Psychotherapy

Insight as a Common and Specific Impact of Psychotherapy: Therapist-Reported Exploratory, Directive, and Common Factor Interventions

Andrew A. McAleavey and Louis G. Castonguay

Online First Publication, September 23, 2013. doi: 10.1037/a0032410

CITATION

McAleavey, A. A., & Castonguay, L. G. (2013, September 23). Insight as a Common and Specific Impact of Psychotherapy: Therapist-Reported Exploratory, Directive, and Common Factor Interventions. *Psychotherapy*. Advance online publication. doi: 10.1037/a0032410

© 2013 American Psychological Association
0033-3204/13/$12.00 DOI: 10.1037/a0032410

Insight as a Common and Specific Impact of Psychotherapy: Therapist-Reported Exploratory, Directive, and Common Factor Interventions

Andrew A. McAleavey and Louis G. Castonguay
The Pennsylvania State University

The facilitation of insight—broadly defined as forming new connections about one's self, others, and emotions—is viewed as a key process in many forms of psychotherapy. However, relatively little empirical work has addressed what types of therapeutic techniques may facilitate or hinder insight, especially in applied settings. In this practice-research network study, 31 clients and 16 therapists completed questionnaires after 401 sessions of psychotherapy. Multilevel linear modeling was used to explore whether insights are associated with various types of treatments and therapist-reported interventions, while taking into account differences between clients, therapists, and sessions. The results indicate that the types of treatment, as defined by the theoretical orientation of therapists' supervision, were not related to client-rated insight, although this analysis requires more statistical power. However, sessions that included more therapist-reported exploratory interventions than usual for a given client were found to be lower in insight than other sessions for the same client. Similarly, therapists who reported using more exploratory interventions than other therapists had clients who reported experiencing less insight after sessions than other clients. In contrast, therapists who reported using more directive interventions than other therapists, on average, had clients who reported more insight. However, interaction effects revealed that a more complex interpretation of the data was necessary. Specifically, therapists who reported using more directive interventions than their peers, on average, had clients who reported more insight only if the therapists did not also report using high levels of exploratory interventions. Furthermore, directive interventions were associated with insight only when they were used in sessions that also had high levels of common factors. Overall, this study shows that there are both treatment-specific interventions and common factors that are associated with insight, suggesting that understanding differences between types of psychotherapy may require more nuanced analyses within and between treatments.

Keywords: insight, psychotherapy training, psychotherapy techniques, practice-research network, multilevel linear modeling

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

There is considerable evidence available through single research studies, meta-analyses, and literature reviews (Lambert, 2013; Nathan & Gorman, 2007) to say with confidence that many forms of psychotherapy are effective treatments for psychological and psychiatric disorders. However, substantial uncertainty regarding the mechanisms of psychotherapy remains, and many have argued that more research into potential mediators and mechanisms of psychotherapeutic change is required (Kazdin, 2009). Research into such mechanisms across psychotherapy types may inform psychotherapists in their practice by helping them identify useful clinical interventions to make with their clients.

Two groups of mechanisms are typically identified in the literature: common factors and unique factors (Castonguay, 1993). Common factors are those elements that are ubiquitous in all forms of psychotherapy, or at least in several of them. Unique factors are elements of a particular psychotherapy that are assumed to be absent in other types of psychotherapy. Numerous lists of common factors have been devised over the years (Frank, 1961; Garfield, 1980; Marmor, 1976; Rosenzweig, 1936). Similarly, many sets of variables proposed to be unique to a specific treatment have been identified in classic textbooks and more recent treatment manuals. Although any statement about the process of change should be made tentatively, both common and unique factors are likely to explain, or at least predict, part of psychotherapy's effectiveness (for two recent attempts to quantify this, see Cuijpers et al., 2012; Norcross & Lambert, 2011). Both common and unique factors may be what Frank (1976) referred to as "features" or "functions": features are elements of therapy such as the setting where it takes place, the therapeutic relationship that develops between client and therapist, as well as techniques that are being used. In contrast, functions are the impacts of these features on the client.

From both a historical and theoretical perspective, one of the most important impacts of psychological therapies has been insight: the development of new understandings or cognitive changes, especially with regard to better understanding oneself or one's difficulties. In the early development of psychotherapy,

Andrew A. McAleavey and Louis G. Castonguay, Department of Psychology, The Pennsylvania State University.

Correspondence concerning this article should be addressed to Andrew A. McAleavey, Department of Psychology, The Pennsylvania State University, 346 Moore Building, University Park, PA 16802. E-mail: aam239@psu.edu

insight was deemed an intrinsic component of the talking cure (Messer & McWilliams, 2007). And although its roots clearly belong to the psychodynamic tradition and much of the theoretical and empirical work that has emphasized insight originated from psychodynamic perspectives, over the years, the concept of insight has spread to a number of theories of psychotherapy, including the often-contrasted behavioral treatments (Brady, 1967). The concept of insight has been so prevalent that numerous scholars and clinicians have argued that the creation of new client self-understanding is a principle of change (or a general therapeutic effect) that applies across therapies (Frank & Frank, 1991; Goldfried, 1980).

Despite its prevalence, there have been numerous points of disagreement regarding both the therapeutic value of insight as well as its definition. These disagreements have been central in the division of psychotherapeutic orientations into "insight-oriented" and "directive" treatments. Insight-oriented treatments are psychotherapies in which insight is seen as a primary goal or core mechanism and in which, at least theoretically, the development of new cognitions precedes symptomatic improvement. In its most strict definition, "insight-oriented" has meant only psychoanalysis or psychoanalytic psychotherapy (Frank, 1993), but a more common and inclusive definition includes psychodynamic, person-centered, process-experiential, and interpersonal therapies and may be better termed "evocative" therapies because they all focus on the exploration of internal experiences as an agent of change (Frank & Frank, 1991). It should be noted that although few modern insight-oriented therapists and researchers would claim that insight is necessary and sufficient for therapeutic change, insight remains seen as a powerful and desirable outcome.

Systems of psychotherapy that have been conventionally identified as less insight-oriented and more directive include cognitive, behavioral, and dialectical-behavioral therapies among others. These therapies tend to emphasize actions and continued practice of skills as mechanisms of change, frequently based on the assumptions that (1) although self-understanding is helpful, it must be followed with training, practice, and regular implementation of new skills to allow substantive change to occur; and/or (2) that behavior change can lead to increased self-awareness rather than vice versa (Grosse Holtforth et al., 2007).

Even though insight is emphasized more as a vehicle of change in some forms of therapy than in others, it may be the case that the frequency of insight does not differ across these orientations. There are at least two ways that this could come to be. First, it is possible that every orientation has developed specific techniques that promote insights with similar efficiency, regardless of the theoretical importance of insight as a mechanism of change within a particular theory. For example, accurate empathy in client-centered psychotherapy and Socratic dialogue in cognitive therapy can both facilitate insight at times when used within their respective approaches (Goldfried, 1980); perhaps these techniques serve the same therapeutic function in their respective psychotherapies and the result is approximately equal levels of insight across treatments. A second possibility is that orientation-specific techniques are not the most important contributors to the occurrence of insight. Rather, some have suggested that common factors—those environmental, interpersonal, or contextual factors found in all psychotherapies (Lambert, 2013)—might be directly responsible for the beneficial effects of psychotherapy, including insight (Wampold, Imel, Bhati & Johnson-Jennings, 2007).

Previous research on the frequency of insights has led to mixed results. At least one study has found that insight occurs more frequently in a psychodynamic treatment than in cognitive–behavioral therapy (CBT) (Llewelyn et al., 1988) when using postsession free-response forms completed by clients and coded by the researchers. However, more nuanced results were obtained by Gershefski, Arnkoff, Glass, and Elkin (1996) based on the coding of posttreatment free-response answers of treatment completers in the National Institute of Mental Health Treatments for Depression Collaborative Research Program who were asked to report on the particularly helpful aspects of their treatments. These authors created categories of helpful impacts that included "new learning, awareness, or understanding" of four types of information: cognitive, interpersonal, biological, and general new information that was not specific to any treatment orientation. In the general category, there were no differences between the percent of clients reporting this as a helpful impact of treatment. Interestingly, each of the categories for treatment-specific new learning was most frequently reported in the specific, predicted orientation (i.e., cognitive new learning was reported most frequently in CBT; interpersonal therapy was associated with new learning about interpersonal information, and imipramine was associated with new biological information). This finding suggests that whereas general insights might be common to the psychotherapies tested in this study, the content of insights in different therapies may be different.

