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Linsner, Jerome Paul, Ph.D.

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ASSESSING THE THERAPEUTIC RELEVANCE OF INSIGHT

by

JEROME PAUL LINSNER

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York.

1987

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Paul L. Wachtel, Ph.D.

Michael M. Moskowitz, Ph.D.

Irving H. Paul, Ph.D.

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The City University of New York

Abstract

ASSESSING THE THERAPEUTIC RELEVANCE OF INSIGHT

by

Jerome Paul Linsner

Adviser: Professor Paul L. Wachtel

The generic concept of "emotional" versus "intellectual" insight has not enabled therapists to reliably evaluate patient progress. This study used a case-specific insight scale to demonstrate a new clinical model for assessing the therapeutic relevance of insight. The crucial distinction was whether patients' insights facilitate or obstruct their efforts to carry out their inferred, unconscious "plan" for therapy.

The research was conducted within the conceptual framework developed by Joseph Weiss (Control Mastery theory). According to this psychoanalytic model, the patient enters treatment motivated to resolve his conflicts, which he does primarily by testing his unconscious pathogenic beliefs in relation to the therapist. Therapeutic progress hinges on whether the therapist passes or fails the patient's "tests".

Shifts in insight associated with a patient's advances and retreats were studied, utilizing transcribed recordings of a short-term dynamic therapy. The Plan Compatibility of Insight Rating Scale (PCIRS) was developed and applied by clinical judges to pre- and post-test segments of patient speech. PCIRS ratings were correlated with ratings of therapist behavior and other indices of patient

functioning from previous published studies by others in the field (Scale of Therapist Passing Versus Failing Patient Tests; Experiencing Scale; Adaptive Regression Scale; Long-Term Voice Spectrum).

Interjudge reliability on the PCIRS was high. Results supported the hypothesis that "pro-plan" insights would tend to be associated with signs of increased adaptive regression and decreased anxiety, while "anti-plan" insights would tend to manifest the opposite relationships. Predictions that pro-plan insights would be more likely to appear following passed rather than failed tests, whereas anti-plan insights would tend to appear following failed tests, were also supported. In addition, the case-specific PCIRS showed a significant relationship between insight and therapist behavior, whereas the generic constructs used to measure insight with the alternative Experiencing Scale did not.

The concept of plan compatibility was shown to provide a clinically useful model for identifying characteristics of therapeutically relevant insight, for describing the conditions under which it arises, and for assessing the patient's progress. The increased efficacy of utilizing case-specific criteria over generic constructs to evaluate subprocesses related to insight was also demonstrated.

Acknowledgements

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I am deeply indebted to Dr. Marshall Bush, who worked closely with me through all phases of the research. Without his guidance, standards of excellence and his steadfast encouragement, this study would not have been possible.

I am especially grateful to members of the research group at Mount Zion Hospital for the many hours they devoted to rating clinical material. I would like to express my appreciation to Dr. Joseph Weiss and Dr. Harold Sampson for helping me lay the groundwork, and for their continued feedback. I also would like to thank Dr. George Silberschatz for making materials available, for helping with statistical analysis, and for his friendly advice and many helpful suggestions.

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Table of Contents

List of Tables and Figures

CHAPTER 1

INTRODUCTION

Organization of the Dissertation

This dissertation attempts to provide empirical support for the assumption that insight occupies a central position in the therapeutic process. A clinical model for evaluating the therapeutic relevance of insight will be presented, and relationships among insight, in-session patient functioning and therapist behavior will be demonstrated.

Chapter One is designed to state the purposes and goals of this research, to introduce the topic of insight in psychotherapy, and to put forward reasons why previous research into insight has been unproductive. In order to achieve these objectives, Chapter One includes a partial review of the insight literature that will be expanded in Chapter Two.

The main body of the literature review is presented in Chapter Two, which discusses (1) early and contemporary psychoanalytic theoretical assumptions underlying the concept of insight, (2) difficulties in the clinical evaluation of insight, (3) adaptive regression, (4) empirical research and attempts to measure insight, and (5) methodological issues in psychotherapy research.

Chapter Three discusses Control Mastery theory — the theoretical framework within which the study is conducted. It includes a review of research into Control Mastery hypotheses pertinent to this study.

The research design is presented in Chapter Four. Results and discussion are presented in Chapters Five and Six, respectively.

Introduction to Insight in Psychotherapy

Psychoanalytic theory broadly defines insight to be the awareness of pathogenic unconscious conflicts. The fundamental assumption that a causal relationship exists between acquisition of insight and therapeutic progress is widely accepted by psychodynamic clinicians. A sampling of these views is found below: Munroe (1955) concludes that the development of insight is "the crux of the therapeutic process" (p. 520) for all psychoanalytic schools of thought, and Greenson (1967) writes that all analytic techniques share the characteristic of seeking to increase the patient's insight about himself*, and that all non-analytic events, such as abreaction, are directed to enable insight to take place. Fromm-Reichman (1950) states that awareness and evaluation of repressed material must be an integral part of the psychotherapy process. Langs (1982) considers the primary goal of psychotherapy to be insight into the unconscious dimensions of one's difficulties. Singer (1970) also looks upon the development of insight to be the basic aim of psychotherapy, and equates the gaining of self-knowledge with emotional well-being. Paul (1978) suggests that the long-range alterations and reorganizations which are the goals of therapy are best achieved through the process of discovering unconscious ideas and unrecognized and unacknowledged feelings,

*The masculine pronoun is used in the generic sense throughout this dissertation for the sake of brevity and readability. The reader is asked to always keep the missing feminine pronoun in mind.

impulses and conflicts. Luborsky (1984) considers increased understanding of problems to be a preliminary stage to change and improvement. Basch (1980) writes that a resolution of psychological problems can be reached only by gaining insight into the process that gives rise to them. Blum (1979) argues that, "interpretation leading to insight is the specific and most powerful agent of the psychoanalytic curative process" (p. 43). And finally, Wolberg (1982) writes that insight "can provide the individual with a substantive motivation for change and turn the spotlight on essential areas of alteration; without it a person may wander about aimlessly in the dark" (p. 18).

Although the development of insight is construed to be the sine qua non of psychoanalytically-oriented therapy, the criteria for evaluating the therapeutic significance of patients' insight, and therefore for guiding clinical judgment of how treatment is proceeding, are generic and vague. Many have noted the confusion surrounding the term "insight" and, in the light of its purported clinical importance, have called for a more systematic study of insight that might clarify how it works, and that might produce operational criteria by which the therapeutic potential of insight could be determined (Scharfman & Blacker, 1980; Brady, 1967; Ludwig, 1966; Richfield, 1954; Zilboorg, 1952).

Insight is generally felt to be a complex mental event with two dimensions, cognitive and emotional, that provide signs for evaluating therapeutic progress. At the cognitive level, the patient must gain a conscious awareness of unconscious material. Reid and Finesinger (1952) refer to this component of insight as "generic insight," or the

"knowledge-yielding process" (p. 728) by which the significance of some pattern of relations is grasped. This dimension of insight encompasses the ideational aspect of an instinctual impulse represented in conscious awareness (Wallerstein, 1975). Awareness of material from the deepest layers of one's unconscious is considered to produce the most therapeutic results (Segal, 1962). Brady (1967) arranges the ideational content of patient productions on a continuum that ranges from less insightful to more insightful. According to his scheme, at the least insightful level, the person is merely aware that he has a disorder or recognizes that something is interfering with maximal functioning. On the other end of the scale, conflicts that first occurred very early during development emerge into awareness. Between these two poles the person is aware of the dynamic factors behind his symptoms. What the patient talks about, and therefore presumably understands about himself, is assigned degrees of therapeutic importance and taken to be an indication of the extent of potential change that might be expected.

It is generally thought that people differ in their capacity to gain and verbalize insights, and this difference governs the amount of therapeutic success they can anticipate. Appelbaum (1975) notes the common clinical impression among analysts that fostering insight in patients who can't tolerate the regression involved in insight acquisition can result in psychosis and suicide. Choice of treatment (e.g., supportive versus expressive therapy) includes an assessment of the person's capacity for insight. Conversely, the level of insight obtainable is believed to be a function of whether one is undergoing

supportive or reeducative therapy, expressive or reconstructive therapy, or psychoanalysis, with the latter form of treatment producing the most salutary insight (Brady, 1967).

The second critical dimension along which insight is evaluated is the extent to which the ideational content is accompanied by appropriate emotion. The presence or absence of affect signifies that insight is "emotional" as opposed to being "intellectual," "neutral" or "false". Emotional insights are thought to be associated with therapeutic progress and behavior change, while intellectual insights are thought to be defensive acts, and are not associated with improvement (Ludwig, 1966; Marmor, 1964; Richfield, 1954; Zilboorg, 1952). One difficulty in making such a discrimination is that what constitutes "appropriate" emotion varies from individual to individual (Zilboorg, 1952). In addition, the final determination of whether or not insight was emotional or intellectual is made retrospectively according to the degree of successful therapy outcome that is manifested (Roback, 1974). The need to establish criteria that distinguish emotional from intellectual insight is a major problem in the psychoanalytic literature (Sandler, Dare & Holder, 1973).

