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Psychodynamic Psychotherapy, Insight, and Therapeutic Action

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It has often been observed that, in general, different psychotherapies do equally well. Some have taken this as good evidence that therapeutic action in psychotherapy rests not on the factors specific to individual therapies, but on common factors. I argue against this view in favor of a theory of therapeutic action deriving from psychodynamic psychotherapy. This identifies the therapeutic relationship (and with it, many so-called common factors) and "psychodynamic insight" as therapeutic factors. I review the evidence from outcome studies and from studies into two concepts related to insight, specifically reflection function and psychological defense. I argue that the best interpretation of the evidence supports the claim that insight, in interrelation with the therapeutic relationship, contributes to therapeutic action.

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Does insight contribute anything to the therapeutic action of psychoanalysis? It has often been observed that, in general, different psychotherapies do equally well. Some have taken this as good evidence that therapeutic action in psychotherapy rests not on the factors specific to individual therapies, those that distinguish them from one another, but on common factors (Strupp, 1977). If this is correct, then most psychotherapies are mistaken in their rival accounts of how psychotherapy works, as such accounts are normally derived from distinctive theories of mental functioning (e.g., ones that emphasize conditioning, cognitions, or unconscious psychological conflict). My focus here is on the account of therapeutic action defended by psychoanalysis, psychoanalytic psychotherapy, and other psychodynamic psychotherapies, which have traditionally claimed a central role—although not an exclusive or even primary role—for the specific and characteristic factor of *insight*.

To begin, I outline what I intend by the term "insight." Then, I present the view that common factors are the most significant in therapeutic action and discuss some difficulties that arise for the argument. I then present a contemporary psychodynamic account of therapeutic action, focusing on the therapeutic relationship and the place of insight in relation to it. I present the argument favoring insight as a therapeutic factor based on outcome studies and on evidence relating to reflective function and psychological defense.

INSIGHT IN PSYCHODYNAMIC THEORY AND THERAPY

The term "insight" has no fixed meaning in psychotherapy. It could be taken to cover any form of learning about oneself. More specifically, it can mean learning that one's ways of relating interpersonally are maladaptive. In these senses, insight occurs in many types of treatment. Our interest here is in what I shall term "psychodynamic insight," insight as it is theorized in psychodynamic approaches and commonly identified as a—perhaps the—defining specific factor in psychodynamic therapy.

Psychodynamic insight is concerned with understanding the dynamics of one's mental states and processes. It involves grasping the *connections* between

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one's emotions, motivations, thoughts, and behavior, past and present, including one's interpretations of and relations with others (Castonguay & Hill, 2007; Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988). According to psychodynamic theory, many of these connections are formed unconsciously and defensively, issuing from psychological conflict. In therapy, understanding the dynamics that manifest maladaptive (distressing, unsatisfying, unrealistic) patterns of thought, emotion, motivation, and/or behavior is primary.

For example, a young woman, who presented with bulimia, who feels powerless, lacking control, and submissive in relationships with men, comes to recognize a pattern, a network of connections, in which she treats herself badly, as others do, feeling that she deserves this:

> I see now that I don't do much to assert myself when I'm on a date, that I just go along with him and just, like, hope that he likes me. But then I get mad that he doesn't treat me better and it's confusing because I also see how I get mad at me when this happens—it's like then I feel bad and like that maybe I deserve how I'm treated. Ya know, I don't think I try to be more—ya know, assert myself more because I don't want to be disliked and maybe dumped . . . but I also somehow feel that I deserve not to be liked and so when I get treated bad it feels like it was supposed to happen. (Messer & McWilliams, 2007, pp. 24–25)

Thus, she has connected one aspect of her powerlessness, lack of control, and submissiveness to feelings of worthlessness and to fear of rejection. The insight may consist in making these connections for the first time, or (more weakly) in recognizing their strength and importance in her psychic economy, or (more strongly) in recognizing the feelings of worthlessness and fear for the first time. Developments of the woman's insight would involve coming to understand further connections to the thought that she deserves not to be liked, perhaps to significant relationships in the past and to other aspects of her life in the present. As this example indicates, it is the insight of the patient, not merely the therapist's insight into the patient, which is of therapeutic importance.

Insight (from now on, all references to insight shall be to psychodynamic insight) comprises two elements. The first relates to specific insights: understanding the (often unconscious) dynamics underlying particular conscious thoughts, feelings, choices, and behavioral reactions, especially those that manifest maladaptive patterns. The second, which we may call "insightfulness," relates to a general capacity or ability for self-understanding in this sense (e.g., Sugarman, 2006).

Insight aims at recognizing one's mental states and their interconnections (again, extending to one's interpretations of others as well). To clarify and support this, I specify insight further in terms of psychological defense and reflective function.[1]

Psychological defenses function both to protect us from excessive anxiety and to protect the integration of the self (Cramer, 2006). They differ from coping mechanisms in being unconscious, effortless, and unintended. Defenses have been characterized according to maturity (Perry, 1990, 1992; Vaillant, 1992; Vaillant, Bond, & Vaillant, 1986). All defenses except the most mature (e.g., sublimation, suppression, and humor) work by distorting both how we understand and experience ourselves and our attributions of mental states to others (e.g., Vaillant, 1993). Thus, defenses are incompatible with insight, as insight requires truthfulness while all but the most mature defenses require its absence. We may say, then, that the development of insight involves learning about and deconstructing one's defenses (though not necessarily under this conceptualization of them).

Reflective function is an operationalized measure of the quality of "mentalization," the capacity to make sense of one's behavior and that of others in terms of mental states. Increased reflective function involves greater accuracy in one's understanding of one's motives and those of others. Improvements lead from naïve, simplistic, rigid, or unintegrated attributions of mental states to a form of reflection that is open, flexible, and integrative (Fonagy, Steele, Morgan, Steele, & Higgitt, 1991; Fonagy et al., 1996; Grienenberger, Kelly, & Slade, 2005). These features of high reflective functioning indicate its orientation toward reality—the openness to receive information, the flexibility to alter one's judgment in the light of new information and the complexity of the phenomena, and attention to

coherence, qualification, and nuance in one's judgments of motives.

Insight into oneself is not an *intellectual* recognition of a psychological truth, and insightfulness is not a purely intellectual capacity (Freud, 1914). First, insight has an emotional dimension—the emotion, desire, thought, connection that is acknowledged is at the same time experienced affectively, and it is acknowledged, typically, *through* being experienced. For example, the patient not only knows of her anger toward authority figures; she comes to feel (a version of) this anger. Second, insight requires exploration of a mental state's network of connections to other states (described in terms of "associative networks" below), the depth of its penetration into one's experience and expectations of the world, and the behaviors it motivates. This requires "working through." Just as in mourning, one must, time and again, in connection with many different and varying situations, come to realize and accept the loss of someone loved, so the full emotional reality of recognizing a pattern in one's thought, feelings, and behavior takes time to register and take root (Greenson, 1967).

Psychodynamic psychotherapies that aim to support the development of insight have utilized interpretations of resistance and transference in particular to achieve this, and researchers have typically accepted this connection. Thus, the debate over the therapeutic action of insight has focused on whether "interpretive" (or "expressive") psychodynamic therapies that utilize such techniques have generated better outcomes than either "supportive" forms of psychodynamic therapy or nonpsychodynamic therapies.

"COMMON FACTORS" AND THE CHALLENGE TO INSIGHT

"Common Factor" Views

The view that therapeutic action is much more the result of factors that are common to different psychotherapeutic schools and techniques than the result of factors that are specific to schools is a challenge to the claim that insight contributes importantly to the outcome of psychodynamic therapies. The common factor view, as I shall call it, has some influential defendants. In the latest (sixth) edition of *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change*, Lambert (2013) updated his previous discussion of these issues. There are three possible interpretations of the commonly observed finding that different therapies perform equally well in outcome studies: that similar outcomes result from different factors in different therapies; that studies have not accurately measured outcomes, so that real differences in effectiveness have not been discovered; or that the outcomes are similar as they result, at least primarily, from common factors "that are curative, though not emphasized by the theory of change central to a particular school" (p. 199). He favors the latter, a conclusion he has defended since at least 1992, when he argued that 40% of therapeutic improvements resulted from the client and life outside therapy, 30% from common factors, and 15% from expectancy effects, leaving just 15% the result of specific factors (Lambert, 1992). In his much-cited book, Wampold (2001) goes further, arguing that "the evidence indicates that, at most, specific ingredients account for only 1% of the variance in outcomes" (p. 204). Bracken et al. (2012) concurred, stating that "the evidence that nonspecific factors, as opposed to specific techniques, account for nearly all the change in therapy is overwhelming" (p. 431).

