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CHAPTER 12

RESEARCH ON DYNAMIC THERAPIES

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Once psychoanalysis or psychodynamic therapy ruled the earth. Unlike the dinosaurs, it did not disappear but rather sprouted many variations and new offspring. Today those offspring have forgotten everything about their origins.

A chapter on dynamic therapy (DT) has been omitted from some editions of this handbook. Not including one may have been seen as somewhat consistent with the decrease in the place and importance of psychodynamic psychotherapies in academic psychology, especially in English-speaking countries. However, we think the underrepresentation of DT is unfortunate, as its main ideas are at the foundation of many forms of psychotherapy, including recently developed ones (e.g., Summers & Barber, 2009). Ignoring and neglecting the historical legacy and clinical wisdom of dynamic therapy may adversely impact clinical care (e.g., the role of emotions, implicit cognitions, and defenses). It is quite clear (e.g., Summers & Barber, 2009) that many forms of therapy evolved from psychoanalysis, including cognitive and humanistic therapies. Some of the important theorists behind these relatively newer approaches were trained as psychoanalysts (e.g., A. T. Beck, Fritz Perls, Albert Ellis) and for various reasons were dissatisfied with major aspects of psychoanalysis. Thus, these influential individuals went on to make improvements over psychoanalysis and developed their own version of therapy. In their attempts to define their new approach to treatment, they emphasized what was different from psychoanalysis and perhaps minimized what they took with them from those therapies (e.g., the importance of the therapeutic relationship and encouraging a more realistic view of the world). However, more relevant to the present volume is the awakening of psychodynamically oriented researchers in the past two decades. Specifically, there has been an increase in empirical evidence for the efficacy of these DT for specific disorders as well as investigations on how and for whom DT might be helpful, as we will show.

Characteristics of DT

This chapter covers approaches to psychotherapy generally referred to as *psychodynamic* or *analytic*. DT—as well as cognitive-behavior therapy (CBT) for that matter—represents a family of therapies. As in all large families, the degrees of divergence and agreement vary quite a bit. Some members of the families are not even on speaking terms and sometimes even speak different languages. Thus, by necessity, this chapter presents a narrow representation of the psychodynamic family of therapies. Under this large umbrella, there are many approaches, which vary in their understanding of what is the nature of "disease" or "problem" (pathology) and on how to resolve or help deal with them. Most schools of therapy derive their view of pathology and intervention from a theory of human nature that includes, among others, a theory of personality and development. We hesitate to state a view of human nature that would be acceptable to all streams of DT. We would say that psychodynamics would involve recognizing that people are not always aware of the reasons for their behavior, that human motivations are to some extent rooted biologically, and that they are often driven by unknown motives.

Similarly, it would be wonderful if we could easily define what DT is and what it is not. There have been several attempts to characterize psychodynamic psychotherapy (e.g., Blagys & Hilsenroth, 2000); however, it would be almost impossible to find a set of necessary and sufficient conditions to define what is psychodynamic. Nevertheless, DT can be captured by the following characteristics: focus on unconscious processes; focus on affect, cognitions, wishes, fantasies and interpersonal relationships; lack of traditional homework; relatively less guidance, use of open-ended questions; use of interpretation and clarification; consideration of the transference and countertransference; and use of the therapeutic relationship to increase self-awareness, self-understanding, and exploration.

One of the questions we needed to address is whether interpersonal therapy (IPT; Klerman, Weissman, Rounsaville, & Chevron, 1984), popular in the treatment of depression, is a form of DT. IPT is similar to many DTs because it focuses on underlying schemas and repetitive scenarios involving loss and transition, and uses empathy, exploration of painful affects, and (rarely) transference interpretations. It differs in that it is highly focused and includes a significant educational component. In fact, there is research to suggest that in practice IPT is more like CBT than DT (e.g., Ablon & Jones, 2002). Our opinion is that depending on the training of the IPT therapists (e.g., their previous exposure to DT or the extent of their IPT training), the differences between IPT and DT can be elusive. Some meta-analyses of DT (e.g., Leichsenring 2001) included studies of IPT and showed that the overall meta-analytic results were unchanged if excluded. To be conservative, we decided not to include IPT as a form of DT therapy, mainly due to its explicit rejection of some critical dynamic concepts.

In this chapter we cover three general aspects of DT: its efficacy for symptom improvement; the therapeutic alliance and its role in DT; and processes of change, including mechanisms and outcome unique to DT and the correlates of DT techniques.

Research on Addressing the Efficacy of DT

In the past two decades, there have been increasingly more studies examining the therapeutic efficacy of DT (e.g., Shedler, 2010).[1] However, it seems that the number of meta-analyses has increased even more. The majority of these meta-analyses have focused on short-term DT (STDP) rather than long-term DT (LTDP) or psychoanalysis (for notable exceptions concerning possible LTDP superiority over controls and less intense treatments, see Leichsenring & Rabung, 2008, 2011; Smit et al., 2012). Briefly speaking, STDP differs from LTDP in that it generally: (a) takes place in a shorter, often time-limited format (usually at least 8 sessions, often 12 to 20, but sometimes up to 40 depending on the manual, disorder, etc.); (b) typically targets specific symptomatic versus global or structural change; and (c) does so by often identifying and working through a relatively specific dynamic-interpersonal focus conceptualized to underlie expressed psychopathology (e.g., a patient's core-conflictual relationship theme [CCRT] in Luborsky's [1984] supportive-expressive therapy [SE]).

Interventions in STDP are often classified as being on a continuum of "expressive" to "supportive" (Luborsky, 1984). Broadly, expressive (or interpretive) techniques such as transference and defense interpretations seek to augment patient insight and understanding of in-the-moment or repetitive interpersonal and intrapsychic patterns or conflicts. Insight or self-understanding may allow a patient to better tolerate distressing thoughts, affects, and fantasies that are defended against in a way that creates psychopathology; insight might also potentiate working through repetitive intrapsychic and interpersonal dynamics previously disavowed, misunderstood, or unknown. Supportive techniques are conceived both in terms of building the therapeutic alliance and of boosting client capacity to use extant healthy capabilities (e.g., adaptive defenses, social networks) when such a capacity may be compromised (see later in the chapter for a more extensive discussion on both the alliance and dynamic

[1] Due to space restrictions, our original chapter was sharply shortened as we approached our publication deadline. In particular, we had to cut our reference list by more than 50%. We also removed several additional meta-analyses that we had conducted in preparation for this chapter. For space reasons we were required to eliminate references of many studies and meta-analyses, of measures used, and of many theoretical manuals underpinning delivered treatments. We apologize in advance to researchers whose work we are not citing.

interventions). Expressive and supportive interventions are often thought to work synergistically to promote patient change. For example, supportive interventions may create a positive "holding" environment involving therapist and patient that serves as a uniquely safe interpersonal space for: (a) experiments in self-change (e.g., trying out diferent modes of relating through the therapist-patient interaction); (b) expressive exploration of thoughts, feelings, and fantasies; and (c) experiencing emotions and insights in an impactful way as a result of reduced defensivenss.

Generally, previous meta-analyses of DT reached one or more of the following four different conclusions: (1) DT outcome does not differ from alternative therapies (e.g., for DT across disorders, see Leichsenring, Rabung, & Leibing, 2004; for depression, see Leichsenring, 2001; for personality disorders, see Leichsenring & Leibing, 2003); (2) there are small ES differences in favor of DT (e.g., Anderson & Lambert, 1995, at follow-up in some analyses of DT); (3) there are small differences in favor of alternative treatments across disorders (e.g., Tolin, 2010, as compared to some CBTs, though including controls as DT treatments) or in depression specifically (e.g., Driessen et al., 2010 finding a small difference at termination but not follow-up); and (4) DT is significantly superior to control treatments (e.g., for DT across disorders, see Abbass, Hancock, Henderson, & Kisely, 2006; Leichsenring et al., 2004; for somatic conditions specifically, see Abbass, Kisely, & Kroenke, 2009).

In a representative and rigorous meta-analysis of patients with different disorders, Leichsenring et al. (2004) identified 17 well-conducted post-1970 studies of STDP, and found that STDPs yielded large pretreatment-posttreatment ESs for target problems ($d = 1.39$), general psychiatric symptoms ($d = .90$), and social functioning ($d = .80$). The ESs of STDP significantly exceeded those of waiting-list controls ($d = .27$) and treatments as usual ($d = .55$) for treatment of target problems. No significant differences were found between STDP and other forms of psychotherapy at either termination or follow-up.

Meta-analyses have also differed in their inclusion criteria; some of them included any study that mentioned DT while others were more selective. For example, a recent Cochrane review of STDP by Abbass et al. (2006) found 57 studies of STDP, but excluded 34 studies for various design issues, mostly because they did not have a control treatment group. They also excluded studies that had more than a 20% dropout rate. Nevertheless, their meta-analysis included 23 RCTs comprising 1,431 patients, and found moderate-to-large between-groups ES advantages for STDP over control groups on measures of general psychopathology, anxiety, and depression at termination, short-term and long-term follow-up.

Keeping in mind that there are few high-quality studies of DT (Gerber et al., 2011; see also Thoma et al., 2012, for a similar finding in the CBT literature), we considered different inclusion criteria with the wish to include only studies that had the potential to be high quality. We considered strictly following the criteria used by the task force of Division 12 of the American Psychological Association for designating psychotherapies as empirically supported (Task Force on Promotion and Dissemination of Psychological Procedures, 1995; Chambless & Hollon, 1998), as the most convincing evidence for the scientific world and for governmental agencies comes from RCTs. We recognized that these criteria are controversial (e.g., Westen, Novonty, & Thompson-Brenner, 2004) and that RCTs have unique drawbacks in psychotherapy research. Those drawbacks may be more pronounced for the study of DT, which may for example require on the part of the patient a certain amount of psychological mindedness and willingness to introspect to have a chance of working (cf. Barber, 2009). Because manualized DTs seldom include session-by-session guidelines, we included studies where manualization was not definite and to test whether manualization makes a difference.

Methodology for the Meta-Analysis

The inconsistency of results across existing meta-analyses could have been the result of inconsistencies on whether the analysis focused on a specific disorder or not, or whether they included only RCTs or any outcome study. As a way to address those issues and to be consistent with recent trends, we focused on addressing the question of whether DT is effective for the treatment of specific disorders or disorder groups. This resulted in a series of separate meta-analyses for the following disorder groups: depression, anxiety disorders, and personality disorders.

Study Inclusion Criteria

The primary sample of DT studies reviewed and meta-analyzed was taken from the Gerber et al. (2011) quality-based review of RCTs of DT. We used the same terms to search for more recent publications. In addition, we reexamined past reviews and meta-analyses for studies missed in the aforementioned searches and contacted experts in the field for citations for recently completed studies.

To be included, a study had to be an RCT comparing individual DT for adults to either a control condition (e.g., TAU, wait list) or alternative non-DT intervention (e.g., CBT, pharmacotherapy). However, we did include mentalization-based treatment (MBT; Bateman & Fonagy, 2006)—which includes group therapy—as it is a state-of-the-art, well-defined DT for borderline personality disorder and does include a strong individual component. For similar reasons, we included dialectical-behavioral therapy (DBT) as a comparison treatment despite it consisting of both individual and group therapies. We excluded studies that had an eclectic treatment incorporating dynamic ideas. We also did not include studies comparing combined DT and pharmacotherapy (e.g., SSRI) to another combined group using a different therapy (e.g., CBT + SSRI).

Statistical Analyses

Calculations of weighted mean effect size (ES), heterogeneity, and moderator analyses were conducted using Comprehensive Meta-Analysis, version 2.2.046 (Borenstein et al., 2005); a priori, it was decided to conduct our meta-analyses using a random-effects model for a more stringent and generalizable test of the efficacy of DT. For our ES measure, we used Hedge's g—similar to the traditional Cohen's d, but corrected for upward bias (Hedges, 1981). Both g and d are ES statistics standardized by standard deviations units, wherein a g/d of 1.00 indicates that the difference between two means is one (pooled) standard deviation unit large. Values of 0.20, 0.50, and 0.80 are considered small, medium, and large effects, respectively, in social science research, although these conventions apply only to between-group ESs (Cohen, 1992).

Between-groups ESs using outcome scores on continuous measures were meta-analyzed. In the event of incomplete reporting of scores, ESs were imputed or estimated from available data and reported statistical tests as per Lipsey and Wilson (2001). For overall analyses, ESs calculated from scores were chosen over ESs calculated from binary outcomes (e.g., remission) if available, except as noted. When relevant data or tests were not available, attempts were made to contact corresponding authors.[2] Meta-analyses were performed for outcomes at termination, and—when at least three relevant studies with data were available—at short-term follow-up (3 to 9 months posttermination) and long-term follow-up (> 9 months posttermination) periods.

So as to not violate independence when comparing DT to multiple active treatments within the same study (e.g., behavioral therapy and cognitive therapy in Gallagher & Thompson, 1982), data from active treatment groups were collapsed and used to calculate overall ESs and variance as per formulas in the Cochrane Handbook for Systematic Reviews of Interventions (2011). Similarly, when multiple bona fide DTs were performed within the same study (e.g., transference-focused therapy and manualized dynamic-supportive therapy in Clarkin, Levy, Lenzenweger, & Kernberg, 2007), data from these groups were collapsed using the same methodology.

However, for one meta-analysis (depression), we had a sample of studies that allowed us to explore whether DT was differently efficacious from medication and/or alternative psychotherapies. Because it would be invalid to include the same study twice, as it would violate ES-independence criteria for meta-analysis, we included in a particular moderation analysis only the between-groups ES for the treatment type as the focus of that moderation.

Heterogeneity of ESs was examined using the Q statistic and the I^2 index (Higgins & Thompson, 2002). Significant Q statistics indicate that the observed range of ES is significantly larger than what would otherwise be expected based on within-study variances; the I^2 index is a quantification of this heterogeneity, with 25%, 50%, and 75% reflecting respectively low, medium, and high heterogeneity. Robustness of meta-analytic results was also examined by performing a sensitivity analysis to see if a given result relied on the ES of a single study.

[2]Notably, we did receive data from the Clarkin et al. (2007) study of dynamic and DBT treatment of BPD. They sent us estimated pre- and post scores based on the hierarchical linear models they ran to analyze their three treatment groups—as they were the best data available for this study, we used these score estimates in our meta-analyses.

Regardless of observed heterogeneity for a given meta-analysis, exploratory analyses were conducted to assess for moderators of ES. Moderators are categorical (e.g., manualization status) or continuous (e.g., quality score) characteristics of studies, used to predict outcome (i.e., ES). Categorical moderators were assessed using an analysis of variance (ANOVA) of mixed-effects models for each variable hypothesized to influence the ES. Meta-regression analyses using a maximum-likelihood model were conducted to assess the effects of continuous moderators, including an index of study quality scores using the Randomized Controlled Trial Psychotherapy Quality Rating Scale (RCT-PQRS; Kocsis et al., 2010). When describing included studies, we reported both total quality scores (ranging from 0 to 48) and subjective Item 25 "omnibus" study quality rating (1 to 7; 1 being extremely poor, 7 being exceptionally good). Gerber et al. (2011) demarcate a total score of 24 as the minimum for an adequate quality study. If RCT-PQRS scores were not available from Gerber et al. (2011), studies were instead scored by two independent graduate students who attained excellent agreement ($ICC = .97$). With the exception of some comparisons in our depression meta-analysis, all moderator analyses should be considered highly exploratory due to low ($n < 10$) study sample size (see guidelines from Higgins & Green, 2011). Low study sample size may mean that there is not enough data for the moderation to be generalized, may not have enough power to find an extant effect, and can lead to biased results due to heightened effects of between-study characteristic confounds and nonrandom clustering of study characteristics. However, we performed moderator analyses in the interests of synthesizing a preliminary picture of the current state of the literature and to perhaps direct future research questions and analyses. Descriptions of precise moderator findings have sometimes been truncated for space reasons, but we always reported on moderators if significant at least at trend level ($p < .10$).

Publication bias was assessed by examination of publication bias funnel plots and Duval and Tweedie's (2000) trim-and-fill procedure. When asymmetry was evident in the funnel plot, we applied Duval and Tweedie's trim-and-fill procedure to provide an adjusted ES estimate that corrects for the number and assumed location of the missing studies.

Mood Disorders

Reflecting the variety of DTs and STDPs, studies reporting on DT for unipolar depression have used different forms of therapy. From a dynamic perspective, the essential issues in depression are loss and guilt over loss, along with low self-esteem and failures in the attempt to restore self-esteem (Freud, 1917). Treatment generally involves: (a) encouraging greater activity in the patient and instillation of hope; (b) identification of major losses, anger, conflict over anger, guilt, as well as the cycle of self-esteem restoration; and (c) proactive attempt to understand vulnerability in situations and change in response and behavior to prevent recurrence (e.g., Busch, Rudden, & Shapiro, 2004; Summers & Barber, 2009).

There have been two previous meta-analyses focusing on STDP for depression. Leichsenring (2001) meta-analyzed seven studies comparing STDP to CBT, finding no significant differences between them in either outcome scores or rates of remission/response. The most recent meta-analysis (Driessen et al., 2010) included a larger sample of 23 studies: 10 of them were not RCTs, and covered both individual and group therapy for depression. Using data from 13 RCTs, unlike Leichsenring the authors found that STDP was more effective than control groups ($d = 0.80$) but less effective than alternative treatments ($d = -0.35$) at termination, though this difference was not found at follow-up. Driessen et al. did not find significant moderators apart from an advantage of individual over group therapies using uncontrolled ES.

