the academic community beatifies training in empirically supported treatment.[3] Criticisms of empirically supported treatments have been clearly articulated (e.g., Westen et al., 2004), yet there is not much openness in many graduate and postdoctoral training programs to training students in psychoanalytic and psychodynamic theory and therapy. The next two chapters discuss research on the mechanisms of therapeutic action and cognitive neuroscience and how these "nonpsychodynamic" domains of research actually provide significant support for psychoanalytic and psychodynamic ideas. It is time for the fantasies and resistance to these ideas to be brought more to conscious understanding and professional public awareness so that any philosophy of training that believes in the value of science informing practice becomes once again open to discovering truth, wherever it leads. In short, it is time that the empirical status of psychoanalytic and psychodynamic therapy becomes reflected accurately and frequently in the training and development of mental health professionals.

Notes

1. Effect size is a statistical representation of the power of one's finding, with larger numbers representing larger effect sizes. Cohen (1988) noted that effect sizes of .20, .50, and .80 are of small, medium, and large magnitude, respectively.
2. More recently, Blatt, Auerbach, Zuroff, and Shahar (2006) advocated the use of insight-oriented, psychoanalytic therapy for introjective patients but not for anaclitic patients.
3. These ideas would be well heeded by those who advocate the use of ESTs as they currently exist (e.g., Anthony, Ledley, & Heimberg, 2005; Barlow, Levitt, & Bufka, 1999; Herbert, 2003; Nelson-Gray, 2003).

7

Theories and Empirical Studies of Therapeutic Action

In the previous chapter, I provided a selected review on the research evidence that supported the efficacy of psychoanalytic and psychodynamic psychotherapy. I noted that there are two questions of interest for psychotherapy patients, clinicians, and researchers: (1) Does psychotherapy work? And if so, (2) how does it work? The focus of this chapter is on the latter question of how psychoanalytic and psychodynamic psychotherapy works. The theoretical literature has much to say about this, and increasing research on the psychotherapy process is finding that, across theoretical orientations, psychoanalytic and psychodynamic ideas and interventions are quite helpful.

How and Why Treatment Works from a Psychoanalytic/Psychodynamic Perspective

For many years, an immutable principle of psychoanalytic technique was the primacy of *interpretation* as part of the curative process (Strachey, 1934). In this process, analysts serve as an "auxiliary superego," which provides permission for patients to speak about unconscious content and material that might not otherwise be discussed. In the course of speaking, the patient begins to be aware of feelings or desires that can be observed by the analyst, with particular attention to transference reactions. The patient becomes consciously aware of his transference feelings and that they seem peculiar, given the manner by which the analyst has treated the patient. At this point, the analyst makes an interpretation about why these feelings are there and from where they may have originated. This provides the patient with the opportunity to better understand

and master them. For instance, a patient who comes to treatment for increasing feelings of anger toward his wife may find that, although he can speak openly about his wife's inadequacies, he cannot speak a negative word about his mother. When the therapist observes this to the patient, he becomes highly resentful toward her for suggesting such a terrible thing and eventually gets angry at such a "terrible idea." The therapist then interprets that that patient's anger toward her may reflect some pent-up feelings he has had for years toward his mother, who discouraged the expression of any negative feelings toward her or any loved ones. In traditional approaches, this interpretation could then be used to foster insight into the reasons why the patient experiences such conflict in expressing his angry feelings toward his wife.

Yet many have come to be critical of the traditional understanding of interpretation. Binder, Strupp, and Rock (1992, p. 610) wrote, "There are no clearly articulated, published guidelines for when and how to provide an interpretation." Spence (1992, p. 564) noted how Fenichel (1941) and Schafer (1976), who described with greater richness what was meant by interpretation, failed to provide "convincing clinical confirmation of its validity." In fact, Spence boldly suggested that few models exist in the published literature that demonstrate the therapeutic value and potency of interpretation. Even more disturbing, Spence cited examples of how analysts each tend to provide unique interpretations of the same material taken from one patient. This leads to many questions about whether interpretations can be "accurate" and how such interpreted material actually leads to a therapeutic effect in patients. For instance, it would not be at all surprising to find that ego-analytic therapists make interpretations centering on patients' conflicts and defenses, whereas object-relations therapists make interpretations centering on patients' representations of themselves or others.