At the moment-to-moment level of analysis, Mahrer et al. (1987) reported insights in 2% of client-identified "good moments" in experiential psychotherapy sessions. This is a relatively low percentage, compared with a different study that identified insights in 15% of the "good moments" in a psychodynamic treatment (Stalikas, de Stefano, & Bernadelli, 1997). This difference may provide evidence either that specific therapies produce different kinds of insight and/or that insights may be more or less important (indicated by the presence or absence in "good moments") in certain psychotherapies. However, the difference may instead be due to a number of factors other than treatment, including client population, assessment of "good moments," and researcher bias. Because the two studies were not associated with one another, it is difficult to draw conclusions.

A small number of investigations have examined specific therapist interventions that may facilitate insight. Raingruber (2000), using qualitative methods in a naturalistic sample of nurse psychotherapists, found that focusing on feelings during sessions helped clients develop self-understanding. A few separate analyses by Hill and colleagues (e.g., Hill et al., 1988) have identified open-ended questions and probes for insight as particularly likely to precede clients' disclosure of insight on a speaking-turn by speaking-turn basis, using psychotherapy analogs. However, few efforts have been made to replicate or extend these studies to assess whether their findings are generalizable to more therapists and actual clients engaged in ongoing psychotherapy. Until this is done more systematically, it is difficult to confidently draw meaningful conclusions from this literature (see Hill & Knox, 2008, for further review).

Kolden et al. (2000), using the Therapeutic Realizations Scale, found that therapists' use of past-focused interventions specifically

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

correlated with occurrence of past-focused insight, whereas directive interventions uniquely correlated with present-focused understanding. This suggests that some identifiable therapist behaviors not only correlate with insight at the session level, but that certain specific therapist behaviors lead to specific client insights.

There is also some evidence that insight is, at least within a long-term psychodynamic treatment, a mediator of symptomatic improvement. Johansson et al. (2010) showed that transference interpretations, which were experimentally manipulated in a controlled trial of a dismantling design of a psychodynamic treatment, predicted superior outcome through their successful promotion of insight for individuals with baseline low quality of object relations. This study provides an important finding, suggesting that a treatment-specific intervention (transference interpretation) may directly influence the impact of therapy on the client (i.e., achievement of insight), which in turn may lead to improved mental health. It also points out a potential client-level variable (i.e., quality of object relations) that may be related to insight as well.

In summary, it seems that insights, or new understandings, tend to occur in several kinds of psychotherapy, although it is not clear whether they occur at the same level across all treatments. The content of insights achieved during therapy may be linked to the therapeutic orientation of the treatment and/or the content focus of therapeutic intervention. And there is at least some evidence that insight can be an important mediator between psychotherapeutic interventions and symptomatic outcome. Further, at least some client variables may be significantly related to insight. However, it is not clear how psychotherapists promote, create, or facilitate the experience of insight, and the studies on the issue to date have not provided adequate information to identify which common or specific treatment elements and interventions might be associated with insight, especially outside of controlled trials.

In this study, we sought to address two primary questions:

1. Is insight common across types of treatment, in that it occurs at equivalent rates in different treatment types?

2. Are interventions derived from some treatments (e.g., insight-oriented treatments) more associated with insight, on average, than interventions derived from other treatments, and therefore might they be more facilitative of insight?

To address these questions, we conducted a study within a practice research network (PRN), to maximize the external validity of findings (Castonguay, Barkham, Lutz, & McAleavey, 2013). Before conducting the study, however, we had to consider how best to measure insight and the interventions that might facilitate it.

Insight has proven to be a difficult construct to define and assess, and researchers of different backgrounds have approached the concept of insight in different ways (Connolly Gibbons, Crits-Christoph, Barber, & Schamberger, 2007). To help address this issue, a group of experts in several psychotherapeutic orientations have recently developed a consensus definition of insight in broad terms: "A conscious meaning shift involving new connections" (Hill et al., 2007). Because the emphasis of this definition is on new understandings, we selected an existing measure that addresses several elements of insight (self, relationships, and emotions) and is consistent with the Hill et al. definition.

With respect to interventions, we decided to use a measure that assesses multiple types of interventions from different therapeutic orientations (rather than a measure that relies solely on interventions from a single orientation) because of the accumulating evidence that therapists use a broad range of interventions, even within a single session. This is evidenced by a recent survey that showed that the use of interventions from therapists' nonprimary orientation is commonplace (Thoma & Cecero, 2009), and previous studies that have shown that therapists tend to use interventions derived from multiple orientations in sessions, even when conducting manualized treatments (Hilsenroth, Blagys, Ackerman, Bonge, & Blais, 2005; McCarthy & Barber, 2009; Trijsburg et al., 2004). We used a self-report measure of interventions, which may have some limitations relative to observer ratings. However, therapists' self-report of intervention use may have additional strengths, for instance, being closer to the therapist's intentions. Due primarily to statistical concerns, we also aggregated across multiple subscales of this interventions measure. Thus, this is not a study of individual techniques per se, but instead of average differences across a few broad aggregations of techniques: directive, exploratory, and common factors interventions.

Method

Participants

Therapists. Therapists were recruited from the Clinical Psychology Ph.D. program at a large Mid-Atlantic university. The only eligibility requirement for therapists was that they had to be actively conducting supervised adult psychotherapy during the 2010 to 2011 academic year. Of the total 20 eligible trainee therapists identified, 17 were successfully recruited to the study. One therapist joined the study but did not successfully recruit any client participants, leaving a total sample of 16 trainee psychotherapists. Therapists ranged in age from 24 to 34 years, and eight therapists were female. The majority of therapists (13) identified as white/Caucasian, one self-identified as black/African American, and two as multiracial.

Therapists in this study ranged from <1 to 6 years of psychotherapy experience, with a mean of 2.7 years. The number of face-to-face clinical hours at the beginning of participation ranged from 40 to 1,500, with a mean of 469 hr. Therapists engage in year-long practicum, each with a different supervisor and theoretical orientation. In the 2010 to 2011 academic year, five practica were offered: cognitive–behavioral, psychodynamic, psychodynamic-humanistic, general outpatient psychiatric, and advanced psychodynamic. These practica are used in this study to define the types of treatment used by therapists.

Clients. Clients were recruited from the adult clientele of a training clinic at a large university providing outpatient psychotherapy as a community mental health center. Clients were recruited for this study by their therapists, after institutional review board-approved procedures. Therapists were allowed to select the total number of clients on their caseload they would be willing to recruit, before their beginning participation in the study. For therapists who elected to recruit fewer clients than their full caseload, we randomized which of their clients would be recruited to minimize the likelihood of sampling bias. All clients in the clinic older than 18 years and being treated by one of the participating therapists were eligible for the study, with the exception of those with a diagnosed psychotic disorder, developmental disorder, and/or intellectual disability.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

The participating therapists recruited 31 clients to the study. The client sample had a diverse set of diagnostic concerns and many had multiple diagnoses, with an average of 2.7 diagnoses given per client. Of these, 28 clients had been given a diagnosis on Axis I and 25 had been given a diagnosis on Axis II. The most common types of Axis I disorders were mood disorders (20 clients) and anxiety disorders (17 clients), and the most common diagnosis on Axis II was borderline personality disorder (11 clients).