However, what is to be considered a "common" or "nonspecific" factor is unclear. Two conflicting criteria are used: factors that a wide variety of therapies have in common and factors that are not theorized as primary mediators of therapeutic action. As I argue below, the two categories are not identical. Furthermore, Lambert (2013, p. 201) goes on to claim that "many specific variables can be subsumed under the common factor rubric," and indeed his list of common factors (p. 200) includes such items, more usually identified as specific factors, as insight, working through, cognitive learning, and encouragement of experimenting with new behaviors. But if common factors are not theorized while specific factors are, we cannot subsume the latter under the former (by definition).

Frank's classic discussion of therapeutic action works at a more abstract level: Therapies work "by strengthening the therapeutic relationship, inspiring expectations of help, providing new learning experiences, arousing the patient emotionally, enhancing a sense of mastery or self-efficacy, and affording opportunities for rehearsal and practice" (Frank & Frank, 1993, p. 44). Thus, "common" factors include contact with a

therapist, discussion of the presenting problem, the client's expectation of improvement, demand characteristics of the assessment situation that encourage displays of improvement, response-contingent reinforcement, suggestion effects, and the therapeutic relationship, especially the provision of warmth, empathy, and positive regard. The relationship and the related idea of the therapeutic alliance have been dominant in research and in the case made by Lambert, Wampold, and others (Norcross, 2011).

There are three key objections to this view that common factors, rather than specific factors, are central to therapeutic action. The first, focusing on the issue of the therapeutic alliance, is that the step from prediction to causation cannot be secured. The second is that the therapeutic relationship has been theorized as a factor in therapeutic action since the origin of psychoanalysis, so it is at best misleading to consider it "nonspecific" (and hence "common," if this refers to untheorized factors). The third is that there is recent evidence supporting the importance of insight, at least in long-term psychodynamic psychotherapy (LTPP). I shall argue that the best theoretical framework, given the evidence we have at present, is not an "either–or" choice between "common" factors (in particular, the therapeutic relationship) or specific factors (in particular, psychodynamic insight), but one in which they are understood in mutual support and dynamic interaction.

The Therapeutic Alliance, Moderators, and Mediators

It is commonly claimed that the single best predictor of treatment outcome is the strength of the therapeutic alliance, with the correlation typically ranging from 0.17 to 0.26, with an average of 0.22 (Martin, Garske, & Davis, 2000). Two issues in the debate are, first, whether this correlation has been adequately established and, second, whether alliance is not only a predictor, but also a moderator or mediator, of outcome (Kazdin, 2007), as the common factor view outlined above takes common factors to be mediators of outcome.

Barber, Khalsa, and Sharpless (2010) noted that most studies of the correlation between alliance and outcome measure alliance at an early point in the treatment, but outcome is usually assessed as a change in symptoms from pretreatment to posttreatment. If alliance is to be a *predictor* of outcome, then what needs to be measured is the change in symptoms from the point of measuring alliance to posttreatment; any change in symptoms from pretreatment to the point at which alliance is measured should be discounted. Most studies fail to discount or exclude changes that occur during this early phase of treatment. Barber (2009) reviewed those few that do and finds that in only two of seven studies does alliance predict outcome, and even in those, the correlation is relatively small. An alternative possibility is that both alliance and outcome are predicted by early symptomatic change (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; DeRubeis & Feeley, 1990).

Even if the strength of alliance does predict outcome, it would be a further step to claim that the alliance either moderates or mediates outcome (Crits-Christoph, Connolly Gibbons, & Hearon, 2006; DeRubeis, Brotman, & Gibbons, 2005). Theoretically, as Bordin (1979, p. 253) argued, we can expect that "the effectiveness of a therapy is a function in part, if not entirely, of the strength of the working alliance." If we understand alliance as a measure of how well the therapist and patient are working together, the greater the strength of the alliance, the more work gets done. This entails that the alliance is a moderator; that is, it enables the therapeutic work to occur, influencing the degree of change. Yet it may not be an independent moderator, if what contributes to the development of strong alliance independently moderates or mediates outcome. As detailed in the next section, there is reason to take this line. Barber et al. (2010) noted that studies of the alliance as moderator are limited, which is unsurprising given the methodological difficulties involved, as the alliance emerges over time and is rarely measured at the same time as the treatment variables.

They also review three studies of the alliance as mediator, that is, contributing independently to therapeutic action, bringing about change itself. The studies together provide some weak support for the view, but more research is clearly needed. Barber (2009) argued that the alliance, rather than being a mediator, is more likely simply an indicator of whether therapy is going well or not. Even if we allow that the alliance is a mediator, the correlation coefficients indicate that the alliance accounts for around 5–7% of the variation among outcomes (Beutler, 2009; Messer & Wolitzky, 2010).

The final difficulty with establishing the alliance as either moderator or mediator is the lack of clarity over how alliance should be understood, the use of different assessment tools, the variety of outcome measures to which alliance is correlated, and so on (Messer & Wolitzky, 2010). Hatcher (2010) argued that alliance is best understood as a way of thinking about how well the therapist and patient are *working* together, but researchers commonly fail to distinguish it from other elements of the relationship. For example, Martin et al. (2000, p. 438) understood it in terms of "the affective bond between patient and therapist," thus confusing alliance with liking, respect, warmth, and so on. Measurements of the correlation of alliance with outcome may, in many cases, be measurements of the correlation of other relationship factors with outcome. Unsurprisingly, Ackerman and Hilsenroth (2003) found that therapists who were flexible, experienced, honest, respectful, trustworthy, confident, interested, alert, friendly, warm, and open formed strong alliances with their patients. Conversely, poor alliances were formed by therapists who showed disregard for their patients, who were distracted, self-focused, less involved, uncertain of their ability to help, tense, tired, bored, distant, aloof, critical, defensive, blaming, or generally unable to provide a supportive environment (Ackerman & Hilsenroth, 2001). These personal and relationship factors, or indeed something which unites and is expressed through them, may be operating as either moderator or mediator of outcomes, rather than the alliance itself.

We should conclude that the evidence does not currently support the view that the alliance independently contributes to outcomes. Nevertheless, it indicates something important about how the therapeutic relationship is working. It is to the question of the therapeutic relationship as a "common factor" that we now turn.

THE THERAPEUTIC RELATIONSHIP IN PSYCHODYNAMIC PSYCHOTHERAPY

Rejecting the Common Factor View of the Therapeutic Relationship

There was a well-known orthodox line of thought in psychoanalysis that its therapeutic action rested on insight *as opposed to* such forms of emotional support as might be found in other psychotherapies. These forms of support were said to amount to "suggestion" (Eissler, 1953; Glover, 1931, 1955; Jones, 1910). This orthodox view is indefensible, and the importance of the therapeutic relationship (including the alliance), at least as moderators of outcome, has been theorized in psychodynamic psychotherapy since Freud. Hatcher (2010) argued that the clinical techniques of psychoanalysis, including the analysis of resistance and of transference, can be understood as means of preserving the personal bond, emphasized by Freud (1912), and protecting and strengthening the alliance, thus promoting the therapeutic work. The view that the relationship operates as a mediator, not only as a moderator, also has considerable historical precedent, going back to Bibring (1937) and Zetzel (1956, 1966). Since at least the 1950s in the United Kingdom and the 1960s in the United States, psychoanalysts have come to recognize the therapeutic action of the relationship, as moderator and/or mediator, and there are few psychoanalysts who would accept the orthodox view now (Abend, 2001; Messer & Wolitzky, 2010; Wallerstein, 1995). The case in favor of the therapeutic action of the relationship is overwhelming and the debate closed (Diamond & Christian, 2011; Eagle, 2011; Gabbard & Westen, 2003).

While, of course, all therapies involve some form of therapist–patient relationship, to think of the therapeutic relationship as a "common" or "nonspecific" factor in Lambert's (2013) sense of "not emphasized by the theory of change central to a particular school" is a significant mistake. I outline below a contemporary psychodynamic account of the therapeutic action of the relationship, eschewing technicalities and controversial theoretical constructions as far as possible, as they obscure the common ground and main lines of argument (Smith, 2001, 2007). (See Wallerstein, 1995, and Eagle, 2011, for historical and contemporary surveys, respectively.)

Structural Change and Associational Networks

To understand how the therapeutic relationship may mediate change, we first need to describe the nature of the change, theoretically understood. A central aim of psychoanalysis has been "structural" change, leading, in particular, to a greater unity or coherence of the self

(e.g., Brenner, 1976; Fairbairn, 1952; Freud, 1923; Guntrip, 1969; Kohut, 1984; Levy et al., 2006; Loewald, 1979; Steiner, 1989; Strachey, 1934; Wallerstein, 1988). Although there is considerable discrepancy in how structural change is conceived, divergences stem primarily from metapsychological and other theoretical commitments (Pine, 1988; Wallerstein, 1988). Underlying the divergence is a deep commonality (Westenberger-Breuer, 2007), which Gabbard and Westen (2003) formulated as follows: Structural change involves altering the patient's unconscious "associational networks" that support maladaptive defensive strategies, interpersonal patterns of relating, and emotional reactions. Such networks may involve connections between representations and affects, for example, that authority figures will always be angry; or they may involve wishes that others behave in certain ways; or they may involve beliefs, fantasies, and expectations about interpersonal relations, for example, that if one expresses anger, others will withdraw their love. The existence and operation of such associational networks, operating outside and independently of consciousness to influence judgments, decisions, emotions, and behavioral reactions, have been firmly established through work on implicit memory (Westen & Gabbard, 2002a, 2002b) and automatic, nonconscious functioning (Dijksterhuis, 2010; Hassin, Uleman, & Bargh, 2005).