Spence (1992) offered some ideas as to why the mechanism of interpretation has been hard to identify and understand. First, he noted that interpretations need to be understood in the context of patients' psychological developmental level. Patients are all too often assumed to have an adult-functioning ego that can hear and understand issues that are being reenacted in treatment from a much younger period of development, often times preverbal. This means that an interpretation that may indeed explain the reason for patients' problems cannot be heard by patients who are not psychologically ready to hear

it. For instance, the man previously described, who was angry at his wife, may not recognize how his conflicted feelings toward his wife may be strongly related to his feelings toward his mother as reflected in the transference. Second, Spence highlighted the fact that patients must have a good working alliance with the therapist and be oriented to hearing the interpretation that is provided. Even when interpretations may not be accurate or may miss important content, Spence noted that "the voice of the analyst takes on added significance that goes far beyond the utterances themselves, and endows whatever is expressed with a persuasive power that is something more than its semantic content alone" (p. 569). I saw this happen not too long ago with a relative who sought out analytic treatment. Although he found his therapist to be quite helpful, he found that her comments were hard to take because he had not yet developed the positive alliance and trust that made such interventions really powerful. Regretfully, he ended treatment with her (though he was able to find a psychodynamic therapist with whom he felt more comfortable).

Cooper (1989) also evaluated theories of therapeutic effectiveness, with particular attention devoted to the nature of interpretation. In describing how traditional analytic treatment works, he provided part of a hypothetical "catechism" of how analysis—and analytic therapy for that matter—works. The process sets out to make "the unconscious conscious. How is that done? By interpreting defense and resistance in the context of the transference. What is it that changes? The rational demands of the ego expands [sic] its domain at the expense of the irrational id. There is thus a structural and dynamic change; the ego is strengthened, and it has a greater repertoire of more flexible defenses available to it for its necessary protective purposes" (p. 9).

Such ideas about interpretation had been prominent in American psychoanalysis for many years, but Cooper (1989) drew attention to the increasing influence of object relations theories in explaining therapeutic action. He noted that as early as 1960, Loewald (1960) observed that the process of change is not based on the interpretive skills of analysts or therapists but on the fact that patients' relationship with the analyst becomes a new type of object relationship. Here, patients establish a relationship with the therapist that is not as traumatic as the childhood environment in which it occurred. This new relationship allows a "corrective emotional experience"

relationship is created with the therapist, older representations may "shatter," which "allows the flowering of previously thwarted positive emotional and relational capacities" (ibid.). Thus, Cooper (1989) observed a meaningful theoretical change from the sanctity of interpretation to that of elements rooted in the therapeutic dyad. Similar to Michels (1986), Cooper suggested that therapeutic action is composed of insight (which is inherently linked with interpretation), the intensity of the emotional experience (which occurs with new learning in the context of powerful affect), and the new relationship with the therapist.

This trend toward the influence of the therapy relationship has been observed elsewhere, and it is certainly the case that interpretation, though a fundamental component of psychoanalytic and psychodynamic treatment, is not as powerful as a mechanism as it had been originally understood to be (e.g., Frederickson, 1999; Gabbard, 2000, 2004; McWilliams, 2004; Weiner, 1998). Many theorists and clinicians now accept that the acquisition of new knowledge (insight via interpretation), along with the experience of the therapy relationship, are what accounts for the success of many treatments. Pulver (1992, p. 204) described these two domains as being fundamentally related: "An understanding relationship cannot be maintained without insight into the dynamics of the relationship itself." Stern and colleagues (1998) specifically described this relational element as "implicit relational knowing." They considered this as a type of procedural memory based on knowledge of how relationships work. Implicit relational knowing integrates affect, cognition, and behavioral interactions in the interpersonal domain and is acquired early in life. Transference, therefore, is a phenomenon rooted in this memory system, and interpretation "rearranges the patient's conscious declarative knowledge" (p. 906) of relationships. Stern and colleagues went on to articulate in great detail elements of the relationship and how particular moments in the course of interaction provide important pathways toward meaningful change in patients' way of experiencing relationships. Stated somewhat differently, effective psychotherapy may be understood, in part, as helping persons develop their memory systems of meaningful interpersonal relationships that allow them to become happier and more adapted.

In more contemporary times, therapeutic action is seen as being multiply determined. Gabbard and Westen (2003) described three broad categories of interventions that are associated with therapeutic

action: (1) those that foster insight; (2) those that make use of aspects of the therapeutic relationship; and (3) those that use secondary strategies, such as direct confrontation of dysfunctional beliefs, working with patients' problem-solving skills, and exposure. As previously noted, insight occurs in the context of two therapeutic techniques: free association and interpretation. By its very nature, free association allows patients to give voice to ideas and thoughts when they would normally would not. In this sense, patients can "discover" mental content that would otherwise not be given much, if any, conscious awareness. Consequently, therapists, guided by theory, can offer interpretive hypotheses or ideas about what the newly discovered material may mean.