In our meta-analysis, we have tended to be inclusive rather than exclusive. However, we excluded studies where DT was delivered in combination with other treatments. We also sought to explore moderators not investigated by previous meta-analyses—such as type of alternative treatments, impact of study quality, and addition of pharmacotherapy. Our preferred outcome measure (if available) was the Hamilton Rating Scale for Depression (HRSD).

Controlled Comparisons

The comparison of DT for depression to control conditions (two "treatment as usuals" [TAUs], one wait list, and one pill-placebo) suggested a moderate controlled ES (study $n = 4$, subject $n = 303$, $g = 0.457$ [0.097 to 0.818], $p = 0.013$, fail-safe N of 12). Heterogeneity was found at a trend level ($Q = 6.794$, $I^2 = 55.846$, $p = 0.079$).

Although we did not find any significant categorical moderators, there was a trend indicating that better study quality was associated with smaller controlled ES (slope = −0.0368, total model $p = 0.079$; see Cuijpers, van Straten, Bohlmeijer, Hollon, Andersson, 2010, for a similar finding in the depression literature overall). As patient population varied highly between studies (e.g., severity, duration, comorbidity), our findings should be interpreted cautiously.

Active Treatment Comparisons

At termination, DT and alternative treatments did not differ (study $n = 11$, subject $n = 830$, $g = -0.115$ [−0.257 to 0.026], $p = .110$), with no significant heterogeneity among ESs. This result was sensitive to the removal of Cooper et al. (2003), which results in an estimate of a small ES benefit to using alternative treatments over DT (study $n = 10$, subject $n = 696$, $g = -0.161$ [−0.315 to −0.007], $p = 0.040$). Conversely, checking for publication bias via trim and fill suggested the existence of unpublished studies favoring DT, raising the ES estimate to a still-insignificant $g = -0.096$. We did not find any evidence that DT had significantly different between-groups ESs when compared against antidepressants versus alternative therapies ($Q = 0.232$, $p = 0.630$), when compared against CBT versus non-CBT treatments ($Q = 1.032$, $p = 0.310$), or even when compared against CBT *or* antidepressants versus remaining alternative treatments ($Q = 0.785$, $p = 0.376$). Total quality score (slope = −0.0100, *ns*), manualization of DT ($Q = 0.093$, $p = 0.760$), whether or not the depressed population was geriatric ($Q = 0.857$, $p = 0.355$), and number of sessions of DT (slope = 0.00128, *ns*) were also not significant moderators of ES. At termination, DT and alternative therapies for depression—including CBTs and antidepressants—likely effect similar overall outcomes. Any overall difference, if extant but undetected, is likely to be of small ES.

DT was also not significantly different from alternative treatments at short-term follow-up (study $n = 6$, subject $n = 496$, mean $FU = 4.29$ months, $g = -0.122$ [−0.524 to 0.280], $p = 0.553$), with no evidence of publication bias or that the result was due to including any single study. However, unlike termination, ESs at short-term follow-up did have significant heterogeneity ($Q = 14.732$, $I^2 = 66.061$, $p = 0.012$). In an exploratory moderator analysis comparing alternative treatment types ($Q = 5.447$, $p = 0.020$), we found that at short-term follow-up DT performed significantly worse against CBTs (study $n = 4$, subject $n = 299$, $g = -0.380$ [−0.756 to −0.004], $p = 0.048$) than when compared to non-CBT treatments (study $n = 2$, subject $n = 57$, $g = 0.530$ [−0.103 to 1.163], $p = 0.101$). Some dynamic therapists anticipate symptoms return around termination, and this bounce in symptoms may be an expectable reaction in DT. Also, at short-term follow-up, we found a significant moderation ($Q = 6.660$, $p = 0.010$) suggesting that DT was inferior to alternative treatments for geriatric (study $n = 2$, subject $n = 96$ $g = -0.853$ [−1.484 to −0.222], $p = 0.008$) but not nongeriatric patient populations (study $n = 4$, subject $n = 400$, $g = 0.086$ [−0.247 to 0.419], $p = 0.611$). It is possible that older patients may benefit more from concrete, direct interventions for depression because the concerns leading to their depression may be more grounded in actual experience associated with aging (e.g., loss of support, declining physical health) than in internal conflict. Because all geriatric studies used CBTs as their comparison therapies, it is difficult to disambiguate whether the geriatric patient population or use of CBTs (or perhaps both or neither) was the primary reason for DT diminished performance among these studies. However, in both DT and CBT, geriatric depressed patients improve less than other patients. Among only studies in which DT was compared to a CBT, DT performed significantly worse than CBTs ($Q = 4.922$, $p = 0.027$) in geriatric studies ($g = -0.625$ and −1.096) than in nongeriatric studies ($g = -0.157$ and −0.149). This finding is consistent with the interpretation that the moderation showing diminished comparative efficacy for DT against CBTs may in fact be driven by diminished DT efficacy for geriatric patients rather than a superiority of CBTs per se.

Finally, DT did not differ from alternative treatments at long-term follow-up (study $n = 5$, subject $n = 487$, mean $FU = 23$ months, $g = -0.205$ [−0.546 to 0.136], $p = 0.239$), again with no evidence of publication bias or single-study sensitivity. As at short-term follow-up, ESs at long-term follow-up displayed significant heterogeneity ($Q = 9.772$, $I^2 = 59.068$, $p = 0.044$). No moderators were significant, notably including geriatric patient population. Furthermore, at long-term follow-up, *all* alternative treatments investigated were CBTs (with the exception of the supportive therapy group from Cooper et al. [2003], which does not differ notably in ES from

the study's CBT group). Thus, the use of CBT vs. non-CBT comparison therapies cannot explain observed ES heterogeneity at this time point.

Combined DT + Pharmacotherapy Versus Pharmacotherapy

Using remission rates as the common outcome variable, we found a moderate ES advantage at termination (study $n = 3$, subject $n = 295$, $g = 0.470$ [0.036 to 0.904], $p = 0.034$) of combined DT and antidepressant treatment over antidepressants alone, with no indication of publication bias (see Cuijpers, Dekker, Hollon, & Andersson, 2009; de Maat et al., 2008 for similar findings). There was, however, significant heterogeneity among the three studies ($Q = 6.649$, $I^2 = 69.919$, $p = 0.036$). No moderators were significant.

Conclusions: The Efficacy of DT for Depression

Despite limiting our meta-analysis to only RCTs and individual DT, our results converge with those of Driessen et al. (2010). We found that DTs are as therapeutically effective as alternative treatments (both psychosocial and pharmacological) in the treatment of depression at the end of active treatment and at short- and long-term follow-up. DT was also found to be more effective than control conditions. We further found that combined DT and pharmacotherapy may be more efficacious than pharmacotherapy alone, a finding that has not often been confirmed in the literature.

Some versions of DTs for depression may meet criteria for being *probably efficacious* as defined by APA Division 12 "empirically supported treatments" criteria (e.g., brief dynamic interpersonal therapy, parent-infant psychodynamic therapy [Cooper et al., 2003]). Conversely, no one specific version of DT for depression meets full, formal APA Division 12 criteria to be designated a well-established EST because there has not been a replication by a *separate* research group of any effective, manualized form of DT for depression (Chambless & Hollon, 1998; Connolly Gibbons, Crits-Christoph & Hearon, 2008). However, it is not always clear just how different from each other various versions of DT for depression actually are in theory and practice—in many instances, the manuals appear largely convergent. This raises the interesting question as to how to decide that a specific treatment has been replicated in order to meet Division 12 criteria. Regardless of DT's official status as an EST or not, readers need to keep in mind that few treatments have been shown to be more effective than other active treatments for depression (Cuijpers, van Straten, Andersson, & van Oppen, 2008). In light of the strong trend in the meta-analytic literature of equivalence for depression between major therapeutic models, future investigations might pay specific attention to which specific depressed patients might be best suited for DT versus other therapies (see Barber & Muenz, 1996; Barber et al., 2012).

Anxiety Disorders

Though DT is widely used to treat anxiety disorders (e.g., Goisman, Warshaw, & Keller, 1999), the empirical literature supporting its effectiveness is nascent but growing (see Slavin-Mulford & Hilsenroth, 2012, for a review including naturalistic and quasi-experimental empirical evidence). The question of whether DT is efficacious for the treatment of anxiety disorder is one of the most important areas of research in terms of addressing the specific versus common hypothesis of psychological change (cf. Castonguay & Grosse Holtfort, 2005; Schut & Castonguay, 2001). Many CBT researchers may agree that nonspecific (common) factors could explain positive results in depression, but they would argue that the specific aspects of CBT for anxiety disorders are responsible for the greater rate of improvement for those disorders (cf. Chambless, 2002; Chambless & Ollendick, 2001).

Dynamic conceptualizations of the etiology, maintenance, and treatment of anxiety symptoms do often differ dramatically from those commonly described in the CBT traditions, and propose different specific mechanisms of change. DT for anxiety disorder is well-exemplified by manualized panic-focused psychodynamic psychotherapy (PFPP; Busch, Milrod, Singer, & Aronson, 2011). PFPP posits that panic attacks arise from specific unconscious conflicts, most commonly conflicts of dependency and attachment (e.g., panic as a way to indirectly express a need for care without requiring direct acknowledgment of surrounding conflicts) or feelings of anger (e.g., panic as an aggressive means of coercing attention or as a fearful reaction to the anger felt toward essential figures). Guilt about dependent and angry wishes is also frequently a contributor, with panic acting as a means of unconscious punishment. Treatment involves interpreting the emotional significance of panic, the psychological meaning

of specific symptoms and panic triggers, identifying the relevant intrapsychic conflicts alluded to above, and increasing the understanding of inner experiences related to panic and their underlying dynamics. As in many DTs, this would entail working through repetitive conflicts surrounding the psychological meanings of panic through demonstration that the same conflicts may be emerging in multiple settings, including in the transference.

To date there has never been a meta-analysis synthesizing the literature on the effects of DT in the controlled treatment of anxiety disorders. Due to the paucity of studies, we have decided to focus on anxiety disorders in general. So as to include multiple anxiety disorders in the same meta-analysis, we used the author-identified primary outcome measure when available to calculate ESs. When primary outcome was not explicitly indicated, the judgment of the meta-analysis authors was used to select outcome measures for analysis based on the specific psychopathology of the disorder in question. Regarding the construct of general anxiety, the clinician-based Hamilton Rating Scale for Anxiety (HRSA) was our preferred outcome measure.

Controlled Comparisons

Keeping in mind the very small number of studies analyzed, DT was superior to control conditions with a large estimated controlled ES (study $n = 3$, subject $n = 105$, $g = 0.775$ [0.381 to 1.168], $p < 0.001$, fail-safe $N = 10$). Two studies used a minimal treatment control (Alstrom et al., 1984a, 1984b; providing study assessments, psychoeducation, and recommendation/instruction for self-exposure but no ongoing treatment), while one used a wait-list control (Brom, Kleber, & Defares, 1989). There was no significant heterogeneity among ESs, nor was there single-study sensitivity. A trim-and-fill check for publication bias suggested adjustment downward to $g = 0.630$ (0.313 to 0.946). Given the quality of those studies, their date of publication (none after 1990), and their small sample sizes, replication of controlled ES for DT against controls is needed, especially against active controls.

Active Treatment Comparisons

DT for anxiety disorders did not have significantly different outcomes compared to alternative treatments (study $n = 8$, subject $n = 390$, $g = 0.083$ [−0.247 to 0.413], $p = 0.622$). This result was insensitive to the removal of any single study from the meta-analysis, and there was no indication of publication bias. A significant level of heterogeneity among study outcomes was found ($Q = 17.544$, $I^2 = 60.101$, $p = 0.014$). As several DT treatment protocols contained explicit references to minor exposure elements (e.g., a recommendation to self-expose and then discuss in SE therapy for GAD), we were curious as to whether the inclusion of such a stipulation in the treatment protocol moderated ESs. However, whether a DT used such a minor exposure element (Alstrom et al., 1984a, 1984b; Crits-Christoph et al., 2005; Leichsenring et al., 2009) did not significantly moderate ESs ($Q = 0.084$, $p = 0.772$). It remains possible, however, that in commonly delivered DT there are elements of exposure (cf. Lambert & Ogles, 2004). It is also possible that commonly delivered CBTs include elements of DT such as interpretations of unconscious wishes and defenses. A single moderator was significant: DT for disorders *other than* GAD was more comparatively efficacious than DT for GAD ($Q = 5.370$, $p = 0.020$). More specifically, we found a small ES benefit to using DT over alternative treatments when treating anxiety disorders other than GAD (study $n = 4$, subject $n = 203$, $g = 0.364$ [0.008 to 0.720], $p = 0.045$), whereas DT for GAD was not significantly different from alternative treatments (study $n = 4$, subject $n = 187$, $g = -0.238$ [−0.602 to 0.126], $p = 0.199$).

At short-term follow-up, equivalence between DT and alternative treatments was maintained (study $n = 6$, subject $n = 304$, average $FU = 6.16$ months, $g = -0.154$ [−0.691 to 0.383], $p = 0.573$), a finding that was also insensitive to removing any single study. This result may need to be interpreted cautiously, as a high level of heterogeneity was found among ESs ($Q = 25.087$, $I^2 = 80.070$, $p < 0.001$). In addition, a trim-and-fill check for publication bias imputed the existence of studies to the right of the estimated ES, raising the estimate to an insignificant g = 0.182. Using exploratory moderator analysis we found some suggestion that, by follow-up, DT for GAD may be significantly less effective than alternative treatments ($Q = 5.310$, $p = 0.021$). At short-term follow-up, DT for GAD was moderately worse than alternative treatments (study $n = 3$, subject $n = 159$, $g = -0.601$ [−1.125 to −0.077], $p = 0.025$), while there was no significant difference between DT and other therapies when treating other anxiety disorders (study $n = 3$, subject $n = 145$, $g = 0.275$

[−0.255 to 0.805], $p = 0.309$). This follow-up result, however, was dependent on our inclusion of Durham et al. (1994), which was unbalanced to the detriment of DT (i.e., no manual or even theoretical formulation was used for DT but were for the CBT conditions). Replication using another manualized DT would help elucidate to what extent our moderator analysis reflects a "true" disadvantage of DT for GAD, or merely bias due to differences in treatment fidelity. No other moderator was found to be significant.

Conclusions: The Efficacy of DT for Anxiety Disorders

Despite common beliefs to the contrary (cf. Chambless, 2002; Tolin, 2010), the evidence from RCTs suggests that DT is largely neither better nor worse for treatment of anxiety disorders than are other active treatments (predominantly CBTs), a finding carried into short-term follow-up. We also found evidence that DT may have a medium-to-large ES advantage over minimal-to-no treatment controls on primary outcome, although among a small number of older studies.

One limitation to our meta-analysis is that these results are—with the exception of the GAD moderation analysis—collapsed across disorders (see Table 12.2), and notably included no controlled studies of obsessive-compulsive disorder. With the current studies available, it is not possible to further disambiguate the relative effects of DT for different anxiety disorders. Another limitation is the low quality of some studies included in the meta-analysis (e.g., both Alstrom studies; Pierloot & Vinck, 1978), though study quality did not moderate ESs. Furthermore, several studies had pilot-level sample sizes. Nevertheless, our meta-analysis introduces the possibility that DT for anxiety disorders may be as efficacious as alternative treatments. Several large scale DT RCTs are currently underway (investigating panic disorder and social phobia), and their results will be published over the next few years. Future research into the effects of DT for specific anxiety disorders is warranted, especially for GAD.

Personality Disorders (PD)

It is always difficult to provide a summary statement about the essence of DT for any disorder, but even more so for PD due to the diversity of PDs and of forms of DT. Following Magnavita (1997), one could say that DT for PD generally entails the identification of maladaptive, recurring patterns of thinking, perceiving, and behavioral and emotional responding, and the restructuring of these patterns, primarily through linking the current and transference patterns to early relational disruptions of attachment and trauma. For example, Kernberg's transference-focused psychotherapy (TFP) for borderline personality disorder (BPD) proposes that the symptomatology of BPD (e.g., flip-flopping "split" perceptions of relationships as being all-good or all-bad, intolerable feelings of emptiness) emerges from pervasively unintegrated self-object representations (Clarkin et al., 2006). Accordingly, the primary mechanism of treatment in TFP is the gradual elucidation and integration of these split-off self-object representations as they emerge in the transference. In an attempt to integrate these disparate and polarized self-object representations, the therapist brings these representations into conscious conflict with another when otherwise they would pass without recognition of their mutual incoherence. Therapists further seek to analyze both what triggers the emergence of particular representations and what defensive roles the separation and switching between "good" and "bad" representations serves. This is thought to help the patient improve their reality testing, ability to mentalize the thoughts and feelings of others (see Bateman & Fonagy, 2006), interpersonal stability, and sense of internal coherence and wholeness.