The uncertainty surrounding characteristics of therapeutically effective insight is related to equally vague causal explanations of how insight fosters change. In general, it is believed that once a patient understands his unconscious motivations he will be able to give up or change undesirable behavior because of increased cognitive control. Wallerstein (1975) states that insight enhances the ego's control and mastery functions; insight enables the patient "to master

outer stimuli more appropriately and respond more relevantly" (p. 74). Reid and Finesinger (1952, p. 731) attribute salutary results to insight that is capable of "penetrating the repressive barrier and making the ego aware of certain hypercathected wishes that were previously unconscious." Such insight (which they call "dynamic insight") relieves symptoms because of its problem-solving and tension-reducing effects: "To feel that one is catching on to and getting hold of oneself is undoubtedly an anxiety-relieving self-esteem building syntonic experience."

Martin (1952) conceptualizes insight to be a sudden, abreactive "aha" phenomenon that is associated with a reintegrative experience. Drawing on four stages of creativity formulated by Hutchinson* (preparation, incubation, inspiration, and elaboration) as a paradigm, Martin thinks that insight is therapeutic because it reintegrates elements of a fragmented psyche that had been dissociated to avoid experiencing the intolerable anxiety of severe conflicts. Ludwig

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*Hutchinson (1939;1941) associates insight with the solution of creative problems so difficult that they transcend the abilities of the intellect, and feels the occurrence of insight implies expansion of the intellect brought about by a reorganization and reintegration of diverse elements. Insight is thus described by Hutchinson as the "aha" experience, during which the individual suddenly discovers new solutions to old problems.

Hutchinson describes a creative cycle during which the individual engages in trial and error activity and may temporarily abandon all efforts to solve his problem. Then, months or years of unfulfilled efforts culminate in an unpredicted episode of inspiration. The moment of insight is characterized by emotional rapture and a profusion of ideas that occur rapidly but fleetingly, thus compelling the individual to make them consciously explicit, and to embark on a period of verification, elaboration, or evaluation.

Martin (1952) applies Hutchinson's ideas to psychopathology and therapy; severe emotional conflicts are construed to be pathogenic in that they present a complex intellectual task that surpasses the ego's ability to grasp or master. The patient thus narrows his focus of

(1966, p. 316) also conceptualizes insight to operate as an "integrative or learning experience whereby many (previously apperceptive) disparate thoughts and emotions are unified into some meaningful framework and provide a new solution to a previously unsolved problem." He also believes insight may be an "unlearning" experience whereby "the many psychologic distortions relating to people (for example, the transference neurosis) or situations are seen in more proper objective perspective."

Not all writers believe insight plays such an important clinical role in psychotherapy. While some have attempted to reconceptualize the cause and effect relationship of insight to change, others have relegated insight to an unimportant and peripheral position during treatment. Masserman (1954) notes that patients' insights are usually consistent with their therapist's theoretical orientation, and concludes that insight in psychotherapy represents "that mutually happy state in which the patient professes acceptance of the current formulations of his therapist" (p. 324). Bandura (1961; 1969) and Krasner (1958) have suggested that insight is the outcome of persistent suggestion and conditioning whereby the therapist ultimately persuades the patient to adopt the therapist's ideas about the patient's functioning.

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consciousness and fragments his experience into diverse elements that requires reintegration. The process of insight during psychotherapy follows a path similar to the one formulated by Hutchinson, with the patient gaining insight in sudden, dramatic, emotional episodes.

Noy (1978) also argues that the ability to transcend the boundaries of the intellect is a common feature that the process of creativity shares with insight during psychoanalysis.

Hobbs (1962) considers insight to be essentially an epiphenomenon of psychotherapy with little intrinsic value. He discounts the idea that patients discover previously hidden truths about themselves, saying, that what "insights" do are to provide a set of internally consistent theories that are capable of bringing order to the patient's confusion. Brady (1967) argues that even insights which bear little or no correspondence to a patient's history or reality can order his thinking if the insights are convincing. While agreeing that spurious insights can sometimes diminish fear and anxiety and therefore free the individual from pathological defenses, Wolberg (1982) believes that any salutary effects of "blatantly deceptive" insight will be temporary, and may eventually result in a relapse.

Alexander and French (1946) agree that insight may not always be the cause of change in therapy, but they believe that insight can be an important indicator that improvement resulting from some other therapeutic means has taken place. Menninger and Holtzman (1973) also conclude that although insight is associated with recovery, it is uncertain whether it is a product or a provocation of change. Writing from a humanistic perspective, Rogers (1951) concurs that insight is often experienced by patients and therapists as "additional evidence of the strength of the [therapeutic] process which has been set in motion" (p. 108), rather than as something given to them by the therapist to stimulate change. Insights thus operate as referents of newly acquired, self-understanding brought about by other aspects of the therapeutic setting. Finally, Wallerstein (1975) argues that insight is neither a precondition nor a direct consequence of change, but

rather is the "ideational representation" of change in ego functioning. Noting that change typically occurs from life experience without concomitant insight, Wallerstein argues that insight may be an important and necessary artifact of expressive psychotherapy brought about by the fact that change within this context results from verbal interchanges. Insight is the individual's rationale for the change; once newly acquired behavior becomes automatic, this rationale "sink(s) into the descriptive unconscious (the preconscious) from which (the rationale) can be recalled if needed during a period of new stresses" (p. 75).

The conceptual ambiguities surrounding the role of insight in psychotherapy are reflected in the research literature, a review of which is presented in Chapter Two. Research into insight has included early cognitive studies by Gestalt psychologists, comparative outcome studies of insight versus non-insight treatment, attempts to measure insight, and studies of individual therapies relating insight to patient improvement. In general, the methodological deficiencies of the studies render the results irrelevant or unhelpful in understanding insight. With very few exceptions, neither the outcome studies nor therapy studies focused on subprocesses within the patient-therapist interaction, and thus they do not shed light on the characteristics of insight associated with behavior change, or on the conditions in therapy that facilitate the acquisition of therapeutic insight.* Other methodological deficiencies have been noted. In

*The relative usefulness of single-case experimental designs over between-groups designs is discussed in Chapter Two under the section "Methodological Issues in Psychotherapy Research."

exhaustive reviews of the research literature, Fisher and Greenberg (1977) and Roback (1974) report that insight was not operationally defined, measured or demonstrated to have taken place, and that operations used by therapists to facilitate insight were not described. In addition, patients, therapists, type of therapy and conditions of therapy were not consistent with what dynamic clinicians generally agree to be necessary for dynamic therapy to take place.

Several attempts have been made to measure insight. However, these have typically been restricted to self reports and observer ratings, and suffer from many of the same deficiencies in operationalizing insight or selecting patients as found in the outcome and therapy studies. A few studies have rated recordings of psychotherapy patients using generic rating scales. Although these studies are much sounder methodologically, the use of traditional generic criteria for measuring insight does not help to identify characteristics of therapeutically significant insight, or to elucidate the factors in the patient-therapist interaction that foster insight.

Statement of the Problem

Despite the fact that the psychoanalytic school emphasizes insight as a key factor in patient improvement, little research has been reported that helps to clarify the role of insight in dynamic psychotherapy. It is postulated that this lack of productive research into insight is due largely to the following reasons. First, psychoanalytic theory does not have a well-developed causal theory of therapeutic insight. Second, traditional concepts of emotional versus

intellectual insight are difficult to apply clinically. Third, most research has examined differences between groups of patients assigned either to "insight-" or "non-insight-" oriented treatment rather than focusing on the patient-therapist interaction. Fourth, studies which have investigated immediate patient progress during treatment use process variables that provide a generic measurement of insight, rather then applying a patient-specific insight scale. These points will be further elaborated in Chapter Two.

This dissertation will develop a patient-specific insight scale based on a revised psychoanalytic model that conceptualizes insight according to its therapeutic usefulness. The focus of the investigation will be on the content and dynamics of patient cognitions in a single case. Classes of insight will be identified and related to independent measures of patient functioning and to therapist behavior.

Purpose and Objectives

A new conceptual approach, based on Control Mastery theory, will be presented for understanding insight during psychotherapy. Control Mastery theory provides a framework consonant with contemporary ego psychology and cognitive theory for conceptualizing purposive unconscious cognitive processes in mental functioning. According to this scheme, pathology stems from distorted, unconscious beliefs that develop in response to traumatic childhood experiences. The patient is perceived as motivated to overcome these beliefs by working to disconfirm them in his relationship with his therapist, and as entering treatment with an unconscious plan for achieving certain goals in

therapy. This theory has been developed by Joseph Weiss and tested, under the direction of Joseph Weiss and Harold Sampson, by the Mount Zion Research Group in a series of studies on patient behavior in psychoanalysis and psychotherapy (Weiss & Sampson, 1986). A more comprehensive treatment of Control Mastery theory is presented in Chapter Three.

The conceptual approach of Control Mastery theory makes it possible to solve the problem of defining and identifying therapeutically useful insight. First, the clinical evaluation of insight is recast as useful versus not useful, according to its potential for advancing the patient's inferred therapy goals, rather than conceptualized in terms of emotional versus intellectual insight. Second, insights that are potentially useful and not useful can be inferred during the opening phases of treatment and stated as a testable hypothesis. Third, since insight is evaluated according to its semantic content rather than its emotional context, it can be identified during the course of the therapy by comparing the content of the patient's speech to the content of insight categories predicted in the case formulation. Fourth, segments of patient speech that match categories of insight hypothesized to be useful, or not useful, can then be correlated with independent measurements of immediate patient functioning.