There are many ways the therapy relationship serves as a vehicle of therapeutic action according to Gabbard and Westen (2003). First, it allows for the experience of a relationship that can correct or repair damage done from past, intimate relationships with meaningful others (e.g., parents). A kind and caring parental figure, for instance, can help undo the damage or a destructive and overly critical father or mother. Second, patients learn how to internalize and comfort themselves by hearing and experiencing such things from the therapist. Third, patients can internalize a more favorable, accepting, and curious attitude toward their affective experience that is demonstrated by their therapist. For instance, the man described earlier who found it horrifying to speak negative thoughts about his mother may be able to examine such ideas and thoughts with curiosity and with less danger than he previously though such ideas carried. Fourth, and related to that previously mentioned, patients can internalize the ability to self-reflect, or to enhance their reflective functioning capacities. Finally, therapeutic action occurs by way of the identification and interpretation of the transference–countertransference dynamics. In all of these processes, implicit, procedural memory networks that have been maladaptive become the focus of attention such that patients can learn a more adaptive, healthy way of experiencing their life.

A final, but very interesting, aspect of Gabbard and Westen's (2003) discussion of therapeutic action is in their overview of secondary strategies. These are activities not commonly associated with psychoanalytic and psychodynamic treatment yet that nevertheless are believed to be therapeutic. Two ways this occurs are through implicit and explicit confrontation of particular content. For instance, when

therapists say, "That's an interesting thought," there is an implicit message that patients should direct their attention to that thought. In a more direct way, therapists may ask patients to engage in more direction exploration of their inner world. A patient who believes that most people do not have anxiety when it comes to asking out a person on a date may hear her therapist say, "I'm not sure I see it that way—everybody has anxiety in these situations." Here, the patient is told head-on that she is not unique in this regard. Such a comment can provide an avenue by which the patient and therapist can look at why the patient's anxiety seems so different from others. Another secondary strategy is to examine directly a patient's manner by which he problem solves. Such a strategy involves a current situation in which the patient seeks to address a problem area. Here, the therapist and patient can look at the way a patient's defenses are operating, can address self and object representations that may be distorted in the situation, and then can work together on how to better address the problem. Such a strategy could be used with the patient described earlier, when he finds himself angry with his wife when discussing a financial matter. He and the therapist could look at ways he distorted some of his perceptions toward his wife in that situation and could consider ways to interact with her that are less conflicted and more based on rational ways of thinking about the situation.

Another secondary strategy is to use the technique of exposure. This technique was developed from behavioral interventions for many anxiety disorders, yet its idea is very much part of psychoanalytic history: It is only when patients come in direct psychological contact with the feared object or situation that they can experience in more adaptive ways the feared stimulus and can use more rational and adaptive means by which to experience it. What makes exposure different from a psychoanalytic and psychodynamic orientation is that self and object representations may be examined, as can common patterns of defense and the developmental origins of such fears. Unlike behavior therapy, which focuses mostly on how to perform the technique of exposure to get the patient to respond a particular way, psychoanalytic and psychodynamic approaches take much interest in the inner experience and development of the anxiety, which ultimately increases the chances of better mastery and recovery from the disabling anxiety symptoms.

Another secondary strategy described by Gabbard and Westen (2003) includes the use of therapist self-disclosure. Patients' ability

to identify with their therapist is fostered by self-disclosure and subsequently the ability to internalize their experience as part of the human experience, not to mention their ability to master their world by drawing on the representation of the therapist who had successfully managed such conflicted feelings. As an example of this process, I will share an experience from my own analytic treatment. During one session, I was speaking about my frustration and feelings of inferiority and inadequacy after a manuscript I had submitted for publication was not accepted. My therapist indicated that he, too, was resubmitting a manuscript that he thought was one of the best articles he had written. His self-disclosure then brought to my conscious awareness comments made in the past by two of my colleagues, both of whom had been very successful in their scholarship. One had told me the very same thing about having trouble publishing one of his very best pieces of scholarship. The other told me how frustrated he had become with certain kinds of journals, which seemed disinterested in his program of research. Consequently, he found other outlets for his work, which have allowed his work to become very widely cited and respected. The net effect of my analyst's self-disclosure was an increase in my ability to internalize my past successes and to realize that I was just as capable as others whom earlier I had thought were more competent than I was.

A final set of secondary strategies described by Gabbard and Westen (2003) is therapists' use of affirmation and validation, along with other facilitative strategies. Although this is not typically thought of as a technique in insight-oriented psychotherapy, affirmation and validation are quite useful in helping patients better develop their sense of self-awareness and self-acceptance. Facilitative strategies can include psychoeducation or the use of humor to help patients to better understand their inner world. For instance, patients new to therapy may need some direction about how psychotherapy works and what to expect from their therapist.