Prior synthesis of the clinical literature via meta-analysis indicates that psychotherapy is generally efficacious in the treatment of PD (Perry, Banon, & Ianni, 1999). Leichsenring and Leibing's (2003) meta-analysis was the first to examine the specific efficacy of DT in the treatment of PD, as compared to the efficacy of CBT. Based on 15 studies (6 controlled, 9 naturalistic), they reported large within-groups (or uncontrolled) ESs for both overall change ($d = 1.46$) and specific measures of personality pathology ($d = 1.56$ from the subset of 6 studies that reported personality pathology scores). The uncontrolled ES for DT was not significantly different than the one calculated for CBT ($d = 1.00$ from a sample of ten studies). Notably, all ESs were calculated using data from the furthest point available from termination (average 78 weeks for DT and 13 weeks for CBT), perhaps explaining why the ES for DT was arithmetically (but not significantly) larger than the one found for CBT. From those results, they inferred that DT (and, to a lesser extent, CBT)

can cause long-term, sustained change in psychopathology. More recently, Abbass, Town, and Driessen (2011) meta-analyzed a small number of controlled and uncontrolled studies examining DT for patients with depression and co-morbid personality pathology, finding both large within-group ESs and no significant differences in efficacy compared to other investigated treatments.

In the current meta-analysis, we focused on between-groups ES estimates for PD treatment, averaging together ESs from patient-reported and/or observer-reported measures of psychopathology within the study. We refer to this composite ES as "general outcome." Assessing general outcome across measures allows for the inclusion of more studies within the meta-analysis. However, there is broad disagreement as to what precisely constitutes change within a given PD, never mind across PDs. As such, we also performed a secondary set of meta-analyses for both between-groups and controlled ESs for improvement in specific psychopathology construct for which at least three studies could contribute an ES (e.g., three controlled studies used a variant of the Inventory for Interpersonal Problems [IIP; Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988]).

Controlled Comparisons

At termination, DT for PD was more effective than controls for general outcome (study $n = 7$, subject $n = 452$, $g = 0.593$ [0.258 to 0.918], $p = 0.001$, fail-safe $N = 52$). Control conditions included two enhanced TAUs (Bateman & Fonagy, 2009; Doering et al., 2010), two TAUs (Bateman & Fonagy, 1999; Gregory et al., 2008), and three wait-list controls (Abbass, Sheldon, Gyra, & Kalpin, 2008; Emmelkamp et al., 2006; Winston et al., 1994). Though this comparison showed moderate heterogeneity ($Q = 15.903$, $I^2 = 62.272$, $p = 0.014$)—as to be expected from including different intensities of control treatments—there was no evidence of publication bias or that the result was driven by any single study.

The heterogeneity of control conditions used should caution against overinterpretation of the precise magnitude of the controlled effect size. However, we could not meaningfully test moderator effects of using active controls versus inactive controls *or* testing for borderline personality disorder (BPD) patients versus other PD patients because all BPD studies used an active control and all others used an inactive control. Furthermore, we could not examine the effects of manualization as only one study in this comparison (Emmelkamp et al., 2006) did not qualify as manualized; this study—comparing DT versus a wait-list for avoidant PD treatment—had the lowest controlled ES ($g = -0.030$). No moderators were significant, though future explorations of moderators (e.g., number of therapy sessions) might be better served using samples with the same types of control treatments (e.g., only versus wait-list).

Active Treatment Comparisons

DT did not differ from alternative therapies for PD in terms of general outcome (study $n = 7$, subject $n = 528$, $g = -0.145$ [−0.342 to 0.052], $p = 0.150$). This ES estimate was not impacted by significant heterogeneity or indication of publication bias, nor did any one study drive this finding. As only one study was unmanualized (Emmelkamp et al., 2006; though see footnote 4), it was not possible to investigate whether manualization affected ES. No moderators were significant. In particular, we did not find significant moderation for whether the study concerned the treatment of BPD ($Q = 0.093$, $p = 0.761$) or a primary Cluster-C disorder. ($Q = 0.152$, $p = 0.696$).

In terms of short-term follow-up, there was again no significant difference in general outcome between DT and alternative treatments (study $n = 5$, subject $n = 381$, average $FU = 6$ months, $g = -0.056$ [−0.367 to 0.255], $p = 0.723$). There was a trend toward heterogeneity among ESs at follow-up ($Q = 7.784$, $p < 0.100$, $I^2 = 48.616$), though there was no indication of publication bias. The result was not single-study sensitive. Again, only Emmelkamp et al. (2006) was not manualized, though it did have the lowest ES ($g = -0.658$). Exploratory meta-regression suggested a trend of a significant, positive relation between number of dynamic sessions and between-groups ES (slope = 0.04395, total model $p < 0.100$).

Secondary Analyses: Specific Treatment Outcomes of DT for PD

In a secondary set of analyses, we performed meta-analyses for both between-groups and controlled ESs for improvement in any specific psychopathology construct for which at least three studies could contribute an ES (e.g., three controlled studies used a variant of the IIP). Six constructs were identified: personality pathology

(e.g., STIPO, PDQ); general symptomatology (e.g., SCL-90); global functioning (measured by the GAF); interpersonal problems (measured by the IIP); depression (measured by the BDI); and suicidality (e.g., rates of patients attempting suicide). All six constructs had enough studies contributing data to perform preliminary meta-analyses for controlled outcome. However, only three constructs (general symptomatology, personality pathology, and interpersonal problems) had enough studies to meta-analyze DT compared to other active therapies.

We found no significant differences between DT and other therapies on measures of personality pathology (study $n = 6$, $g = -0.108$ [−0.357 to 0.140], $p = 0.392$), general symptomatology (study $n = 4$, $g = -0.078$ [−0.291 to 0.136], $p = 0.476$), and interpersonal problems (study $n = 4$, $g = 0.019$ [−0.194 to 0.232], $p = 0.861$). For controlled ES, DT had a significant advantage over control treatments on measures of general symptomatology (study $n = 5$, $g = 0.565$ [0.135 to 0.994], $p = 0.010$), suicidality (study $n = 4$, $g = 0.649$ [0.394 to 0.904], $p = 0.000$), global functioning (study $n = 3$, $g = 0.579$ [0.204 to 0.955], $p = 0.002$), interpersonal problems ($n = 3$, $g = 1.245$ [0.463 to 2.028], $p = 0.002$), personality pathology ($n = 3$, $g = 0.311$ [0.015 to 0.607], $p = 0.040$), and a trend toward an advantage in treating depressive symptomatology (study $n = 4$, $g = 0.645$ [−0.060 to 1.349], $p = 0.073$). It is possible that the controlled ES for personality pathology outcome may be somewhat underestimated at treatment termination relative to follow up, as both Bateman and Fonagy (1999 for original study, 2008 for follow-up report) and Gregory et al. (2008 for original, 2010 for follow-up) report long-term follow-up between-groups ESs for personality pathology that are substantially larger than our estimate here ($d = 1.80$ and $d = 1.31$, respectively).

Conclusions: The Efficacy of DT for PD

Among the small number of RCTs of DT for PDs, DT is superior to control conditions, but not different than alternative treatments in terms of general psychopathological outcome at termination and short-term FU. We did not find any indication from exploratory moderator analysis that DT showed significantly different between-groups ESs when treating either BPD or Cluster-C PDs. It may behoove future dynamic trials of PD treatments to use more active controls to better assess the efficacy of DT treatment and examine whether benefits of DT over active controls is maintained after termination (for evidence that this may be true, see follow-up reports Bateman & Fonagy, 2008; Gregory et al., 2010).

Given the nature of DT (its goals and processes), there may be the expectation that DT would do well with and perhaps better than other types of psychotherapy with personality pathology and interpersonal relations. However, we found that overall equivalence between DT and other treatments for PD is the rule when specifically examining personality pathology, general symptomatology, and interpersonal problems. It seems that the Dodo Bird verdict (Luborsky, Rosenthal, et al., 2002) applies to existing controlled studies of PD up to short-term follow-up. We further showed superiority of DT over controls in the domains of general symptomatology, suicidality, global functioning, interpersonal problems, personality pathology, and—less definitively—depressive symptoms. With regard to controlled effect, DT may have the strongest evidence base in the domain of PD treatment.

In fact, DT's first full "EST" has come from the treatment of personality pathology: TFP has recently been designated a *well-established* treatment for BPD by APA Division 12 (2012). Mentalization-based treatment has also been determined to be *probably efficacious* for BPD (APA Division 12, 2012) for exhibiting clear superiority to both a strong TAU and a manualized enhanced TAU in two RCTs, one RCT showing large ES advantages over TAU over 5 years after treatment. Several individual manualized variants of DT might also be considered at least *probably efficacious* for the treatment of PDs as per APA criteria (Chambless & Hollon, 1998): Vaillant McCullough's STDP (Svartberg et al., 2004 for Cluster-C), brief relational therapy (Muran et al., 2005 for Cluster C), intensive STDP (Abbass et al., 2008; Winston et al., 1994 for general PD), brief adaptive psychotherapy (Muran et al., 2005, Winston et al., 1994 for general PD and Cluster C), psychodynamic psychiatric management (McMain et al., 2009/2012, for BPD), and manualized dynamic-supportive therapy (Clarkin et al., 2007, for BPD, though less preferable to TFP on measures of suicidality).

Unambiguously, DTs should be considered viable and efficacious treatments for personality pathology. Especially in consideration of the dearth of well-studied, efficacious treatments for PDs compared to other disorders, replications and extensions of several DT treatments for PDs are highly warranted. Clearly, there is a need to

TABLE 12.1 Description of DT RCTs of Mood Disorders (Depressive Dxs)

Study	Depression Type	Dynamic Therapy Groups	Comparison Groups	Follow-Up Period (mos.)	Primary Outcome Findings	Total/ Overall Quality Score	Outcome Measure
Barber et al. (2012)	Chronic MDD	20 sessions SE, MAN ($n = 51$)	ADP ($n = 55$), PL ($n = 50$)	None	SE = ADP = PL	43/6	HRSD
Barkham et al. (1999)	Subsyndromal, dysthymia, mild MDD	2 weekly sessions then 1 session 3 months later VBDIT, MAN ($n = 54$)	VBCBT ($n = 62$)	12	VBDIT = VBCBT Long-term FU: VBDIT < VBCBT	29/4	BDI
Burnand, Andreoli, Kolatte, Venturini, and Rosset (2002)	MDD	82 inpatient days of DIT + ADP, UNMAN ($n = 35$)	ADP ($n = 39$)	None	DIT + ADM > ADM	27/4	HRSD
Cooper, Murray, Wilson, and Romaniuk (2003)	Postpartum	10 sessions PIPT, MAN ($n = 45$)	CBT ($n = 42$), NDC ($n = 47$), TAU ($n = 50$)	4, 13, and 55	Termination: PIPT = CBT, NDC on scores but PIPT > CBT, NDC on remission; PIPT > TAU Short-term FU: PIPT = CBT, NDC, TAU Long-term FU: maintained	37/5	EPDS
de Jonghe, Kool, van Aalst, Dekker, and Peen (2001)	MDD with or without dysthymia	8 weekly and 8 sessions every 2 weeks DST + A DP, UNMAN ($n = 72$)	ADP ($n = 57$)	None	DST + AD > AD	35/6	HRSD
Gallagher and Thompson (1982)	Geriatric MDD	16 sessions over 12 weeks BRT, UNMAN ($n = 10$)	CT ($n = 10$), BT ($n = 10$)	1.5, 3, 6, and 12	Termination: BRT = BT, CT Short- and long-term FU: maintained	27/4	HRSD
Gallagher-Thompson and Steffen (1994)	Geriatric major, minor, or intermittent depressive disorder	16–20 sessions BDT, UNMAN ($n = 30$)	CBT ($n = 36$)	3	BDT = CBT	27/6	RDC improvement or remission
Hersen, Bellack, Himmelhoch, and Thase (1984)	MDD	12 sessions BDT + PL (undefined), UNMAN ($n = 22$)	SST + PL ($n = 25$), ADP ($n = 14$)	None	BDT + PL = SST + PL, AD	31/4	HRSD

Maina, Forner, and Bogetto (2005)	Dysthymia, minor depressive disorder, or adjustment disorder with depressed mood	Avg. 20 sessions BDT, UNMAN ($n = 10$)	SP ($n = 10$), WLC ($n = 10$)	6	BDT, SP > Wait list Short-term FU: BDT > SP	22/3	HRSD
Maina, Rosso, and Bogetto (2009)	First-episode MDD	Avg. 18.3 sessions BDT + ADP, UNMAN ($n = 41$)	ADP ($n = 51$)	6, 28, 48, but only for remitters	Termination: BDT + AD = AD Short-term FU: BDT + AD > AD Long-term FU: maintained	38.5/5.5	HRSD
Salminen et al. (2008)	MDD	16 sessions BDT, UNMAN ($n = 26$)	ADP ($n = 25$)	None	BDT = AD	28/5	HRSD
Shapiro et al. (1994)	Mild, moderate, and severe MDD	8 or 16 sessions of BDIT, MAN ($n = 57$)	8 or 16 sessions of CBT ($n = 59$)	3.75 and 12	Termination: BDIT < CBT on BDI but not on other measures of depression and symptoms Short-term FU: maintained Long-term FU: 8-session BDIT < 8-session CBT, 16-session CBT, and 16-session BDIT	35/7	BDI
Thompson, Gallagher, and Breckenridge (1987)	MDD	16–20 sessions BDT, UNMAN ($n = 24$ before wait-list integration, 30 post)	BT ($n = 30$ post wait-list), CT ($n = 31$ post wait list), DTC ($n = 19$)	12 and 24	Termination: BDT = CT, BT Long-term FU: maintained	18/4	HRSD, RDC remission at FU
Thyme et al. (2007)	Dysthymia or subsyndromal depression	Avg. 21 sessions BDT, UNMAN ($n = 21$)	AT ($n = 18$)	3	Termination: BDT = AT Short-term FU: Maintained	17/3	HRSD
Vitriol, Ballesteros, Florenzano, Weil, and Benadof (2009)	MDD with childhood trauma	Avg. 12 sessions BDT, UNMAN ($n = 44$)	Enhanced TAU ($n = 43$)	3	Termination: BDT > TAU Short-term FU: Maintained	27/4	HRSD

ADP = Antidepressant Drug Protocol, AT = Art Therapy, BDI = Beck Depression Inventory, BDIT = Brief Dynamic-Interpersonal Therapy, BDT = Brief Dynamic Therapy: BRT = Brief Relational Therapy BT = Behavioral Therapy, CBT = Cognitive Behavioral Therapy, CT = Cognitive Therapy, EPDS = Edinburgh Postnatal Depression Scale GAD = Generalized Anxiety Disorder, HRSD = Hamilton Rating Scale for Depression, MAN = Manualized Therapy, MDD = Major Depressive Disorder, NDC = Nondirected Counseling, PC = Psychodynamically Informed Counseling, PIPT = Parent-Infant Psychodynamic Therapy, PL = Placebo, SE = Supportive-Expressive Therapy, SP = Manualized Supportive Psychotherapy, SST = Social Skills Training, TAU = Treatment as Usual, UNMAN = Unmanualized Therapy, VBCBT = Very Brief CBT, VBDIT = Very Brief Dynamic-Interpersonal Therapy, WLC = Wait List Control

TABLE 12.2 Description of DT RCTs for Anxiety Disorders

Study	Disorder	Dynamic Therapy Groups	Comparison Groups	Follow-Up Period (mos.)	Primary Findings	Total/ Overall Quality Score	Outcome Measure
Alstrom, Norlund, Persson, Harding, and Ljungqvist (1984a)	Agoraphobia	Avg. 8.5 sessions DST, UNMAN ($n = 14$ at T, 13 at FU)	PE ($n = 11$ at T, 9 at FU); AR ($n = 17$ at T and FU); BTC ($n = 19$ at T, 12 at FU)	9	Termination: DST = PE; DST > AR & BTC Short-term FU: DST > PE, AR, & BTC	19/3	AIPS global rating
Alstrom, Norlund, Persson, Harding, and Ljungqvist (1984b)	Specific social phobia	Avg. 9.4 sessions DST, UNMAN ($n = 16$ at T, 13 at FU)	PE ($n = 7$ at T and FU); AR ($n = 9$ at T, 6 at FU); BTC ($n = 10$ at T, 8 at FU)	9	Termination: DST < PE; DST > AR & BTC Short-term FU: maintained	19/3	AIPS global rating
Brom, Kleber, and Defares (1989)	PTSD	Avg. 18.8 sessions TBDT, MAN ($n = 26$)	TD ($n = 28$); BHT ($n = 26$); WLC ($n = 20$)	3	Termination: TBDT = BHT, TD; TFDT > WLC Short-term FU: maintained	23/5	Combined: TSS + IES
Crits-Cristoph, Gibbons, Narducci, Schamberger, and Gallop (2005)	GAD	16 sessions SE therapy adapted to GAD, MAN ($n = 14$)	SP ($n = 14$)	None	SE = SP on scores, SE > SP on remission	35.5/5	HAM-a
Durham et al. (1994)	Chronic GAD	8 or 16 sessions of an unspecified model, UNMAN ($n = 29$)	8 sessions CT ($n = 20$); 16 session CT ($n = 15$); AMT ($n = 16$)	6	Termination: DT <AMT, CT-8 and CT-16 Short-term FU: maintained	29/5	HAM-a for Termination, STAI-T (Form Y) for FU

Leichsenring et al. (2009)	GAD	30 sessions SE for GAD, MAN (n = 28)	CBT (n = 29)	6	Termination: SE = CBT on primary outcome, some secondary Short-term FU: maintained	38/6	HAM-a
Milrod, Leon, Busch, et al. (2007)	Panic disorder with and without agoraphobia	24 sessions PFPP, MAN (n = 26)	AR (n = 23)	None	PFPP > AR	42/6	PDSS
Pierloot and Vinck (1978)	General anxiety	Avg. 19.77 sessions FDT, UNMAN (n = 9)	SD (n = 13)	Mean of 3.95 months	Termination: FDT < SD Short-term FU: FDT = SD	8/2	Combined: PSS-a + TMAS + STAI-T