Such central psychodynamic concepts as object relations and transference fit easily into this structure. We can understand "object relations" as "the cognitive, affective, and motivational processes mediating interpersonal functioning, and ... the enduring patterns of interpersonal behavior that draw upon these intrapsychic structures and processes" (Westen, 1990, p. 686). Internalized "objects," in this sense, include "schemas" or "models" of oneself, other persons, particular relationships, and relationship structures, embedded in and organized by associational networks. Current interpersonal relationships are impacted upon by these enduring patterns, assimilating our present to our past: When a "node" in the network, for example, a representation of a particular interpersonal situation, is "activated," the network as a whole comes into play to interpret experience or influence behavior. This process is also what underpins transference. The minimal resemblance of the analyst to a patient's significant "object" leads to a set of responses, attitudes, and behaviors deriving from the patient's object relations. Hence, unconscious models of ourselves and significant others, deriving from the past, affect our perception, cognition, motivation, and affective states in myriad, patterned ways.

This model of interpersonal mental functioning has received considerable empirical support, for example, the "internal working model" of attachment theory (Cassidy & Shaver, 1999), Stern's (1985) concept, in developmental psychology, of RIGs (Representations of Interactions that have been Generalized), and Andersen and colleagues' theory of the relational self in personality psychology (Andersen & Chen, 2002; Andersen & Thorpe, 2009).

The Therapeutic Relationship

Many conceptions of therapeutic action in the contemporary psychodynamic literature can be understood in these terms. Through the patient's experience of a new type of relationship with an interested, persistently curious, caring, nonmoralizing, and nonretaliatory person, the patient's maladaptive expectations and representations are disconfirmed and the development of more adaptive ones encouraged (Eagle, 2011; Zuroff & Blatt, 2006). This view is supported by the work of Stern and attachment theory on the development in children of models of self, others, and relationships, and by Weiss and Sampson (1986), who showed that when the therapist, through her behavior and reactions, disconfirms some "unconscious pathogenic belief" of the patient, there is therapeutic progress, indicated by the emergence of new themes, greater flexibility of defenses, and reduced anxiety. When the therapist fails to disconfirm such a belief, and the patient is looking to her to do so, this is followed by defensive behavior and a lack of progress.

This model of therapeutic action has its historical antecedents in Fairbairn (1952), Winnicott (1965), and Loewald (1960), among others. Experiencing the therapist as a (new) good object enables the formation of a new object relationship, and the transformation of old, maladaptive object relationships. But it is neither likely nor therapeutic for the analyst to be experienced just as a new, good object. The process of transformation requires that the problematic associative networks be "activated"; that is, the patient must also experience

the therapist in terms of his existing, problematic object relationships, or in other words again, the patient must form a transference along these lines. The emotional dimensions of the object relationship must be present and meaningful to the patient for the therapeutic relationship to transform his object relationships.

Thus, once we abstract from debatable metapsychological and etiological theories, it becomes clear that psychodynamic therapies identify the therapeutic relationship as central to therapeutic improvement and that there is a well-developed psychodynamic theory, many aspects of which have received independent empirical support, of how the relationship brings about therapeutic change.

This theoretical situation may be contrasted with that in other, nonpsychodynamic forms of therapy, such as cognitive and behavioral therapies (CBTs); the contrast clarifies how psychodynamic theories more easily accommodate the therapeutic action of the therapeutic relationship. Castonguay, Constantino, McAleavey, and Goldfried (2010) noted that the place of the relationship in therapeutic action was both theoretically and clinically neglected for many years in CBTs. While warmth and empathy were noted as important moderators, few researchers theorized accounts of why this should be until the mid-1980s. Such factors were very much "nonspecific," and this view is still very widespread among CBT scholars. As Safran and Muran (2006) noted, the concept of the alliance has been important in keeping the therapeutic relationship in focus at a time when cognitive and behavioral therapies gave it little attention. Thus, Bjornsson (2011) criticized CBTs for failing to integrate relationship factors into their accounts of therapeutic action, while Kazdin (2007) and Power and Dalgleish (2008) argued that the traditional account of therapeutic change as a result of changes in cognitions is no longer tenable. However, theoretically cohesive accounts of the importance of the alliance were developed in the late 1990s, albeit requiring "theoretical extensions" of CBT (Castonguay et al., 2010). Interestingly, a number of important contributions (e.g., Goldfried, 1985; Kohlenberg & Tsai, 1991; Young, 1999) recommended interventions focused on the therapeutic relationship itself, which Young (1999) compares to transference interpretations in psychodynamic therapies. Power and Dalgleish (2008) provided a good example of how cognitive behavior theory is, in many ways, becoming recognizably more psychodynamic in its understanding of the mind. The advent of cognitive analytic therapy (Ryle & Kerr, 2002) also indicates rapprochement.

This account is not intended to establish that the therapeutic relationship *is* a mediator or even a moderator of outcome; that argument has been made extensively elsewhere (e.g., Norcross, 2011). My argument has been that, if it is, it is a mistake to draw the conclusion that "common factors" *as opposed to* specific factors are most efficacious.

This does not mean that there is no disagreement between the common factor view, as I have termed it, and psychodynamic theories of therapeutic action, because the latter, of course, have also maintained a distinct and independent role for insight, typically understood as a specific factor in psychodynamic psychotherapies. It is to this point of disagreement that we now turn. Before doing so, it is worth noting that relationship factors may act both as independent mediators of outcome and as moderators for insight. Thus, to establish insight as a mediator, it is not necessary to show that it is independent of moderating effects of relationship factors.

Insight and the Therapeutic Relationship

What place may we find for insight in the model of therapeutic action above (again, I abstract from the metapsychological debates)? A way in lies in understanding how it is that the patient can experience the therapist both in terms of his existing, problematic object relationships and as a new, good object (Eagle, 2011). How does the good object relationship grow from the bad? A large part of the answer is that the experience of the therapist as a bad object is subject to mutual examination which is open-minded, nondefensive, and empathic (on the part of the therapist). This contributes to the patient's feeling understood, accepted, and supported and encourages the patient to explore how his mind works, how his feelings, expectations, and thoughts interact (Eagle, 2011). Hence, the "corrective" nature of the experience of the relationship lies, in part, in coming to understand the obstacles erected by existing object relationships to experiencing the analyst as a new, good object.

Interventions that support the development of the patient's insight (recalling that this covers both specific insights and insightfulness) are an integral part of the relationship and its therapeutic action. Thus, as remarked above, Hatcher (2010) argued that we can understand Freud's interpretations of transference and resistance as preserving and strengthening the alliance, a view reaffirmed by Sterba (1934) and Greenson (2008). Of course, the *manner* (phrasing, timing, tone, attitude) in which the therapist draws the patient's attention to his patterns of experience and behavior will be central to the therapeutic effects of doing so (Barber, Crits-Christoph, & Luborsky, 1996), as it must enable the patient to experience the therapist as a good object in that very experience, often painful, of recognizing such patterns.

It transpires that the efficacy of such interventions interacts with the quality of the patient's object relations (QOR) and the strength of alliance, which also interact with each other:

1. Patients with low QOR do worse in interpretive therapy than patients with high QOR (Piper, Joyce, McCallum, & Azim, 1998).
2. Supportive interventions are more helpful in cases of poor alliance, interpretive interventions in cases of good alliance (Gaston, Piper, Debbane, & Garant, 1994).
3. The strength of alliance is predicted by the patient's QOR (Ackerman, Hilsenroth, & Knowles, 2005).
4. For patients with low QOR, strengthening the alliance is directly correlated with a better outcome (Piper, Boroto, Joyce, McCallum, & Azim, 1995).
5. A stronger alliance is also predicted by the therapist's having the traits of a "good object"—being honest, respectful, trustworthy, and so on (Ackerman & Hilsenroth, 2003).

Putting these results together, we may infer that low patient QOR needs to be compensated for by a stronger alliance if the patient is to benefit from interpretations aimed at increasing insight. To achieve this stronger alliance, additional supportive measures are needed. As Luborsky (1984) argued, the more disturbed the patient, the greater the need for supportive interventions, whereas less disturbed patients can benefit from interpretive interventions. In this way, supportive relationship factors (and therapist and patient variables) act as a moderator for insight.

Where the conditions are in place for interventions that support insight to benefit the patient, then, because such interventions are equally developments within the relationship, we may say that the (supportive) aspects of therapeutic action that work through the relationship and those (expressive) aspects that work through the development of insight are inseparable (Wallerstein, 1995).