Therapeutic Action in and outside of Psychoanalytic and Psychodynamic Theory

As can be seen from the previous material, psychoanalytic and psychodynamic treatment can incorporate multiple types of interventions to reach their therapeutic aims and goals. It is not surprising,

therefore, to see that some are beginning to integrate psychoanalytic and psychodynamic theory and therapeutic approaches with ideas and techniques from other theories in an effort to achieve maximal therapeutic effectiveness. This has occurred primarily in the union of cognitive behavioral theory with psychoanalytic and psychodynamic theory. In fact, the idea that psychoanalysis could be merged with behavioral theory is not new to psychology. Dollard and Miller (1950) were some of the first to note that, by repressing or blocking one's awareness of anxiety, individuals were likely to use the same processes again. This is a basic principle of learning—that individuals are likely to repeat a "behavior" if it is associated with favorable outcomes (i.e., reinforcement). In this case, the behavior in question is the mental act. Clark Hull (1951), too, tried to create a mathematical formula of how drives interacted with features of a situation to produce certain behaviors. In fact, there multiple articles and books now address how analytic theory and therapy can be integrated with cognitive-behavioral theory and therapy (e.g., Bornstein, 2005; Bucci, 1997; Epstein, 1994; Horowitz, 1987; Kohlenberg & Tsai, 1991; Messer, 1986; Shevrin, Bond, Brakel, Hertel, & Williams, 1996; Singer & Singer, 1992; Wachtel, 1977, 1987; Westen, 2000).

A well-articulated discussion about integrating psychodynamic and cognitive-behavioral therapies was provided by Westen (2000). Although a detailed review of this paper is outside of the scope of this chapter, I highlight a few of the critical points he made about this issue. First, he suggested that although psychodynamic theory is comprehensive and integrative in its description of how mental processes lead to behavior, it all too often does not operationalize its terms in an easy-to-understand, mechanism-specific way. By way of contrast, he noted that cognitive-behavioral approaches focus on specific processes and provide directed instructions on how to intervene. This approach, however, does not provide the richness and complexity of the interactive processes that account more completely for the processes observed in clinical practice. Second, he noted that psychodynamic theory assumes that behavior will change by focusing on the internal processes behind them; in contrast, cognitive-behavioral theory focuses on skills and behaviors needed to obtain real change with less attention to the complexity of the internal cognitive processes. Both approaches, he suggested, are important, and depending on the needs of the patient, greater attention may be needed to internal versus external processes (or vice versa). Third,

psychodynamic approaches attend much more to unconscious processes and mechanisms, whereas cognitive-behavioral approaches take greater interest in what is conscious and immediate in awareness. Both unconscious and conscious mechanisms account for psychological conflict, distress, and disrupted behavior. Thus, targeting both processes is important and likely necessary for patients to achieve the results they desire. Because of these basic differences, Westen suggested that psychodynamic and cognitive-behavioral therapy can and should be integrated to maximize therapeutic effectiveness.

It should not be assumed that Westen's (2000) ideas are widely agreed on. For instance, the imposition of more cognitive-behavioral techniques has much potential to affect the transference. Patients' experience of therapists' directiveness may activate transference phenomena that complicate treatment; they may invoke different kinds of representations of therapists that heretofore had not been seen, experienced, or understood. For instance, a therapist who has a very Socratic, didactic orientation toward cognitive-behavioral psychoeducation could invoke in patients a representation of the therapist as a teacher and educator. This could elicit all kinds of feelings and attitudes, both positive and negative. These experiences are part of the transference, although they may be part of understanding the real person of the therapist if, for instance, the therapist has poor tolerance of a patient's failure to quickly acquire the material that is being taught or the therapist has poorly developed skills in educating or explaining important concepts to a patient. Another potential problem is that a failure to understand the complexity and contributing variables toward a patient's conflicts and problems may lead to the implementation of a cognitive-behavioral technique that could not work or may produce contradictory results. By contrast, if the treatment is "too successful," patients may erroneously believe that they have mastered their difficulties and decide they have benefited all they can from treatment, when the therapist may have good reason to believe otherwise.

This being said, it is nonetheless true that different types of psychotherapy (e.g., cognitive-behavioral, brief) have been reported to have therapeutic efficacy. Moreover, it is true that many psychoanalytic and psychodynamic therapists and researchers believe that other theories of treatment can be integrated with psychodynamic therapy so that maximal therapeutic effectiveness can be

obtained. Thus, two additional questions arise that are important to understand about therapeutic action: (1) Are there *common mechanisms* of therapeutic action in many forms of treatment that account for therapeutic success? And if so, (2) are these mechanisms *specific to* psychoanalytic and psychodynamic interventions? To address these questions, I now turn attention to the psychotherapy research literature and what it has to tell us about these issues.