Finally, insight can be considered as a continuous variable and therefore rateable on almost any section of patient speech. Insight is treated as an expression of the system of beliefs patients hold about themselves, others and the world -- beliefs that frame their reality and guide behavior. The acquisition and development of

insight will be conceptualized as an on going, fluctuating process. This study will explore subprocesses related to awareness of one patient's beliefs, and microscopic shifts in insight associated with the patient's advances and retreats during individual therapy sessions.

This research employs conceptual and methodological tools evolved by the Mount Zion Research Group as elaborated in Chapter Three. Building on previous research, this study will test hypotheses about insight, in an exploratory way, utilizing transcribed recordings of a completed short-term (16-sessions) dynamic therapy. An attempt will be made to define two important classes of clinically significant insight -- one believed to have positive and the other negative therapeutic consequences, to describe fundamental characteristics of each, and to demonstrate conditions under which they arise. In addition, it will attempt to show that a patient-specific insight scale is more sensitive to fluctuations in insight than a generic measurement of insight.

Previous researchers identified and rated certain kinds of facilitative behavior by the therapist, and rated subsequent patient functioning on three process variables: (1) A measure of adaptive ego functioning (Holt's Adaptive Regression Scale, or ARS, adapted for transcribed psychotherapy segments by Bugas (1986), (2) Long-Term Voice Spectrum (LTS), an electronic analysis of voice characteristics applied by Kelly (1986) that reflect stress and anxiety, and (3) The Experiencing Scale, a psychotherapy process rating scale that taps insight, as well as other constructs. This research will expand these

previous studies, which are discussed in Chapter Four, by identifying insight and investigating the extent to which it occurs following facilitative and non-facilitative therapist behavior, and is related to indices of in-session patient functioning.

New patient-specific categories of potentially "useful" and "not useful" insight will be developed utilizing a case formulation inferred by a group of independent clinical judges during previous research. These new insight themes will be used in conjunction with the case formulation and a five-point scale to rate the degree to which transcribed segments of patient speech correspond to the categories of insight predicted to be useful and not useful. The scale was developed in this study. It will be demonstrated that insights designated as useful are more likely to arise following certain kinds of facilitative behavior by the therapist and to be associated with independent measures of immediate therapeutic progress, whereas insights designated as not useful tend to follow certain types of nonfacilitative behavior by the therapist and to be associated with signs of a lack of progress or retreat. The concepts of "facilitative" and "non-facilitative" therapist behavior, and "useful" and "not useful" insight are explained in Chapter Three.

Ratings on the insight scale will be correlated with ratings on a scale measuring appropriateness of therapist responses to establish the relationship between therapist behavior and patient insight. In addition, ratings on the insight scale will be correlated with ARS and LTS ratings to measure the relationship between insight and other indications of the level of in-session patient functioning. Finally,

the relationship between the case-specific insight scale developed in this study and the therapist behavior scale will be compared and contrasted with correlations obtained using the Experiencing Scale to demonstrate that a patient-specific insight scale is more sensitive to microscopic fluctuations of insight than a generic measurement of insight.

CHAPTER 2

LITERATURE REVIEW

This chapter discusses (1) early theoretical assumptions concerning insight, (2) difficulties in the clinical evaluation of insight, (3) new psychoanalytic perspectives on insight, (4) adaptive regression, (5) empirical research and attempts to empirically measure insight, and (6) methodological issues in psychotherapy research.

Introduction

In psychoanalysis and psychotherapy, cure is purportedly preceeded by insight, yet the concept of clinically significant insight remains elusive, and the criteria for differentiating therapeutically effective insight from ineffective insight are not well developed. It is generally recognized that people often change their behavior without expressing insight (Kris, 1956), or that the apparent development of insight on some occasions seems to contribute to cure, while at other times it remains "patently ineffective" (Richfield, 1954). Nevertheless, the psychoanalytic theory of therapy assumes that the acquisition of insight into unconscious conflicts will promote the patient's capacity to alter neurotic behavior (Gill, 1963).

This study attributes some of the problems in developing criteria for assessing the therapeutic value of a patient's insights to the fact that theoretical writing has tended to focus on the extent to

which patients attempt to use insight as a resistance. Additional sources of difficulty in conceptualizing insight are postulatd to arise from the continuing influence of early psychoanalytic perceptions that the patient is (1) incapable of acquiring insight into his unconscious defenses, motives and thoughts without assistance from the therapist, (2) powerless to regulate his defenses, and (3) unable to overcome his own repressions.

Insight: Early Theoretical Assumptions

"The truth shall make you free," proclaimed the apostle St. John (John 8:32), "but first," adds an anonymous posterist, "it will make you miserable." Coupled with its contemporary admonishment, this adage captures the common view that insight into one's unconscious trends is an inherently aversive experience.

Patients are depicted to be locked in a painful dilemma. On the one hand, treatment is conducted on the assumption that the patient's capacity to alter neurotic behavior depends on insight into unconscious conflicts. On the other hand, awareness of repressed, unconscious libidinal and aggressive drives, postulated by psychoanalytic theory to be the primary determinant of pathology (Fenichel, 1945; Glover, 1955), causes the patient to feel shame, guilt and intolerable anxiety. The patient will persist in resisting awareness of his unconscious wishes, both to avoid the ensuing anxiety, and to perpetuate his continued desire to have them gratified. Appelbaum (1975) suggests that a common transference resistance is to prolong dependency gratifications by continuing to try to please the analyst with

insights, and states that insight, like any other behavior, is typically used in the service of defense to oppose change. Fenichel (1945) notes the resistance function of insight, stating that patients will use a new insight to reinforce other repressions. Fairbairn (1958) writes of the patient's, "general tendency to maintain the inner world as a closed system at all costs, and the central role played by this general tendency in the maintenance of psychopathological states and the resistance of the patient to psycho-analytical therapy" (p. 384). Zilboorg (1952) warns that insight strengthens the repressive forces of the ego:

> There are many other ways in which patients, by way of welcoming a new "insight" or depreciating it, still merely wish (unconsciously) to tell us that they have had enough, that one discovery is plenty and they do not want to go any further. It is not the well-known flight into health that I have in mind here, but that resistance which is aroused by certain insights because those very insights open the way to further confrontation with deeper anxieties which the ego is unwilling to suffer looking at. (p. 8)

Analysts have thus been alerted to the resistance functions of insight.

The emergence of unconscious material, and the ultimate therapeutic effectiveness of psychotherapy is seen to hinge on the removal of the patient's resistances by the therapist (Berneld, 1941; Fenichel, 1945;). Strachey (1934) states that removal of resistance is essential for the patient to become "really" conscious of his unconscious conflicts. Alexander (1950) writes, "...correct interpretation of material which is about to emerge from repression, together with the analysis of the ego's defenses, is primarily responsible for the therapeutic effectiveness of psychoanalysis" (p. 441). However,

attempts to resolve a resistance leads to an immediate increase in discomfort and attempts by the patient to unconsciously oppose its analysis (Freud, 1911b; 1912a; 1912b; 1913; 1914; 1915a). Bush (1978; 1984) thus notes the ambiguous role of insight during treatment: On the one hand, conscious, rational mental processes are seen to be crucial in exerting control over unconscious impulses. On the other hand, conscious thought can oppose the successful interpretation of resistances.*

Traditional psychoanalytic notions about insight formation are also influenced by early hypotheses of how unconscious mental content becomes conscious. Early in his career, Freud conceptualized unconscious instinctual impulses as non-verbal mental material that need word representations before they can be brought to consciousness (Freud, 1915b; 1923), thus implying that unconscious mental contents are made conscious when the analyst supplies the word representation. This idea continues to influence perceptions of how the patient becomes aware of unconscious material.

A closely related idea is that awareness of unconscious material that occurs after analysis of resistance does so in the context of

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*In an critical examination of Freud's Project for a Scientific Psychology, Bush (1978, p. 5) argues that although Freud did not achieve a clinically useful explanation of how consciousness helps the patient master unconscious conflict, he made observations that are potentially relevant for understanding how insight works: (1) conscious, logical thought is indispensible to detect and correct distortions in one's thinking; (2) the most difficult distortions to overcome are those which result from trauma; (3) insight will not occur in states of strong emotional arousal because strong affect disrupts normal cognition and leads to revival of older, more primitive ways of thinking; and (4) repeated rethinking is necessary to recognize and overcome painful memories and old associative connections, and to very gradually establish new ways of perceiving and experiencing things.

regression that renders cognitive processes incapable of organizing and verbalizing the material without mediation by the therapist (Loewald, 1960). Loewald (1960) and Levenson (1982) conceptualize insight as a creative act of language wherein the patient, guided by the therapist's words, uses words himself to help him reach the analyst's higher level of ego organization. The therapist's interpretations are crucial because they supply both the form and content of the patient's insights. Blum (1979) also argues that insight's relationship to the mastery of conflict goes beyond making the unconscious conscious; insight provides a creative solution by establishing causes, meanings and connections, and by creating new organization and structure. The ability to become aware of unconscious material and to overcome the regression brought about by the analytic situation is thus made contingent on interpretations by the therapist (Greenson, 1976; Langs, 1982).