INSIGHT: THE EVIDENCE FROM OUTCOME STUDIES

Correlating Insight and Therapeutic Success

So much for the theoretical account. The challenge that Lambert, Wampold, and others may put to psychodynamic theories is this: If psychodynamic insight is a modulator or mediator specific to psychodynamic psychotherapy, why hasn't this shown up in the outcome studies comparing the efficacy of psychodynamic and other therapies?

A first response is that outcome studies need something clear to measure, and the measures commonly used in outcome studies (e.g., for depression, the Beck Depression Inventory [Beck, Ward, Mendelson, Mock, & Erbaugh, 1961] or the Hamilton Rating Scale for Depression [Hamilton, 1960]) are oriented toward symptoms. They do not measure what psychodynamic psychotherapy, especially in its long-term and psychoanalytic forms, would claim to be uniquely best at achieving (Blatt & Auerbach, 2003; Kazdin, 2008). Perhaps the specific factor of insight contributes to the distinctive goals of such therapies.

"Structural change" to a subject's "associational networks" and "object relations" is indicated by verbalization of affective experience and behavior, tolerating a wider range of emotional experiences, being more emotionally "alive," maintaining a realistic self-esteem, having a more satisfying sex and love life, understanding oneself and others in more nuanced ways, being more creative and fulfilled in work, and living with greater freedom and flexibility (e.g., Cogan, 2007; Shedler, 2010; Wallerstein, 1988; Westenberger-Breuer, 2007). Measuring these involves gauging the development of inner capacities and resources, not an easy task. The Shedler–Westen Assessment Procedure

(Shedler & Westen, 2007; Westen & Shedler, 1999a, 1999b) provides an important attempt to do this, but outcome research employing it is yet to be done. To date, one study (Cogan & Porcerelli, 2005) has found that patients ending psychoanalysis score significantly higher than those entering it, but no further conclusions can be drawn. Cogan (2007) presented initial data supporting the idea that fully achieving these goals could take a significant length of time in therapy. Hence, the empirical work is yet to be done on establishing whether long-term psychodynamic psychotherapy (LTPP) uniquely delivers therapeutic success in its own terms.

Second, we cannot expect measurements comparing the efficacy of psychodynamic psychotherapy with other therapies always provide results relevant to the therapeutic action of insight. First, not all psychodynamic treatments aim at supporting the development of insight; only interpretive forms do. Second, psychodynamic theories claim that the therapeutic relationship plays a significant role, and the evidence indicates that it moderates the effects of insight. Thus, insight may only be effective when the therapeutic alliance is strong, and a variety of factors may affect this, including patient variables (Gabbard, 2004); early outcome studies, at least, typically failed to focus on these differences. Third, it may be that gains in insight require a lengthy therapeutic treatment in order to bring about their effects.

Significant correlations between therapeutic results and increases in insight have not commonly been found in studies of short-term psychodynamic psychotherapy (STPP) of under 6 months (e.g., Connolly et al., 1999), but they have been found in LTPP (over 50 sessions and/or 1 year) for moderately disturbed patients (Høglend et al., 1994; Luborsky et al., 1988). Furthermore, although in some tension with the findings reported above on the interaction between QOR and interpretive therapies, Levy et al. (2006) and Bateman and Fonagy (2008) found a correlation between increased reflective function (hence insight) and outcomes in borderline patients in LTPP, whereas Johansson et al. (2010) found a significant correlation between increased insight and improvement in interpersonal functioning in LTPP for patients with low QOR at outset, but not for those with already high quality object relations. (For further reviews of the correlation between insight and outcome, see Connolly Gibbons, Crits-Christoph, Barber, & Schamberger, 2007; Messer & McWilliams, 2007; Shedler, 2010.)

The Therapeutic Action of Insight

Given this correlation between increased insight and outcomes in LTPP, if insight modulates or mediates outcomes, we would expect to find this demonstrated in the increased effectiveness of LTPP over other forms of therapy. Evidence supporting this conclusion is just beginning to emerge. Recent studies and meta-analyses (Knekt et al., 2008, 2011; Leichsenring & Rabung, 2008, 2011; de Maat, de Jonghe, Schoevers, & Dekker, 2009) indicate that the benefits of psychodynamic psychotherapy become much more pronounced *after* 6 months of treatment; and that, while acute disorders are successfully treated by short-term therapies, LTPP is more successful in the long run for chronic distress, mood, anxiety, and personality disorders. These benefits not only endure but also increase over time (Abbass, Hancock, Henderson, & Kisely, 2006; Anderson & Lambert, 1995; Bateman & Fonagy, 2008; Høglend et al., 2008; Leichsenring & Rabung, 2008; Leichsenring, Rabung, & Leibing, 2004; Levy, Ablon, & Kächele, 2012; de Maat et al., 2009). The evidence concerning the success of LTPP was not available previously because the work had not been done: Most outcome studies have compared rival psychotherapies with STPP; for example, in their meta-analysis of studies looking at complex disorders, Leichsenring and Rabung (2011) found just 10 qualifying studies between 1960 and 2010 that looked at LTPP.

Does the greater effectiveness of LTPP (for chronic disorders) show that insight contributes to its outcomes? An alternative explanation presents itself, namely, simply the length of treatment, or some factor that is the product of this, for example, an ever-strengthening therapeutic relationship. To be sure, we need studies comparing interpretive forms of LTPP to other treatments lasting as long. But long-term CBT and behavioral therapy are rare, not least because the need for such long-term treatments is not well supported theoretically in these therapies. But there have been long-term studies comparing supportive and interpretive (or "expressive") psychodynamic psychotherapy, perhaps

most famously the Menninger Clinic's Psychoanalysis Research Project (PRP). As reported in Wallerstein (1986), this study found no significant differences between the therapeutic outcomes of the two approaches—so insight apparently made no difference.

In fact, this conclusion proved too simple, as more detailed analyses of the results showed. First, patients in this study with higher QOR did better with expressive approaches (Bateman & Fonagy, 2004). Second, complicating the picture further, Blatt (1992) found that "introjective" patients did better with expressive approaches, while "anaclitic" patients did better with supportive ones, a result confirmed by his own studies (e.g., Blatt, Ford, Berman, Cook, & Myers, 1988). "Anaclitic" and "introjective" identify lines of personality development, imbalance in which can give rise to certain forms of psychopathology. The anaclitic line "involves the development of stable, mutually satisfying interpersonal relations," while the introjective line "involves the development of a realistic and positive self-identity" (Blatt, 1992, p. 695). Anaclitic patients are primarily preoccupied with interpersonal relations (e.g., intimacy and sexuality) and use avoidant defenses (withdrawal, denial, repression, displacement), whereas introjective patients are primarily preoccupied with maintaining a viable sense of self (e.g., self-definition, self-control, self-worth, issues of anger and aggression) and use counteractive defenses (projection, rationalization, intellectualization, undoing, reaction formation). As with QOR, the distinction is a matter of "more or less." Thus, insight did make a difference, but it interacted with other variables.

That insight contributes to LTPP's success (with chronic disorders) is indirectly supported by three further considerations:

1. Increases in insight correlated with outcome in LTPP (above), and there are also correlations between the patient's level of insight and outcomes for both STPP and LTPP (Conte et al., 1990; Gelso, Kivlighan, Wine, Jones, & Friedman, 1997; Høglend et al., 1994; Luborsky et al., 1988; Piper, Joyce, Rosie, & Azim, 1994a, 1994b).
2. Psychodynamic psychotherapy secures greater improvements in variables related to insight than other forms of therapy (Grosse Holfort et al., 2007). Levy et al. (2006) reached this finding in the case of borderline personality disorder, using measurements of reflective function; Gibbons et al. (2009) found it for patients with major depressive disorder, generalized anxiety disorder, panic disorder, borderline personality disorder, and adolescent anxiety disorders, using a measurement for self-understanding; and Kallestad et al. (2010) found it for a generalized measure of insight (not psychodynamic insight specifically) for patients with Cluster C personality disorders.
3. Johansson et al. (2010) found that improvements in insight *precede* improvements in interpersonal functioning. So the development of insightfulness does not come all at once, at the end of therapy, as a result of therapy; its gradual development during therapy supports interpersonal functioning at the end of therapy and beyond.

The view defended here is the best explanation for the results discussed previously. If the success of LTPP rested on relationship factors only, this would not explain why interpretive and supportive forms of LTPP —which are differentiated precisely in terms of expressive interventions that are correlated with increased insight—produce different results for different types of patient. It is more economical to think that insight contributes to outcomes, indeed is a mediator, albeit one moderated in complicated ways by patient and relationship variables. That said, the precise interaction between expressive interventions, patient variables (such as QOR), and relationship variables (such as the therapeutic alliance) in relation to outcomes is still unclear.