Empirical Studies of Therapeutic Action

There have been multiple studies on psychotherapy outcomes, with attention devoted to what accounts for the favorable outcome across theoretical models and various techniques. In a review of several meta-analyses of this issue, Lambert and Barley (2002) devised an empirical summary of what the literature says about psychotherapy outcome: 40% of the improvement is accounted for by *extratherapeutic change*; 30% is accounted for by *common factors*; 15% is accounted for by *techniques*; and 15% is accounted for by *expectancy factors*. Extratherapeutic change is a general term that describes patients' efforts to seek help and reassurance from others, either while in treatment or waiting for treatment. This includes the support of family, friends, clergy, and support groups. This also accounts for the finding that people who wait for treatment report getting better on their own without treatment (which is highly variable by person, based on many individual factors).

A substantial component of treatment success is related to common factors, which specifically relates to certain aspects of therapists and their therapeutic relationship. These include therapists' interpersonal style, attributes, and qualities (e.g., empathy, warmth, showing positive regard, kindness, compassion), and the therapist–client relationship. This finding is robust across decades of psychotherapy research (more than 60 years) and multiple meta-analyses of this literature and is independent of theoretical model. It is clear that some therapists are better than others and that their skills are strongly linked to outcome. Although the implementation of specific therapy techniques is believed to account for some degree of improvement (15% in their analysis), Lambert and Barley (2002, p. 19) concluded, "Conventional reviewing procedures of the comparative studies of different psychotherapies have not consistently demonstrated the

preeminence of any particular school of therapy in treating clients across the broad categories of anxiety, depression, and interpersonal problems." They added that what appears to be consistent in the literature is that individuals who seek some form of psychotherapy tend to be about 80% better than their counterparts who do not seek treatment. Their conclusion, which is consistent with recent others (e.g., Beutler & Harwood, 2002; Castonguay & Beutler, 2006; Wampold, 2001), is that therapists need to be highly attuned to their own behavior and attitude toward their patients and focused on the quality of the therapeutic alliance. As for students who are beginning to learn how to do psychotherapy, Lambert and Barley wrote, "Training in relationship skills is crucial for the beginning therapist" (p. 27). More so, they encouraged experienced professionals to keep very focused on their ability to foster and to maintain a favorable therapeutic relationship.

As a means by which to assess common factors that are responsible for therapeutic effectiveness, Goldfried, Newman, and Hayes (1989) developed the Coding System of Therapeutic Focus (CSTF). This is a rating system designed for coders to evaluate the types of interventions performed in psychotherapy sessions. Five "axes" are assessed:

1. Components of the client's functioning (e.g., emotions and thoughts)
2. Connections that are made between intrapersonal or interpersonal themes
3. General types of interventions used (e.g., support)
4. The persons who are the focus of the intervention
5. The time frame of the focus

Goldfried, Castonguay, Hayes, Drozde, and Shapiro (1997) used the CSTF system to compare manually driven cognitive-behavioral and interpersonal-psychodynamic treatments for depression. They found that the interpersonal-psychodynamic treatment consisted more of therapists' exploration of clients' problematic interpersonal relationships, their misperceptions of others, and how these patterns were part of their life. Attention also was directed toward the historical origins of these problems and how the problems may manifest themselves in the interaction with the therapist. By way of contrast, cognitive-behavioral therapists focused more on the future and what clients might do to function more effectively.

Because this study was done via treatment manuals, Goldfried, Raue, and Castonguay (1998) were interested in the naturalistic

practice of cognitive-behavioral and psychodynamic-interpersonal psychotherapies. Past research had suggested that master psychodynamic-interpersonal therapists believed that the most important parts of a session consisted of greater levels of emotion; in contrast, cognitive-behavioral therapists believed the most important portion of a session was associated with a decrease in patients' emotional experiencing. Given these past issues, Goldfried et al. recruited 22 master cognitive-behavioral and 14 master psychodynamic-interpersonal therapists to participate in a study in which their work with a patient would be evaluated with the CSTF. They were asked to identify therapeutically significant portions of their session to evaluate what the therapists actually were doing at that time. Therapists of both orientations were found to place more of a focus on patients' self-observations, self-evaluations, expectations, and general thoughts, emotions, and behaviors during the significant portions of the session. Cognitive-behavioral therapists were more likely to compare or contrast the patient's functioning with others, to encourage between-session activities, to focus more on other people, and to focus attention on the patient's future. Psychodynamic-interpersonal therapists were more likely to highlight a patient's emotional reactions, to make a reference to their experience, and to highlight instances of more general themes in the patient's life. Many similarities were found between the two orientations during clinically significant portions of the session. These included a greater focus on the patients' ability to observe themselves in an objective way, their evaluation of their self-worth and expectations, their thoughts in general, their emotions, and aspects of their generalized aspects of their functioning. In general, Goldfried et al. concluded that master therapists are generally more similar than different, blending interventions that usually are associated with one specific orientation.