Clients could begin participation in this study at any point in their treatment course. At the start of their participation, clients ranged from having 2 to 144 previous sessions with their therapist. Therapists rated their clients' treatment phase at the start of participation on a 120-point ruler-like scale. Responses ranged from 0 to 91, with a mean of 46.4. Thus, although there is a wide range of psychotherapy experience, the average client in this study was approximately one-third of their way through a projected treatment course at the study's beginning.

Measures

Multitheoretical List of Therapeutic Interventions. The Multitheoretical List of Therapeutic Interventions (MULTI; McCarthy & Barber, 2009) is a 60-item inventory of therapeutic interventions used during a session. Each item on the MULTI describes a therapist behavior (e.g., "I focused on the ways my client copes with his or her problems") and provides a 5-point Likert-type scale, anchored at 1: *Not at all typical of the session* and 5: *Very typical of the session*. Items were developed based on a review of therapeutic manuals and iterative consultations with experts. The MULTI has eight subscales, each representing a single orientation of psychotherapy. The subscales have been found to adequately represent each theory based on face, content, and criterion validities, and the overall structure of the measure has been tested in confirmatory factor analyses across multiple samples (McCarthy & Barber, 2009). The subscales are Cognitive Therapy (CT), Behavioral Therapy (BT), Dialectical-Behavioral Therapy (DBT), Psychodynamic Therapy (PD), Process-Experiential Therapy (PE), Person-Centered Therapy (PC), Interpersonal Therapy (IPT), and Common Factors (CF). Although observer and client ratings are possible using the MULTI, in the present study, only therapist ratings of interventions were collected. When completed by therapists, the MULTI has demonstrated adequate reliability and construct validity. For all subscales, the internal consistency reliabilities were moderate to very good in this sample (range: 0.72–0.89; see Table 1).

Session Impacts Scale. The Session Impacts Scale (SIS; Elliott & Wexler, 1994) is a 17-item inventory of subjective impacts of psychotherapy sessions. Each item provides a brief description of an impact followed by a paragraph describing the impact in detail, and is rated on a 5-point Likert-type scale (1: *not at all*; 2: *slightly*; 3: *somewhat*; 4: *pretty much*; 5: *very much*). The Understanding subscale of this measure, as defined by Stiles et al. (1994), is composed of three items: *realized something new about myself*; *realized something new about someone else*; and *more aware of or clearer about feelings, experiences*. Scores on the Understanding subscale should therefore yield a comprehensive measure of insight, consistent with the Penn State definition's criteria of comprising new understandings, with potential relation to self, others, and emotions (Hill et al., 2007). This is the measure of insight in the present study. In the present study, the alpha for the Understanding subscale was 0.78.

Procedure

Once a client was recruited to the study and signed the informed consent, clients and therapists completed postsession questionnaires immediately after every session of psychotherapy during data collection. Clients completed the SIS, and therapists completed the MULTI. Data collection continued as long as the client and therapists continued to engage in psychotherapy or until the therapists' practicum changed at the end of the academic year.

The 16 therapist participants and 31 client participants completed 453 sessions of psychotherapy during the data collection period. Missing data reduced the number of sessions on which there was complete data (both client and therapist forms) to 401 sessions. In this overall sample, the number of clients per therapist ranged from 1 to 4, with a mean of 2. In the current study, because we were interested in estimating both therapist and client effects

Table 1
Overall Means, Standard Deviations, and Bivariate Correlations of the Variables in the Overall Sample

Measure	Insight	Directive	Exploratory	CF	CT	BT	DBT	PC	PE	PD
Mean	3.21	2.24	2.67	3.35	2.38	2.08	2.25	2.89	2.56	2.56
SD	1.21	0.66	0.69	0.70	0.75	0.61	0.71	0.80	0.73	0.72
Insight	0.78									
Directive	0.169**	0.89								
Exploratory	−0.064	0.650**	0.85							
CF	0.135**	0.468**	0.495**	0.72						
CT	0.140**	0.963**	0.657**	0.420**	0.88					
BT	0.163**	0.966**	0.541**	0.391**	0.928**	0.83				
DBT	0.181**	0.934**	0.649**	0.522**	0.825**	0.847**	0.73			
PC	−0.099*	0.575**	0.929**	0.443**	0.592**	0.478**	0.564**	0.73		
PE	−0.005	0.627**	0.909**	0.518**	0.628**	0.527**	0.629**	0.751**	0.75	
PD	−0.068	0.596**	0.928**	0.409**	0.598**	0.492**	0.604**	0.804**	0.770**	0.77

Note. CF = Common Factors; CT = Cognitive Therapy; BT = Behavior Therapy; DBT = Dialectical-Behavioral Therapy; PE = Process-Experiential Therapy; PC = Person-Centered Therapy; PD = psychodynamic therapy. *N (sessions)* = 401; *N (clients)* = 31; *N (therapists)* = 16. Cronbach α for each measure is on the diagonal.
* $p < .05$. ** $p < .01$.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

for some analyses, we removed five therapists who only successfully recruited one client each. This left a subsample of 338 sessions of psychotherapy from 26 clients (range: 5–32 sessions per client) of 11 therapists (each with two to three clients). We used both the overall sample and the subsample in the analyses.

It is important to note that the MULTI ratings from this sample have also been used as part of an analysis in a separate research study regarding therapist–supervisor orientation, interventions, and session quality (McAleavey, Castonguay, & Xiao, manuscript submitted for publication). However, the insight ratings and study design of this project are separate and have not been examined.

Analyses

Before our hypothesis testing, the eight subscales of the MULTI were simplified based on empirical and theoretical reasons, similar to the process used by Boswell, Castonguay, and Wasserman (2010). Specifically, the subscale scores for CT, BT, and DBT were aggregated to form a "Directive" intervention composite score. This decision was empirically based on the fact that these subscale scores' zero-order correlations were high in this sample: CT and BT, $r = 0.931$; CT and DBT, $r = 0.833$; and BT and DBT, $r = 0.855$ (see Table 1). The subscale scores for PD, PE, and PC were also aggregated to form an "Exploratory" intervention composite score, because these also correlated strongly: PC and PD, $r = 0.808$; PC and PE, $r = 0.763$; and PD and PE, $r = 0.781$.[1] The internal consistency alpha for the Directive composite in this sample was 0.89, and for the Exploratory composite, it was 0.85. No other bivariate zero-order correlations among the MULTI subscales were greater than $r = 0.65$. In addition, the training program does not offer specific training in IPT, and the clinic does not routinely conduct or supervise it as a treatment, so the IPT scale was not included in any analyses. Using these composites also had the benefit of reducing concerns about low power and increased Type I errors that are associated with the inclusion of too many effects: instead of all eight subscales of the MULTI, we used only three values. Thus, the intervention scales used in analyses were Directive, Exploratory, and CF (which was included in its original form). The means, standard deviations, and correlations for all observed variables in the analysis are included in Table 1.

As noted by Adelson and Owens (2012), data in psychotherapy research are often nested, with observations not being independently sampled from a single distribution of data but rather sampled repeatedly from clusters of related data. Multilevel linear modeling (MLM, also called hierarchical linear modeling and mixed-effects modeling) accounts for violations in the assumption of independence made in basic (e.g., regression, analysis of variance) analyses when nesting is present. In this sample, the nesting structure is sessions within clients within therapists, which is three levels (sessions, clients, and therapists). Preliminary analysis based on intercepts-only models and restricted maximum likelihood estimation showed that client-rated insight had substantial variation at each level of nesting: the Level 2 (client) intraclass correlation (ICC) was $\rho = .455$, and the Level 3 (therapist) ICC was $\rho = .281$. This indicated that almost half of the total variation in client-rated insight was attributable to differences between clients in the sample, and approximately 28% of the variation was attributable to differences between therapists in this sample. The remaining variance (.264, or 26%) is residual variance, which is combined error variance and variation between sessions. These analyses demonstrated the need to model these data using all three levels of nesting. It should be noted that simulation studies have often shown that higher-level parameters in MLM may be biased at low sample sizes of the higher-level observation (e.g., clients and therapists). In particular, the standard error of variance components assessed at higher levels may be underestimated without sufficient number of therapists and/or clients, leading to increased Type I error when interpreting these specific effects (which is of particular interest when differences between therapists are the primary research question). However, Maas & Hox (2004), in a two-level simulation study, suggested that 10 groups (i.e., clients or therapists) would be sufficient for estimation of fixed effects. Based on this, we have limited our interpretations in this sample to fixed effects as much as possible, and tried to account for the limited number of clients and therapists where possible. Nevertheless, the limited number of higher-level clustering units (i.e., clients and therapists) limits the power in this sample.