AIPS = Alstrom Interview of Phobic Symptoms, AMT = Anxiety Management Training, AR = Applied Relaxation, BTC = Basal Therapy Control, BHT = Behavioral Hypnotherapy, CT = Cognitive Therapy, CBT = Cognitive-Behavioral Therapy, DST = Dynamic Supportive Therapy, FDT = Focal Dynamic Therapy, GAD = Generalized Anxiety Disorder, HAM-a = Hamilton Anxiety Rating Scale, MAN = Manualized Therapy, PDSS = Panic Disorder Severity Scale, PE = Prolonged Exposure, PFPP = Panic Focused Psychodynamic Psychotherapy PSS-a = Psychiatric Status Schedule-Anxiety Subsection (PTSD = Post-Traumatic Stress Disorder, SD = Systematic Desensitization, SE = Supportive-Expressive Therapy (SP = Manualized Supportive Psychotherapy, STAI-T = State-Trait Anxiety Inventory (Trait), TBDT = Trauma-Based Dynamic Therapy, TD = Trauma Desensitization, TSS = Trauma Symptoms Scale, TMAS = Taylor Manifest Anxiety Scale, UNMAN = Unmanualized Therapy, WLC = Wait-List Control

TABLE 12.3 Description of DT RCTs for Personality Disorders

Study	Disorder	Dynamic Therapy Groups	Comparison Groups	Follow-Up Period (mos.)	Primary Findings	Total/ Overall Quality Score	Outcome Measures
Abbass et al. (2008)	Mixed PD	Avg. 27.7 sessions ISTDP, MAN ($n = 14$)	WLC ($n = 13$)	None	ISTDP > WLC	27/5	BSI-GSI, GAF-Symptoms, GAF-Social-occupational , IIP-64
Bateman and Fonagy (1999)	BPD	18 months of partial hospitalization MBT, MAN ($n = 19$)	TAU ($n = 19$)	6, 12, 18, 60	MBT > TAU Short-term FU: maintained Long-term FU: maintained	29.5/6	BDI, GAF (Long-term FU Only), IIP-Circumflex, Parasuicidal composite, SAS, SCL-90-R, ZRS (Long-term FU Only)
Bateman and Fonagy (2009)	BPD	78 individual/78 group sessions MBT, MAN ($n = 71$)	Enhanced TAU ($n = 63$)	None	MBT > Enhanced TAU	45/7	BDI, GAF, IIP-Circumflex, Parasuicidal composite, SCL-90-R
Clarkin et al. (2007)	BPD	102 sessions TFP, MAN ($n = 23$); at least 52 sessions SP, MAN ($n = 22$)	DBT ($n = 17$)	None	TFP = DBT, SP	26/4	AIAQ, BIS-II, BAI, BDI-II, GAF, OAS-M, SAS
Doering et al. (2010)	BPD	102 sessions TFP, MAN ($n = 52$)	CETC ($n = 52$)	None	TFP > CETC	32/5	BDI, BSI-GSI, GAF, Parasuicidal composite, STIPO

Emmelkamp et al. (2006)	Avoidant PD	20 session BDT (multiple manuals, including both Malan, 1979 and Luborsky, 1984), UNMAN[3] (n = 22, 25 at short-term FU)	CBT (n = 18, 22 at Short-term FU), WLC (n = 16)	6	Termination: BDT < CBT; BDT = WLC Short-term FU: maintained	24/5	AS, LWASQ, PDBQ-Avoidant, SPAI
Giesen-Bloo et al. (2006)	BPD	Avg. 231 sessions (for "completers"[4]) TFP, MAN but poor adherence[5] (n = 42)	SFT (n = 44)	N	TFP < SFT	42/7	BPDSI, General psychopathology factor score
Gregory et al. (2008)	BPD and substance abuse/ dependence	52 sessions DDT, MAN (n = 15, 11 at Long-term FU)	TAU (n = 15, 13 at Long-term FU)	18	Termination: DDT > TAU Long-term FU: maintained	31/5	BDI, BEST, DES, Parasuicidal Composite, SPS
Hellerstein et al. (1998)	Mixed PD, Cluster C and PD-NOS	30–40 sessions STDP, MAN (n = 14)	SP (n = 12 at termination, 10 at Short-term FU)	6	STDP = SP	30/5	IIP, SCL-90-R, TCS
McMain et al. (2009/2012)	BPD	Avg. 31 sessions PPCM, MAN (n = 90)	DBT (n = 90)	6, 12, 18, 24	Termination: PPCM = DBT Short-term FU: maintained Long-term FU: maintained	44/7	BDI, IIP-64, MRSSE (Parasuicidality), SCL-90-R, STAEI, ZRS

(*Continued*)

[3] Both despite and in part because of the citing of several disparate DT manuals and texts, we did not consider the therapy in Emmelkamp et al., 2006 to be manualized. It is unclear that a specific formulation of DT for the treatment of avoidant PD was used, especially in comparison to the use of Beck's schema-focused CBT for PD in the comparison treatment.

[4] Though Giesen-Bloo et al. (2006) chose 3 years as the analysis period for their study, the supermajority of patients (>80%) in both the TFP and SFT groups had not terminated with their therapist in this window (see Levy, Meehan, & Yeomans, 2012 for discussion).

[5] Though Giesen-Bloo et al. (2006) ostensibly investigated manualized DT of TFP, Yeomans (2007) claims that TFP therapists were neither properly trained nor supervised in TFP. Indeed, the published level of adherence to TFP was remarkably low, while the adherence to SFT was very high, though the original study authors counterclaimed this did not affect TFP treatment efficacy (Giesen-Bloo & Arntz, 2007).

TABLE 12.3 *(Continued)*

Study	Disorder	Dynamic Therapy Groups	Comparison Groups	Follow-Up Period (mos.)	Overall Findings	Total/ Overall Quality Score	Outcome Measures
Muran, Safran, Samstag, and Winston (2005)	Cluster C & PD-NOS	30 sessions BAP, MAN ($n = 22$); 30 sessions BRT, MAN ($n = 33$)	CBT ($n = 29$)	6	Termination: BAP = BRT = CBT Short-term FU: maintained	40/5	GAS, IIP, SCL-90-R, TCS (patient and therapist),WISPI
Svartberg, Stiles, and Seltzer (2004)	Cluster C PD	40 sessions STDP, MAN ($n = 25$ at Termination, 22 at short-term FU, 23 at long-term FU)	CBT (n = 25 at Termination, 24 at Short-term FU, 21 at Long-term FU)	6, 12, 24	Termination: STDP = CBT Short-term FU: maintained Long-term FU: maintained	38/6	IIP, MCMI, SCL-90-R
Winston et al. (1994)	Mixed PD, primarily Cluster C	Avg. 40.3 sessions of ISTDP, MAN ($n = 25$); BAP, MAN ($n = 30$)	WLC ($n = 26$)	None	ISTDP + BAP > WLC	22/3	SAS, SCL-90-R, TCS

AIAQ = Anger, Irritability, and Assault Questionnaire, AS = Avoidance Scale, BAP = Brief Adaptive Psychotherapy, BDI = Beck Depression Inventory, BEST = Borderline Evaluation of Severity over Time (BIS-II = Barratt Impulsiveness Scale-II), BPD = Borderline Personality Disorder, BPDSI = Borderline Personality Disorder Severity Index, BRT = Brief Relational Therapy, BSI-GSI = Brief Symptom Inventory—Global Severity Index, CBT = Cognitive-Behavioral Therapy, CETC = Community Expert Treatment Control, DBT = Dialectical-Behavioral Therapy, DDT = Dynamic-Deconstructive Therapy, DES = Dissociative Experiences Scale, GAF = Global Assessment of Functioning, GAS = Global Assessment Scale, IIP = Inventory of Interpersonal Problems, IPDE = International Personality Disorder Examination, ISTDP = Intensive Short-Term Dynamic Psychotherapy LWASQ = Lehrer Woolfolk Anxiety Symptoms Questionnaire, MAN = Manualized, MCMI = Millon Clinical Multiaxial Inventory, MBT = Mentalization-Based Treatment, MRSSE = Medical Risk of Suicide and Self-Injurious Episodes, OAS-M = Overt Aggression Scale-Modified, PDBQ = Personality Disorder Belief , Questionnaire, PPCM = Psychodynamic Psychiatric Case Management, SAS = Social Adjustment Scale, SCL-90-R = Symptom Checklist-90-Revised, SFT = Schema-Focused Therapy, SP = Manualized Supportive Psychotherapy, SPS = Social Provisions Scale, SPAI = Social Phobia Anxiety Inventory, STAEI = State-Trait Anger Expression Inventory, STDP = Short-Term Dynamic Psychotherapy, STIPO = Structured Interview for Personality Organization, TAU = Treatment as Usual, TCS = Target Complaints Scale, TFP = Transference-Focused Psychotherapy, UNMAN = Unmanualized, WISPI = Wisconsin Personality Inventory, WLC = Wait-List Control, ZRS = Zanarini Rating Scale for Borderline Personality Criteria

encourage the replication of important findings by independent researchers. However, the lack of incentives to replicate outcome studies needs to be addressed by the field.

THE EFFICACY OF DT AND "WHAT WORKS FOR WHOM"

As described earlier, there has been a notable increase in the quality (Gerber et al., 2011) and number of RCTs addressing DT efficacy. Our three meta-analyses for specific disorders are consistent with the overall conclusion that in RCTs, DT has been shown to be as effective as alternative therapies at termination and follow-up and superior to control conditions (e.g., TAU, wait-list controls).

Overall, we were particularly cautious not to overexclude studies in a manner favorable to DT. We included studies of nonmanualized DT. Pointedly, we did not include studies in which a "stripped-down" DT-like condition was unambiguously used as a control.[5] However, we did not thoroughly screen for more subtle straw-man or "intent-to-fail" DT conditions. Such "intent-to-fail" DT conditions might include versions of DT in which therapists are artificially restricted such as by being specifically forbidden to discuss relevant symptoms (e.g., eating disorder behavior in Garner et al., 1993). We might also consider as being intent-to-fail studies where it is not evident that the investigators drew upon empirical or theoretical literature describing psychodynamics or DT for the target condition (e.g., Durham et al., 1994; Emmelkamp et al., 2006). Past meta-analytic investigations have suggested that rigorously and systematically filtering for "intent-to-fail" treatments tends to yield findings of no significant differences between treatments (Benish, Imel, & Wampold, 2008, for PTSD; Wampold, Minami, Baskin, & Tierney, 2002, for depression). Engaging in such a process for DT—that is, meta-analyzing only DT studies systematically selected as bona fide (see Wampold et al., 1997, for a description of what might constitute a bona fide therapy)—might be a topic worthy of future study. However, the problem is who decides what is a bona fide DT.

Notably, none of the meta-analyses we performed found DT to be significantly inferior or superior to alternative treatments at either termination or follow-up. In addition, DT was always found to be superior to combined control conditions. Interestingly, despite the fact that we did not exclude what may be relatively poor studies of DT (e.g., Durham et al., 1994; Giesen-Bloo et al., 2006 as argued by Levy, Meehan, & Yeomans, 2012), we found little evidence that DT was inferior to alternative treatments for any disorder group. There were some exceptions from moderation analyses (see our earlier discussions of depression treatment follow-up and DT for GAD treatment); however, they must be considered exploratory due to the small number of studies analyzed (Higgins & Green, 2011).

Our exploratory moderator analysis did not reveal consistent moderators of between-groups ES across disorders. For example, we did not find a consistent relation of between-groups ESs and quality score or number of sessions of DT perhaps because of the limited statistical power of our samples. A more omnibus (folding across disorders) meta-analysis might be necessary to elucidate the effects of specific moderators in DT given the number of available studies. Also of note is that we did not find a consistent relation between DT manualization and between-groups ES, perhaps because manualization is common in RCTs (for an RCT of manualized vs. unmanualized DT for PD, see Vinnars, Barber, Noren, Gallop, & Weinryb, 2005). However, we point out that assessing fidelity is not a panacea. For example, whether fidelity is assessed or not does not guarantee that the treatment delivered did not include interventions from another treatment (e.g., Ablon & Jones, 1998; McCarthy & Barber, 2009), that investigator allegiance did not impact treatment delivery, or that there is no variability in the delivery of the therapy for a specific

[5] An example would be the manualized control therapy (titled "emotion-focused psychotherapy" but not to be confused with Les Greenberg's humanistic-experiential therapy) from the Shear, Houck, Greeno, & Masters (2001) study of panic disorder. The therapy was devised to represent nonprescriptive, nonspecific therapy that might be provided in the community to panic patients. Active components included supportive listening, problem solving, and general identification and discussion of emotions. Despite Shear et al. (2001) explicitly stating that the therapy was "not a psychoanalytic therapy," it was included in the Tolin (2010) meta-analysis of CBT vs. other therapies as a bona fide DT, which it clearly is not. Another illustrative example would be Linehan et al., 2006, which compared DBT to an enhanced TAU condition wherein TAU therapists identified their primary orientation as dynamic or eclectic. Nevertheless, Smit et al., 2012, included this as a valid long-term DT condition in their meta-analysis.

intervention. Merely knowing that adherence was assessed does not suffice, and the field will need to assess ways of integrating the data from adherence with outcome to decide how to evaluate the outcome of any RCT. This is a complex question as there is some evidence that adherent delivery of a treatment is not associated with outcome (Webb, DeRubeis, & Barber, 2010).

Investigator allegiance, which was not explored in our meta-analysis, may explain some of the variance in treatment outcomes, especially in trials of lower methodological quality (see Munder, Gerger, Trelle, & Barth, 2011, for a recent meta-analysis showing this relation). Allegiance could be especially relevant when the counterallegiance therapy is unmanualized but the allegiance-syntonic therapy is. In this situation, the unmanualized counterallegiance therapy may be more likely to be a "stripped-down," unrigorous, and/or unrepresentative version of that therapy, unformulated to the disorder in question. Thus, any future meta-analytic investigations of manualization may need to be examined through the lens of imbalance in manualization and in the context of allegiance. As is obvious from Tables 12.1 through 12.3, many different exemplars of DT were used in these analyses. Though all DTs share important characteristics, there nevertheless remain significant theoretical and implementation differences between many of these treatments (e.g., primacy of interpretation of the transference relationship in TFP versus more circumspect transference interpretations in MBT). The few RCTs that have directly compared different models of DT mostly involved PD patients and have reported mixed findings. One such study investigating BPD treatment (Clarkin et al., 2007) compared two forms of manualized DTs (TFP versus manualized dynamic-supportive therapy), and the results were mostly equivocal with the notable exceptions of suicidality and some secondary outcome measures (e.g., reflective functioning) in favor of TFP. Conversely, Muran et al. (2005) did report results suggesting that BRT may be somewhat superior to BAP in the treatment of Cluster-C personality disorders and PD-NOS. It is entirely possible that differences in the effectiveness of DTs exist for different disorders and patient types. However, due to the small sample of studies, heterogeneous comparison conditions, and differences in specific disorders treated, we cannot meaningfully contribute to the question of whether or not certain bona fide dynamic treatments are better than others in the treatment of psychopathology.

Including a wide range of DT could be conceived to both increase and harm generalizability of the meta-analytic results in different ways. On the one hand, that we included several DT exemplars might indicate that the "average" DT performed in an RCT is equivalent to alternative treatments, a finding which may or may not extend to delivery of DT by experts in the field. This might also imply that the characteristics shared amongst DTs are in some way therapeutically sound, or at the very least not counterproductive to treatment. On the other hand, meta-analyzing several DTs at once makes it difficult to determine whether certain DTs drive our findings more than others. By that same token, it may be also problematic to collapse all comparison treatments into "alternative therapies" (see Siev & Chambless, 2007, suggesting differential effectiveness of different CBTs) or control treatments (ranging from wait-list controls to intensity-matched, manualized TAUs). The limited size of the evidence base necessarily restricted our methodological rigor, as not enough comparisons are available to meta-analyze within a disorder group in such a granular way.

Importantly, meta-analyzing at the level of diagnostic entities is unlikely to lead to the identification of relevant differences in treatment efficacy for clinical subpopulations (Beutler, 2002). "Fit" between the patient and the therapist, the therapeutic relationship, and the therapy itself may together account for more of the variance in outcomes than the treatment model alone, considered apart from "fit" (cf. Beutler, 2009). In other words, the question of "what works for whom" is relevant not only on the level of treatment type and disorder, but also regarding characteristics of patients, therapists, the therapeutic relationship, and their interrelationship (see Norcross, 2011 for meta-analytic reviews on many related topics; Muran & Barber, 2010 and later in this chapter regarding the therapeutic alliance specifically).

Barber et al. (2012) reported secondary analyses from an urban, disadvantaged, chronically depressed RCT sample suggesting that SE therapy may be specifically efficacious for minority males and White females. In a unique study that further illustrates this principle of "fit," Heinonen, Lindfors, Laaksonen, and Knekt (2012) found an interaction influencing treatment outcome between the personality of a therapist and the therapy they were practicing in an RCT treating a mixed-disorder sample. Whereas more extroverted and interpersonally

active therapists tended to effect better outcomes in both short-term therapies investigated (a DT and problem-solving therapy), more introverted, cautious, and nonintrusive therapists effected better outcomes in the long-term DT condition. Different implementations of the same therapeutic model (e.g., which techniques are actually used, to what degree they are used, use of proscribed counter-theory interventions) could also have differential impact on patient change (e.g., Høglend et al., 2008, found that use of transference interpretations is perhaps most important for patients with more severe deficits in object relations; see also McCarthy, 2009).