Another set of interesting studies on the psychotherapy process was produced by the Berkeley Psychotherapy Research Group, headed by Enrico Jones. Jones (1985, 2000) developed an interesting assessment tool to assess intervention strategies used by therapists in their sessions. This measure is the Psychotherapy Process Q-Set, which contains 100 items that describe therapist, patient, and therapist–patient activities that occur in the psychotherapy hour. Raters listen to an entire psychotherapy session and then place all 100 items into one of nine categories. The categories are ranked from "most characteristic" to "least characteristic," and a fixed number of items

go into each category. This structure forces the ratings into a normal distribution and requires the rater to think carefully and critically about each item prior to placing it into a category. Many studies have supported the validity of the measure to assess change processes (Jones, Hall, & Parke, 1991).

Jones and Pulos (1993) were interested in the processes actually utilized in session by cognitive-behavioral and psychodynamic therapists. Since many studies have failed to find differences across types of psychotherapies, Jones and Pulos were interested in whether actual differences in technique and process existed. Using the archival transcripts of 32 patients in either brief psychodynamic or cognitive-behavioral treatment, they obtained Q-set ratings assigned by expert raters. Although therapeutic outcome was comparable across groups, there were differences in the therapy processes. Psychodynamic treatment was most characterized by the following:

- An emphasis on patients' current or recent life situation
- Interpersonal relationships
- Therapists identifying a recurring theme in patients' experience
- Therapists clarifying or rephrasing patients' communication
- Patients initiating important content for discussion
- A focus on patients' self-image and how feelings and perceptions are linked to the past
- Therapists emphasizing patients' feelings for them to experience them more deeply
- Patients feeling depressed
- Therapists conveying a sense of acceptance

Cognitive-behavioral treatment was most characterized by the following:

- Therapists exerting control over the interaction
- Therapists behaving like a teacher
- A focus on cognitive themes
- An emphasis on patients' current or recent life situation
- A discussion of what patients could do outside of the session
- A focus on patients' self-image
- Therapists explaining a rationale for the technique, adopting a supportive stance, and clarifying or rephrasing a patient's communication

Jones and Pulos (1993) also found 57 significant differences on other item ratings, suggesting that there are many differences

between cognitive-behavioral and psychodynamic treatment. A factor analysis of the 100 items yielded four broad factors: psychodynamic technique, cognitive-behavioral technique, patient resistance, and patient negative affect. Factor scores were then correlated with many of the outcome measures, with very many interesting results. The psychodynamic technique factor was favorably correlated with four of the five positive outcomes in the cognitive-behavioral group and one of the four outcome measures in the psychodynamic group. The cognitive-behavioral factor was only correlated with one favorable outcome in the psychodynamic group and not any in the cognitive-behavioral group. The patient resistance factor was associated with a negative outcome in all five outcome measures in the cognitive-behavioral group and in two of the four outcome measures in the psychodynamic therapy group. Jones and Pulos concluded that many of the psychodynamic suppositions about psychotherapy process underlie favorable outcomes and that a sizeable portion of the favorable outcome in cognitive-behavioral therapy was associated with patients' ability to attend to their affect and to develop insight into their problems, which Jones and Pulos characterized as a metacognitive process.

In another study, Ablon and Jones (1998) were interested in how well prototypes of psychodynamic and cognitive-behavioral psychotherapy sessions were related to what clinicians actually did. They had 11 psychodynamic and 10 cognitive-behavioral clinicians use the Psychotherapy Process Q-Set (Jones, 1985, 2000) to create ideal prototypes of what sessions should look like. The top 10 items that characterized psychodynamic therapy were as follows: Discussion of the patient's dreams or fantasies, therapist neutrality and attention toward the patient's use of defenses, the therapist making connections between the therapeutic relationship and other relationships, the therapist being empathically attuned and interpreting warded off wishes, feelings, or ideas, and the therapist conveying a sense of acceptance along with the patient achieving a new level of insight. Cognitive-behavioral prototypes consisted of the following top 10 items: discussions of what the patient is to do outside of the session; a focus on cognitive themes and the patient's treatment goals; the therapist encouraging the patient to try out new ways of behaving with others and actively exerting control over the therapist-patient interactions; the therapist adopting a supportive stance, the dialogue being specifically focused; the therapist asking for more information

or elaboration; and the patient's current or recent life situation being examined.