Finally, Freud's early hypotheses about mental functioning depicted the patient to be helpless in effecting any influence over his mental life. Unconscious mental life was seen to be automatically regulated by a dynamic-economic interplay of impulses and defenses that operated outside the control of the ego and its decision making capacities (Freud, 1911b; 1912a; 1912b; 1913; 1914; 1915a). The patient could not independently gain insights into unconscious conflicts even if motivated to do so, which he wasn't.

Clinical Assessment of Insight

A theory that conceptualizes the patient as lacking both the cognitive capacity and the motivation to gain insight on his own gives cause to doubt the face value of articulated insight, with respect to its therapeutic significance. The therapist is compelled to search for elusive signs of emotional involvement which might indicate that a patient's insight represents a successful transformation of unconscious mental contents to conscious awareness, rather than a defensive, purely intellectual understanding of his neurosis.

When the patient's insights are accompanied by a release of emotion, it is taken as a sign that ideas which previously existed out of the patient's awareness have suddenly entered consciousness. The emotionality involved is variously explained as catharsis or abreaction (Zilboorg, 1952), an emotional response to a previously unconscious fact about oneself (Reid & Finesinger, 1952), or the re-experiencing of severely conflicting attitudes that have been repressed in order to avoid the intolerable anxiety associated with them (Martin, 1952; Alexander & French, 1946).

Insights that are experienced or expressed in an emotionless manner are "intellectual" or "pseudo".* These serve a defensive

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*Kernberg (1975, pp. 92-93; 161) uses the term "pseudo insight" in a different way to refer to verbalizations of borderline patients which have the appearance of being insight, but, at closer examination, represent primary process thinking rather than references to deeper layers of the mind. Wallerstein (1975) makes a similar observation about insight in some schizophrenics that consists of both the awareness of an instinctual impulse and the perception and expression of appropriate affect, and therefore cannot be termed "intellectual insight." However, Wallerstein argues that such "insight" does not indicate more adaptive ego functioning, but represents awareness that results from the failure of repression.

function by enabling the patient to avoid confronting material that is fundamental to his neurosis and anxiety-arousing. Richfield (1954) says intellectual insights may result from counterphobic attitudes, reaction-formations or a compulsive identification with the normal. Wallerstein (1975) equates intellectual insight with the defense of isolation, which separates off the contained affect.

The clinical usefulness of the concepts of emotional versus intellectual insight is limited, however, as evidenced by the fact that neither "emotional" nor "intellectual" insight is clinically found to consistently predict therapy outcome (Alexander, 1950; Kris, 1956). In addition, clinicians tend to apply these criteria for differentiating the two retrospectively according to therapy outcome: if the patient improves, his insights were emotional, if not, they were intellectual (Richfield, 1954; Roback, 1974).

Several writers have attempted to escape this circularity by reconceptualizing insight in terms that suggest different criteria for identifying therapeutically significant insight. Martin (1952) insists that total involvement in one's inner conflict is a prerequisite for all insight. According to Martin, the most important manifestation of insight is to be found in the dramatic "aha" phenomenon, and he lists physical concomitants that he asserts are always observable during insight. These include rapidly shifting facial expressions, disrupted respiratory functions, blanching and flushing, and "the most significant objective phenomenon simultaneous laughing and crying" (p. 27). Zilboorg (1952), on the other hand, sees the acquisition of insight as a gradual process that cannot be fractional-

ized into component parts, and that should not be assessed as such:

> Insight is a state of personality or ego functioning as much as a neurosis is a special state of ego functioning, and the method of properly assessing it should not rest (even though unconsciously) on the antiquated faculty psychology which looks for the intellectual, the affective, and the volitional components of a given psychological state. Rather, it should be considered as the ultimate and crowning point of integration of ego functioning. Considered from this point of view, we will not make the mistake of trying to 'give' insight, nor will we try to delve into how much comprehension and how much feeling we may find in a given state of our patient's knowledge of himself at a given time. (p. 9)

Drawing on the epistemology of Bertrand Russell, Richfield (1954, p. 405) defines insight in terms of how it is obtained, by acquaintance or by description. He coins the terms "descriptive insight" to refer to insights "that provide the patient with truths about himself by making use of his capacity to comprehend the words employed in the interpretation," and "ostensive insights" which "incorporate the actual, conscious experience of their referents." Richfield insists that his terms "entail no judgments about emotions, dynamic mechanisms of defense, nor cognitions which are incompatible with known facts," but posits a reciprocal relationship between the two types of insight that results in the patient becoming aware of his unconscious experience by acquaintance. Richfield concludes that awareness of repressed material is therapeutic when the pathogenic conflicts are known by ostensive insights -- that is, when "the ego shall have a relation to repressed forces comparable to their relation to the id in their original unconscious state." Although Richfield sheds light on Freud's injunction, "Where id was there shall ego be," and partially addresses his question of how insight can "manifest the emotive properties

necessary to effect the behavioral readaptions involved in cure" (p. 300), he does not provide criteria for differentiating "descriptive" and "ostensive" insight within the therapy session.

Wallerstein (1975) also recognizes the dilemma of attempting to distinguish between intellectual insight and emotional insight. Like Zilboorg, he suggests that since insight may be either in the service of making the ego more adaptive or more rigidly defensive, the clinical significance of insight could be determined by evaluating whether it weakens or strengthens ego functions. Wallerstein states that such a change would be reflected by alterations in behavior, patterns of defenses and trait configurations. He does not elaborate on this suggestion, and leaves the impression that, again, the clinician must perform a post hoc analysis of the therapeutic significance of insight.

New Psychoanalytic Perspectives on Insight

Some contemporary analysts have begun to reconceptualize the role of insight in psychotherapy in light of recent developments in the psychoanalytic understanding of mental functioning and patient behavior. Bush (1978; 1980) concludes that classical resistance analysis theory has produced a weak explanation of insight formation and its role in behavior change. In particular, Bush feels that emphasis on removing resistances to awareness of repressed instinctual impulses is a carry-over from Freud's earliest understanding of neurosis, and that the explanation of how non-verbal unconscious content becomes conscious is scientifically untenable. He also argues that

the theory does not adequately assess defensive behavior in terms of unconscious convictions about situations of danger.

Kohut (1977) asserts that while early emphasis regarding insight was on revealing drive-wishes and the resistances which protect the individual from experiencing anxiety associated with them, a more recent focus has been on revealing aspirations that were repressed and avoided due to traumatizing events early in the patient's development. Kohut attributes this change to modifying the topographic point of view with its emphasis on making unconscious impulses conscious, and to increased attention to the structural model with its emphasis on "expanding the domain of the ego" (p. 135).

Many writers have traced the development of psychoanalytic thinking about increased unconscious control over mental operations (e.g., Rapaport, 1958; Sampson, 1976; Bush 1978; Weiss & Sampson, 1986). In 1926, Freud formulated the signal theory of anxiety, which introduced the idea that defenses can be regulated by decision making processes of the ego based on considerations of danger and safety. Later analysts further developed these ideas. Lowenstein (1954) states that when the patient feels reassured that actual sexual or aggressive impulses will not be gratified by the analyst, he is able to lift defenses, and to give verbal expression to and to gain insight into warded-off drives. Sandler (1960) states that the ego can control perceptions and defenses in response to feelings of safety. Rangell (1981) stresses the centrality of Freud's signal theory of anxiety to psychoanalytic therapy, and writes that the patient actively and routinely "tests every intended instinctual discharge or incoming percep-

tion or unconscious fantasy before it is admitted to consciousness" (p. 120). He states further that the acquisition of insight has a therapeutic effect on the anxiety signal. In addition to anxiety, Rangell suggests that other signals of unpleasure such as guilt, shame or depression can also influence the patient's regulation of defenses. Weiss (1986a) has suggested that a person has the capacity to decide to repress or to think about threatening content depending on his assessment of whether it is safe to experience it. Weiss and Sampson's (1986) theoretical and research developments form the basis for the current study, and are presented in Chapter Three, "Theoretical Perspective."

Adaptive Regression: Cognitive Operations During Insight

Traditionally, the analyst's interpretations disolve defenses to release unconscious, repressed material in two ways: (1) By interpreting the content of the repressed, thus increasing its intensity, and (2) by weakening a resistance structure by making it conscious and explaining its function to the patient. In each case, the patient must have the cognitive capacity to engage in a process of regression which is adaptive in that it allows the ego to be exposed to previously warded-off content.

Kris (1950) describes regression that does not represent chronic failure of ego functioning, but rather is controlled and executed purposively as a strategy for gaining insight, and thus manifests a degree of autonomy that an individual is able to exert over his mental and emotional life. He emphasizes that the ability to allow oneself

to temporarily and partially regress is necessary for insight to take place. Schafer (1954, p. 80) argues that the ability to actively suspend "defensive, regulatory and organizing ego attitudes" on a temporary basis in order to gain access to and to synthesize unconscious and preconscious mental processes is an adaptive skill. Menninger and Holzman (1973) consider self-regulated regression a prerequisite for successful psychotherapy. Holt regards assessment of the extent to which primary process thinking is present but well controlled, and therefore available for constructive use, or is poorly controlled, to be an important differential for diagnosing significant psychopathology, and developed a method of systematically scoring adaptive regression on the Rorschach (Holt, 1977).