In the context of "what works for whom," it is possible that DT may be able to help fill treatment gaps, both by developing efficacious treatments that are tolerable to different patients and that may be specifically efficacious for particular patients. For instance, Milrod, Leon, Barber, Markowitz, and Graf (2007) found that DT may be *more* efficacious for patients with Cluster-C personality pathology than for patients without, a counterintuitive finding (awaiting replication) considering many view personality pathology as an obstacle to treatment. Clinically speaking, enhanced DT efficacy for panic and PD comorbid patients may be highly relevant because 20% to 50% of panic patients may qualify for a PD (e.g., Massion et al., 2002; Milrod, Leon, Busch, et al., 2007; Ozkan & Altindaq, 2005). Similarly, using data from the NIMH TDCRP depression RCT (Elkin et al., 1989), Barber and Muenz (1996) have shown that depressed patients with comorbid obsessive-compulsive PD had better outcomes with IPT than cognitive therapy (CT), while patients with comorbid avoidant PD (APD) did better with CT than IPT. This could be understood as an instance of anticomplementarity. Patients with more obsessive personalities may be best served by a therapy (IPT) that challenges them to explore their inner lives and interpersonal relationships on a feeling level rather than a thinking level, while patients with more avoidant personalities may do best in a more directive therapy (CT) that challenges them to actively break out of their passive or retreating patterns (see also Liebowitz, Stone, & Turkat, 1986). On the other hand, overly aggressive behavior on the part of DT therapists—as represented by both the concentration of interpretations delivered and by disaffiliative patient-therapist interactions surrounding and during interpretation—may be sometimes deleterious to outcome in APD patients (Schut et al., 2005), suggesting possible limits or complications to anticomplementarity. In terms of matching among dynamic treatments, data suggest that more introjective (i.e., ruminative, preoccupied with self-definition) patients improve more in longer-term, explorative psychoanalysis, while more anaclitic (i.e., strongly emotionally dependent, concerned with relatedness) patients improve more in more active and shorter DT (Blatt, 1992; Blatt & Shahar, 2004). Although these possible treatment recommendations certainly behoove replication, they nevertheless illustrate the manifest need for deeper analysis of trial data.

Overall, these findings suggest that therapy-patient "match" may be highly relevant to treatment planning. Certainly, meta-analyses such as ours are helpful in demonstrating fairly robustly the repeated, controlled efficacy for DT across multiple disparate studies. Indeed, we have shown that current RCT data indicate that—with a few tenuous exceptions—DT is likely equivalent to alternative therapies and superior to control conditions in the treatment of many forms of psychopathology. However, there is also a need to study for whom and under what circumstances different effective therapies—including DT—may be most efficacious. This challenge is perhaps a way to fruitfully engage practitioners of different theoretical backgrounds in collaborative endeavor with researchers.

Like many psychotherapy researchers, we postulate that understanding the process of therapy will increase our ability to develop further our treatments, to make them more effective, and to perhaps individualize them better for the needs of specific individuals. We now turn to the research on those processes and begin our survey by examining a construct that has attained paramount importance in psychotherapy research, the therapeutic alliance.

The Therapeutic Alliance in DT

Alliance Construct

The therapeutic alliance was first a psychodynamic construct, before it became a transtheoretical formulation (Bordin, 1979), an integrative variable (Wolfe & Goldfried, 1988), and a common factor (Wampold, 2001). The history of the construct dates back to Freud's early suggestion of the importance of making a "collaborator" of the patient in the therapeutic process, but was

brought to prominence by the ego psychological tradition with its emphasis on the reality-oriented adaptation of the ego to the environment. A number of ego psychologists (Bibring, 1937; Greenson, 1967; Sterba, 1934; Zetzel, 1956) developed the alliance construct to counteract a perceived overemphasis on transference in many object relational approaches and to provide theoretical justification for greater technical flexibility. By highlighting the critical importance of the real, human aspects of the therapeutic relationship, the construct provided grounds for departing from the idealized therapist stance of abstinence and neutrality. In general, it highlighted the importance of the therapist being supportive and the patient identifying with the therapist and adapting to the therapist view of the treatment process.

Over the years, many dynamic theorists have grappled with questions of how to conceptualize the alliance and transferential aspects of the therapeutic relationship and whether the alliance construct is meaningful and useful (Brenner, 1979; Dickes, 1975; Hanly, 1992; Kanzer, 1975; Lacan, 1973; Langs, 1976). For example, criticisms have ranged from suggesting the alliance construct can lead to leaving transferential aspects unanalyzed to promoting conformity to the therapist's desires. Interestingly, the alliance construct has not received much attention from the interpersonal tradition. This is probably due to the tradition's more flexible approach to the therapist's position and recognition of the therapist's ultimate embeddedness in the interpersonal field and irreducible subjectivity. This perspective has been more radically advanced by contemporary relational analysts, who have promoted an intersubjective and social constructivist take on the therapeutic relationship (e.g., Aron, 1996; Mitchell, 1988, 1993). From a relational take, Safran and Muran (2000, 2006) have argued that developing the alliance and resolving alliance ruptures are not prerequisite to change, but rather the very essence of the change process.

Alliance Research

Beginning in the 1970s, the alliance construct became the focus of the psychotherapy research community. This was due in large part to two major contributions: (1) Luborsky's (1976) development of the Penn Helping Alliance Questionnaire (HAq), which yielded measures of Perceived Helpfulness (Type I: to what extent the patient perceived the therapist to be helpful) and Collaboration or Bonding (Type II: to what degree the patient and therapist were working together); and (2) Bordin's reformulation that defined the alliance as comprised of three interdependent dimensions—Agreement on Tasks, Agreement on Goals, and the Affective Bond—which became the basis for the development of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). These contributions spurred a proliferation of research on the alliance, as well as further measurement development. They also (Bordin's conceptualization especially) contributed to the growing interest in psychotherapy integration and the understanding of common factors that has been evident in the field since the 1980s (e.g., Goldfried, 1980).

With the development of so many alliance measures, both Hatcher (2010) and Horvath (2006) have argued that there has been a cost in the loss of definitional precision: The variety of measures has brought a variety of idiosyncratic definitions of the alliance construct and arguably a great deal of confusion about its meaning. In addition to the HAq and the WAI, other measures most often used include the Vanderbilt Psychotherapy Process Scale (VPPS; O'Malley, Suh, & Strupp, 1983) and the California Psychotherapy Alliance Scales (CALPAS; Gaston & Marmar, 1994). The VPPS has subscales measuring Patient Psychic Distress, Patient Participation, Patient Hostility, Patient Exploration, Patient Dependency, Therapist Warmth and Friendliness, Therapist Exploration, and Negative Therapist Attitude.

According to Horvath, Del Re, Flückiger, and Symonds's (2011) recent meta-analysis, two thirds of the studies conducted regarding the alliance-outcome relationship involved these four "core" measures, which shared less than 50% of the variance. Arguably, the confusion comes from the emphasis of patient versus therapist contributions, the relation between alliance and technical intervention, and the relation between alliance and outcome. The HAq was especially criticized for conflating the quality of the relationship with outcome by its measure of Type I alliance, Perceived Helpfulness (Barber & Crits-Christoph, 1996) and was revised to address this criticism by removing several items (Luborsky et al., 1996). Trying to disentangle the alliance from these relationships, however, may be impossible: To illustrate, although the WAI emphasizes purposeful collaboration and does not include any

items regarding patient or therapist contribution (unlike the CALPAS and VPPS), its emphasis on agreement on tasks and goals does suggest that technique and outcome are inherent to its conceptualization of the alliance. Nevertheless, we review the research regarding these relationships.

Alliance and Outcome

Survey

There are now several meta-analyses on the predictive relationship between therapeutic alliance and treatment outcome in psychotherapy (e.g., Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). The most recent (Horvath et al., 2011) surveyed studies up to 2009 and supported previous efforts demonstrating a consistent but modest relationship, with no apparent significant difference among treatment orientations. In an update of this effort, we examined this relationship in only psychodynamically oriented treatments, with a significant expressive component; we removed two studies that used only premature termination as a criterion variable, and we added four studies published since 2009 and up through 2011 ($N = 36$: Cailhol et al., 2009; Hendrikson et al., 2010; Muran et al., 2009; Owen & Hilsenroth, 2011; contact the authors for the complete list of studies). Our reanalysis yielded a medium ES of $r = .284$ (95% CI .25–32, $p < .001$) for the alliance-outcome relationship in DTs that was statistically significant. Thus we found no significant difference from the Horvath et al. (2011) result of $r = .275$ ($N = 190$) for all treatments. There is also ample evidence in DTs that weakened alliances are correlated with unilateral termination (e.g., Muran et al., 2009; Tryon & Kane, 1993).

Early Gains

There have been some noteworthy challenges to the interpretation of the alliance-outcome correlation. A number of studies have examined the relationship between early treatment gains and alliance with some finding the former carries the predictive load. In other words, it has been suggested that the alliance itself could simply be a product of earlier changes in symptoms. Several studies have failed to demonstrate that the alliance predicts subsequent symptom change when controlling for early treatment gains (Barber et al., 1999; Barber et al., 2001; DeRubeis & Feeley, 1990; Feeley, DeRubeis, & Gelfand, 1999; Strunk, Brotman, & DeRubeis, 2010). Several other studies, however, have still found that the alliance is predictive of outcome above and beyond the impact of early gains (e.g., Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Brottman, 2004; Constantino, Arnow, Blasey & Agras, 2005; Gaston et al., 1991; Klein, Schwartz, et al., 2003; Strauss et al., 2006). The lack of convergence in the literature reflects the complexity of the alliance construct and the need for further research in this regard.

Alliance and Contributing Factors

Regardless of specific theoretical slant, the alliance is essentially a construct developed to understand the interaction of two people (i.e., the patient and the therapist) in the therapy context. As such, the alliance subsumes a pair of individuals' life histories, expectations, personality constellations, interpersonal and attachment styles, ways of organizing experience, and worldviews. These factors represent an important set of variables related to the development of the therapeutic alliance.

Patient Factors

Research has identified several important patient factors that contribute to the formation of a strong alliance. For example, patient preconceptions and expectations regarding improvement have been found to be associated with the quality of the alliance such that positive expectations are linked to stronger alliances and better overall treatment outcomes (Messer & Wolitzky, 2010; Watson & Kaloogerakos, 2010).

Patient personality has also been associated to the alliance: Open, agreeable, extraverted, conscientious personality traits are associated with strong alliance, whereas the presence of personality pathology strongly predicts poor early alliance (see Sharpless, Muran, & Barber, 2010). In fact, research suggests that people with personality disorders pose the most difficulty for establishing and maintaining the therapeutic alliance (for a review, see Bender, 2005). In particular, patients with borderline, narcissistic, antisocial, and paranoid personality features are likely to have troubled interpersonal attitudes and behaviors that will complicate, but not necessarily compromise the development of the therapeutic alliance.

Patients' interpersonal functioning, object relations, and attachment style have also been associated with the alliance (see Sharpless et al., 2010, for a review). Patients with affiliative styles

are more likely to manifest strong alliances than patients who are more anxious, avoidant, uncomfortable with interpersonal exchanges, and fearful of interpersonal closeness. However, there is also some evidence that poor alliances can improve with patients that have a history of interpersonal problems or those who present interpersonal challenges (see Benjamin & Critchfield, 2010, for a review). Piper, Ogrodniczuk, and Joyce (2004) identified the quality of object relations as a moderator of the alliance-outcome relation in short-term individual therapy. Diener and Monroe's (2011) meta-analysis indicated a positive relationship between patients' attachment security and the therapeutic alliance.

Therapist Factors

Similar to the findings on patient variables, some therapist factors have been identified as facilitators of the alliance, whereas other qualities may impede positive alliance development. Research has generally focused on therapist attachment, personality traits, and factors that comprise technical skill and ability. Some of these variables are relatively stable, core characteristics of the therapist's person (e.g., attachment, personality), whereas other factors appear to be conducive to therapist training or remediation (e.g., technical skills).

In their review of the research, Ackerman and Hilsenroth (2003) identified several key personal qualities that support the development of a positive alliance, including professional demeanor, friendliness, empathy, flexibility, honesty, trustworthiness, confidence, genuineness, alertness and warmth. On the other hand, therapists who are perceived by patients as rigid, uncertain, exploitive, overly critical, distant, aloof, and/or distracted tend to experience negative alliances (Ackerman & Hilsenroth, 2001). More recent research on therapist contributions to the alliance has demonstrated a predictive relation of such personality traits as agreeableness, conscientiousness, and congruence (see Chapman et al., 2009; Hersoug, Høglend, Havik, von der Lippe, & Monsen, 2009; Nissen-Lie, Monsen, & Rønnestad, 2010; Taber, Leibert, & Agaskar, 2011). There are also a few studies suggesting that therapists' attachment security (i.e., low-attachment anxiety, low-attachment avoidance, greater comfort with closeness, strong interpersonal relations) predicts alliance (e.g., Black, Hardy, Turpin, & Parry, 2005; Schauenburg et al., 2010). And in a recent meta-analysis of 53 studies addressing the relevance of therapist racial/ethnic identity, there was no indication that therapist-patient match in this regard has implications for the therapeutic alliance or treatment success (Cabral & Smith, 2011).

Finally, there is research indicating that specific therapist factors such as therapist skills and abilities (as opposed to the aforementioned, nonspecific trait-based factors) make considerable contributions to the alliance. Techniques such as the appropriate use of silence, mindfulness, apposite transference interpretation, countertransference and self-disclosure contribute to a strong alliance (see Crits-Christoph, Barber, & Kurcias, 1993; Davis & Hayes, 2011; Hayes, Gelso, & Hummel, 2011), whereas misdiagnosis, poor case conceptualization, and excessive or mechanical use of technique have been associated with negative alliance (Hersoug et al., 2009; see Sharpless et al., 2010). With regard to ability, there is growing evidence demonstrating that therapists' individual differences predict alliance quality and treatment success, that some therapists are better at developing alliances, as well as achieving better outcomes (see Baldwin, Wampold, & Imel, 2007; Luborsky et al., 1986; Najavits & Strupp, 1994; Wampold, 2001).

Alliance Ruptures and Resolution: Postsession Analysis

Across-Treatment Evaluations

Although there is much research supporting that a strong and improving alliance predicts a positive treatment outcome (as cited earlier), there is also a growing body of research examining alliance patterns across the course of treatment and demonstrating patterns of deterioration or rupture and in cases of good outcome rupture resolution. This research was initially informed by the work of Mann (1973) and Gelso and Carter (1994), who suggested that there are identifiable patterns of alliance development: specifically, an initial high alliance when patients become mobilized and hopeful, a middle phase of low alliance when patients feel ambivalent about therapy, and then (if this phase is successfully negotiated) a high alliance indicating a working through.

Testing this perspective, Golden and Robbins (1990) analyzed two successful therapy cases and found that patients' alliance ratings increased, dropped, and then increased again during the course of the therapy, despite the fact that therapists exhibited a fair amount of warmth

and friendliness and high levels of exploration consistently throughout both treatments. Patton, Kivlighan, and Multon (1997) videotaped 16 patients and six therapists over two semesters. Analysis indicated that a quadratic high-low-high pattern of alliance development was present and related to improved outcome. Although a significant linear increase across sessions was also observed, it was found to be unrelated to client outcome. In a later study Kivlighan and Shaughnessy (2000) used cluster analysis to examine patterns of alliance development in 79 therapist-patient dyads across four counseling sessions. They found three distinct patterns of alliance development: stable alliance, linear alliance growth, and quadratic alliance growth. The quadratic pattern of alliance development was associated with greater improvement compared to other patterns of alliance development.

Stiles and colleagues (2004) initially sought to replicate Kivlighan and Shaughnessy's (2000) findings that a U-shape (high-low-high) alliance pattern was predictive of good outcome. When they were unable to replicate this finding, they shifted their focus from the global alliance pattern to the examination of discrete high-low-high, or V-shape rupture-repair episodes. In a sample of 79 cases (mixed dynamic and cognitive-behavioral), they identified rupture-repair episodes in 17 (21.5%) of the cases and found that these cases evidenced larger gains than the rest of the sample. Strauss et al. (2006) replicated this predictive relationship to outcome in a sample of CT cases, finding rupture-repair sequences in 14/25 (56%) of the cases examined. In contrast, although Stevens, Muran, Safran, Gorman, and Winston (2007) also found 22/44 (50%) cases (mixed dynamic and cognitive-behavioral) with rupture-repair episodes, they did not find a relationship between these and outcome. In a recent meta-analysis of these three studies (Safran, Muran, & Eubanks-Carter, 2011), the aggregated correlation of rupture-repair episodes to treatment outcome indicated a medium effect of .24 (95% CI .09–39, $p > .01$) that was statistically significant.