Two sets of fixed effects models were devised to address our two research questions. To address the first question, whether the treatment type influences the occurrence of insight, we used our best available approximation of psychotherapy orientation of treatment: the orientation of the supervision practicum in which each therapist was enrolled and receiving supervision. Because there were five practica at the time of data collection, practicum was treated as a five-category fixed effect predicting insight. Due to the relatively large number of practica (5) and relatively small number of therapists (2–5) within practicum even in the larger sample (which limits power to detect variation in insight as a function of practicum), several precautions were taken. First, practicum was treated as a fixed effect and no potential moderators of this effect were tested. Second, we conducted these analyses on the overall data set, as opposed to the limited subset, because the overall data set includes at least two therapists per practicum, although some of the therapists only successfully recruited one client each. The benefit of this is that it allows for a better estimate of practicum effect (in the limited data set, this test would be completely conflated with the effect of the therapists in two practica). However, this is still a weak (underpowered) statistical test, and estimation problems with such small numbers of therapists and clients may occur. Reese, Toland, and Hopkins (2011) reported a similar problem, and these authors followed Hox's (2010) suggestion that one solution to this problem is eliminating the therapist random effect. Thus, we did so for models that included practicum. Essentially, this should minimize estimation difficulties while maximizing the potential to find a significant effect of practicum (albeit artificially and with the possibility of inflated Type I error). However, using this method, the client effect is no longer distinguishable from therapist effects. As the optimal solution to this difficulty is not obvious, we replicated these analyses across data sets and nesting structure. The interpretation of the primary research question (i.e., whether insight varies as a function of practicum) did not change across data set (whether using the overall

[1] Preliminary analyses conducted using the subscale scores, rather than the Exploratory and Directive summary scores, showed no meaningful differentiation of the individual subscales from the aggregated scores in relation to insight.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

sample or the smaller subset) or nesting structure (two-level or three-level approach described previously), providing somewhat more confidence in the findings. However, given the small number of therapists per practicum and clients per therapist, this analysis should still be considered preliminary. In addition, we also compared practicum on the levels of therapist self-report intervention use in the same ways. Most inferences did not change direction when using alternate statistical approaches. However, one difference was noted when comparing practicum in terms of self-reported Exploratory intervention use, described later in the text.

To address our second research question (whether interventions derived from different psychotherapy families are associated with insight), a second set of models were conducted. These analyses collapsed therapists across practica.[2] Because the effect of specific psychotherapy techniques could depend on the other techniques that were also used in a given session or by a therapist, we included all two-way interactions between the nine fixed effects (session, client, and therapist levels for each of Directive, Exploratory, and CF use) in our initial model, and sequentially removed nonsignificant effects using Wald tests for each parameter, which, in every instance, converged with the likelihood ratio test of overall model improvement.

Before analysis, the MULTI subscales were decomposed into three levels of effects: therapist-, client-, and session-level effects by recentering. Session-level and client-level effects were centered on their cluster means, whereas therapist-level effects were grand-mean-centered. Therapist-level effects represent the average level of technique use of a given therapist, across all their clients, compared with other therapists. Client-level effects represent the average level of technique used by a therapist for a particular client, relative to other clients of that therapist. Session-level effects represent the level of techniques used in a given session relative to other sessions of the same client.

Results

The overall means and standard deviations are reported in Table 1. We have provided least-squares means (accounting for nesting within clients) between practica on therapist-reported intervention use in Table 2. These analyses showed no significant differences between practica in CF use, but there were significant omnibus effects across practica for Directive and Exploratory self-report intervention use. As described previously, these analyses were replicated using the smaller data set and the three-level nesting structure. The interpretation of most effects was unchanged when using these alternate methods. Only the effect on Exploratory intervention changed when including a random effect for therapists, from having a significant difference across practica to no significant differences between practica (which is consistent with a drop in power with the three-level nesting structure). When significant omnibus effects were identified (as for Directive and Exploratory intervention use), pairwise comparisons between practica were conducted using Tukey–Kramer adjustment to control Type I error. These comparisons showed that therapists on the CBT practicum reported using more directive interventions with their clients, on average, than did therapists on the Advanced Psychodynamic, $t(25.3) = 4.27$, $p = .02$, and the General Psychiatric Outpatient, $t(25.4) = 4.25$, $p = .02$, practica. In addition, therapists on the Psychodynamic practicum reported using more Exploratory interventions than did therapists on the General Psychiatric Outpatient practicum, on average, $t(26.6) = 3.70$, $p = .01$, and was nearly significantly greater than the Advanced Psychodynamic practicum, $t(26.3) = 2.89$, $p = .06$. No other pairwise comparisons were significant at $p < .05$.

To test whether the practicum (as a marker of theoretical orientation of the therapy itself) was a significant predictor of insight, we conducted an MLM analysis with practicum as a five-level categorical fixed effect predicting client-rated insight. With the exception of taking into account the nested error structure of these data, this analysis is conceptually identical to an analysis of variance comparing the mean insight level across treatment type. As stated previously, this was conducted in the larger overall sample rather than the subset used for the second analysis. Results of this analysis showed that, in this sample, treatment type was not a significant predictor of client-rated insight, $F(4, 26.4) = 0.49$, $p = .74$. Thus, when accounting for nesting of clients and therapists, the theoretical orientation guiding the therapists' supervision did not predict the level of insight that clients reported after sessions of psychotherapy. However, the small number of therapists per practicum in the sample limits the statistical power of this analysis (because effects associated with treatment type may be difficult to discriminate from effects due to therapist and client), and thus a null finding should be interpreted with caution. Least-squares means (estimated population margins) and pairwise comparisons for the practicum are also in Table 2.

In the second set of analyses, testing our second main research question regarding therapist-reported intervention related to insight, the final model included several significant effects, including two two-way interactions. The final fixed effects in the model are presented in Table 3. Both session-level and therapist-level Exploratory intervention use were negatively associated with insight. That is, sessions that included more Exploratory intervention than usual for a given client were also likely to be lower in insight than other sessions for the same client. Similarly, therapists who reported using more Exploratory techniques than other therapists had clients who reported experiencing less insight after sessions than other clients. However, there was a positive relationship between Directive techniques and insight at the therapist level, showing that therapists who reported using more directive techniques than other therapists, on average, had clients who reported more insight.

The significant interactions provide additional information. To aid interpretation, these interactions are plotted in Figures 1 and 2. The first interaction, presented in Figure 1, shows moderation of the therapist-level effect of directive interventions. As can be seen, therapists who were high on Directive interventions essentially only had clients with higher-than-average insight levels if the therapist was not also using Exploratory interventions more than other therapists. Interestingly, it also seems that therapists who used lower-than-average Directive interventions demonstrated no

[2] We also conducted similar analyses adding practica as a covariate, to investigate whether practicum orientation may influence the effect of therapist-reported intervention use on insight. This effect was not significant in this sample. However, given the limited sample size already described, this analysis is not presented because it is likely extremely underpowered, but is considered an important task for future research on intervention use and insight.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Table 2
Comparisons of Therapist-Reported Intervention Use and Insight Across Practica: Least-Squares Means and Pairwise Comparisons

Team	Sessions	Clients	Therapists	Insight		Directive		Exploratory		Common factors	
				Estimate	*SE*	Estimate	*SE*	Estimate	*SE*	Estimate	*SE*
Humanistic/Psychodynamic	56	5	2	3.29	0.45	2.32[ab]	0.21	2.70[ab]	0.24	3.09	0.25
Psychodynamic	32	4	2	2.90	0.51	2.41[ab]	0.24	3.48[a]	0.27	3.51	0.28
CBT	50	4	2	3.70	0.50	3.16[a]	0.24	2.98[ab]	0.27	3.77	0.27
Advanced psychodynamic	114	7	5	2.90	0.38	1.88[b]	0.18	2.50[ab]	0.20	3.34	0.21
General psychiatric outpatient	149	11	5	3.16	0.31	1.98[b]	0.14	2.30[b]	0.16	3.01	0.17
				$F(4, 26.4) = 0.49$ $p = .74$		$F(4, 25.6) = 5.69$ $p < .01$		$F(4, 26.1) = 3.96$ $p = .01$		$F(4, 26.6) = 1.79$ $p = .16$	

Note. Least-squares means account for unequal sampling across clients and are estimated population marginal means for each practicum. Omnibus Type 3 tests (F tests) are included in the table. Means that share a superscript are not significantly different from each other (Tukey–Kramer adjusted) $p < .05$.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

relationship between Exploratory intervention use and insight, negating the otherwise significant negative main effect for therapist-level Exploratory intervention use.