Once the prototypes were developed, they were then compared with 68 brief psychodynamic and 32 cognitive-behavioral archival psychotherapy sessions in which outcome measures of psychiatric symptoms were obtained. In the study, 30 of the psychodynamic patients were treated for a wide range of psychiatric symptoms, whereas the other 38 were treated at a different clinic with a manualized version of brief therapy for posttraumatic stress disorder (PTSD). The cognitive-behavioral therapy group was treated for unipolar depression. The psychodynamic prototype was favorably associated with three of the six outcome measures in one of the psychodynamic groups and five of the six outcome measures in the cognitive-behavioral group. The cognitive-behavioral prototype was favorably associated with one rating of improvement in the one of the psychodynamic groups and one outcome measure in the cognitive-behavioral. There were no correlations between outcome and intervention (psychodynamic or cognitive-behavioral) in the PTSD group. These results suggested that psychodynamic clinicians tended to incorporate more cognitive-behavioral techniques (and not resemble the prototype created by expert judges), whereas cognitive-behavioral clinicians tended to intervene in ways similar to what expert judges described; however, favorable outcome was much more strongly associated with psychodynamic interventions than cognitive-behavioral interventions. Ablon and Jones (1998) pointed out that, in another study with this same sample, cognitive-behavioral interventions that focus on the impact of the distorted cognitions on patients were actually negatively associated with a favorable outcome (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996). This appeared to be associated with problems in the therapeutic alliance, and by adhering strictly to the manual's emphasis on looking at the negative impact of the cognitions, the relationship suffered, which ultimately produced a negative outcome. As for the absence of results in the PTSD group, Ablon and Jones noted that the PTSD group was known to have benefited by treatment by scores on the outcome measures. Consequently, the lack of findings may reflect a lack of sensitivity to detecting meaningful process variables in the Psychotherapy Process Q-Set. In sum, Ablon and Jones concluded that clinicians do not tend to adhere to prototypes in their work with patients.[1]

Because of the evolving interest in mechanisms of therapeutic action in psychoanalysis and related therapies, Ablon and Jones

(2005) decided to look at process variables in these types of treatments to see if they could provide empirical support for hypotheses about therapeutic mechanisms. They obtained an experienced, expert panel of psychoanalysts and asked them to develop a prototype of an ideal psychoanalytic therapy hour, which appeared very similar to the analytic prototype in Ablon and Jones (1998). This prototype was then compared with judges' ratings of psychotherapy processes in three different treatments: psychoanalysis, long-term psychoanalytic psychotherapy, and brief psychodynamic therapy. The judges' ratings correlated with the prototype as one might expect: The highest correlation was between psychoanalysis and the prototype ($r = .58$); the next highest was between psychoanalytic therapy and the prototype ($r = .45$); and the lowest correlation was between brief psychodynamic therapy and the prototype ($r = .37$).

Ablon and Jones (2005) also reported two case studies of patients who had undergone psychoanalysis and for whom multiple years of treatment data were available. Over seventy sessions were rated, and a prototype for each analysis was created. Not only did the ratings differ for each analysis, but the factor structure of the ratings varied, too. For the first patient, three broad factors emerged that consisted of patient self-exploration/analyst acceptance, analyst's activity, and a series of items related to a unique set of transactions of transference–countertransference between the patient and analyst over the patient's sexual thoughts and feelings. The second patient's ratings also clustered into three factors: positive transference/countertransference, analyst's authoritative responses, and eroticized transference. Ablon and Jones noted that these findings have important implications about the nature of what is therapeutically effective. Specifically, it is the repetitive, interactional nature of patient and therapist that creates certain kinds of therapy processes, and these processes are unique to each patient–therapist dyad. Ablon and Jones believed that their findings bridge the gap between insight and interpersonal relationship mechanisms of therapeutic action. Insight is derived from a relationship, and relationship dynamics are necessary for insight to be offered by the analyst. Such ideas cut across various models of therapeutic action in psychoanalytic theory and provide a broader context by which the process may be understood.

