

# Psychodynamic psychotherapy, insight and therapeutic action

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Forthcoming in *Clinical Psychology: Science and Practice*

## Abstract

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, viz. 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.

Keywords: insight, psychodynamic psychotherapy, therapeutic action, common factor

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 – though not an exclusive or even primary role (§3) – for the specific and characteristic factor of *insight*.

In §1, I outline what I intend by the term ‘insight’. In §2, I present the view that common factors are the most significant in therapeutic action, and discuss some difficulties that arise for the argument. In §3, I 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 in §4, and on evidence relating to reflective function and psychological defense in §5.

### **1. 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 one's emotions, motivations, thoughts and behavior, past and present, including one's interpretations of and relations with others (Castonguay & Hill, 2007, p. 144; 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.

An 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, (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 of 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.<sup>1</sup>

Psychological defenses function both to protect us from excessive anxiety and to protect the integration of the self (Cramer, 2006, p. 7). 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, Chapter 2). Thus defenses are incompatible with insight as insight requires truthfulness while all but the most mature defense requires 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 et al., 1996; Fonagy, Steele,

Morgan, Steele, & Higgitt, 1991; Grienberger, 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 their anger towards authority figures; they come 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 non-psychodynamic therapies.

## **2. ‘Common Factors’ and the Challenge to Insight**

### **2.1 ‘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) updates 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, 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) concur, stating that 'the evidence that non-specific 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 'non-specific' 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 (§§3.1-3.3), 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 (§2.2). 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 'non-specific' (and hence 'common', if this refers to untheorized factors) (§3.1-3.3). The third is that there is recent evidence supporting the importance of insight, at least in long term psychodynamic psychotherapy (LTPP) (§4). 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.

## **2.2 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 .17 to .26, with an average of .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, & Sharpless (2010) note 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 pre-treatment to post-treatment. 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 post-treatment; any change in symptoms from pre-treatment 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) reviews 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) argues, 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, i.e. 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) note 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, i.e. contributing independently to therapeutic action as a mediator, bringing about change itself. The studies together provide some weak support for the view, but more research is clearly needed. Barber (2009) argues that the alliance, rather than being a mediator, is more likely simply a monitor 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, p. 306; Messer & Wolitzky, 2010, p. 114).

The final difficulty with establishing the alliance as either moderator or mediator is the unclarity 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) argues 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, e.g. Martin et al. (2000, p. 438) understand 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.

### **3. The therapeutic relationship in psychodynamic psychotherapy**

#### **3.1 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, p. 406, 1955, p. 394; Jones, 1910, p. 254). This orthodox view is indefensible, and the importance of the therapeutic relationship (including the alliance), at least as moderators of outcome, have been theorized in psychodynamic psychotherapy since Freud. Hatcher (2010) argues 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 UK and the 1960s in the USA, psychoanalysts have come to recognize the therapeutic action of the relationship, as moderator and/or mediator, and there are few psychoanalysts who would now accept the orthodox view now (Abend, 2001, p. 5; Messer & Wolitzky, 2010, p. 106; Wallerstein, 1995, p. 291). 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 ‘non-specific’ factor in Lambert’s (2013, p. 199) 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.)

### **3.2 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). While 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) formulate 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, e.g. 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, e.g. 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, has been firmly established through work on implicit memory (Westen & Gabbard, 2002a, 2002b) and automatic, non-conscious 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, e.g. 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 relation. 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, e.g. 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 Generalised), and Andersen and colleagues' theory of the relational self in personality psychology (Andersen & Chen, 2002; Andersen & Thorpe, 2009).

### **3.3 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, non-moralizing and non-retaliatory person, the patient's maladaptive expectations and representations are disconfirmed and the development of more adaptive ones encouraged (Eagle, 2011, p. 230; 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, Sampson, & the Mt. Zion Psychotherapy Research Group (1986), who showed that when the therapist, through their 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 them 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’, i.e. the patient must also experience the therapist in terms of their 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 their 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, non-psychodynamic forms of therapy, such as cognitive and behavioral therapies; the contrast clarifies how psychodynamic theories more easily accommodate the therapeutic action of the therapeutic relationship.