The second interaction, plotted in Figure 2, concerns session-level variation between Directive interventions and CF interventions. Briefly, this interaction shows that sessions high in Directive interventions (relative to other sessions of the same client) were associated with increased insight only when session-level CF was also high. Otherwise (if sessions were relatively low in CF), session-level variation in Directive interventions was associated with lower insight.

Discussion

Although insight is a frequently discussed topic in psychotherapy, empirical investigations of insight have been both limited and mixed. In this study, we sought to assess whether insight might be considered a common impact of psychotherapy (i.e., common across treatment types) and whether treatment-specific or common factor therapist behaviors may be more attributable to its facilitation. In this sample, the differences between treatment type—defined by the theoretical supervision of each therapist—were not significantly related to insight as rated by clients. This suggests that insight may be considered what Frank (1961) called a "common function" of psychotherapy: an impact that occurs across different schools of psychotherapy. This is consistent with the fact that the formation of novel cognitive and emotional connections after therapy sessions is theoretically valued across treatment types.

However, this conclusion must be tempered. The main reason for caution is that the sample in this article is far from ideal to make treatment comparisons, because the power to detect any such differences is quite low. As such, the null finding should not be overinterpreted. Additionally, although the measure of self-report technique in the study did correspond to differences between practica in theoretically predictable ways (the CBT practicum was highest in Directive and the Psychodynamic practicum was highest in Exploratory), this is far from conclusive proof that self-report of techniques can be used instead of independent observer ratings.

In addition, we did find some evidence that the therapeutic orientation of interventions (broadly categorized into Exploratory and Directive) can predict insight: that is, although the mean level of insight did not differ across practica in this limited sample, the self-reported interventions used by the therapist were nevertheless meaningfully related to insight. Surprisingly, the directions of our main effects were the opposite of our expectations: Exploratory interventions were negatively related to insight, whereas Directive interventions were positively related with insight. On the face of it, this is counter to the notion that exploratory interventions are insight-oriented. Although this does not necessarily mean that the use of these interventions inhibited insight because the direction of causation cannot be determined in this data, it does suggest that therapists' reported use of these interventions was a reliable marker of lower insight achieved in a given session and also differentiated between therapists in terms of their clients' typical levels of insight across sessions. This negative association could be due to the affectively charged nature of these interventions, in that when therapists use them in excess, clients may have difficulty processing the material. That is, it is possible that when these interventions are frequent in sessions or across sessions, they have the potential to leave clients overwhelmed, and may even engender

Table 3
Technique Use as a Predictor of Insight: Final Fixed Effects Model and Type III Tests of Significance for Each Parameter

Effect	Estimate	Standard error	DF	*t*	*p*
Intercept	3.785	0.280	22.5	13.5	<.001
Session-level Exploratory	−0.333	0.119	309	−2.79	.006
Therapist-level Exploratory	−1.572	0.471	23.1	−3.34	.003
Therapist-level Directive	1.588	0.485	22.8	3.27	.003
Session-level Directive	0.219	0.138	309	1.59	.112
Session-level Common Factors	0.069	0.108	309	0.64	.523
Interaction: Therapist-level Exploratory by therapist-level Directive	−2.355	0.809	22.1	−2.91	.008
Interaction: Session-level directive by session-level Common Factors	0.804	0.342	315	2.35	.019

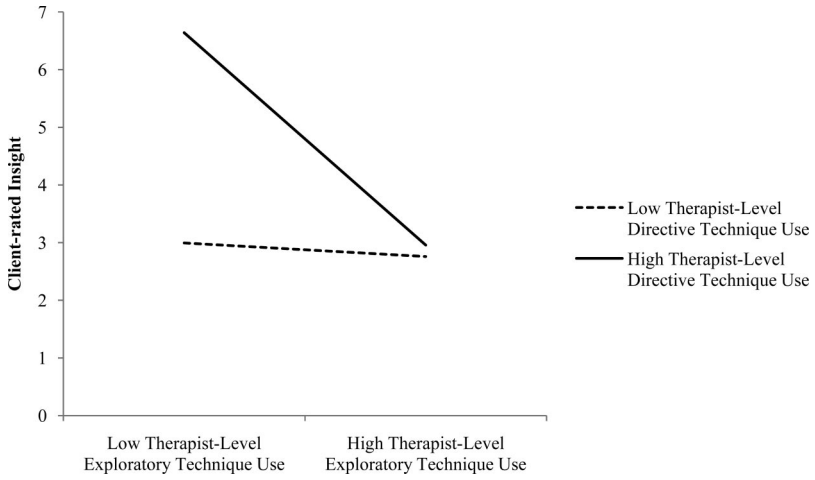

Figure 1. Interaction between therapist-level Directive technique use and therapist-level Exploratory technique use. *Note.* Interaction plots values at +1 SD and −1 SD for each variable, to aid interpretation.

some resistance on the part of the client. In fact, certain authors (Clarkin, Yeomans, & Kernberg, 2006) have suggested that therapist use some of these interventions carefully to avoid eliciting negative reactions from clients.

One alternative is that increases in therapist-reported exploratory interventions may represent increases in therapist rigidity. Previous studies have suggested that when therapists persist in their interpretation rather than flexibly adjusting to the client's reaction, negative outcomes (e.g., dropout) are more likely (Piper, Azim, Joyce, & McCallum, 1991; Schut et al., 2005). Other alternate explanations are possible. For instance, the negative main effects could be found because the therapists used these interventions more when clients were not achieving insight (when they might have had the sense that their clients were stuck and in need of developing a new understanding), in an effort to help them do so, but the intended effects were not achieved. Another possibility, related to Stiles' (1988) responsiveness problem in psychotherapy research, is that once insights are achieved in a session (through whatever mechanisms may be), therapists begin to decrease their insight-oriented intervention use, which could account for this negative relationship. Given these plausible alternatives, as well as some additional experimental findings suggesting that at least certain exploratory interventions can increase occurrence of insight (Høglend et al., 2006; Johansson et al., 2010), future research on specific exploratory interventions is needed before appropriate conclusions can be drawn beyond the fact that an aggregated variable of global exploratory interventions can be markers of lower insight across sessions and clients.