INSIGHT: THE WIDER ARGUMENT

Given the connection of psychodynamic insight into reflective function and psychological defense, a wider argument, taking in other sources of evidence, can be made for the operation of insight as a mediator in therapeutic outcomes.

Reflective Function

Greater reflection function enables a better understanding of both oneself and others, increased emotional

self-control, and improved interpersonal functioning (Bateman & Fonagy, 2008; Fonagy, 2006; Fonagy, Gergely, Jurist, & Target, 2002; Fonagy & Target, 1996). It is important in child development (Fonagy et al., 1995; Grienenberger et al., 2005; Lieberman, 1999). Insecure attachment in the infant is associated with poor reflective functioning of the caregiver, but an insecurely attached caregiver with high reflective function may nevertheless have a securely attached child. A more accurate, empathic understanding of others commonly contributes to better functioning in work and love and requires a degree of understanding of oneself, for example, a sensitivity to the way in which one is disposed to misinterpret others defensively, the ability to disentangle one's own subjectivity from what one reads in another, and the capacity to understand one's reactions to others as a result of particular interpretations of them (Gabbard & Horowitz, 2009).

So insightfulness can be correlated with therapeutic gain via reflective function, while a lack of insightfulness is correlated with (at least certain forms of) pathology through the correlation of poor reflective functioning and pathology and, more indirectly, through the correlation of poor reflective functioning and insecure attachment, and the correlation of this with pathology.

Because reflective functioning is a scalar concept, we may expect gradual improvement over time; it improves with practice. The first steps in developing greater insight will be through reaching particular insights, but over time, this process contributes to the expansion, accuracy, and speed/automaticity of insightfulness. With automaticity, insightfulness has become embedded in a new way of relating to others. The development of insightfulness, then, may itself be counted as a structural change, as one's associational networks and object relations are more attuned to the truth of how one and others actually are. The therapeutic relationship supports this orientation toward reality, as the truthfulness—the truth-seeking attitude—of the therapist is internalized by the patient. *Where the other is truthful*, and supports us to become more truthful, corrective emotional experiences can facilitate the acquisition of insight, and the development of self-understanding can lie in relationship with another (Eagle, 2011). Thus, the therapeutic relationship supports the development of insight together with secure attachment, and these jointly support improvements in interpersonal and general functioning.

Psychological Defense

The theory of psychological defense makes various predictions that have been tested empirically, and an excellent review of some of the evidence is given in Cramer (2006). Defense use increases under conditions of stress and anxiety (whether internal or external) and decreases the subjective experience of anxiety (Cramer, 2006, pp. 142–144, 159–160); and both excessive use of neurotic defenses and the use of age-inappropriate immature defenses are associated with both subclinical pathology (i.e., among "normal"—nonpatient—samples; Cramer, 2006, pp. 235–236) and clinical pathology (Cramer, 2006, pp. 253–254). Conversely, the use of mature defenses soon after adolescence predicts positive adjustments to life's challenges later on (Cramer, 2006, pp. 210–211, 218).[2]

Given that defenses involve the distortion of one's understanding of oneself and others, and that insight involves understanding oneself (and others) more truthfully, seeing the connections and patterns that defense hides, we may infer a strong connection between a lack of insight and pathology. Conversely, greater insight, indicated by the absence of defenses (or use of only nondistorting mature defenses), is correlated with improvements in psychic health and interpersonal functioning. The deconstruction of defenses constitutes an increase in insight and contributes to these therapeutic outcomes.

CONCLUSION

Lambert, Wampold, Frank, and others have argued that common or nonspecific factors, such as the therapeutic alliance and aspects of the therapeutic relationship, are central to therapeutic action, while specific factors—such as insight in psychodynamic psychotherapy—make relatively little contribution. I have argued against this claim, which I named the common factor view. I first identified psychodynamic insight as insight into the connections between one's mental states and behavior, past and present, including one's interpretations and relations with others, many of which connections are unconscious

and defended against. I elaborated this conception in relation to theories of psychological defense and reflective function. I then considered a series of challenges to an argument central to the common factor view, specifically whether the therapeutic alliance is merely a predictor, a moderator, or a mediator of outcomes. I argued that it is misleading to talk of the therapeutic relationship as a common factor; while it is "common" to different psychotherapies, it is not "nonspecific," as it has been extensively theorized by psychodynamic therapies since Freud. I provided a contemporary theoretical account of its action and found a place for the therapeutic action of insight, noting that the efficacy of insight was moderated by both relationship and patient variables. I then made the case for insight as a therapeutic factor based on evidence from outcome studies, explaining why more evidence for this conclusion has not been forthcoming and outlining several key findings. Increases in insight correlate with outcomes in LTPP, and a series of recent studies indicate that LTPP may have greater efficacy than other therapies for chronic disorders. After considering an alternative explanation of this finding, I argued that the best explanation for the overall evidence from the outcome studies considered is that insight contributes to outcomes, at least in LTPP, although its interrelation with patient and relationship variables is still somewhat unclear. I ended with a further argument for this conclusion from independent evidence related to reflective function and psychological defense. On these grounds, taken all together, it is reasonable to believe that psychodynamic insight plays an important role in the therapeutic action of psychodynamic psychotherapy, and the common factor view needs to be rethought.

NOTES

1. While the measurement of reflective function (Fonagy et al., 1995) and defenses (Conte & Plutchik, 1995; Cramer, 2006) has been operationalized, there is no agreed operationalized measure for insight. However, Johansson et al. (2010), Luborsky et al. (1988), and Høglend, Engelstad, Sørbye, Heyerdahl, and Amlo (1994) all used clinical ratings based on detailed interviews, and in each case, the measures have proven valid and reliable, establishing that psychodynamic insight can be measured.

2. Many other specific claims following from psychodynamic theory regarding psychological defense have received separate empirical support. For example, see Dixon (1981) on preconscious inhibition in perception; Adams, Wright, and Lohr (1996) explaining homophobia as repressed homosexuality; Erdelyi (2006) for an empirically grounded theory of repression; and Berlin and Koch (2009) on neuroscientific evidence for dissociation. A number of researchers have also applied empirical methods to clinical data and corroborated the predictions made by the psychodynamic model, for example, Dahl, Kächele, and Thomä (1988), Luborsky (2001), and Luborsky and Luborsky (2006).

REFERENCES

Abbass, A. A., Hancock, J. T., Henderson, J., & Kisely, S. (2006). Short-term psychodynamic psychotherapies for common mental disorders. *Cochrane Database of Systematic Reviews*, *4* (Article No. CD004687). doi:10.1002/14651858.CD004687.pub3

Abend, S. M. (2001). Expanding psychological possibilities. *Psychoanalytic Quarterly*, *70*, 3–14. doi:10.1002/j.2167-4086.2001.tb00587.x

Ackerman, S. J., & Hilsenroth, M. J. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy: Theory, Research, Practice, Training*, *38*, 171–185. doi:10.1037/0033-3204.38.2.171

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review*, *23*, 1–33. doi:10.1016/S0272-7358(02)00146-0

Ackerman, S. J., Hilsenroth, M. J., & Knowles, E. S. (2005). Ratings of therapist dynamic activities and alliance early and late in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, *42*, 225–231. doi:10.1037/0033-3204.42.2.225

Adams, H. E., Wright, L. W., & Lohr, B. A. (1996). Is homophobia associated with homosexual arousal? *Journal of Abnormal Psychology*, *105*, 440–445. doi:10.1037/0021-843X.105.3.440

Anderson, E. M., & Lambert, M. J. (1995). Short-term dynamically oriented psychotherapy: A review and meta-analysis. *Clinical Psychology Review*, *15*, 503–514. doi:10.1016/0272-7358(95)00027-M

Andersen, S. M., & Chen, S. (2002). The relational self: An interpersonal social-cognitive theory. *Psychological Review*, *109*, 619–645. doi:10.1037/0033-295X.109.4.619

Andersen, S. M., & Thorpe, J. S. (2009). An IF-THEN theory of personality: Significant others and the relational self. *Journal of Research in Personality*, *43*, 163–170. doi:10.1016/j.jrp.2008.12.040

Barber, J. P. (2009). Toward a working through of some core conflicts in psychotherapy research. *Psychotherapy Research*, *19*, 1–12. doi:10.1080/10503300802609680

Barber, J. P., Connolly, M. B., Crits-Christoph, P., Gladis, M., & Siqueland, L. (2000). Alliance predicts patients' outcome beyond in-treatment change in symptoms. *Journal of Consulting and Clinical Psychology*, *68*, 1027–1032. doi:10.1037/1949-2715.S.1.80

Barber, J. P., Crits-Christoph, P., & Luborsky, L. (1996). Effects of therapist adherence and competence on patient outcome in brief dynamic therapy. *Journal of Consulting and Clinical Psychology*, *64*, 619–622. doi:10.1037/0022-006X.64.3.619

Barber, J. P., Khalsa, S.-R., & Sharpless, B. A. (2010). The validity of the alliance as a predictor of psychotherapy outcome. In J. C. Muran & J. P. Barber (Eds.), *Therapeutic alliance: An evidence-based guide to practice* (pp. 29–43). New York, NY: Guilford Press.