In-Session Evaluations

In contrast to the efforts mentioned above that examined patterns of postsession alliance ratings for evidence of rupture and resolution, there are a number of studies that have examined in-session evidence of ruptures and resolution. For example, Muran et al. (2009) in a clinical trial of 128 PD patients comparing a cognitive with a dynamic and an alliance-focused treatment asked patients and therapists to complete a postsession questionnaire (PSQ; Muran, Safran, Samstag, & Winston, 1992), which included a self-report measure of the alliance (WAI-12; Tracey & Kokotovic, 1989), as well as self-report indices measuring the occurrence of ruptures, rupture intensity, and the extent to which ruptures were resolved. They found that ruptures occurred frequently in the first six sessions of the three therapy treatments: Ruptures were reported by 37% of patients and 56% of therapists. Ruptures were also found to negatively predict outcome, and failure to resolve these ruptures predicted dropout. Eames and Roth (2000) also administered the WAI items and the rupture indices from the PSQ after Sessions 2 through 5 to 11 therapists and 30 of their patients receiving treatment as usual at outpatient clinics in the United Kingdom. Similar to Muran et al. (2009), they found that therapists reported ruptures more often, reporting them in 43% of sessions, while patients reported them in 19%.

Sommerfeld, Orbach, Zim, and Mikulincer (2008) examined the difference between patient-report and observer-ratings of ruptures. In a study of 151 sessions from five patients in DT, patients completed PSQs and reported ruptures in 42% of the sessions. Based on transcripts, judges identified confrontation and withdrawal ruptures using Harper's coding system (1989a, 1989b): Rupture markers were identified by observers in 77% of sessions. Eubanks-Carter, Muran, and Safran (2010) developed an observer-based coding system (not requiring transcription) the Rupture Resolution Rating System (3RS) and compared it to patient-rated PSQs in a sample of 48 sessions from early treatment of 20 cases. They found patients reported ruptures in 35% of sessions, observers detected withdrawal rupture markers in every session, and confrontation rupture markers in 75% of sessions. Colli and Lingiardi (2009) developed a transcript-based method for assessing alliance ruptures and resolution, the Collaborative Interaction Scale (CIS), and applied it to a sample of 32 sessions from 16 patients receiving either cognitive or dynamic psychotherapy. They found significant correlations between negative therapist interventions (e.g., showing hostility) and patient rupture markers and between positive therapist interventions (e.g., focusing on the here and now of the relationship) and collaborative patient processes (e.g., talking about feelings or thoughts).

In sum, these studies of in-session events suggest that alliance ruptures are quite prevalent, however measured. They demonstrate that (a) patients report ruptures in 19% to 42% of sessions, (b) therapists report them in 43% to 56% of sessions, and (c) third-party raters observe ruptures anywhere from 41% to 100% of sessions. In studies that examined postsession alliance ratings across treatment to identify the prevalence of rupture-repair sequences, patients reported such sequences in 22% to 56% of cases, suggesting these are fairly common events that deserve more intensive study of what they entail.

Alliance Rupture Resolution: Task Analyses

Several researchers have employed the task analytic paradigm (Rice & Greenberg, 1984), which blends qualitative and quantitative methods to study rupture resolution as a process of change. Although they did not identify their method as task analysis, one of the earliest studies of ruptures and resolution, conducted by Foreman and Marmar (1985), employed an approach that is consistent with task analysis. They selected six cases of short-term dynamic therapy in which the early alliance was rated as poor by observers; in half of these cases, the alliance remained weak and outcome was poor, while in the other half, the alliance improved and good outcome was achieved. They found that addressing and drawing links among the patient's defenses, guilt and expectation of punishment, and problematic feelings in relation to the therapist most strongly differentiated between good and poor outcome cases. Exploration of problematic feelings in the patient's other relationships did not differentiate the two groups.

Safran, Muran, and colleagues built upon Foreman and Marmar's study by undertaking a more intensive examination of the process of rupture resolution in a series of small-scale studies following the task analytic paradigm (Safran, Crocker, McMain, & Murray, 1990; Safran & Muran, 1996; Safran, Muran, & Samstag, 1994). They compared matched resolution and nonresolution sessions from seven different cases, pulled from a pool of more than 29 cases, based on selection criteria from patient-rated PSQs, and then applied various measures of psychotherapy process to the transcribed sessions to operationalize multiple dimensions (that is, interpersonal behavior, emotional involvement, and vocal quality) of each patient and therapist position in the resolution process. They then conducted a series of lag one sequential analyses and tested the significance of transitional probabilities in order to confirm the hypothesized sequences and demonstrate a difference between resolution and nonresolution sessions.

The result of their task analysis was a stage-process model, which is comprised of four interactions involving patient and therapist: (1) *Attending to the Rupture Marker*, (2) *Exploring the Rupture Experience*, (3) *Exploring the Avoidance*, and (4) *Emergence of Wish/Need*. They observed that the type of rupture marker (withdrawal or confrontation) dictated differences in the resolution process. For example, the common progression in the resolution of withdrawal ruptures consists of moving through increasingly clearer articulations of discontent to self-assertion, in which the need for agency is realized. The progression in the resolution of confrontation ruptures consists of moving through feelings of anger, to feelings of disappointment and hurt over having been failed by the therapist, to contacting vulnerability and the wish to be nurtured. Typical avoidant operations that emerge, regardless of rupture type, concern anxieties resulting from the fear of being too aggressive or too vulnerable associated with the expectation of retaliation or rejection by the therapist. In short, the result demonstrated evidence supporting the significance for the therapist and the patient to participate in a collaborative inquiry about the rupture event, including patient expression of negative feelings and therapist nondefensiveness.

Building on the work of Safran and Muran (1996), three additional studies have developed similar rupture resolution procedures using the task analytic paradigm. Agnew, Harper, Shapiro, and Barkham (1994) tested a psychodynamic-interpersonal model of resolution of confrontation ruptures using one good outcome case of eight-session psychodynamic-interpersonal therapy from the Sheffield study of treatment for depression. One rupture and one resolution session were selected based on changes in postsession, patient rated alliance scores. Confrontation rupture markers in these sessions were identified using Harper's coding system for identifying confrontation ruptures (Harper, 1989a). Similar to Safran and Muran's (1996) model, Agnew et al. (1994) begin the resolution process with the therapist acknowledging the rupture, and then exploring the rupture collaboratively with

the patient to reach a shared understanding. However, whereas Safran and Muran's (1996) model depicts resolution as a progression toward clarification of the patient's underlying wish or need, Agnew et al. (1994) place greater focus on linking the alliance rupture to situations outside of therapy and discussing new ways to handle those situations.

Bennett, Parry, and Ryle (2006) used task analysis to examine rupture resolution in cognitive analytic therapy (CAT; Ryle, 1997) for BPD. The task analysis was performed using six cases, four with good outcome and two with poor. Rupture sessions were selected based on deviations in postsession, patient-rated alliance scores. Based on a qualitative analysis by experienced CAT clinicians, a total of 107 ruptures from 82 sessions across the six cases were observed, and evidence for resolution was examined, from which a rational model of rupture resolution was developed. Consistent with Safran and Muran's (1996) research, Bennett et al. (2006) found that in good outcome cases, therapists recognized and focused attention on the majority of ruptures, while in poor outcome cases they usually failed to notice or draw attention to the alliance threat. Bennett et al. also stressed a collaborative, nondefensive stance on the part of the therapist. However, in contrast to Safran and Muran's (1996) focus on the immediate process and progressive clarification of the patient's underlying needs, Bennett et al. placed greater emphasis on linking the rupture to a preestablished case formulation and to the patient's other relationships.

Similarly, Aspland, Llewelyn, Hardy, Barkham, and Stiles (2008) used task analysis to refine a preliminary model of rupture resolution in CBT. They examined ruptures (confrontation and withdrawal) and resolution in two good outcome cases of CBT for depression from the Second Sheffield Psychotherapy Project (Shapiro et al., 1994). Cases were identified based on changes in postsession, patient-rated alliance scores. For each of the two cases, a rupture session and a resolution session were selected. Two experienced clinicians examined transcripts of the sessions and identified confrontation and withdrawal markers following Harper's (1994) and Safran and Muran's (2000) descriptions of these types of ruptures. The judges also identified markers of resolution, which was defined as reengagement in the task of therapy. Aspland et al. observed that most ruptures appeared to arise from unvoiced disagreements about the tasks and goals of therapy, which led to negative complementary interactions in which the therapist focused on the task and the patient withdrew. Resolution occurred when therapists shifted their focus from the therapy task to issues that were salient for the patient. Consistent with Safran and Muran, Aspland et al. (2008) emphasized the therapist's collaborative stance. However, in contrast to Safran and Muran (2000), as well as Agnew et al. (1994) and Bennett et al. (2006), Aspland et al.'s (2008) final resolution model did not include any overt recognition or discussion of the rupture itself.

Alliance Ruptures: Qualitative Studies

Although there is growing evidence to support the importance of recognizing and addressing ruptures in the therapeutic alliance, there are also a number of qualitative studies demonstrating the difficulties of doing so for therapists in practice. To begin with, patients are not always able or willing to reveal when they are uncomfortable or disagree with their therapist. Rennie (1994) found in a study of 14 patients that their deference to their therapists played a significant role in therapeutic interactions. He found a number of factors to be associated with patient deference, including fear of criticizing the therapist, need to meet the therapists perceived expectations, acceptance of the therapist's limitations, fear of threatening the therapist's self-esteem, and a sense of indebtedness to the therapist among others. If, as these findings suggest, patients believe protecting their therapists is the best way to maintain the relationship, it is understandable that they would be reluctant to talk openly with them about their concerns regarding treatment. It is thus critical for therapists to be able to pick up on cues that the alliance is in trouble and address them in a way that allows the patient to participate without undue anxiety.

Unfortunately, research conducted by Hill and colleagues has shown that even experienced therapists may have considerable difficulty recognizing such moments. Regan and Hill (1992) asked 24 patients and therapists to report on thoughts or feelings that they were unable to express in treatment, and they found that most things left unsaid by both patients and therapists were negative. In addition, they found therapists were only aware of 17% of the things patients left unsaid. Taking a different tack, Rhodes,

Hill, Thompson, and Elliott (1994), asked 19 therapists and therapists-in-training to recall events from their own treatment and found that although some of the patients were able to talk openly about their negative feelings towards the therapist, patients who felt uncomfortable addressing misunderstanding events were able to conceal them from their therapists and the misunderstandings remained unaddressed, often leading to termination.

Hill, Thompson, Cogar, and Denman (1993) extended the investigation into patient covert processes (reactions to in-session events) to include things left unsaid and secrets in a sample of 26 patients. As in their previous studies, they found that therapists were often unaware of patients' unexpressed reactions. They also found that patients were particularly likely to hide negative feelings and that even experienced, long-term therapists were only able to guess when patients had hidden negative feelings 45% of the time. Furthermore, 65% of the patients in the study left something unsaid (most often negative), and only 27% of the therapists were accurate in their guesses about what their patients were withholding. In a later study, Hill, Nutt-Williams, Heaton, Thompson, and Rhodes (1996) conducted an analysis of 11 therapists' recollections of impasse events that had ended in termination and also found that patients did not reveal their dissatisfaction until they quit therapy. Moreover, therapists reported that they became aware of patients' dissatisfaction only with the announcement of termination and were often taken by surprise.

Even if therapists do become aware of their patients' reservations, it may prove quite difficult to address them in a way that is beneficial to the treatment. A number of studies have suggested that therapists' awareness of patients' negative reactions can be detrimental to outcome (e.g., Fuller & Hill, 1985; Martin, Martin, Meyer, & Slemon, 1986; Martin, Martin, & Slemon, 1987). There is empirical evidence to support various interpretations of this type of finding. One is that therapists may increase their adherence to their preferred treatment model in a rigid fashion, rather than responding flexibly to a perceived rupture in the alliance. Another is that therapists may respond to patients' negative feelings by expressing their own negative feelings in a defensive fashion.

Piper, Azim, Joyce, and McCallum (1991) found an inverse relationship between the proportion of transference interpretations and both alliance and outcome for 64 patients with a history of high-quality object relations. Examining the findings, they hypothesized that increased concentration of transference interpretations may have been an attempt to repair a weakened alliance. They observed an alternating pattern of silences and transference interpretations and found that the inverse relationship between transference interpretations and alliance strengthened over the course of the treatment. This suggests that the patients and therapists may have been engaged in a vicious cycle in which therapists intensified their transference interpretations in a counterproductive attempt to remedy the situation, as the alliance continued to weaken. In a later study, Piper et al. (1999) compared a sample of 22 dropouts with 22 matched completers on pretherapy and therapy process variables. In addition to assessing patient hostility and patient and therapist exploration and focus on transference, they examined the last session prior to drop out for typical patterns. Qualitative analysis of the therapeutic process indicated that sessions typically started with patients expressing dissatisfaction or disappointment with treatment and therapists responding with transference interpretations. As the patients continued to withdraw or express resistance, therapists often continued to focus on transference issues. Sessions often ended with patients agreeing to continue treatment at the recommendation of the therapist, but never returning.

Hill et al. (2003) interviewed 13 experienced therapists about their experiences working with patient expressions of anger. Therapists reported having significantly more difficulty handling overt or asserted expressions of anger. They tended to experience anxiety (e.g., feeling incompetent) and anger at the patient when faced with such expressions and to challenge patients, which resulted in further negative interactions.

The findings in these studies are consistent with those of the Vanderbilt II study conducted by Strupp and his colleagues (Henry, Schacht, Strupp, Butler, & Binder, 1993; Henry, Strupp, Butler, Schacht, & Binder 1993). In this study, a group of experienced therapists ($N = 16$) treated a cohort of patients and were subsequently given a year of intensive training in a manualized form of psychodynamic treatment. The training paid special attention to helping therapists detect and manage maladaptive interpersonal patterns as they are enacted in the therapeutic relationship. Following their training, the therapists treated a

second cohort of patients. Evaluation of the differences in the therapeutic process and outcome showed that therapists were, in fact, able to shift their work to correspond more closely with the treatment manual. At the same time, however, the researchers found that rather than being able to treat their patients more skillfully, therapists displayed more hostile behaviors (medium effect that approached statistical significance) and complex communications, such as those that can be seen as both helpful and critical (large significant effect): Both forms of interpersonal behavior have been shown to be related to poor outcome in previous research (Henry, Schacht & Strupp, 1986, 1990). The results of this study suggest that, even when trained to recognize negative process, therapists may respond with counterhostility or defensiveness.

In contrast, several studies suggest that when therapists *are* able to respond nondefensively, attend directly to the alliance, adjust their behavior and address rifts as they occur, the alliance improves. For example, Lansford (1986) looked at six short-term therapy cases, identifying weakening and repairs in the alliance. Independent raters were able to predict outcome by observing excerpts showing weakening and repair of the alliance even though these segments made up a small proportion of the therapy (as little as 8%). Analysis showed that segments when therapists and patients took direct action to repair weakened alliances were followed by the highest levels of patient alliance ratings and the degree of success in addressing weaknesses was predictive of outcome. And the aforementioned studies by Foreman and Marmar (1985) and by Rhodes et al. (1994) yielded similar results, supporting the importance of addressing ruptures directly and nondefensively.

Alliance-Focused Training: Clinical Trials

The research reviewed thus far demonstrates both the importance of addressing ruptures and the difficulties for therapists to do so. The findings of the Vanderbilt studies mentioned earlier, for example, demonstrated how difficult it can be to train therapists to resolve alliance ruptures. Accordingly, therapists may sometimes adhere to manuals in a rigid fashion that interferes with their normally supportive style (Henry, Strupp, et al., 1993), and there was little outcome benefit as a result of such training (Bien et al., 2000). Similarly, Castonguay, Goldfried, Wiser, Raue, and Hayes' (1996) study of cognitive therapy for depression, and Piper and colleagues' (Piper, Azim, Joyce, & McCallum, 1991; Piper, Ogrodniczuk, et al., 1999) and Schut et al.'s (2005) studies of psychodynamic therapy have found evidence that some therapists attempt to resolve ruptures by increasing their adherence to a theoretical model (e.g., challenging distorted cognitions in cognitive therapy or making transference interpretations in dynamic therapy). These studies found that this rigid adherence in the context of a rupture is linked to poor outcome and premature termination.

Nevertheless, there is also more recent research demonstrating that training therapists in manualized approaches that emphasize the development of an alliance and abilities to resolve ruptures may actually have a beneficial impact on treatment. For example, Hilsenroth, Ackerman, Clemence, Strassle, and Handler (2002) examined the effect of providing structured training in short-term dynamic psychotherapy to 13 graduate student clinicians treating 34 outpatients, who were then compared to a matched group of 15 student clinicians and another 34 outpatients. The training included a focus on a therapeutic model of assessment, which sought to incorporate collaborative goal setting, the development of a therapeutic bond into the assessment phase of treatment, and intensive instruction in SE techniques. Analysis of alliance ratings made after the third or fourth session of therapy found that the structured training was associated with higher alliance scores as rated by patients and by therapists than a standard supervision condition.

For another example, Bambling, King, Raue, Schweitzer, and Lambert (2006) evaluated the impact of two alliance-focused supervision conditions (alliance skill-focused and alliance process-focused supervision) versus a no-supervision condition in a brief eight-session treatment of 127 patients with major depression. In the skill-focused supervision, therapists were given explicit advice and guidance concerning the kinds of behaviors and interventions likely to enhance alliance. In the process-focused supervision, the therapists were trained to monitor implicit client feedback, changes in client anxiety level, flow of exchanges, resistance, and perceived dynamics in the relationship with the therapist. Eight sessions of supervision were provided, including one pretreatment. The results indicated a significant benefit of both supervision

conditions over the no-supervision condition on working alliance, symptom change, and treatment retention, but no differences were found between supervision conditions.