On the other hand, therapists in the study who reported using directive interventions more frequently than other therapists had clients who reported higher levels of insight on average. The interaction effect showed that this was essentially only true of therapists who did not also report using higher-than-average levels of exploratory interventions. At a minimum, this suggests that

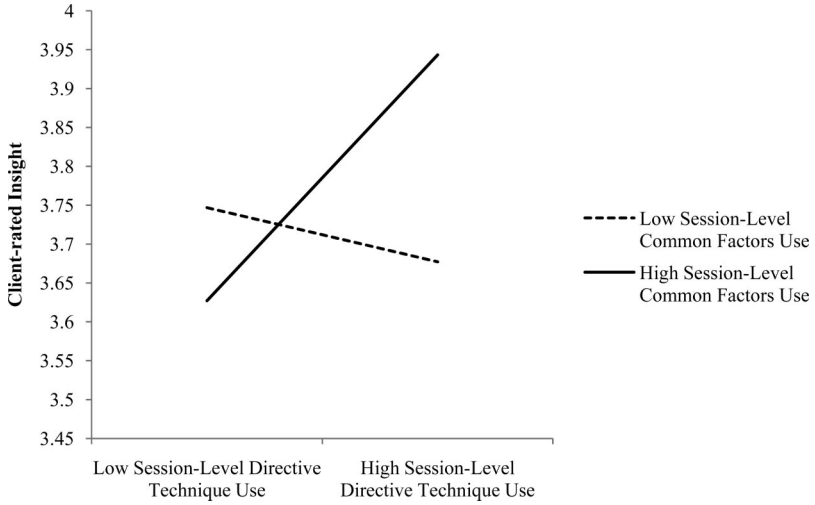

Figure 2. Interaction between session-level Directive technique use and session-level Common Factors. *Note.* Interaction plots values at +1 SD and −1 SD for each variable, to aid interpretation.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

directive interventions are not contraindicated when a therapist desires the client to develop new understandings. Instead, this study suggests that when therapists report more directive interventions, consistently across clients and sessions, this actually means that clients will leave sessions feeling as if they have learned a considerable amount about themselves, others, and their emotions. Perhaps, therapists who consistently provide these interventions are able to facilitate insights directly, through suggestion and pointed interpretation of events, in ways that move the client quickly to certain insights. The psychoeducational aspects of many directive therapies may also play a role, as clients may have indicated that they learned new things about themselves after hearing a description of how automatic thoughts are proposed to function in cognitive theory, for instance. On the other hand, it is interesting that the increased insight observed for high therapist-level directiveness appears limited to therapists who did not also report high levels of Exploratory interventions. This suggests that providing a focused Directive therapy may be more beneficial for insight than providing an integrative or diffuse psychotherapy—especially when Directive interventions are involved. That is, perhaps Directive techniques, to be maximally helpful to clients, not only need to be typical of a therapist, but also need to be consistently the primary interventions used by a therapist. As Beutler, Forrester, Gallagher-Thompson, Thompson, and Tomlins (2012) have shown, therapist directiveness in general is highly likely to interact with client factors, such as resistance. As there was no measure of client resistance in the present study, we might infer that there are some unmeasured client factors that may also inform this interpretation. In reviewing the literature on directiveness, Beutler et al. (2003) have suggested that therapist directiveness is potentially productive, but requires that therapists take care to address potential negative reactions from clients. The present study may provide another set of potential concerns in the application of Directive interventions: that they may best be applied in the absence of consistent Exploratory interventions, at least in terms of promoting new client understandings. This may in part be a function of client variables: perhaps not all client presentations are amenable to such pure interventions, but when they are, such interventions may be quite effective in generating insight.

The session-level interaction in the present study also informs the application of Directive interventions while highlighting the importance of CF. These session-level effects differ from the just-described therapist-level effects because they can be thought of as deviations of one session from the typical interventions used by a therapist—essentially, how the therapist acted in a given session that was different from how that therapist typically acted. This showed that sessions that were high in Directive interventions were only associated with greater insight when the therapist also reported using more CF interventions than usual; otherwise, using more Directive interventions than usual was slightly negatively associated with insight. One possible interpretation of this is that the CF interventions were providing a necessary, but not sufficient, baseline level of therapeutic environment, which enabled the client to accept and optimally make use of the therapist's directiveness. Conversely, CF interventions were not always associated with more insight, suggesting that, at least as measured by the MULTI, they were neither facilitative nor inhibitory of insight but rather were moderators of other interventions. This interaction between common and Directive interventions implies that the two sets of interventions are intrinsically related, rather than isolatable. Future research should account for both unique and common sources of interventions when investigating processes of change in psychotherapy.

One important finding of this study was the high ICCs for client-level and therapist-level insight. Because both the number of clients and therapists in this study are relatively small, interpreting these figures may require replication. However, these would be important to explore in future study. Significant differences between therapists in terms of their clients' outcomes have been often found (Baldwin & Imel, 2013). It could be that a part of this variability can be attributed to differences between therapists in the amount of insight achieved by their clients. About 46% of the overall variance of insight in this study was attributable to differences between clients (which includes both the client and any client–therapist dyadic factors that might be present). Client variables such as pretreatment level of insight or quality of object relations, as well as such variables as diagnosis, may contribute to these differences.

In general, this study shows the potential (along with some limitations described later) of using dimensional ratings of psychotherapy interventions. Assessing interventions used in specific sessions through dimensional questionnaires offers a different, but complementary, way of conceptualizing differences between psychotherapies in the more typical way: by using a categorical variable to indicate the type of psychotherapy being administered. Instead of making the implicit assumption that the meaningful differences between clients' experience of therapy are due to the type of therapy being delivered, dimensional intervention-type ratings (like on the MULTI or other measures of technique) allow for multidimensional and continuous descriptions of treatments. That is, by using these ratings, researchers cannot only say whether a treatment was psychodynamic or behaviorally oriented, they can offer information regarding "how" psychodynamic or behavioral (or how integrative) it was—or at least progress toward this possibility. This may be pertinent and important to our understanding of psychotherapy, because research has frequently found that categorical descriptors of psychotherapy types do not capture the range of similarities and differences between treatments. For instance, even theoretically similar types of therapy can be quite different from each other in practice: using data from a multisite clinical trial including three different CTs (all based on a common treatment model), Malik, Beutler, Alimohamed, Gallagher-Thompson, & Thompson (2003) found that these CTs were considerably different from each other in observers' ratings of, for instance, the therapists' use of symptom-focused interventions (in fact, the overall levels of variability on this intervention were equivalent between the three CTs and among the other treatments, with some forms of CT appearing more similar to nondirective treatments). Conversely, sometimes nominally distinct treatments have been found to be similar in many ways. For instance, Goldfried, Raue, and Castonguay (1998) found that among master psychotherapists, few elements of therapeutic focus differentiated CBT from psychodynamic therapists, whereas both groups of clinicians differed similarly between previously identified "significant" and "less significant" moments of psychotherapy. Thus, using dimensional ratings may allow researchers to identify similarities and differences between treatments even when the categorical treatment names might suggest otherwise. Dimensional

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

methods also allow for decomposition of effects on multiple levels of intervention—what the therapist typically does, what the client typically experiences, and what is specific to a given session. As such, the use of dimensional analyses of theoretical-orientation type variables may be helpful for examinations of therapist effects, or how it is that therapists seem to be differentially effective, even when applying the same type of psychotherapy.

Limitations and Future Directions

There are a few important limitations to this study. First, the correlational nature of this design precludes inferences of causality. This is particularly important with regard to the relationship between interventions and ratings of insight, because the natural assumption is that the interventions are predicting (or facilitating/inhibiting) insight. However, the exact reverse may be possible as well in some or all instances. It is important to note that many of the effects found in this study may be explained through other mechanisms than the few suggested in this discussion, and that it may not be possible to fully capture the complexity of these results in any text.

There is also reason to think that the use of self-report (both by clients and therapists) in this study may be a limiting factor. Although insight can be rated from other perspectives, it is possible that client self-report may provide the most important, if potentially biased, perspective on this issue. However, therapist intervention self-ratings may be quite different from an observer rating of therapist actions, and observer ratings may be preferable because they may be more objective and reliability estimates may be obtained for them. Thus, in this study, we cannot say that we measured therapist intervention use. Instead, we have only measured what therapists reported, which is likely a combination of therapeutic intentions, actual behaviors, recollection, and socially desirable responding (e.g., responding in the way they think they "should" have acted in the session), among other potential influences. Conceptually, it would have also been interesting to test differences between more specific subscales of the MULTI rather than the composite Exploratory and Directive effects that we used. However, the high correlations between the subscales suggest that detecting meaningful differences between these subscales in these data might not be possible and may not reflect the way therapists completed the measure.