Bateman, A., & Fonagy, P. (2004). *Psychotherapy for borderline personality disorder: Mentalization-based treatment*. New York, NY: Oxford University Press.

Bateman, A., & Fonagy, P. (2008). Comorbid antisocial and borderline personality disorders: Mentalization-based treatment. *Journal of Clinical Psychology*, *64*, 181–194. doi:10.1002/jclp.20451

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, *4*, 561–571. doi:10.1001/archpsyc.1961.01710120031004

Berlin, H., & Koch, C. (2009). Neuroscience meets psychoanalysis. *Scientific American Mind*, *20*(2), 16–19. doi:10.1038/scientificamericanmind0409-16

Beutler, L. E. (2009). Making science matter in clinical practice: Redefining psychotherapy. *Clinical Psychology: Science and Practice*, *16*, 301–317. doi:10.1111/j.1468-2850.2009.01168.x

Bibring, E. (1937). Symposium on the theory of the therapeutic results of psychoanalysis. *International Journal of Psychoanalysis*, *18*, 170–180. Retrieved from http://www.pep-web.org/document.php?id=ijp.018.0125a

Bjornsson, A. S. (2011). Beyond the "psychological placebo": Specifying the nonspecific in psychotherapy. *Clinical Psychology: Science and Practice*, *18*, 113–118. doi:10.1111/j.1468-2850.2011.01242.x

Blatt, S. J. (1992). The differential effect of psychotherapy and psychoanalysis with anaclitic and introjective patients: The Menninger Psychotherapy Research Project revisited. *Journal of the American Psychoanalytic Association*, *40*, 691–724. doi:10.1177/000306519204000303

Blatt, S. J., & Auerbach, J. S. (2003). Psychodynamic measures of therapeutic change. *Psychoanalytic Inquiry*, *23*, 268–307. doi:10.1080/07351692309349034

Blatt, S. J., Ford, R. Q., Berman, W., Cook, B., & Myers, R. (1988). The assessment of therapeutic change in schizophrenic and borderline young adults. *Psychoanalytic Psychology*, *5*, 127–158. doi:10.1037/0736-9735.5.2.127

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice*, *16*, 252–260. doi:10.1037/h0085885

Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C., ... Yeomans, D. (2012). Psychiatry beyond the current paradigm. *British Journal of Psychiatry*, *201*, 430–434. doi:10.1192/bjp.bp.112.109447

Brenner, C. (1976). *Psychoanalytic technique and psychic conflict*. Madison, CT: International Universities Press.

Cassidy, J., & Shaver, P. R. (1999). *Handbook of attachment: Theory, research and clinical applications*. New York, NY: Guilford Press.

Castonguay, L. G., Constantino, M. J., McAleavey, A. A., & Goldfried, M. R. (2010). The therapeutic alliance in cognitive-behavior therapy. In C. J. Muran & J. P. Barber (Eds.), *Therapeutic alliance: An evidence-based guide to practice* (pp. 150–171). New York, NY: Guilford Press.

Castonguay, L. G., & Hill, C. (Eds.). (2007). *Insight in psychotherapy*. Washington, DC: American Psychological Association. doi:10.1037/11532-000

Cogan, R. (2007). Therapeutic aims and outcomes of psychoanalysis. *Psychoanalytic Psychology*, *24*, 193–207. doi:10.1037/0736-9735.24.2.193

Cogan, R., & Porcerelli, J. H. (2005). Clinician reports of personality pathology of patients beginning and patients ending psychoanalysis. *Psychology and Psychotherapy: Theory, Research, and Practice*, *78*, 235–248. doi:10.1348/147608305X28727

Connolly, M. B., Crits-Christoph, P., Shappell, S., Barber, J., Luborsky, L., & Shaffer, C. (1999). Relation of transference interpretations to outcome in the early sessions of brief supportive-expressive psychotherapy. *Psychotherapy Research*, *9*, 485–495. doi:10.1080/10503309912331332881

Connolly Gibbons, M. B., Crits-Christoph, P., Barber, J. P., & Schamberger, M. (2007). Insight in psychotherapy: A review of empirical literature. In L. Castonguay & C. Hill (Eds.), *Insight in psychotherapy* (pp. 143–165). Washington, DC: American Psychological Association.

Conte, H. R., & Plutchik, R. (Eds.). (1995). *Ego defenses: Theory and measurement*. Oxford, United Kingdom: John Wiley & Sons.

Conte, H. R., Plutchik, R., Jung, B. B., Picard, S., Karasu, T. B., & Lotterman, A. (1990). Psychological mindedness as a predictor of psychotherapy outcome: A preliminary report. *Comprehensive Psychiatry*, *31*, 426–431. doi:10.1016/0010-440X(90)90027-P

Cramer, P. (2006). *Protecting the self: Defense mechanisms in action*. New York, NY: Guilford Press.

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

Dahl, H., Kächele, H., & Thomä, H. (Eds.). (1988). *Psychoanalytic process research strategies*. Berlin, Germany: Springer.

DeRubeis, R. J., Brotman, M. A., & Gibbons, C. J. (2005). A conceptual and methodological analysis of the nonspecifics argument. *Clinical Psychology: Science and Practice*, *12*, 174–183. doi:10.1093/clipsy.bpi022

DeRubeis, R., & Feeley, M. (1990). Determinants of change in cognitive therapy for depression. *Cognitive Therapy and Research*, *14*, 469–482. doi:10.1007/BF01172968

Diamond, M., & Christian, C. (2011). A brief history of therapeutic action: Convergence, divergence, and integrative bridges. In M. Diamond & C. Christian (Eds.), *The second century of psychoanalysis: Evolving perspectives on therapeutic action* (pp. 3–20). London, United Kingdom: Karnac.

Dijksterhuis, A. (2010). Automaticity and the unconscious. In S. Fiske, D. Gilbert, & G. Lindzey (Eds.), *Handbook of social psychology* (pp. 228–267). New York, NY: McGraw-Hill.

Dixon, N. F. (1981). *Preconscious processing*. Chichester, United Kingdom: Wiley.

Eagle, M. N. (2011). *From classical to contemporary psychoanalysis: A critique and integration*. New York, NY: Taylor & Francis.

Eissler, K. R. (1953). The effect of the structure of the ego on psychoanalytic technique. *Journal of the American Psychoanalytic Association*, *1*, 104–143. doi:10.1177/000306515300100107

Erdelyi, M. H. (2006). The unified theory of repression. *Behavioral and Brain Sciences*, *29*, 499–511. doi:10.1017/S0140525X06009113

Fairbairn, W. R. D. (1952). *Psychoanalytic studies of the personality*. London, United Kingdom: Tavistock.

Fonagy, P. (2006). In praise of simplicity: Commentary on Ablon and Jones. *Journal of the American Psychoanalytic Association*, *53*, 579–589. doi:10.1177/00030651050530020801

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization and the development of the self*. New York, NY: Other Press.

Fonagy, P., Leigh, T., Steele, M., Steele, H., Kennedy, R., Mattoon, G., … Gerber, A. (1996). The relation of attachment status, psychiatric classification, and response to psychotherapy. *Journal of Consulting and Clinical Psychology*, *64*, 22–31. doi:10.1037/0022-006X.64.1.22

Fonagy, P., Steele, H., Morgan, G., Steele, M., & Higgitt, A. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal*, *13*, 200–217. doi:10.1002/1097-0355(199123)12:3%3C201:AID-IMHJ2280120307%3E3.0.CO;2-7

Fonagy, P., Steele, M., Steele, H., Leigh, T., Kennedy, R., Mattoon, G., et al. (1995). Attachment, the reflective self, and borderline states: The predictive specificity of the Adult Attachment Interview and pathological emotional development. In S. Goldberg, R. Muir, & J. Kerr (Eds.), *Attachment theory: Social, developmental and clinical perspectives* (pp. 233–278). New York, NY: Analytic Press.

Fonagy, P., & Target, M. (1996). Playing with reality: I. Theory of mind and the normal development of psychic reality. *International Journal of Psychoanalysis*, 77, 217–233.

Frank, J. D., & Frank, J. B. (1993). *Persuasion and healing: A comparative study of psychotherapy*. Baltimore, MD: Johns Hopkins University Press.

Freud, S. (1912). The dynamics of transference. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud, XII* (pp. 99–108). London, United Kingdom: Hogarth Press.

Freud, S. (1914). On the history of the psycho-analytic movement. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud, XIV* (pp. 1–66). London, United Kingdom: Hogarth Press.

Freud, S. (1923). The ego and the id. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud, XIX* (pp. 1–66). London, United Kingdom: Hogarth Press.

Gabbard, G. O. (2004). *Long-term psychodynamic psychotherapy: A basic text*. Washington, DC: American Psychiatric Publishing.