According to traditional theory, adaptive regression is accompanied by an increase in anxiety, since the patient's most basic motivation is to avoid awareness of unconscious material. Ego functioning must therefore be high, and the analyst must strive to titrate the experience of anxiety in order for the patient to be able to tolerate the regression brought about by the analytic situation. Greenson (1967, p. 37), for example, writes that an ego capable of observing, thinking, remembering and judging is indispensable for the acquisition of insight. He states that "nonanalytic" procedures such as abreaction or suggestion must, at times, be employed to diminish anxiety and fearfulness in order to enhance ego functioning and the capacity for insight.

Conversely, the new paradigm, as represented above by Freud (1926), Kohut, Sandler, Rangell, Lowenstein, and Weiss, does not

emphasize the resistance function of insight, and implies that adaptive regression can occur in the context of decreased anxiety. Patients do not necessarily continue to be in conflict with unconscious material when it emerges into consciousness since they are able to regulate defenses based on assessment of conditions of safety.

Empirical Research

Introduction

The research literature pertaining to insight is organized under four main headings: (1) early research by cognitive psychologists which focused on perceptual organization and experiments of simple problem-solving tasks with apes; (2) outcome studies conducted on hospitalized schizophrenic patients and on college students with public speaking phobias that compare the therapeutic effectiveness of "behavioral treatment" to "insight-oriented treatment"; (3) the measurement of insight; and (4) therapy studies that relate insight to patient progress.

Cognitive Studies

Problem-solving characteristics of insight were investigated in a series of studies on apes by the Gestalt psychologists, as represented by Wertheimer, Koffka and Kohler, at the turn of the century when behaviorist theories that defined mental functioning in terms of blind fumbling and trial-and-error behavior dominated the scene (Hilgard & Bower, 1966). Gestalt psychologists identified several descriptive characteristics of insight that include general level of intelligence,

the role of past experience (i.e., memory traces) in facilitating problem-solving, and the importance of being able to examine all aspects of a situation. In formulating their ideas about insight, they were guided by laws of organization, particularly the Law of Pragnanz, which states that mental events tend to move toward "the good gestalt" which has such properties as regularity, simplicity and stability. Although the Gestalt psychologists reinstated insight as an important psychological event and form of learning (Hilgard & Bower, 1966; Ludwig, 1966), their research referred primarily to intellectual and perceptual processes directed toward understanding the outer world, rather than in gaining knowledge of one's inner experience (Singer, 1970). Their ideas are thus difficult to extrapolate to the higher mental processes that occur in humans during psychotherapy.

Outcome Studies

Several studies attempt to demonstrate the differential effects of insight-oriented and operant behavioral treatments of chronic hospitalized schizophrenic patients. As reported by Fisher and Greenberg (1977) and Roback (1974), each study followed a similar approach: One group of patients was assigned to group therapy where the therapists either (1) employed reinforcement therapy (Hartlage, 1970), (2) fostered group interaction that minimized investigation of personality dynamics (Semon & Goldstein, 1957), or (3) provided a warm, accepting, and permissive atmosphere with no attempt to facilitate insight or focus on difficulties (Coons, 1957). A second group of patients was assigned to a "traditional therapy group" where the time was spent

either (respectively) (1) "interpreting statements, fostering transference, and encouraging insight" (Fisher & Greenberg, p. 351), (2) facilitating understanding of underlying motivations, or (3) focusing on cognitive understanding of personal difficulties. All three studies concluded that insight-oriented treatment either is worse or is not different than non-insight oriented treatment in improving the hospital adjustment of schizophrenic patients.

Similar investigations involving desensitization procedures were conducted on recruited, non-neurotic college students with speech anxiety (Paul, 1966; Meichenbaum, Gilmore & Fedoravicius, 1971), severely phobic chronic psychiatric patients (Lazarus, 1961; Gelder & Marks, 1966; Gelder, Marks & Wolff, 1967), and university clinic outpatients diagnosed as either neurotic or personality disordered (Sloane, Staples, Cristol, Yorkston, & Whipple, 1975a; 1975b). In these studies patients received either systematic relaxation and desensitization procedures, insight-oriented treatment, combined treatment, or attention-placebo treatment. In general, these studies demonstrated the superiority of behavioral techniques in treating anxiety associated with public-speaking situations or in helping patients with circumscribed phobias. They also suggested that "insight treatment" tends to be more beneficial for subjects who manifest social anxiety across a variety of interpersonal situations, and concluded that behavioral and insight treatment attain parity in their usefulness with other types of patients.

The studies referred to above share the common conceptual shortcoming of casting insight treatment in amorphous terms. Fisher

and Greenberg (1977) join Roback (1974) in underscoring methodological deficiencies common to outcome studies: insight was not operationalized, insight gain was not measured, and therapist operations designed to foster insight were not specified. Fisher and Greenberg thus note the straw man quality and vagueness of treatments labeled as "insight-oriented." In addition, neither the type of patients nor therapists corresponded to what are generally considered appropriate for dynamic psychotherapy.* Finally, the inability of outcome studies to isolate mechanisms of change, such as insight, has been pointed out by several researchers (e.g., Bergin & Strupp, 1972; Strupp, 1986; Greenberg, 1986; Russell & Trull, 1986). The question of measuring average changes across groups versus studying patterns of change within specific patients is discussed in the section, "Methodological Issues in Psychotherapy Research."

The Measurement of Insight

Insight has been measured in a number of studies by the comparative analysis of information yielded by self-reports, observer ratings, normalized data, and internal states as revealed by inventories or projective materials. As presented below, decisions of how to employ these measurement procedures were typically determined by the definition of insight used by a particular experimenter.

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*One exception were the studies by Sloane et al. (1975a; 1975b) in which college clinic patients were given either behavioral or analytic therapy. Experienced psychoanalysts and formally trained behavior therapists were used, techniques were stipulated in advance, and it was confirmed that the therapists were indeed using different techniques. The authors concluded that no clear evidence was found to indicate the superiority of one form of therapy over the other.

Gross (1948) attempted to construct a rating scale, ranging from +2 to -2, on which subjects could measure "self-insight." Gross used as his point of departure the idea that self-insight was related to "the ability of the individual to accept as true those truths which are implicitly denied by social usage and to accept as false those falsehoods which are implicitly or explicitly affirmed by social usage" (p. 222). His "S-I scale" measured insight by computing the degree of agreement between how the subject answered "lie items," and evaluations of how "most people" would answer the items. While a low positive correlation was obtained with the S-I scale and admission of personal problems by college students, the scale correlated significantly with the Chapin Social Insight Scale. Although Gross suggests that the S-I scale could be useful in assessing the effectiveness of therapy, Grossman (1951) notes that the scale appears to be too general for clinical or research purposes.

Grossman (1951) conceptualized insight as a perceptual phenomenon that indicated "the correctness of the perception of one's own behavior and motivation, and the correctness of the perception of one's feelings and attitudes toward others" (p. 109). Grossman's emphasis on perceptual correctness led him to attempt to assess insight by measuring the difference between the subject's stated attitudes, feelings and behavior, and his actual behavior. In order to accomplish this, he constructed two measures of insight, one behavioral, the other attitudinal, which were administered to 20 male college students prior to, immediately following and four weeks after three 60-minute therapy sessions. Each subject was then rated by the

therapist for insight on a scale that ranged from poor to excellent. He validated the two scales by correlating the post-session inventory scores with the therapist's ratings. First, Grossman constructed an insight inventory (Part I) based on the Guilford-Zimmerman Temperament Survey, which he used to establish how the subject consciously perceived his overt behavior. The subjects were then asked to rate themselves in comparison to other male students on an activity/passivity rating scale. It was assumed that the larger the discrepancy between the subject's ratings and his test scores, the less insight the subject had about his behavior. The second insight inventory (Part II) was based on the Thematic Apperception Test, which was considered to reveal the subject's attitudes and feelings about himself and others. Grossman constructed multiple-choice items that reflected the feelings and attitudes expressed by the subjects in their TAT stories. The subject's degree of insight was measured by the discrepancy between the interpretation by two psychologists of the salient TAT material, and the subject's answers to the items on the inventory. Grossman attained good test-retest reliability scores on the first inventory (Part I), but found that it did not correlate with the therapist's ratings. The Self-Inventory Part II did correlate with the therapist's ratings. Despite the insignificant results attained in Part I of the inventory, Grossman felt it held the greatest promise for clinical and research applications, and suggested ways of increasing its validity. Grossman acknowledged that the higher validity of Part II indicates that it was a more sensitive measure of insight, and that this sensitivity was probably due to the fact that it was less generic and more patient-specific in content than part I. However, he

dismissed Part II of the inventory as too time consuming and laborious to serve research purposes. A major shortcoming of the study was that Grossman did not spell out the criteria that the therapist used to evaluate insight, or describe the "therapist's deliberate attempts to facilitate insight" (p. 112).