Castonguay, Constantino, McAleavey, & Goldfried (2010) note 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 ‘non-specific’, and this view is still very widespread among CBT scholars. As Safran and Muran (2006) note, 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) criticizes CBTs for failing to integrate relationship factors into their accounts of therapeutic action, while Kazdin (2007, p. 8) and Power & Dalgliesh (2008, p. 367ff.) argue 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, p. 160). Interestingly, a number of important contributions (e.g. Goldfried, 1985; Kohlenberg & Tsai, 1991; Young, 1999) recommend interventions focused on the therapeutic relationship itself, which Young (1999, p. 34) compares to transference interpretations in psychodynamic therapies. Power and Dalgliesh (2008, Chapter 5) provide 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* than specific factors are most efficacious. For theories deriving from psychoanalysis have extensively theorized the action of the relationship.

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.

### **3.4 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 their existing, problematic object relationships and as a new, good object (Eagle, 2011, pp. 232ff.). 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, non-defensive 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 their mind works, how their feelings, expectations and thoughts interact (Eagle, 2011, pp. 223-4). 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) argues 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 (1965). Of course, the *manner* (phrasing, timing, tone, attitude) in which the therapist draws the patient's attention to their 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:

Patients with low QOR do worse in interpretive therapy than patients with high QOR (Piper, Joyce, McCallum, & Azim, 1998).

Supportive interventions are more helpful in cases of poor alliance, interpretive interventions in cases of good alliance (Gaston, Piper, Debbane, & Garant, 1994).

The strength of alliance is predicted by the patient's QOR (Ackerman, Hilsenroth, & Knowles, 2005).

For patients with low QOR, strengthening the alliance is directly correlated with a better outcome (Piper, Boroto, Joyce, McCallum, & Azim, 1995).

A stronger alliance is also predicted by the therapist's having the traits of a 'good object' – being honest, respectful, trustworthy, etc. (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, while 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, Chapters 10, 11).

#### **4. Insight: the Evidence from Outcome Studies**

##### **4.1 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 towards 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, toleration 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) presents 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 six months (e.g. Connolly et al., 1999), but have been found in LTPP (over 50 sessions and/or 1 year) for moderately disturbed patients (Høglend, Engelstad, Sørbye, Heyerdahl, & Amlo, 1994; Luborsky et al., 1988). Furthermore, though 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, while 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.)

#### **4.2 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; Knekt et al., 2011; Leichsenring & Rabung, 2008, 2011; de Maat, de Jonghe, Schroevers, & Dekker, 2009) indicate that the benefits of psychodynamic psychotherapy become much more pronounced *after* six months' 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 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 ten 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, viz. simply the length of treatment, or some factor that is the product of this, e.g. 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 are 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, pp. 40-41). 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), while 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 interacted with other variables.

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

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).

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 disorders, 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.

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 from §3.4 onwards. 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.

## **5. Insight: the Wider Argument**

Given the connection of psychodynamic insight to reflective function and psychological defense (§1), a wider argument, taking in other sources of evidence, can be made for the operation of insight as a mediator in therapeutic outcomes.

### **5.1 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; Grienberger 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, e.g. 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, p. 285). Thus, the therapeutic relationship supports the development of insight together with secure attachment, and these jointly support improvements in interpersonal and general functioning.

## **5.2 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. 142-4, 159-60); and both excessive use of neurotic defenses, and the use of age-inappropriate immature defenses, is associated with both subclinical

pathology (i.e. among ‘normal’ – non-patient – samples) (Cramer, 2006, pp. 235-6) and clinical pathology (Cramer, 2006, pp. 253-4). Conversely, the use of mature defenses soon after adolescence predicts positive adjustments to life’s challenges later on (Cramer, 2006, pp. 210-11, 218).<sup>2</sup>

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 non-distorting 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.

## **6. Conclusion**

Lambert, Wampold, Frank and others have argued that common or non-specific 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 (§1). 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, viz. whether the therapeutic alliance is merely a predictor, a moderator, or a mediator of outcomes (§2). 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 ‘non-specific’, 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 (§3). 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 of 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 (§4). I ended with a further argument for this conclusion from independent evidence related to reflective function and psychological defense (§5). 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.

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<sup>1</sup> While the measurement of reflective function (Fonagy et al., 1995) and defenses (Conte & Plutchik, 1995; Cramer, 2006, pp. 15-18) has been operationalized, there is no agreed operationalized measure for insight. However, Johansson et al. (2010, p. 441), 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.

<sup>2</sup> Many other specific claims following from psychodynamic theory regarding psychological defense have received separate empirical support. For example, see Dixon (1981, Chapter 7) 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, e.g. Dahl, Kächele, and Thomä (1988), Luborsky (2001), Luborsky and Luborsky (2006).