In addition, the fact that we found no significant differences between practicum orientations in the level of insight does not necessarily mean that the different types of psychotherapy achieve the same types of insights or do so through the same mechanisms. It simply suggests that, at least from the client perspective, Exploratory and Directive intervention measures may not be the most important determiners of insight achievement. This is one effect of using a measure of insight consistent with a consensus definition, as noted by Hill et al., (2007): although the core part of the definition was consensual, numerous additional factors such as type or depth of insight could be assessed in parallel. More research is needed to identify whether insights may themselves differ across treatments. The differences between orientations in the present study were also operationalized by using the orientation of training practicum, which may not be ideal. These training practica, although taught by expert therapists, are essentially training experiences, so it is assumed that the treatments may be provided with suboptimal skill and/or adherence. We did have some convergent evidence, in the form of therapist-reported interventions, to suggest that the practica were related to different theoretical models of treatment. However, the skill level of interventions and variable experience level of the therapists in this study may affect generalizability outside of training settings.

Importantly, based on these data, we cannot know that insight is universally a positive therapeutic event. Whereas postsession self-report may be likely to be sensitive to small shifts in clients' understanding that would be unavailable to other perspectives, it may also be insensitive to insights that are helpful in the long-term, but unpleasant or difficult to understand within the therapy hour. Further research using observer ratings of insight depth may be especially helpful in this regard. However, we also cannot say that a *lack* of insight is always *un*productive. In fact, it may be useful in psychotherapy to have several different kinds of sessions, including noninsight-related "maintenance" sessions, in which the client does not achieve new understandings, but may solidify earlier beliefs and/or devise new plans for continuing progress.

Broadly speaking, this study also highlights some of the difficulties associated with conducting research within practice, and specifically in conducting studies in a PRN. The limited number of therapists per practicum, especially the relatively small number of therapists who successfully recruited more than one client, is one of the most significant limitations of this study. We were unable to provide therapists in this study with any incentives for participation, although future research should certainly consider that and other ways to increase the number of therapist participants. A larger number of therapists would likely have led to greatly improved power to detect differences between practica. Still, the presence of this study within a PRN—an organization that is devoted to promoting research in this clinical setting—allowed for a relatively large number of therapists (17) to be recruited overall. We might hypothesize that recruiting so many trainee therapists to volunteer in a research project requiring their time after sessions may not be easy without such an established infrastructure.

Conclusion

In summary, the evidence from this study bolsters both a common factors and an orientation-specific argument for the generation of insight in psychotherapy. The findings suggest that insight, broadly defined, may be a common impact of psychotherapy: it seemed to occur at roughly equal levels across treatment types in this training clinic sample, although differences may have emerged with more statistical power. In addition, CF, as assessed by therapist self-report on the MULTI, meaningfully interacted with Directive interventions in predicting insight, providing further evidence that paying attention to elements of psychotherapy that are shared across treatments is important. However, there were clear findings that interventions derived from Exploratory and Directive orientations (not the treatments themselves), as rated by therapists, were associated with insight. These findings, which suggested that frequency of Exploratory interventions were negatively and Directive interventions were positively associated with insight, clearly indicate that even though common factors are important, therapist reported techniques derived from and inspired by more specific theoretical orientations remain essential in understanding how psychotherapy produces its effects. Thus, rather

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

than advocating an either/or approach to deciding whether common factors or specific treatment interventions are effective, we believe that this study suggests that the two must be considered in concert.

References

Adelson, J. L., & Owen, J. (2012). Bringing the psychotherapist back: Basic concepts for reading articles examining therapist effects using multilevel modeling. *Psychotherapy, 49,* 152–162. doi:10.1037/a0023990

Baldwin, S. A., & Imel, Z. E. (2013). Therapist effects: Findings and methods. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of psychotherapy and behavior change* (6th ed., pp. 258–297). Hoboken, NJ: Wiley.

Beutler, L. E., Forrester, B., Gallagher-Thompson, D., Thompson, L., & Tomlins, J. B. (2012). Common, specific, and treatment fit variables in psychotherapy outcome. *Journal of Psychotherapy Integration, 22,* 255–281. doi:10.1037/a0029695

Beutler, L. E., Moleiro, C., Malik, M., Mark Harwood, T., Romanelli, R., Gallagher-Thompson, D., & Thompson, L. (2003). A comparison of the Dodo, EST, and ATI factors among comorbid stimulant-dependent, depressed patients. *Clinical Psychology and Psychotherapy, 10,* 69–85. doi:10.1002/cpp.354

Boswell, J. F., Castonguay, L. G., & Wasserman, R. H. (2010). Effects of psychotherapy training and intervention use on session outcome. *Journal of Consulting and Clinical Psychology, 78,* 717–723. doi:10.1037/a0020088

Brady, J. P. (1967). Psychotherapy, learning theory, and insight. *Archives of General Psychiatry, 16,* 304–311. doi:10.1001/archpsyc.1967.01730210044008

Castonguay, L. G. (1993). "Common factors" and "nonspecific variables": Clarification of the two concepts and recommendations for research. *Journal of Psychotherapy Integration, 3,* 267–286.

Castonguay, L., Barkham, M., Lutz, W., & McAleavey, A. (2013). Practice-oriented research: Approaches and applications. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of psychotherapy and behavior change* (6th ed., pp. 85–133). Hoboken, NJ: Wiley.

Clarkin, J. F., Yeomans, F. E., & Kernberg, O. F. (2006). *Psychotherapy for borderline personality: Focusing on object relations*. Arlington, VA: American Psychiatric Publishing, Inc.

Connolly Gibbons, M. B., Crits-Christoph, P., Barber, J. P., & Schamberger, M. (2007). Insight in psychotherapy: A review of empirical literature. In L. G. Castonguay & C. E. Hill (Eds.), *Insight in psychotherapy* (pp. 143–165). Washington, DC: American Psychological Association. doi:10.1037/11532-007

Cuijpers, P., Driessen, E., Hollon, S. D., van Oppen, P., Barth, J., & Andersson, G. (2012). The efficacy of non-directive supportive therapy for adult depression: A meta-analysis. *Clinical Psychology Review, 32,* 280–291. doi:10.1016/j.cpr.2012.01.003

Elliott, R., & Wexler, M. M. (1994). Measuring the impact of sessions in process-experiential therapy of depression: The Session Impacts Scale. *Journal of Counseling Psychology, 41,* 166–174. doi:10.1037/0022-0167.41.2.166

Frank, J. D. (1961). *Persuasion and healing*. Baltimore, MD: Johns Hopkins University Press.

Frank, J. D. (1976). Restoration of morale and behavior change. In A. Burton (Ed.), *What makes behavior change possible?* (pp. 73–95). New York: Brunner/Mazel.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: The Johns Hopkins University Press.

Frank, K. A. (1993). Action, insight, and working through: Outlines of an integrative approach. *Psychoanalytic Dialogues, 3,* 535–577. doi:10.1080/10481889309538993

Garfield, S. L. (1980). *Psychotherapy: An eclectic approach*. New York: Wiley.