Feldman and Bullock (1955) operationalized insight as the disparity between self-judgments and the judgments of others, and had 52 student nurses rate themselves on eight traits assigned positive or negative values by the experimenters. After rating themselves, the nurses rated how they thought their peers saw them on the same traits, and then rated six of their peers on the same traits. They then correlated self-ratings with how the subjects thought others saw them, self-ratings with the ratings of their peers, and ratings indicating how the subjects anticipated others saw them with the actual ratings of others. The experimenters concluded that the measurement of insight into "one's social stimulus value" was achieved with the greatest validity when ratings by peers were compared with subjects' ratings of how they expected their peers to see them, rather than comparing self-ratings with peer ratings.

Smith (1959) tested the hypothesis that "the more defensive the individual, the less insight he will have" (p. 275). Smith had 11 male and three female management trainees roleplay interpersonal situations. Insight was measured by having each participant indicate who among the group, including himself, took three negative roles (aggressing, blocking, and withdrawing). The difference between the number of roles a subject attributed to himself, and the average

number credited to him by the group constituted an insight score. This insight score was compared with two measurements of defensiveness, the K scale of the MMPI, and ratings by other group members. Smith found a significant rank order correlation between his insight score and the group ratings of defensiveness. However, as in a similar previous study involving 45 male and 45 female college students, he got a significantly negative correlation between insight on negative role behavior and the K scale, which he attributed to the inappropriateness of applying to a normal population a scale normalized on a psychiatric population.

Tolor and Reznikoff (1960) argued that a reciprocal relationship exists between being able to comprehend causal factors underlying attitudes and behavior within oneself and being able to comprehend them in social situations. Noting that clinicians openly acknowledge this relationship by regarding personal psychotherapy as a prerequisite for conducting treatment, they posited that insight could be measured by determining the degree to which a patient accurately interprets a number of hypothetical situations. Seventy-three hospitalized patients representing a range of "neuropsychiatric disorders" and 56 student nurses were presented 27 brief hypothetical situations that depicted the use of 13 common defense mechanisms. Each subject selected among four statements the one they felt best explained the hypothetical situation. Tolor and Reznikoff then validated their Insight Scale by comparing patients' test scores with independent ratings of each patient's general level of insight, as evaluated by their psychiatrist and by psychologists who had tested them. Patients were

rated on a five-point scale ranging from "significantly below average for most patients" to "significantly above average for most patients" according to the following definition: "Insight is the extent to which an individual comprehends the causative factors underlying or determining feelings, attitudes and behavior. Insight is conceived of as lending itself to measurement on some sort of continuum and also as intimately combining an understanding of others and the self" (p. 289). A significant positive correlation was obtained between the psychiatrists' and psychologists' judgments of patients' insights and the patients' scores on the Insight Test, but the authors concluded that the relationship was not strong enough "to permit individual predictions" (p. 295). The insight ratings by the therapists did not correlate with type of psychopathology or intelligence. Scores from the Insight Test (the hypothetical situations) did not demonstrate any relationship with sex or age, but did correlate with intelligence, and discriminated between psychiatric patients and non-patients, with the patients having less insight.

Others (Eskey, 1958; Rashkis, 1963) have attempted to define and measure insight in terms of the patient's verbalized awareness of impairment. These studies are presented below.

In summary, experimenters have tested their hypotheses about insight by either comparing self ratings with observer ratings, self ratings with normalized data, or self ratings with measurements of feelings or attitudes. Several of the studies implicitly or explicitly connected insight to defensiveness, but none tested this hypothesis in a clear manner. The above studies variously operation-

alized insight as the degree of agreement between how the subject answered "lie items" and evaluations of how "most people" would answer such items; the discrepancy between how the subject perceived his attitudes, feelings and behavior and the scores reflecting internal states or normalized data; the disparity between self-judgments and the judgments of peers on traits assigned negative and positive values; the difference between self-judgments about negative social roles and the judgments of peers; the degree to which a patient can accurately interpret hypothetical situations concerning themes of defensiveness; the degree of congruence between an individual's view of himself and the view others have of him, and the degree to which a patient verbalizes awareness of impairment. Such definitions of insight are not readily related to the process of psychotherapy.

In addition to problems defining insight, the above studies rely to a large extent on observer inference and self-reports. The reliability and validity of such measurement procedures are subject to distortions by halo effects, bias toward leniency or severity, central tendency responses, and position or proximity biases. Beutler and Hamblin (1986) suggest two methods for reducing measurement bias. First, they suggest using a large number of observers and having them work independently and blindly; this increases the stability of scales that rate internal experience, and reduces the relative influence of individual rater bias. Secondly, Beutler and Hamblin suggest that the validity of observations can be increased by training raters according to specific criteria, and identifying judges who are the most effective in meeting the proscribed criterion levels of accuracy.

Two generic insight scales that incorporate the methods described by Beutler and Hamblin have been developed -- The Experiencing Scale, and the Morgan Patient Insight Scale. The Experiencing Scale (EXP; Klein, Mathieu, Gendler & Kiesler, 1970; Klein, Mathieu-Coughlan & Kiesler, 1986) is among the most widely used psychotherapy process rating scales. Derived from a Rogerian client-centered framework, this seven-point scale is thought to tap such constructs as insight, patient involvement, lack of resistance and free association. At the low end of the scale the patient is abstract, impersonal, and minimally involved; he is remote from his feelings and unable to understand their implicit meanings. At the high end of the scale, he is aware of his feelings and internal processes; he is involved in his experience and is able to articulate and explore it (Appendix F). EXP can be applied equally well by either clinically naive or sophisticated judges, with interjudge reliability ($\underline{r}_{\underline{kk}}$) approximately .80 or above (using three or more judges). Although EXP is thought to tap insight as one of its constructs, it does not separate out other factors that influence the process of therapy, such as patient involvement, level of resistance and level of free association. A more detailed description of EXP can be found in the "Discussion of Instruments" section.

The Morgan Patient Insight Scale rates patient productions on a ten-point continuous scale for nine generic categories of insightfulness. In brief, it rates indications that the patient can recognize: (1) relevant ideas, affect or behavior; (2) habitual patterns of behavior: (3) playing an active rather than passive role; (4) indica-

tions of defensiveness or resistance; (5) connections between problems; (6) repressed thoughts, feelings or impulses, (7) cause and effect, learning from experience; (8) relationship of present to past experiences, and (9) that psychological experience is cumulative. Morgan (cited by Broitman, 1985) reports good interrater reliability (.92), and good internal reliability (mean of r = .508). Broitman (1985) notes that the validity of the scale has not yet been established, but used the scale to study insightfulness in three short-term therapies because she found the scale reflected concepts about insight that appear in the clinical literature, and thus possessed excellent face validity. Broitman found a highly significant correlation between the Morgan scale and the Experiencing Scale (r ranged from .6 to .8 across three cases), suggesting that the two scales are sensitive to the same variables and are essentially identical.

Therapy Studies that Relate Insight to Patient Progress

Eskey (1958) attempted to investigate the relationship of insight into presence of illness to patient improvement, as measured by length of hospitalization, among 300 psychotic hospitalized patients. He divided patients into three groups of no insight, partial insight, and insight on the basis of an evaluation of each patient's verbalized statements during their mental status examination. Declarations by the patient such as "something is wrong with my mind," or "I don't think I need psychiatric help" were taken as indications of the level of insight the patients possessed into their difficulties. Eskey did not find any reliable differences in the length of hospitalization among the three groups, and concluded that patients with insight do

not improve more rapidly than patients without insight. Eskey argued that the type of insight he studied was related to intellectual insight that occurred during psychotherapy.

Rashkis (1963) also attempted to relate insight to improved functioning among hospitalized patients. He reports that patients who scored high on tests of perceptual organization responded to continued questioning about their illness either by giving (over the course of treatment) an increasing proportion of statements that denied they were ever sick, or by giving an increasing proportion of insightful statements. Patients who scored low on perceptual organization tended to show an increase in unrelated statements and in statements of a low-order explanatory type. Two to four-year follow-up studies of these patients revealed that all of the high perceptual organizers who showed an increase in denial had been transferred or rehospitalized, while all of the those who had developed insight remained out of the hospital. Approximately two-thirds of the low perceptual organizers had been rehospitalized. Rashkis concluded that the ability to use good perceptual organization in interpersonal transactions is necessary to keep out of the hospital. He also notes that the "denial patients" seemed to be markedly overdefended or defenseless, thus implying that insight is related to defensiveness. Although Rashkis emphasized the importance of distinguishing between patients who learn to say the right kind of things and those who demonstrated a capacity to use dynamic concepts in a rational way, he does not describe how this was achieved. He also fails to describe the methodology employed to rate and measure insight.

In a study designed to look at the development of insight in different group settings, Mann and Mann (1959) randomly selected 96 graduate students and placed them into a discussion group, a task-oriented study group, and a group that used group-centered role playing to promote insight. Insight was defined as the degree of congruence between an individual's view of himself and the view others have of him. Mann and Mann reported that all three groups increased significantly in insight with no differences among groups in the amount of insight attained, and that no relationship between increased insight and individual adjustment was ascertained. However, the authors do not describe how insight was measured, the qualifications of the therapist, what techniques were used, or how adjustment was measured.