In a more recent paper, Ablon, Levy, and Katzenstein (2006) evaluated the therapeutic activities of 17 psychodynamic clinicians who were treating patients with panic disorder. Though their aims were

many, a major focus of the study was to identify which prototypical treatment processes best characterize psychodynamic treatment and which prototypical processes are most predictive of positive outcome. On all outcome measures, patients fared much better at the end of treatment than at the beginning of treatment. Sessions were scored on the Psychotherapy Process Q-Set during the 12th session, and ratings were compared with psychodynamic, cognitive-behavioral, and interpersonal psychotherapy prototypes derived from past studies (Ablon & Jones, 1998, 2002). Results indicated that therapy processes conformed most with cognitive-behavioral prototypes ($r = .50$), followed by psychodynamic ($r = .35$) and interpersonal prototypes ($r = .32$). In terms of content, effective treatment was associated with helping patients recognize, experience, and express negative emotions, sexual desires, and fears about their dependency and separation in the context of a caring, empathic therapy relationship. A favorable outcome was associated with two of three outcome measures when evaluating sessions for their prototypically interpersonal interventions and with one outcome measure when evaluating sessions for their prototypically psychodynamic interventions. The cognitive-behavioral therapy prototype was not associated with any of the three outcome measures. Taken as a whole, these findings suggest that psychodynamic clinicians tend to employ a multitude of interventions and that those specific to interpersonal and psychodynamic treatment are more associated with favorable outcomes. As Ablon et al. suggest, to better understand what kind of interventions are actually being employed in treatment, the "resolving power of the (psychotherapy) microscope must be turned higher" (p. 228).

Summary

This chapter discussed psychoanalytic and psychodynamic theories about the mechanisms of therapeutic action and corresponding research that has addressed this issue. It is clear that the psychotherapy relationship is highly important in producing a good outcome but that what psychodynamic clinicians actually do in treatment may not always appear to be psychodynamic. Results from Ablon and Jones (2005) demonstrate that prototypes of psychoanalytic treatment are clearly most associated with psychoanalysis. But in today's world of managed care, empirically supported treatments

(ESTs), brief treatments, and limited finances and available time, psychoanalytic and psychodynamic clinicians have effectively learned how to integrate ideas from various schools of therapy to work within these constraints. As Westen et al (2004) pointed out, brief, manualized ESTs have many limitations, and clinicians hoping to build their work on this kind of approach are setting themselves up for significant challenges. By looking more closely at the psychotherapy processes, Ablon, Jones, and colleagues (1993, 1998, 2005, 2006) demonstrated that there is clear empirical support for the effectiveness of psychoanalytic and psychodynamic interventions, more so than those that are more characteristically cognitive-behavioral. These interventions are characterized by elements of the therapeutic alliance, by therapists' attitude toward their patients, and by directing attention to psychoanalytically important components of mental functioning (e.g., fantasies, wishes, defenses, and relationship history). As psychoanalytic and psychodynamic therapy moves into the 21st century, it is clear that there is much to be retained from the theories of therapeutic action as well as things to be better understood and refined. Perhaps the current status of psychoanalytic and psychodynamic therapy research is best captured by a phrase from an old television commercial: "It's not your father's Oldsmobile anymore."

Note

1. Similar findings on clinicians' use of blended interventions have been found in studies with interpersonal psychotherapy and cognitive-behavioral therapy (Ablon & Jones, 1999, 2002).

8

Cognitive Neuroscience

Clinical psychology and psychiatry abandoned psychoanalytic and psychodynamic ideas some time ago as the major paradigm by which cases are conceptualized and treated. This occurred as biological psychiatry and pharmacotherapy advances suggested that a biologically informed treatment had much potential to alleviate psychiatric symptoms and disorders. This is regrettable in that Sigmund Freud himself viewed psychoanalysis as a scientific endeavor that someday would account for mental processes via an understanding of the neurological mechanisms and underpinnings of conscious and unconscious processes, dreams, wishes, instinctual impulses, and the like (Freud, 1895/1953, 1900/1953, 1940/1964). Included in Freud's work in this domain are drawings and neural maps to account for repression and the separation of the conscious and unconscious mind. The interested reader is directed toward Solms (2002) for a more detailed history of Freud's neuroscience writings.

In what follows, I present a selected review of studies and papers on the cognitive and neuroscientific underpinnings of psychoanalytic theory. This work has flourished in recent times, including the development of the multidisciplinary International Neuro-Psychoanalysis Society and its related journal, *Neuro-Psychoanalysis*. As an exemplar of the growing influence of this field, Shevrin (2006, p. 493) wrote:

> This widespread interest in investigating unconscious processes is perhaps one of the most remarkable developments in psychology currently underway. It is tantamount to a paradigm shift away from the previous behaviorist view according to which mental processes as such, whether conscious or unconscious, had no scientific standing. The behaviorist position has almost completely been replaced with a cognitive science view that is fully concerned with mental processes and their unconscious as well as conscious character, at least as concerns perception and memory.