In a pilot study, Crits-Christoph and colleagues (2006) found support for training therapists in alliance-fostering therapy, a 16-session treatment for depression that combines psychodynamic-interpersonal interventions with alliance-focused techniques such as responding to ruptures directly by encouraging patients to express their underlying feelings and the interpersonal issues connected to them. Crits-Christoph et al. found that the training resulted in increases in alliance scores that were moderate to large in size but not statistically significant, as well as small improvements in depressive symptoms and larger improvements in quality of life.

The largest studies that have tested the effectiveness of an alliance-focused treatment have been conducted by Safran, Muran, and colleagues, who developed a short-term, alliance-focused psychotherapy treatment informed by their findings from task analytic work: Brief Relational Therapy (BRT; Safran & Muran, 2000). By closely attending to ruptures, therapists and patients in BRT work collaboratively to identify the patient's core relational processes and to explore in the session with new ways of relating. The emphasis in BRT is on helping the patient to develop a generalizable skill of awareness through the use of metacommunication by which the therapist explicitly draws the patient's attention to ruptures emerging in their interactions that represent markers of core relational processes. One study compared BRT with CBT and STDT in a sample of 128 patients with Cluster C PDs and PD NOS (Muran, Safran, Samstag, & Winston, 2005). This study found that BRT was as effective as CBT and STDP with regard to statistical and clinical significance, and was more successful than the other two treatments with respect to retention. In another study of 18 patients with PD who were identified as at risk for treatment failure from a sample of 60 patients, Safran, Muran, Samstag, and Winston (2005) reported additional evidence that BRT successfully keeps challenging patients engaged in treatment. While Safran, Muran, and colleagues continue to investigate the effectiveness of BRT, they are also exploring ways to integrate relational, alliance-focused principles into standard cognitive therapy. Currently, an NIMH-funded study led by Muran and Safran (Muran, Safran, Gorman, Eubanks-Carter, & Banthin, 2008) is underway to see if integrating rupture resolution training into CBT training improves therapy process and outcome.

Similar efforts to integrate rupture resolution (largely informed by dynamic principles) into CT have been conducted by Castonguay and colleagues. In an effort to improve cognitive therapists' ability to respond to alliance ruptures, Castonguay developed Integrative CT for Depression (ICT; Castonguay, 1996), which primarily integrates Safran and Muran's rupture resolution strategies (Safran & Muran, 1996; Safran & Segal, 1990) into traditional CT. When ruptures are identified, the therapist breaks from the cognitive therapy protocol and addresses the rupture by inviting the patient to explore the rupture, empathizing with the patient's emotional reaction, and reducing the patient's anger or dissatisfaction by validating negative feelings or criticisms and taking at least partial responsibility for the rupture. In a pilot study ($N = 11$), Castonguay et al. (2004) found that patient symptom improvement was greater in ICT than a wait-list condition, and compared favorably to previous findings for cognitive therapy. In a randomized trial comparing ICT to CT ($N = 11$), Constantino et al. (2008) found that ICT patients had greater improvement on depression and global symptoms and more clinically significant change than CT patients. ICT also yielded better patient-rated alliance quality and therapist empathy, and there was a trend toward better patient retention in ICT than in CT. A similar effort to integrate rupture resolution strategies into CT for GAD was undertaken by Newman, Castonguay, Borkovec, Fisher, and Nordberg (2008). The study ($N = 18$) found that the integrative treatment significantly decreased GAD symptoms, yielding a higher ES than the average ES of CT for GAD in the treatment literature. Participants also showed clinically significant improvements in GAD symptoms and interpersonal problems with continued gains at 1-year follow-up.

In a meta-analysis that examined the impact of rupture resolution training or supervision on patient outcome in the eight studies mentioned above (Bambling et al., 2006; Bein et al., 2000; Castonguay et al., 2004; Constantino et al., 2008; Crits-Christoph et al., 2006; Hilsenroth et al., 2002; Muran et al., 2005; Newman et al., 2008), Safran, Muran, and Eubanks-Carter (2011) calculated pre-post and group contrast ESs and found a large pre-post r for the rupture resolution training of .65 (95% CI .46 – .78, $p < .001$) and a small between-group ES of .15 (95% CI .04 – .26, $p < .01$), in both cases indicating

a statistically significant effect. Adding to the promise of alliance-focused training suggested by this meta-analysis is the body of research by Lambert and colleagues (Lambert et al., 2003) examining the impact of providing therapists feedback and clinical support when risk for treatment failure is indicated. A poor therapeutic alliance is one of the risk factors and triggers a clinical support tool primarily informed by principles defined by Safran and Muran (2000). In a recent meta-analysis of six major studies (N = 6,151) conducted by Shimokawa, Lambert, and Smart (2010), they found feedback interventions were effective in preventing treatment failure.

Psychodynamic Change Mechanisms and Outcomes

Studies of psychotherapy effectiveness often place symptom change as the ultimate measure of improvement, but many DT patients, practitioners, and researchers have a different perspective about what type of change is expected from therapy. Symptoms are believed to be a product of an unconscious conflict or ambivalence (e.g., a socially unacceptable desire; an unprocessed traumatic event) acquired from early relational experiences. A symptom has the function of expressing that unconscious conflict in a consciously painful but socially acceptable way (e.g., feeling panic instead of anger; dissociating important feelings and memories of a trauma). These conflicts make up part of an individual's personality, and as such personality change is often a goal in DT. Additionally, because these symptoms often repeat earlier interpersonal experiences, discovering new ways of perceiving and relating to others is viewed as a good outcome in DT. Five unique ways in which DT seeks to help patients are: (1) fostering insight into unconscious conflict; (2) increasing the use of adaptive psychological defenses; (3) decreasing rigidity in interpersonal perceptions and behaviors; (4) improving the quality of patients' mental representations of relationships; and (5) increasing their comprehension of their own and others' mental states. These unique DT mechanisms may be outcomes in themselves or mediators by which DT affects symptom change.

Insight

Insight, or self-understanding, is the awareness a person has into his or her motivations, expectations, and behaviors. Self-understanding has been defined in many ways but has long been considered the cardinal goal of DT (Messer & McWilliams, 2007). Insight is thought to be instilled through the therapist's interpretation of similarities between the patient's past and present experiences (e.g., Strachey, 1934) or through the processing of the shared relationship between patient and therapist (e.g., Hirsch, 1998). Frequently, insight is sudden and accompanied by a sensation of discovery, or an "aha" moment (Elliott et al., 1994), although it may develop slowly over treatment (e.g., Jones, Parke, & Pulos, 1992). Insight may affect symptoms by making them feel more manageable through the development of an explanation or narrative as to why those symptoms occur. Alternately, self-understanding may free the individual to act in new ways by providing an emotional release (Freud, 1917/1958) or by triggering a reappraisal of the usefulness of symptom behaviors. Self-understanding may occur at an intellectual or emotional level (Gibbons, Crits-Christoph, Barber, & Schamberg, 2007). Intellectual insight is the cognitive recognition of the origin or purpose of symptoms. Emotional insight refers to the experience of the conflict at a new or different level. Often emotional insight can be a different sensation of an old memory or familiar experience, a corrective emotional experience (Alexander & French, 1946; Sharpless & Barber, 2012), or a sense of mastery over a previously puzzling experience (Grenyer & Luborsky, 1996; Weiss, Sampson, & Mount Zion Psychotherapy Research Group, 1986). Insight has been measured by therapist judgment (e.g., Graff & Luborsky, 1977); observer judgment from interview (e.g., Johansson et al., 2010), session content (e.g., Grenyer & Luborsky, 1996; Messer & McWilliams, 2007), or patient-generated stimulus material (e.g., Falk & Hill, 1995); and patient self-report (e.g., Connolly et al., 1999).

Many studies show that insight increases over the course of DT (e.g., Connolly et al., 1999; Gibbons et al., 2009; Grande, Rudolf, Oberbracht, & Pauli-Magnus, 2003; Kivlighan, Multon, & Patton, 2000; for an exception, see Crits-Christoph et al., 2003). Increases in insight over treatment have been associated with symptom change in DT (Grande et al., 2003; Grenyer & Luborsky, 1996; Johansson et al., 2010; Kivlighan et al., 2000; Gibbons et al., 2009; for exceptions, see Connolly et al., 1999; Crits-Christoph et al., 2003). Some preliminary evidence suggests that changes in self-understanding precede symptom

improvement (e.g., Grande et al., 2003; Kivlighan et al., 2000). Interestingly, changes in insight may be unique to DT, as self-understanding does not change in other treatments, nor is it correlated with symptom change (Connolly et al., 1999; Crits-Christoph et al., 2003; Gibbons et al., 2009; for an exception, see Hoffart, Versland, & Sexton, 2002). However, greater insight may not explain the initial development of symptoms, as seen by the lack of relation to symptom level prior to therapy (Connolly et al., 1999). People who are generally happy and higher-functioning may have little reason to delve into why they act and feel the way they do. Finally, although theorists believe that greater pretreatment insight will predict success in DT (Messer & McWilliams, 2007), the few studies examining this relation are equivocal (e.g., Cromer & Hilsenroth, 2010). Initial insight level is related to treatment retention (Cromer & Hilsenroth, 2010), which may be one partial route through which insight affects change in DT. Overall, insight is strongly implicated in the process of change in DT, and greater precision in the definition and measurement of insight may increase our ability to detect who will benefit most from DT.

Defense Style

Psychological defenses are normative and universal mechanisms by which individuals protect themselves against anxiety arising from unconscious conflict. These mechanisms permit the expression of unacceptable feelings or behavior by the transformation of experience (e.g., denial, or refusal to admit an unpleasant experience happened). Defenses differ from coping mechanisms in that their focus is on managing the internal world of the individual, whereas coping mechanisms are patterns of handling problems in the external world (Cramer, 1998; although see Kramer, 2010). Defenses vary in their levels of maturity, which represents their developmental appearance as well as their effectiveness in managing conflict (e.g., Cramer, 1991; Vaillant, 1992). Less mature defenses are seen in children and in individuals with severe mental illness. They distort perception to reduce anxiety but in doing so lead to strong inappropriate reactions or withdrawal (e.g., splitting, or when something with multiple characteristics is seen as entirely bad or good). Mature defenses are seen in healthy adults and both express and inhibit conflict at the same time (e.g., sublimation, or turning strong desires into socially acceptable products like art or financial success). The type and frequency of defenses used are thought to constitute an individual's personality. A defensive style that employs immature defenses or that uses more mature defenses too rigidly can impair the ability to perceive and interact with the world. DT works to increase the maturity and flexibility of defense use by pointing out the function of defenses and encouraging the use of more adaptive defenses (e.g., Summers & Barber, 2009). Measurement of defenses has been well reviewed elsewhere (Davidson & MacGregor, 1998; Perry & Ianni, 1998) and includes interview measures, projective testing, and self-report instruments. These measures describe the typical defenses employed by an individual as well as an overall maturity level of the person's defense style.

Many studies have demonstrated the decrease in the use of immature defenses over therapy (Akkerman, Carr, & Lewin, 1992; Kneepkens & Oakley, 1996; Roy, Perry, Luborsky, & Banon, 2009), as well as the increase in the use of more mature defenses (e.g., Bond & Perry, 2004; Johansen, Krebs, Svartberg, Stiles, & Holen, 2011, Kramer, Despland, Michel, Drapeau, & de Roten, 2010; Roy et al., 2009). Changes in the maturity of defensive functioning have been related to changes in symptom level (e.g., Akkerman et al., 1992; Bond & Perry, 2004; Johansen et al., 2011; Kneepkens & Oakley, 1996). The most change in defenses may come after the reduction of acute symptoms (Hersoug, Sexton, & Høglend, 2002), and so the temporal relation of defenses and symptom change requires further investigation. Furthermore, changes in defensive style may not be unique to DT, as these changes are present and are related to symptom change in other treatments (e.g., Coleman, Cole, & Wuest, 2010; Johansen et al., 2011). Pretreatment use of maladaptive defenses has been consistently linked with greater symptom levels and psychopathology (e.g., Kramer, 2010; for a review, see Bond, 2004). Possessing greater adaptive defenses at the beginning of treatment also predicted a better response to DT (e.g., Bond & Perry, 2004) and other treatments (Muris & Merckelbach, 1996). Defenses may be uniquely addressed by DT, but may be common to change processes in multiple forms of treatment. Further work needs to examine what factors in therapy create changes in defense style.

Relationship Rigidity

In psychodynamic theory, individuals have characteristic patterns of motivations, expectations, and reactions in their interactions with others that are learned from childhood experiences.

These patterns are used later in life to interpret interpersonal information and guide behavior in new relationships (Blatt, Auerbach, & Levy, 1997; Bowlby, 1988; Freud, 1912/1958). The application of these central interpersonal patterns to new relationships is called *transference* and is generally thought to be found in all individuals to some degree. Less healthy individuals apply their relationship patterns more rigidly, adapt less to the demands of their current relationships, and experience poorer relationships and greater symptoms as a result (e.g., Kiesler, 1996). Dynamic therapists help make patients aware of their relationship patterns, perhaps through increasing insight, so that patients can more flexibly respond in their interpersonal relationships (e.g., Summers & Barber, 2009). Divergent methods have been used to estimate relationship rigidity (for a review, see McCarthy, Gibbons, & Barber, 2008), including amplitude (i.e., the distinctiveness of a single interpersonal theme in a profile of interpersonal themes; Gurtman & Balakrishnan, 1998), pervasiveness (i.e., the frequency of a person's central relationship pattern in a sample of narratives; Crits-Christoph & Luborsky, 1998), dispersion (i.e., the spread of a distribution of interpersonal themes; Cierpka et al., 1998; Slonim, Shefler, Gvirsman, & Tishby, 2011), and profile correlation (i.e., the covariance the interpersonal themes among a patient's relationships; McCarthy et al., 2008).

Rigidity has been shown to decrease in response to DT (Crits-Christoph & Luborsky, 1998; Gross, Stasch, Schmal, Hillenbrand, & Cierpka, 2007; Salzer et al., 2010; Slonim et al., 2011; Tishby, Raitchick, & Shefler, 2007; for exceptions, see Lunnen, Ogles, Anderson, & Barnes, 2006; Weinryb, Wilczek, Barber, Gustavsson, & Asberg, 2004). However, changes in rigidity do not appear to relate to changes in symptoms over the same period (Gross et al., 2007; Lunnen et al., 2006; Staats, May, Herrmann, Kersting, & Konig, 1998; Wilczek et al., 2004; for exceptions, see Crits-Christoph & Luborsky, 1998; Slonim et al., 2011). No studies appear to compare how rigidity might change in different psychotherapies (although see Ruiz et al., 2004) so it remains unclear whether DT uniquely affects relationship rigidity. Levels of relationship rigidity may be independent of psychiatric symptoms, as the concurrent relation observed in the literature has been equivocal (e.g., Slonim et al., 2011; for a review, see McCarthy et al., 2008). Differences in operationalization may account for the mixed findings in the role of rigidity in DT (McCarthy et al., 2008). Furthermore, it is often unclear whether rigidity is measured across relationships (i.e., how similar is a person perceiving and acting in each of their relationships), within relationships (i.e., how similar is a person perceiving and acting in the same relationship), or both across and within, which may have implications for how widespread and distressing a person's interpersonal problems are (Foltz, Barber, Weinryb, Morse, & Chittams, 1999). Finally, interpersonal rigidity may share a curvilinear relation with symptoms (McCarthy et al., 2008; Slonim et al., 2011), as individuals who are either too inflexible or too inconsistent in their relationships may experience more problems. Greater definition and study of rigidity may bring clarity as the concept is brought more in line with how it is experienced and worked through by DT patients and therapists.

Quality of Object Relations (QOR)

Object relations refers to the cognitive and affective representations that individuals have of their relationships and interpersonal life. Creating a schema of relationships is a developmental process that involves several tasks: populating the representation with objects (persons) derived from actual relationships; storing and organizing episodic and emotional information about these relationships; and integrating the conflicting demands within and among these relationships. These mental representations differ in quality depending on the early experiences of the person and his or her ability to resolve specific developmental challenges. Having internal representations of relationships allows for the belief that one's own and others' personalities are stable and enduring, for soothing one's self without the direct assistance of others, and for goal-directed interactions with others. The presumed product of good QOR is long-standing, satisfying interpersonal relationships in the real world and satisfying, comforting memories of relationships past, as well as the ability to form a strong emotional bond with the therapist in DT and to examine and grow from the strains that emerge in that relationship. Measurement of QOR has been well reviewed (Huprich & Greenberg, 2003) and includes clinician interview about relationships, projective testing, and self-report. Whereas most assessment tools describe life-long patterns of QOR, some instruments focus more on the derivatives of object relations, like current

interpersonal functioning (Connolly et al., 1999; Piper et al., 1991).