Abramowitz and Jackson (1974) recruited college students to participate in group sessions designed to improve their social skills and overall adjustment. Students were placed in one of four groups described as interpretive there and then, interpretive here and now, a combination of the two, and an attention-placebo group. All groups met for 10 90-minute sessions with the same therapist who was characterized as adhering to an insight-oriented approach. Blind ratings of tapes confirmed that the four treatment groups differed from one another. Two outcome measures were used, scores on an insight test that rated the ability to understand the motivations of others, and 11 pre- and post-therapy self report measurements. Abramowitz and Jackson reported a significant decrease in self-reported seriousness of core problems and decreased guilt in all groups. They found that the

combination group attained better results than did the other groups. No differences in insight gain were measured across the groups. Fisher and Greenberg (1977) noted that the findings were limited by several deficiencies: neither the type of therapy provided, the type of "patients" studied, nor the definition of insight used are consonant with the practice or theory of dynamic therapy. In addition, the measurement of insight was restricted to self-reports, and the same therapist was used in all groups.

Only one study investigating the comparative effects of insight versus non-insight treatment was found that included a measure of insight. Roback (1972) randomly placed chronically hospitalized, mostly schizophrenic patients into three treatment groups: (1) an "interaction group" where the therapist reinforced member-to-member interaction not aimed at the development of insight, (2) an "insight group" which emphasized member-to-therapist interaction and the deliberate development of insight, and (3) an "insight and interaction group" where the therapist emphasized either member-to-member interaction and insight production, or member-to-therapist interaction and deliberate fostering of insight. In addition, patients were assigned to a fourth control group in which they viewed films. All groups were conducted by the same therapist, whose performance in each setting was judged by independent raters to vary appropriately according to stipulated procedures. Insight was defined as "the client's understanding and/or awareness of the relationship between current behavior (including feelings and attitudes) and past socio-psychological experiences" (p. 412). Two experienced psychotherapists used an insight scale to

rate transcripts for the amount of insight verbally displayed by the patients. In addition, an insight test (the Tolor-Reznikoff Insight Rating scale) was completed by all subjects prior to and after the treatment. Roback found that pre- and post-therapy measurements by the Hospital Adjustment Scale, Wittenborn Psychiatric Rating Scale, Minnesota Multiphasic Personality Inventory, Symptom Disability Checklist, Adjective Check list, Wechsler Adult Intelligence Scale, and the number of days reported out of hospital during a four and one-half month post-therapy period, revealed no significant differences among groups. However, Roback reports that the combined effect of the insight and member-to-member interaction led to "more consistent indicators of change on the 21 dependent variables" than the other treatment groups (p. 416).

Fisher and Greenberg (1977) suggest Roback's findings could be seen as supportive of Freud's position concerning the importance of working through attained insights. However, despite the fact that the definition of insight used in Roback's study is consistent with the psychodynamic conceptualization of insight, the findings are limited in their usefulness in explicating the role of insight during therapy for several reasons. First, the insight scale is neither described nor validated. Second, the treatment (i.e., a graduate student supplying positive reinforcement in the form of approval statements, eye contact and head nodding, and negative reinforcement such as fidgeting and tapping of fingers) cannot really be construed to be psychodynamic therapy conducted by a suitably trained clinician. Finally, chronic, schizophrenic hospitalized patients do not meet the criteria for what

psychoanalysts and psychotherapists believe to be necessary for insight-oriented treatment to be effective.

Three studies have been reported that utilize a single-case experimental design to investigate insight gain. Shilkret (Shilkret, Issacs, Drucker & Curtis, 1986) traced a patient's development of insight into conflicts concerning feelings of omnipotence during the first 100 hours of an analysis. The patient's symptoms and inhibitions were attributed to "largely unconscious fears of her power to harm others (that) stemmed from pathogenic beliefs developed in childhood about her parents' and siblings vulnerabilities" (p. 206).

Shilkret read the process notes of the first 100 hours and identified five levels of insight that the patient achieved into her irrational fears of hurting others -- a problem that was inferred to be a core conflict by clinical judges after reading the first 10 hours of analysis. Shilkret developed a five-point scale to rate each level of the patient's insight into her feelings of omnipotence. At the low end of Shilkret's omnipotence scale, Level 1, "the patient is virtually unaware of her irrational sense of power to harm others" (p. 208); the patient is also judged to be unaware of her feelings of weakness and helplessness. At the highest level of insight, level 5, the patient manifests an explicit awareness that her concerns that she has the power to hurt others can be irrational; "she may distinguish between her thoughts and her actions, or she may attempt to anticipate the realistic consequences of her actions, even if this assessment is difficult for her to make" (p. 364).

131 items that pertained to the scale were identified in the first 100 hours. These items were presented to three judges, who independently rated them on the omnipotence scale. Average interrater reliability was .72. Shilkret found that the mean ratings for 10 hour blocks increased significantly across the 100 hours, suggesting that the patient gained increasing insight into her beliefs of omnipotent power.

In a follow-up study, Drucker and Isaacs (Shilkret, et al., 1986) demonstrated that the patient studied by Shilkret reached each of the five levels of insight largely without interpretative help from the analyst. They also reported evidence that the patient's progress was facilitated by interpretations at the same level as the patient's insights, even though the interventions occurred after the patient had attained her insights. The research by Shilkret et al. is extremely important in that it is the only study located that emphasizes the importances of defining and measuring insight in case-specific terms. (Although Grossman (1951) used the TAT to establish individual subjects' conflictual themes, he concluded that such case-specific measures were too time consuming to be of research value.)

In a study that utilized a generic measure of insight, Broitman (1986) applied the Morgan Patient Insight Scale to five-minute segments of patient speech in three therapies immediately preceeding and following therapist interpretations. Broitman found that patients tended to be more insightful following facilitative, or "pro-plan"* interpretations. Broitman used therapist interpretations identified

*The concept of "pro-plan" will be explained in Chapter Three.

and rated by Fretter (1984; Silberschatz, Fretter & Curtis, 1986) according to the degree to which they facilitated the patient's therapy goals. In all, 237 therapist interpretations were utilized. Broitman had eight judges rate each patient on the Morgan scale after undergoing approximately five hours of individual and group training. Interrater reliability ranged from .3 to .8 with a mean correlation of .58. Broitman reported that the residualized gain scores of eight out of ten of the Morgan subscales correlated positively at the .05 level with the degree to which the therapist's interpretations facilitated the patient's goals. The two sub-scales that did not demonstrate a relationship were item four (the patient recognizes particular behaviors as indications of resistance and defensiveness) and item eight (the patient can relate present experiences to childhood experiences; sees causal relationship as indicated in the principle of psychic determinations.)

Broitman reported correlations between the Experiencing Scale and the Morgan Patient Insight Scale that ranged from .6 to .8 across all three cases, and notes that the two scales may be tapping the same attributes. In addition, she added a tenth item to the Morgan scale that provided a global measure of insight. This item correlated extremely highly with six of the items that correlated with the therapist's behavior. Broitman thus concludes that a single global measure of insightfulness could capture the information yielded by the nine items of the Morgan scale.

The studies by Shilkret, Isaac and Drucker and Broitman are unique in their attempt to link insight gain directly to therapist

behaviors that are specified and measured.

Methodological Issues in Psychotherapy Research

Recent developments in psychotherapy research emphasize the importance of studying patterns of change within specific patients, rather than in attempting to make global statements about the therapeutic process. This shift in priority is accompanied by the necessity to make important methodological and statistical adjustments that include achieving greater specificity in variable definition, narrowing the focus of process measures, investigating microprocesses that occur between patients and therapists, and increasing instrument validity and reliability.

Bergin and Strupp (1972) and Kasdin and Wilson (1978) have argued that research which measures average changes across groups cannot adequately isolate mechanisms of change in therapy, and that between-groups designs do not contribute to a better understanding of the therapeutic process. Increasingly, psychotherapy researchers are calling for greater focus on in-session change processes specific to the patient-therapist dyad. Strupp (1986) urges researchers to gear their methodologies to studying the dynamics of patient-therapist interactions, particularly to the therapist's influence on patient functioning, and not to dismiss therapy outcome as placebo effects. The importance of being able to specify and measure immediate in-session changes that result from specific behaviors is also supported by Greenberg (1986), who emphasizes that interaction between the therapist and the patient should constitute the most meaningful episodes

for psychotherapy research. Gendlin (1986) concurs that researchers need to recognize and study interaction process, and suggests such investigations should focus on patient subprocesses and microprocesses in exploratory studies on individual patients. Similarly, Russell and Trull (1986) argue that methodological approaches which sum the frequency with which category behavior occurrs during sessions should be augmented with sequential analysis of the moment-to-moment impact of the therapist-patient interaction. Such research should include provisions for (1) positing an endpoint towards which movement can be observed, (2) providing terminology for accurately describing sequences of interactions, and (3) characterizing interaction sequences in terms of such factors as cyclicity, latent structure, and relative degree of influence of the therapist and patient.

In order to attempt to account for behavioral variability, increased emphasis has thus been placed on the single case experimental approach (Hersen & Barlow, 1982). Although the experimental case study poses difficulty in generalizing findings, its ability to develop and test hypotheses about clinically effective techniques is considered to compensate for its limitations (APA Commission on Psychotherapies, 1982). Gendlin (1986) argues that exploratory studies on individual cases can "vividly disconfirm a hypothesis and give new leads" (p. 133). The importance of conducting research on audio recordings, transcriptions or process notes from individual treatments is extended to time limited therapies. In a review of the clinical and research advantages and limitations of brief psychotherapy, Strupp, Koss and Butcher (1986), concludes that "brief psychotherapy

offers a unique proving ground for testing the efficacy and utility of techniques -- something that is difficult to accomplish in open-ended treatment" (p. 61). Strupp points out that brief psychotherapy helps to control extraneous influences, and simplifies the logistics of monitoring patient and therapist behavior and collection of follow up data. In addition, the focused goals characteristic of brief treatment fosters criteria for improvement.