Gabbard, G. O., & Horowitz, M. J. (2009). Insight, transference interpretation, and therapeutic change in the dynamic psychotherapy of borderline personality disorder. *American Journal of Psychiatry*, *166*, 517–521. doi:10.1176/appi.ajp.2008.08050631

Gabbard, G. O., & Westen, D. (2003). Rethinking therapeutic action. *International Journal of Psychoanalysis*, *84*, 823–841. doi:10.1516/N4T0-4D5G-NNPL-H7NL

Gaston, L., Piper, W. E., Debbane, E. G., & Garant, J. (1994). Alliance and technique for predicting outcome in short- and long-term analytic psychotherapy. *Psychotherapy Research*, *4*, 121–135. doi:10.1080/10503309412331333952

Gelso, C. J., Kivlighan, D. M., Wine, B., Jones, A., & Friedman, S. C. (1997). Transference, insight, and the course of time-limited therapy. *Journal of Counseling Psychology*, *44*, 209–217. doi:10.1037/0022-0167.44.2.209

Gibbons, M. B., Crits-Christoph, P., Barber, J. P., Stirman, S. W., Gallop, W., Goldstein, L. A., … Ring-Kurtz, S. (2009). Unique and common mechanisms of change across cognitive and dynamic psychotherapies. *Journal of Consulting and Clinical Psychology*, *77*, 801–813. doi:10.1037/a0016596

Glover, E. (1931). The therapeutic effect of inexact interpretation: A contribution to the theory of suggestion. *International Journal of Psychoanalysis*, *12*, 397–411. Retrieved from http://www.pep-web.org/document.php?id=ijp.012.0397a

Glover, E. (1955). *The technique of psycho-analysis*. New York, NY: International Universities Press.

Goldfried, M. R. (1985). In vivo intervention or transference? In W. Dryden (Ed.), *Therapists' dilemmas*. London, United Kingdom: Harper & Row.

Greenson, R. R. (1967). *The technique and practice of psychoanalysis*. New York, NY: International Universities Press.

Greenson, R. R. (2008). The working alliance and the transference neuroses. *Psychoanalytic Quarterly*, *77*, 77–102. doi:10.1002/j.2167-4086.2008.tb00334.x

Grienenberger, J. F., Kelly, K., & Slade, A. (2005). Maternal reflective functioning, mother-infant affective communication, and infant attachment: Exploring the link between mental states and observed caregiving behavior in the intergenerational transmission of attachment. *Attachment and Human Development*, *7*, 299–311. doi:10.1080/14616730500245963

Grosse Holfort, M., Castonguay, L. G., Boswell, J. F., Wilson, L. A., Kakouros, A. A., & Borkovec, T. D. (2007). Insight in cognitive-behavioral therapy. In L. Castonguay & C. Hill (Eds.), *Insight in psychotherapy* (pp. 57–80). Washington, DC: American Psychological Association.

Guntrip, H. J. S. (1969). *Schizoid phenomena, object relations, and the self*. New York, NY: International Universities Press.

Hamilton, M. A. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery, and Psychiatry*, *23*, 56–61. doi:10.1136/jnnp.23.1.56

Hassin, R. R., Uleman, J. S., & Bargh, J. A. (2005). *The new unconscious*. Oxford, United Kingdom: Oxford University Press.

Hatcher, R. L. (2010). Alliance theory and measurement. In J. C. Muran & J. P. Barber (Eds.), *Therapeutic alliance: An evidence-based guide to practice* (pp. 7–28). New York, NY: Guilford Press.

Høglend, P., Bøgwald, K.-P., Amlo, S., Sjaastad, M. C., Sørbye, Ø., Heyerdahl, O., … Johansson, P. (2008). Transference interpretations in dynamic psychotherapy: Do they really yield sustained effects? *American Journal of Psychiatry*, *165*, 763–771. doi:10.1176/appi.ajp.2008.07061028

Høglend, P., Engelstad, V., Sørbye, Ø., Heyerdahl, O., & Amlo, S. (1994). The role of insight in exploratory psychodynamic psychotherapy. *British Journal of Medical Psychology*, *67*, 305–316. doi:10.1111/j.2044-8341.1994.tb01799.x

Johansson, P., Høglend, P., Ulberg, R., Amlo, S., Marble, A., Bøgwald, K.-P., … Heyerdahl, O. (2010). The mediating role of insight for long-term improvements in psychodynamic therapy. *Journal of Consulting and Clinical Psychology*, *78*, 438–448. doi:10.1037/a0019245

Jones, E. (1910). The action of suggestion in psychotherapy. *Journal of Abnormal Psychology*, *5*, 217–254. doi:10.1037/h0071023

Kallestad, H., Valen, J., McCullough, L., Svartberg, M., Høglend, P., & Stiles, T. C. (2010). The relationship between insight gained during therapy and long-term outcome in short-term dynamic psychotherapy and cognitive therapy for cluster C personality disorders. *Psychotherapy Research*, *20*, 526–534. doi:10.1080/10503307.2010.492807

Kazdin, A. E. (2007). Mediators and mechanisms of change in psychotherapy research. *Annual Review of Clinical Psychology*, *3*, 1–27. doi:10.1146/annurev.clinpsy.3.022806.091432

Kazdin, A. E. (2008). Evidence-based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. *American Psychologist*, *63*, 146–159. doi:10.1037/0003-066X.63.3.146

Knekt, P., Lindfors, O., Härkänen, T., Välikoski, M., Virtala, E., & Laaksonen, M. A., … the Helsinki Psychotherapy Study Group. (2008). Randomized trial on the effectiveness of long- and short-term psychodynamic psychotherapy and solution-focused therapy on psychiatric

symptoms during a 3-year follow-up. *Psychological Medicine*, *38*, 689–703. doi:10.1017/S003329170700164X

Knekt, P., Lindfors, O., Laaksonen, M. A., Renlund, C., Haaramo, P., & Härkänen, T., … the Helsinki Psychotherapy Study Group. (2011). Quasi-experimental study on the effectiveness of psychoanalysis, long-term and short-term psychotherapy on psychiatric symptoms, work ability and functional capacity during a 5-year follow-up. *Journal of Affective Disorders*, *132*, 37–47. doi:10.1016/j.jad.2011.01.014

Kohlenberg, R. J., & Tsai, M. (1991). *Functional analytic psychotherapy: A guide for creating intense and curative therapeutic relationships*. New York, NY: Plenum Press.

Kohut, H. (1984). *How does analysis cure?* Chicago, IL: University of Chicago Press.

Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94–129). New York, NY: Basic Books.

Lambert, M. J. (2013). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 169–218). New York, NY: John Wiley & Sons.

Leichsenring, F., & Rabung, S. (2008). Effectiveness of long-term psychodynamic psychotherapy: A meta-analysis. *Journal of the American Medical Association*, *300*, 1551–1565. doi:10.1001/jama.300.13.1551

Leichsenring, F., & Rabung, S. (2011). Long-term psychodynamic psychotherapy in complex mental disorders: Update of a meta-analysis. *British Journal of Psychiatry*, *199*, 15–22. doi:10.1192/bjp.bp.110.082776

Leichsenring, F., Rabung, S., & Leibing, E. (2004). The efficacy of short-term psychodynamic psychotherapy in specific psychiatric disorders: A meta-analysis. *Archives of General Psychiatry*, *61*, 1208–1216. doi:10.1001/archpsyc.61.12.1208

Levy, R. A., Ablon, J. S., & Kächele, H. (2012). *Psychodynamic psychotherapy research*. New York, NY: Humana Press.

Levy, K. N., Meehan, K. B., Kelly, K. M., Reynoso, J. S., Weber, M., Clarkin, J. F., & Kernberg, O. F. (2006). Change in attachment patterns and reflective function in a randomized control trial of transference-focused psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology*, *74*, 1027–1040. doi:10.1037/0022-006X.74.6.1027

Lieberman, A. F. (1999). Negative maternal attributions: Effects on toddlers' sense of self. *Psychoanalytic Inquiry*, *19*, 737–756. doi:10.1080/07351699909534274

Loewald, H. W. (1960). On the therapeutic action of psychoanalysis. *International Journal of Psychoanalysis*, *41*, 16–33. Retrieved from http://www.pep-web.org/document.php?id=ijp.041.0016a

Loewald, H. W. (1979). Reflections on the psychoanalytic process and its therapeutic potential. *Psychoanalytic Study of the Child*, *34*, 155–167.

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy. Manual for supportive–expressive treatment*. New York, NY: Basic Books.

Luborsky, L. (2001). The only clinical and quantitative study since Freud of the preconditions for recurrent symptoms during psychotherapy and psychoanalysis. *International Journal of Psychoanalysis*, *82*, 1133–1154. doi:10.1516/XBXL-7WWX-4MUF-38F5

Luborsky, L., Crits-Christoph, P., Mintz, J., & Auerbach, A. (1988). *Who will benefit from psychotherapy? Predicting therapeutic outcomes*. New York, NY: Basic Books.