Gershefski, J. J., Arnkoff, D. B., Glass, C. R., & Elkin, I. (1996). Clients' perceptions of treatment for depression: I. Helpful aspects. *Psychotherapy Research, 6,* 233–247. doi:10.1080/10503309612331331768

Goldfried, M. R. (1980). Toward the delineation of therapeutic change principles. *American Psychologist, 35,* 991–999. doi:10.1037/0003-066X.35.11.991

Goldfried, M. R., Raue, P. J., & Castonguay, L. G. (1998). The therapeutic focus in significant sessions of master therapists: A comparison of cognitive-behavioral and psychodynamic-interpersonal interventions. *Journal of Consulting and Clinical Psychology, 66,* 803–810. doi:10.1037/0022-006X.66.5.803

Grosse Holtforth, M., Castonguay, L. G., Boswell, J. F., Wilson, L. A., Kakouros, A. A., & Borkovec, T. D. (2007). Insight in cognitive-behavioral therapy. In L. G. Castonguay & C. E. Hill (Eds.), *Insight in psychotherapy* (pp. 57–80). Washington, DC: American Psychological Association. doi:10.1037/11532-003

Hill, C., Castonguay, L., Angus, L., Arnkoff, D., Barber, J., Bohard, A., . . . Wampold, B. (2007). Insight in psychotherapy: Definitions, processes, consequences, and research directions. In L. G. Castonguay & C. E. Hill (Eds.), *Insight in psychotherapy* (pp. 441–454). Washington, DC: American Psychological Association. doi:10.1037/11532-021

Hill, C. E., Helms, J. E., Tichenor, V., Spiegel, S. B., O'Grady, J. C. E., & Perry, E. (1988). The effects of therapist response modes in brief psychotherapy. *Journal of Counseling Psychology, 35,* 222–233.

Hill, C. E., & Knox, S. (2008). Facilitating insight in counseling and psychotherapy. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (4th ed., pp. 284–302). Hoboken, NJ: Wiley.

Hilsenroth, M. J., Blagys, M. D., Ackerman, S. J., Bonge, D. R., & Blais, M. A. (2005). Measuring psychodynamic-interpersonal and cognitive-behavioral techniques: Development of the comparative psychotherapy process scale. *Psychotherapy: Theory, Research, Practice, Training, 42,* 340–356. doi:10.1037/0033-3204.42.3.340

Høglend, P. P., Amlo, S., Marble, A., Bøgwald, K.-P., Sørby, Ø., Sjaastad, M. C., & Heyerdahl, O. (2006). Analysis of the patient-therapist relationship in dynamic psychotherapy: An experimental study of transference interpretations. *American Journal of Psychiatry, 163,* 1739–1746. doi:10.1176/appi.ajp.163.10.1739

Hox, J. (2010). *Multilevel analysis: Techniques and applications* (2nd ed.). Mahwah, NJ: Lawrence Erlbaum.

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

Kazdin, A. E. (2009). Understanding how and why psychotherapy leads to change. *Psychotherapy Research, 19,* 418–428. doi:10.1080/10503300802448899

Kolden, G. G., Strauman, T. J., Gittleman, M., Halverson, J. L., Heerey, E., & Schneider, K. L. (2000). The therapeutic realizations scale – revised (TRS-R): Psychometric properties and relationship to treatment process and outcome. *Journal of Clinical Psychology, 56,* 1207–1220. doi:10.1002/1097-4679(200009)56:9<1207::AID-JCLP7>3.0.CO;2-Z

Lambert, M. J. (2013). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 169–218). Hoboken, NJ: Wiley.

Llewelyn, S. P., Elliott, R., Shapiro, D. A., Hardy, G., & Firth-Cozens, J. (1988). Client perceptions of significant events in prescriptive and exploratory phases of individual therapy. *British Journal of Clinical Psychology, 27,* 105–114. doi:10.1111/j.2044-8260.1988.tb00758.x

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Maas, C. J., & Hox, J. J. (2004). Robustness issues in multilevel regression analysis. *Statistica Neerlandica, 58,* 127–137. doi:10.1046/j.0039-0402.2003.00252.x

Mahrer, A. R., Dessaulles, A., Nadler, W. P., Gervaize, P. A., & Sterner, I. (1987). Good and very good moments in psychotherapy: Content, distribution, and facilitation. *Psychotherapy: Theory, Research, Practice, Training, 24,* 7–14. doi:10.1037/h0085693

Malik, M. L., Beutler, L. E., Alimohamed, S., Gallagher-Thompson, D., & Thompson, L. (2003). Are all cognitive therapies alike? A comparison of cognitive and noncognitive therapy process and implications for the application of empirically supported treatments. *Journal of Consulting and Clinical Psychology, 71,* 150–158. doi:10.1037/0022-006X.71.1.150

Marmor, J. (1976). Common operational factors in diverse approaches to behavior change. In: D. A. Burton (Ed.), *What makes behavior change possible?* (pp. 3–12). New York: Burnner/Mazel.

McCarthy, K. S., & Barber, J. P. (2009). The Multitheoretical List of Therapeutic Interventions (MULTI): Initial report. *Psychotherapy Research, 19,* 96–113. doi:10.1080/10503300802524343

Messer, S. B., & McWilliams, N. (2007). Insight in psychodynamic therapy: Theory and assessment. In L. G. Castonguay & C. E. Hill (Eds.), *Insight in psychotherapy* (pp. 9–29). Washington, DC: American Psychological Association. doi:10.1037/11532-001

Nathan, P. E., & Gorman, J. M. (Eds). (2007). *Treatments that work* (3rd ed.). New York: Oxford University Press.

Norcross, J. C., & Lambert, M. J. (2011). Evidence-based therapy relationships. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 3–24). New York: Oxford University Press. doi:10.1093/acprof:oso/9780199737208.003.0001

Piper, W. E., Azim, H. F. A., Joyce, A. S., & McCallum, M. (1991). Transference interpretations, therapeutic alliance, and outcome in short-term individual psychotherapy. *Archives of General Psychiatry, 48,* 946–953. doi:10.1001/archpsyc.1991.01810340078010

Raingruber, B. (2000). Being with feelings as a recognition practice: Developing clients' self-understanding. *Perspectives in Psychiatric Care, 36,* 41–50. doi:10.1111/j.1744-6163.2000.tb00690.x

Reese, R. J., Toland, M. D., & Hopkins, N. B. (2011). Replicating and extending the good-enough level model of change: Considering session frequency. *Psychotherapy Research, 21,* 608–619. doi:10.1080/10503307.2011.598580

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry, 6,* 412–415. doi:10.1111/j.1939-0025.1936.tb05248.x

Schut, A. J., Castonguay, L. G., Flanagan, K. M., Yamasaki, A. S., Barber, J. P., Bedics, J. D., & Smith, T. L. (2005). Therapist interpretation, patient–therapist interpersonal process, and outcome in psychodynamic psychotherapy for avoidant personality disorder. *Psychotherapy: Theory, Research, Practice, Training, 42,* 494–511. doi:10.1037/0033-3204.42.4.494

Stalikas, A., de Stefano, J., & Bernadelli, A. (1997). Client process in short term dynamic psychotherapy. *Counseling Psychology Quarterly, 10,* 29–38. doi:10.1080/09515079708251409

Stiles, W. B. (1988). Psychotherapy process-outcome correlations may be misleading. *Psychotherapy: Theory, Research, Practice, Training, 25,* 27–35. doi:http://dx.doi.org/10.1037/h0085320

Stiles, W. B., Reynolds, S., Hardy, G. E., Rees, A., Barkham, M., & Shapiro, D. A. (1994). Evaluation and description of psychotherapy sessions by clients using the Session Evaluation Questionnaire and the Session Impacts Scale. *Journal of Counseling Psychology, 41,* 175–185. doi:10.1037/0022-0167.41.2.175

Thoma, N. C., & Cecero, J. J. (2009). Is the integrative use of techniques in psychotherapy the exception or the rule? Results of a national survey of doctoral-level practitioners. *Psychotherapy: Theory, Research, Practice, Training, 46,* 405–417. doi:10.1037/a0017900

Trijsburg, R., Lietaer, G., Colijn, S., Abrahamse, R., Joosten, S., & Duivenvoorden, H. (2004). Construct validity of the Comprehensive Psychotherapeutic Interventions Rating Scale. *Psychotherapy Research, 14,* 346–366. doi:10.1093/ptr/kph029

Wampold, B. E., Imel, Z. E., Bhati, K. S., & Johnson-Jennings, M. D. (2007). Insight as a common factor. In L. G. Castonguay & C. E. Hill (Eds.), *Insight in Psychotherapy* (pp. 119–139). Washington, DC: American Psychological Association. doi:10.1037/11532-006

Received February 9, 2013
Accepted February 11, 2013 ■

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.