research and practice to help front-line mental health and health care providers deliver the highest quality HIV-related counseling and mental health care. For more information about this program, visit http://ucsf-ahp.org/HTML2/servicesProvidersPublications.htm.

DID YOU KNOW?

You can access a FREE searchable archive of back issues of this publication online! Visit http://www.ucsf-ahp.org/HTML2/archivesearch.html.

You can also receive this and other AHP journals FREE, at the moment of publication, by becoming an e-subscriber. Visit http://ucsf-ahp.org/epubs_registration.php for more information and to register!