QOR has been shown to change across DT in multiple studies (e.g., Blatt et al., 1996; Lindgren, Werbart, & Philips, 2010; Porcerelli et al., 2006; Vermote et al., 2010). Changes in QOR overtreatment have been associated with symptom improvement as well (Blatt, Stayner, Auerbach, & Behrends, 1996; Vermote et al., 2010). Change in QOR in other treatments has not been investigated and so remains an open research question. The majority of work on QOR has been as a predictor of suitability or likelihood of success in DT. Better pretreatement QOR has been shown to be associated with greater improvement in symptoms and functioning after DT (e.g., Piper, Joyce, McCallum, & Azim, 1998; Piper, McCallum, Joyce, Rosie, & Ogrodniczuk, 2001; Van et al., 2008; but see Høglend et al., 2006; Joyce, Ogrodniczuk, Piper & Sheptycki, 2010). Pretreatment QOR is not related to outcome in supportive therapy (Piper et al., 1998, 2001; but see Joyce et al., 2010), providing partial evidence for the specificity of QOR in moderating the effectiveness of DT. Better pretreatment QOR has also been linked to better alliances across therapy (e.g., Hersoug, Monsen, Havik & Høglend, 2002; Goldman & Anderson, 2007; Van et al., 2008), which may provide the platform for the work of DT (cf. Piper, Ogrodniczuk, & Joyce, 2004). In addition, QOR moderates the relation between DT interventions and outcome, although it remains unclear how this relation works (e.g., Connolly et al., 1999; Høglend et al., 2006; Piper et al., 2004). Higher levels of QOR have been related to better psychological functioning and can distinguish between clinical and nonclinical samples (e.g., Porcerelli, Huprich, & Markova, 2010).

Reflective Functioning

Perhaps the newest change factor to emerge in the dynamic theory is mentalization, or reflective functioning (RF; Fonagy & Bateman, 2006). Grounded in attachment theory (Bowlby, 1988) and theory of mind (Baron-Cohen, Leslie, & Frith, 1985), RF is the ability to comprehend one's own and other's mental states and to use that information to explain and guide relationship behavior. It is considered to be a developmental achievement that occurs through the empathic mirroring behavior of early caregivers and a lack of disruptive traumatic experiences. Individuals with a high degree of RF are able to contemplate their own and other's cognitive and affective states, distinguish between the implicit and explicit intentions possible in behavior, and understand how relational interactions change and develop over time. The concept of RF was initially developed to explain the experiences of patients with BPD but has been expanded to understand other conditions as well (Fonagy, Bateman, & Bateman, 2011).

Measurement of mentalization has largely used the Reflective Functioning Scale (RFS; Fonagy, Target, Steele, & Steele, 1998), which is coded from clinical interviews (e.g., Harpaz-Rotem & Blatt, 2005; Main, Goldwyn, & Hesse, 2002) or narratives told by patients in psychotherapy (e.g., Karlsson & Kermott, 2006). One study showed a medium-size correspondence when the RFS was applied to different assessment methods (Lowyck et al., 2009). Additional scales to assess disorder-specific mentalization have been added to the RFS (Rudden, Milrod, Target, Ackerman, & Graf, 2006; Taubner, Kessler, Buchheim, Kachele, & Staun, 2011). Other instruments rate RF from individuals' responses to videotaped social interactions (e.g., Arntz & Veen, 2001).

RF has been shown to increase over DT in one study of BPD (Levy et al., 2006), but not in studies of other disorders (Karlsson & Kermott, 2006; Rudden et al., 2006; Vermote et al., 2010). Panic-specific RF did change over the course of treatment for Panic Disorder (Rudden et al., 2006), suggesting that mentalization may have adaptations to particular types of psychopathology. RF did not increase in CBT (Karlsson & Kermott, 2006; Levy et al., 2006) and significantly decreased in a study of interpersonal psychotherapy (Karlsson & Kermott, 2006). Only one study correlated change in RF with change in symptoms and found no association (Vermote et al., 2010). Lower RF prior to therapy was associated with greater symptoms or more severe diagnoses in some studies (e.g., Bazin et al., 2009; Bouchard et al., 2008; Fonagy et al., 1996; Sharp et al., 2011) but not others (e.g., MacBeth, Gumley, Schwannauer, & Fisher, 2011; Fischer-Kern et al., 2010; Taubner et al., 2011). Similarly, pretreatment RF predicted treatment response in one study (Muller, Kaufbold, Overbeck, & Grabhorn, 2006) but not in another (Taubner et al., 2011). The theory and study of RF is still in its infancy, and few definitive conclusions can be drawn about its relation to process and outcome in DT. However, future studies will need to take note of the specific population being examined, as qualitative differences may exist in mentalization

by disorder. Additionally, mentalization-based DT includes interventions and a therapeutic stance that may differ from other types of DT (Fonagy & Bateman, 2006), and so RF may be expected to change more in this form of DT compared to other forms.

Technique Use in DT

The two major types of DT techniques are supportive and expressive (Luborsky, 1984; Piper, Joyce, McCallum, Azim, & Ogrodniczuk, 2001). Supportive techniques include many of the common factors like warmth and empathy but also include ego-strengthening interventions more unique to DT like boundary setting, gratification, and bolstering adaptive defenses. Expressive or interpretative interventions are designed to uncover or "express" the unconscious conflict behind a patient's symptoms. These interventions include exploration of affect and interpersonal themes (i.e., encouraging patients to generate affective and relationship material through free association or selectively focusing the patient's attention on these themes), clarification (i.e., drawing a patient's attention to knowledge they already possess but in a new light), and interpretation (i.e., making meaningful connections between past and present relationship experiences, especially involving the therapist).

The use of DT techniques in a session or segment of a session is often assessed for either a single class of interventions (e.g., transference interpretations) or for DT intervention use on average. Measurement of psychodynamic techniques can be accomplished with frequency counts (e.g., Connolly et al., 1999), percentage of total intervention use in a session (e.g., Piper, Joyce, McCallum, & Azim, 1993), or average subscale scores from intervention measures (e.g., Hilsenroth, Blagys, Ackerman, Bonge, & Blais, 2005; McCarthy & Barber, 2009). A specific type of intervention measure is an adherence scale (e.g., Barber & Crits-Christoph, 1996; Klein, Milrod, & Busch, 1999), which measures the degree to which a therapist followed the principles and techniques set out in a therapy manual. Adherence is often used as a manipulation check to ensure that the treatment was delivered (e.g., Spinhoven, Giesen-Bloo, van Dyck, Kooiman, & Arntz, 2007) but is only infrequently studied in relation to DT process and outcome. Adherence and technique use are not synonymous (adherence is a subset of technique use), but we will not consider them separately here due to the limited number of process studies that examine the effects of DT techniques.

Expressive interventions, when measured together on average, have demonstrated an equivocal relation with treatment outcome (for no relation, see Barber et al., 1996; DeFife, Hilsenroth, & Gold, 2008; Ogrodniczuk & Piper, 1999; Ogrodniczuk, Piper, Joyce, & McCallum, 2000; Owen & Hilsenroth, 2011; for a favorable relation, see Ablon & Jones, 1998; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; Hilsenroth et al., 2005; Hendriksen et al., 2011; for an unfavorable relation, see Barber et al., 2008). Investigations of individual expressive techniques provide some additional detail to the ambiguity of these findings. Exploration of affect has been consistently linked to more positive outcomes (for a meta-analysis, see Diener, Hilsenroth, & Weinberger, 2007). A recent study of graduate trainees conducting DT for anxiety disorders also showed a moderate-size but nonsignificant effect of emotional exploration on outcome (Slavin-Mulford, Hilsenroth, Weinberger, & Gold, 2011). Exploration of interpersonal themes has been linked to outcome on a fairly consistent basis (Gaston et al., 1998; Klein, Milrod, Busch, Levy, & Shapiro, 2003; Slavin-Mulford et al., 2011).

Interpretation and clarification are perhaps the most studied of the expressive interventions, and in contrast to other expressive interventions, are often found to be related to worse therapeutic outcomes (e.g., Høglend et al., 2006; Ryum, Stiles, Svartberg, & McCullough, 2010; Schut et al., 2005; for a review, see Høglend, 2004). It is probable that interpretation and outcome share a small-size negative linear relation, although these studies have been too diverse in their methodology and reporting of their results to compare quantitatively. One obvious explanation of this negative association might be that interpretation has a deleterious effect on patients, although this account is contradicted by the efficacy data for DT as well as by clinical observation. A more subtle understanding of the negative relation between interpretation and outcome has been titled the "high risk-high gain" phenomenon (Gabbard et al., 1994). Targeted and sparing use of interpretations may lead to better outcome, but frequent use of interpretation may destabilize the patient's defense structure and therefore might increase symptoms. This explanation is based on observed helpfulness of interpretation in many cases and the long-standing belief among

dynamic theorists that interpretations can be overwhelming for certain patients (Strachey, 1934). Some studies of the immediate in-session climate associated with interpretation support this account. For instance, interpretations are more related to symptom improvement when followed by emotion processing (McCullough et al., 1991; Milbrath et al., 1999). At the same time, interpretative work has a high probability of being perceived as disaffiliative (Coady, 1991; Klein, Schwartz, et al., 2003; Schut et al., 2005) and may lead to alliance ruptures and poor outcome if not handled correctly by therapists. A final explanation of the negative relation between interpretation and symptoms might be that patients unlikely to improve may receive or pull for more interpretations from their therapists (Høglend, 2004).

Supportive interventions have largely been measured in aggregate as opposed to singly (e.g., Barber, Crits-Christoph, & Luborsky, 1996) or in relation to the expressive interventions in DT sessions (e.g., Hendriksen et al., 2011). Surprisingly, there has consistently been no result when supportive interventions were correlated with outcome (Barber et al., 1996, 2008; Hersoug et al., 2005; Milbrath et al., 1999; Ogrodniczuk et al., 2000). The lack of more thorough investigation of supportive techniques might be due to the greater emphasis placed on expressive techniques in DT theory or due to the tendency to overlook supportive interventions in favor of the therapeutic alliance.

Moderators of DT Technique Use and Outcome

The relation between technique use and outcome in DT has proved quite complex, although in the absence of other factors, it can be recommended that more affective and interpersonal exploration be used but only sparing interpretation. While initially contradictory to psychodynamic theory, the complexity of the association between DT interventions and outcome has caused dynamic theorists and researchers to look for how the process of therapy might influence the relation of technique use and outcome and how different methodologies might produce different findings.

Level of Intervention Use

Psychodynamic theorists have long postulated the powerful but potentially destabilizing nature of their interventions (Strachey, 1934). Paired with the mixed findings of DT technique and outcome, researchers have moved to examine not only a "more is better" linear relation to DT technique use and outcome, in which greater levels of technique predict greater improvement, but also a "just right" curvilinear approach, in which a more moderate level of technique use may be associated with better outcome than very low or very high levels. Piper and colleagues (1991) were perhaps the first to examine this hypothesis empirically, and they found a positively accelerating function of interpretation use and outcome. Low and moderate levels of interpretation were both related to favorable outcome whereas higher levels of interpretation were related to rapidly worsening outcome. However, Ogrodniczuk and Piper (1999) were unable to replicate this finding. In designing his experimental study of transference interpretations, Høglend (personal communication 02/15/10), chose not to assign patients to receive a "high" level of transference interpretation because he and his colleagues thought such a condition would be counterindicated. In the DT arm of a randomized trial for cocaine dependence, Barber and colleagues (2008) observed that very high and low levels of psychodynamic interventions, but not moderate levels, were related to greater drug abstinence, the opposite of the "just right" hypothesis. However, the process of DT for substance use disorders may differ from the treatment of other disorders due to the tendency of many substance dependent patients to use externalizing behaviors (e.g., blaming, substance intake) to manage their own emotional reactions rather than verbalizing their problems more directly. To date, McCarthy (2009) presented the only study to confirm the "just right" hypothesis, in which patients with depression who received a moderate amount of DT interventions improved more compared to patients receiving very low or very high levels.

Therapeutic Alliance

DT techniques are often assumed to influence outcome through the therapeutic alliance, but exactly how this relationship works has been a matter of continued discussion (see prior section on the alliance in DT for more on the complexity of this relationship). For instance, early theorists thought that the alliance represented the rational side of the patient's unconscious and that the interventions of the therapist recognized by the unconscious and responded to with an increased alliance (Greenson, 1965). In support of this idea, technique use at one time point in therapy is often associated with higher levels of alliance at a

later point (e.g., Gaston, Thompson, Gallagher, Cournoyer, & Gagnon, 1998; Patton, Kivilighan, & Multon, 1997). Alliance has also been studied as a distinct factor against which technique competes to explain the variance in outcome (e.g., Barber et al., 1996; Ogrodniczuk et al., 2000). Still others have investigated how the alliance is fostered differently in different treatments (e.g., Spinhoven et al., 2007).

However, many psychodynamic thinkers and researchers believe that alliance provides a context for technique use, such that greater levels of alliance permit DT techniques to be more effective (Gaston et al., 1998). Recent studies have observed an interaction of DT interventions and alliance (Ryum et al., 2010; Owen & Hilsenroth, 2011), and with closer examination the driving factor in the interaction of technique and alliance appears to be the negative effect on outcome of expressive techniques in the context of lower alliances. Outcome is moderate with lower technique use regardless of the alliance level (poor or strong), and is equivalent or slightly better when both a strong alliance and high levels of technique are present. Similarly, Barber and others (2008) found moderate drug abstinence in cocaine-dependent individuals with little differential effect of adherence to expressive technique at lower levels of alliance. At higher levels of alliance, greater adherence predicted slightly greater abstinence than more moderate adherence levels. Adherence was modeled curvilinearly in this study, and nominal adherence was related to the most abstinence at high levels of alliance, compared to both moderate and very high adherence. In contrast to these studies, Høglend and colleagues (2011) found that patients with higher alliances evidenced better outcomes when minimal interpretations were offered whereas patients with lower alliances benefited more from higher (moderate) levels of transference interpretation, although these findings were further qualified by the pretreatment QOR of the patient. At this point, there are simply too few studies examining the interaction of alliance and technique together to draw strong conclusions. Detecting interaction effects often requires large samples and good variability in both factors examined (McClelland & Judd, 1993), and few studies in psychotherapy research have those advantages.

Competence. Competency is how well a therapist employs DT techniques with a given patient and progress of the therapy. Competence is typically judged by individuals with recognized expertise in psychotherapy practice. Some factors entering into a judgment of a therapist's competence are: (a) the ability to formulate patient's personality organization or symptom constellation; (b) the accurate assessment of the patient's need at the moment of intervention, including the patient's receptivity to intervention; (c) the choice of a specific intervention for a given problem, including its appropriateness for the problem; (d) the comparison of the chosen intervention to other potential interventions not selected, especially techniques proscribed for DT; and (e) the execution of the intervention. Holistic judgments are common over a certain period of observation, although competence is often measured for multiple classes of interventions. Greater competence necessitates some use of DT techniques, although the correlation found between DT technique use or adherence to a DT manual may be modest (Barber, Sharpless, Klostermann, & McCarthy, 2007).

Competency has been shown to be related to alliance (Despland et al., 2009), however, the relation between global competence in DT and outcome has been equivocal. In a study of patients with depression a positive relation between competence in expressive techniques and subsequent symptom improvement was found (Barber et al., 1996). Similarly, a positive relation between competency and outcome was observed in very brief (four-session) DT, but only for those patients whose alliances improved over the four sessions (Despland et al., 2009). In a study of psychodynamic treatment for cocaine-dependent individuals, no relation was observed (Barber et al., 2008). Finally, competence was associated with worse outcomes in a study of short-term anxiety-provoking psychotherapy (Svartberg & Stiles, 1994). Clearly more work is needed to understand why the intuitive relation between competence and outcome is not always observed and to investigate the conditions under which competence is related to improvement. One possibility is the breadth of judgments required to assess competence reduces not only reliability of competency estimates, but compounds the problem by multiple unreliabilities across dimensions. When dimensions of competency are examined singly, a clearer picture may emerge.

Accuracy of Interpretations

One dimension of competency in DT is how accurate a therapist's interpretations are to the unconscious conflict of the patient. Accuracy has been defined as the extent to which the interpretations keep with a patient's formulation,

or the theoretical understanding of the patient's problems given his or her unique history. Researchers have used experienced therapists' formulations of their patients (e.g., Piper et al., 1993) or observer-derived formulations (e.g., Luborsky & Crits-Christoph, 1998; Curtis, Silberschatz, Sampson, & Weiss, 1994) as the criterion to compare the accuracy of their subsequent interpretations. There has been a strong positive correlation between accuracy and subsequent outcome (Andruszna, Luborsky, Pham, & Tang, 2006; Crits-Christoph, Cooper, & Luborsky, 1988; Norville, Sampson, & Weiss, 1996; Silberschatz, Fretter, & Curtis, 1986) or alliance (Crits-Christoph et al., 1988; Stigler, de Roten, Drapeau, & Despland, 2007). One interesting new finding is that when outside judges formulate a patient's typical interpersonal problems, greater correspondence of interventions leads to better outcome in IPT but deleterious outcomes in CBT, providing partial evidence that interpersonal-focused psychotherapies may work in a unique and specific way through relationships (Crits-Christoph, Gibbons, Temes, Elkin, & Gallop, 2010).

Despite the evidence for the efficacy of DT, the process of how DT affects change in patients remains unsettled. The relation of technique use to outcome is complex, although interpersonal and affective exploration appear to be generally helpful as well as the sparing use of accurate interpretation. Supportive techniques may provide a necessary backdrop for the development of the alliance and delivery of other techniques. DT techniques may produce the most change with individuals with good pretreatment QOR and high alliances. Much more exciting work into the process of DT remains to be done, including examining how DT techniques relate not just to symptom change but also to change mechanisms and outcomes specific to DT; how complex and curvilinear relations might exist among process variables in DT; and how we might tailor DT for the benefit of different individuals.

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