Luborsky, L., & Luborsky, E. (2006). *Research and psychotherapy: The vital link*. Lanham, MA: Jason Aronson.

de Maat, S., de Jonghe, F., Schoevers, R., & Dekker, J. (2009). The effectiveness of long-term psychoanalytic therapy: A systematic review of empirical studies. *Harvard Review of Psychiatry*, *17*, 1–23. doi:10.1080/10673220902742476

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*, 438–450. doi:10.1037/0022-006X.68.3.438

Messer, S. B., & McWilliams, N. (2007). Insight in psychodynamic therapy: Theory and assessment. In L. G. Castonguay & C. E. Hill (Eds.), *Insight in psychotherapy* (pp. 9–30). Washington, DC: American Psychiatric Association.

Messer, S. B., & Wolitzky, D. L. (2010). A psychodynamic perspective on the therapeutic alliance: Theory, research, and practice. In J. C. Muran & J. P. Barber (Eds.), *Therapeutic alliance: An evidence-based guide to practice* (pp. 97–122). New York, NY: Guilford Press.

Norcross, J. C. (Ed.). (2011). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (2nd ed.). New York, NY: Oxford University Press.

Perry, J. C. (1990). *Defense Mechanism Rating Scales (DMRS)*. Cambridge, MA: J. C. Perry.

Perry, J. C. (1992). Perry's Defense Mechanism Rating Scale. In G. E. Vaillant (Ed.), *Ego mechanisms of defense: A guide for clinicians and researchers* (pp. 253–259). Washington, DC: American Psychiatric Association.

Pine, F. (1988). On the four psychologies of psychoanalysis and the nature of the therapeutic impact. In A. Rothstein (Ed.), *How does treatment help?* (pp. 145–155). Madison, CT: International Universities Press.

Piper, W. E., Boroto, D. R., Joyce, A. S., McCallum, M., & Azim, H. F. A. (1995). Pattern of alliance and outcome in short-term individual psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, *32*, 639–647. doi:10.1037/0033-3204.32.4.639

Piper, W. E., Joyce, A. S., McCallum, M., & Azim, H. F. (1998). Interpretive and supportive forms of psychotherapy and patient personality variables. *Journal of Consulting and Clinical Psychology*, *66*, 558–567. doi:10.1037/0022-006X.66.3.558

Piper, W. E., Joyce, A. S., Rosie, J. S., & Azim, H. S. (1994a). Psychological mindedness, work, and outcome in day treatment. *International Journal of Group Psychotherapy*, *44*, 291–311.

Piper, W. E., Joyce, A. S., Rosie, J. S., & Azim, H. S. (1994b). Patient characteristics and success in day treatment. *Journal of Nervous and Mental Disease*, *182*, 381–386. doi:10.1097/00005053-199407000-00003

Power, M., & Dalgleish, T. (2008). *Cognition and emotion: From order to disorder*. Hove, United Kingdom: Psychology Press.

Ryle, A., & Kerr, I. B. (2002). *Introducing cognitive analytic therapy: Principles and practice*. Chichester, United Kingdom: John Wiley & Sons.

Safran, J. D., & Muran, J. C. (2006). Has the concept of the therapeutic alliance outlived its usefulness? *Psychotherapy: Theory, Research, Practice, Training*, *43*, 286–291. doi:10.1037/0033-3204.43.3.286

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

Shedler, J., & Westen, D. (2007). The Shedler-Westen Assessment Procedure (SWAP): Making personality diagnosis clinically meaningful. *Journal of Personality Assessment*, *89*, 41–55. doi:10.1080/00223890701357092

Smith, H. F. (2001). Obstacles to integration: Another look at why we talk past each other. *Psychoanalytic Psychology*, *18*, 485–514. doi:10.1037/0736-9735.18.3.485

Smith, H. F. (2007). In search of a theory of therapeutic action. *Psychoanalytic Quarterly*, *76*(Suppl.), 1735–1761. doi:10.1002/j.2167-4086.2007.tb00329.x

Steiner, J. (1989). The aim of psychoanalysis. *Psychoanalytic Psychotherapy*, *4*, 109–120. doi:10.1080/02668738900700111

Sterba, R. (1934). The fate of the ego in analytic therapy. *International Journal of Psychoanalysis*, *15*, 117–126. Retrieved from http://www.pep-web.org/document.php?id=ijp.015.0117a

Stern, D. N. (1985). *The interpersonal world of the human infant*. New York, NY: Basic Books.

Strachey, J. (1934). The nature of the therapeutic action of psycho-analysis. *International Journal of Psychoanalysis*, *15*, 127–159. Retrieved from http://www.pep-web.org/document.php?id=ijp.015.0127a

Strupp, H. H. (1977). A reformulation of the dynamics of the therapist's contribution. In A. S. Gurman & A. M. Razin (Eds.), *Effective psychotherapy: A handbook of research* (pp. 3–22). Oxford, United Kingdom: Pergamon Press.

Sugarman, A. (2006). Mentalization, insightfulness, and therapeutic action: The importance of mental organization. *International Journal of Psychoanalysis*, *87*, 965–987. doi:10.1516/6DGH-0KJT-PA40-REX9

Vaillant, G. E. (1992). *Ego mechanisms of defense: A guide for clinicians and researchers*. Washington, DC: American Psychiatric Association.

Vaillant, G. E. (1993). *The wisdom of the ego*. Cambridge, MA: Harvard University Press.

Vaillant, G. E., Bond, M., & Vaillant, C. O. (1986). An empirically validated hierarchy of defense mechanisms. *Archives of General Psychiatry*, *43*, 786–794. doi:10.1001/archpsyc.1986.01800080072010

Wallerstein, R. S. (1986). *Forty-two lives in treatment: A study of psychoanalysis and psychotherapy*. New York, NY: Guilford Press.

Wallerstein, R. S. (1988). One psychoanalysis or many? *International Journal of Psychoanalysis*, *69*, 5–21. Retrieved from http://www.pep-web.org/document.php?id=ijp.069.0005a

Wallerstein, R. S. (1995). *The talking cures*. New Haven, CT: Yale University Press.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Hillsdale, NJ: Erlbaum.

Weiss, J., Sampson, H., & the Mt. Zion Psychotherapy Research Group. (1986). *The psychoanalytic process: Theory, clinical observation and empirical research*. New York, NY: Guilford Press.

Westen, D. (1990). Towards a revised theory of borderline object relations: Contributions of empirical research. *International Journal of Psychoanalysis*, *71*, 661–693. Retrieved from http://www.pep-web.org/document.php?id=ijp.071.0661a

Westen, D., & Gabbard, G. O. (2002a). Developments in cognitive neuroscience: I. Conflict, compromise, and connectionism. *Journal of the American Psychoanalytic*

Association, *50*, 53–98. doi:10.1177/000306510205000 11501

Westen, D., & Gabbard, G. O. (2002b). Developments in cognitive neuroscience: II. Implications for theories of transference. *Journal of the American Psychoanalytic Association*, *50*, 99–134. doi:10.1177/000306510205000 11601

Westen, D., & Shedler, J. (1999a). Revising and assessing Axis II, Part 1: Developing a clinically and empirically valid assessment method. *American Journal of Psychiatry*, *156*, 258–272. Retrieved from http://ajp.psychiatryonline .org/article.aspx?articleID=173271

Westen, D., & Shedler, J. (1999b). Revising and assessing Axis II, Part 2: Toward an empirically based and clinically useful classification of personality disorders. *American Journal of Psychiatry*, *156*, 273–285. Retrieved from http:// ajp.psychiatryonline.org/article.aspx?articleid=173272

Westenberger-Breuer, H. (2007). The goals of psychoanalytic treatment: Conceptual considerations and follow-up interview evaluation with a former analysand. *International Journal of Psychoanalysis*, *88*, 475–488. doi:10.1516/ C563-520Q-1K76-9056

Winnicott, D. W. (1965). *The maturational processes and the facilitating environment: Studies in the theory of emotional development*. London, United Kingdom: Hogarth Press and the Institute of Psycho-Analysis.

Young, J. E. (1999). *Cognitive therapy for personality disorders: A schema-focused approach* (3rd ed.). Sarasota, FL: Professional Resource Press.

Zetzel, E. (1956). Current concepts of transference. *International Journal of Psychoanalysis*, *37*, 369–375.

Zetzel, E. (1966). The analytic situation. In R. E. Litman (Ed.), *Psychoanalysis in the Americas* (pp. 86–106). New York, NY: International Universities Press.

Zuroff, D. C., & Blatt, S. J. (2006). The therapeutic relationship in the brief treatment of depression: Contributions to clinical improvement and enhanced adaptive capacities. *Journal of Consulting and Clinical Psychology*, *74*, 130–140. doi:10.1037/0022-006X.74.1.130

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