The strategic shift toward intensive study of the individual has been accompanied by a recognition that global outcome and process measures fail to yield the desired specificity of factors involved in the therapeutic process (Weiner & Bordin, 1983). Garfield (1978) and Parloff, Washow and Wolfe (1978) have argued that reliable process variables that specifically measure behavior change during psychotherapy need to be developed. Gendlin (1986), however, cautions that in-session process "is not outcome bit by bit." Gendlin asserts that the ability to measure specific patients' subprocesses and microprocesses must be developed, and that such measurements must be distinct from outcome measurement, so that process can be identified and observed even if it is accompanied by unsuccessful treatment. Greenberg (1986) and Russell and Trull (1986) also stress that process must be demarcated from outcome, and that the investigation of immediate in-session performance is a requisite and separate step to understanding therapy outcome.

Beutler and Hamblin (1986) list several pitfalls to be avoided when pursuing single-subject designs. First, measurement procedures that rely on observer inference "are susceptible to halo effects, bias

toward leniency or severity, central tendency responses, and position or proximity biases" (p. 49). Second, ordinal, categorical scales may produce logarithmic or sigmoid rather than more sensitive linear scaling functions, and thus foster misclassifications and bunching errors. Third, pre-post raw change estimates are unstable and do not take into account the effect of initial (baseline) levels on post measurements, resulting in spurious correlations.

CHAPTER 3

THEORETICAL PERSPECTIVE

Introduction to Control Mastery Theory

Control Mastery Theory is a revised psychoanalytic theory developed by Joseph Weiss (1952; 1967; 1971; 1983; 1986a; 1986b; 1986c; 1986d; 1986e) that is generally consonant with contemporary psychoanalytic thought. Its focus is on broadening the psychoanalytic framework for understanding the unconscious cognitive determinants of pathology, and the purposive unconscious operations at work in the patient-therapist interaction. Control Mastery hypotheses have been tested in a series of interrelated studies of patient behavior during psychoanalysis and psychotherapy directed by Joseph Weiss and Harold Sampson and conducted by the Psychotherapy Research Group at Mount Zion Hospital in San Francisco (Sampson, Weiss, Mlodnosky & Hause, 1972; Horowitz, Sampson, Siegelman, Wolfson & Weiss, 1975; Silberschatz, 1978; Gassner, Sampson, Weiss & Brumer, 1982; Fretter, 1984; Broitman, 1985; Bugas, 1986; Bush & Gassner, 1986; Curtis & Silberschatz, 1986; Silberschatz & Curtis, 1986; Weiss & Sampson, 1986; Silberschatz, Curtis, Sampson, Weiss & Kelly, 1987).

Trauma and Pathogenic Beliefs

Control Mastery Theory explicates the central role of pathogenic beliefs and unconscious guilt in the etiology and maintenance of psychopathology. Pathogenic beliefs are formed during childhood as a

consequence of interactions with parents that compel the child to connect his most important wishes and goals to feared, dangerous situations. Pathogenic beliefs are a source of unconscious fear, anxiety, guilt, shame and remorse, and many of an individual's most central symptoms and inhibitions are produced in order to avert the dangers foretold by his pathogenic beliefs. They are irrational in that they are based on false or distorted causal inferences, and become overgeneralized from the child's experiences with his parents.

An important factor in the development of pathogenic beliefs is the irrational sense of self-blame and responsibility that people frequently assume in response to traumatic events that may happen to them or to loved ones. In adults, this can be seen following events such as accidents or disasters. When such trauma occurs, even mature adults often lose their ability to make a realistic appraisal of their role in the event, and develop irrational, unconscious guilt about their more fortunate circumstances, or convictions about how their behavior may have caused the trauma, or how they must behave in the future to prevent the reoccurrence of the event (Gassner, 1986). These convictions may develop at a later time, when the person reconstructs what had happened.

Children are particularly vulnerable to misinterpreting traumatic events because they are dependent on parents to assist them in achieving crucial developmental goals and in discerning reality, and are developmentally inclined to engage in irrational, egocentric and magical thinking. A child's intense need to protect his relationship with his parents will conspire with his limited cognitive capacity to cause

him to make inferences about himself that are self-referential, distorted and incriminating. A child, for example, may causally connect an accident involving a parent to any impulse that he may be experiencing at the time of the accident, and infer, for instance, that his anger was responsible for the parent's injury. Weiss (1986a) provides the following account of a child who made false inferences about the consequences of his behavior:

> Mr. S, at two and one-half years of age was, without warning, sent away for 3 months to stay with his uncle and aunt. He was sent away because his younger brother had developed measles, and the family was afraid that Mr. S would catch the disease. His father drove him to his uncle's home about 100 miles away and left him there, giving him little explanation. The father, to avoid witnessing his son's distress, left abruptly after a brief goodbye and without offering him an explanation for leaving him.
>
> Mr. S, as we were able to discover in analysis, was not completely toilet trained when he was sent away. He had, in addition, been provoking his parents by his mischievous, rowdy behavior. He had, therefore, assumed that he had been sent away as a punishment for these shortcomings. At his uncle and aunt's, Mr. S soon became toilet trained and, in addition, extremely compliant, neat, and deliberate. He stopped being rowdy and became a model boy. On returning home, he was less playful and outgoing than before, and he remained so from for many years...
>
> Many factors other than those discussed here played a part in this patient's childhood traumas. Among them was his jealousy of his brother, who was allowed to stay home while the patient was sent away, and his anger toward his mother for attempting to toilet train him and to curb his energy. Nonetheless, the central element in his neurosis was the unconscious belief that unless he were good (compliant), he would be punished by rejection. (p. 79)

The child's relative dependency causes him to experience a broad range of events as traumatic; in addition to isolated traumatic experiences such as separation, death or illness, children may accrue

pathogenic beliefs in response to patterns of interactions with parents which repeat parental failure over time. Thus, if a parent repeatedly responds to a child's expressions of autonomy with anxiety, or fails to be appreciative of narcissistic performances, or consistently competes with a child, the child may infer that the parent is weak and needy, and conclude that he should inhibit his development and remain dependent to prevent damaging the parent or threatening the relationship. In order to further protect the parent, the child may repress awareness of his distasteful evaluation of the parent, idealize the parent as strong and competent, and identify with the parent's weaknesses by acting weak and incompetent himself. Powerful pathogenic beliefs are thus likely to form during the early stages of life when a child lacks interpersonal experience, is cognitively and emotionally immature, and is dependent upon parents.

Control Mastery Theory's emphasis on the role of trauma in the etiology of psychopathology is consonant with Freud's 1926 signal theory of anxiety, which states that a person will experience anticipatory anxiety whenever he feels he might be in danger of re-experiencing a past trauma. Freud's paradigmatic example of pathogenic beliefs born out of trauma are the young boy's ideas that if he sexually desires his mother he will be castrated, and the young girl's belief that if she is sexually aroused by her father, she will lose her mother's love (Weiss, 1983). The definition of trauma is broadened within the Control Mastery framework to include any experience, isolated or on going, which convinces a person that he must renounce an important instinctual goal or ego striving in order to

avoid damaging his object ties (Weiss, 1986b; 1986c).

The Role of Unconscious Guilt in Pathology and Treatment

Pathogenic beliefs about the harm one has done to primary objects are likely to generate irrational, unconscious guilt which is acutely distressing. In addition to oedipal guilt, Weiss (1986b) emphasizes the pathogenic effects of separation guilt (predicated on the belief that if the child becomes stronger or more independent in relation to a parent, he may hurt that parent), and survivor guilt (the good things in life, such as friendships, health, love, money, fame, etc., come in limited quantities, and therefore are acquired at the expense of others). Guilt is construed as exceedingly dangerous for an individual to experience, since it produces, among other things, anxiety and depression. Bush (1984), conceptualizes the crippling effects of guilt within a Control Mastery perspective:

> The experience of guilt, or just the threat of it, produces anxiety because anxiety is a reaction to danger and guilt is one of the most dangerous human emotions. The danger it poses lies in the fact that guilt feelings can become intolerably painful and produce a need to incur punishment and make restitutions. Unconscious efforts at restitution are often based on magical ideas according to which the suffering of another person can be alleviated or redressed by submitting to the injured person's wishes or by taking an analogous form of suffering upon oneself. In extreme instances people may be driven to suicide or to such extreme degrees of submissiveness and compliance in their efforts at restitution that they sacrifice their individuality and basic sense of self...Guilt destroys feelings of self-esteem and self-worth, undermines one's confidence in one's own good intentions, and makes one less able to defend oneself in the face of false accusations and unmerited mistreatment. It thereby increases one's vulnerability to being traumatized. (p. 3)

Bush concludes that "For all of the foregoing reasons, a person's unconscious defenses are largely organized around the need to reduce, avoid, and repress the experience of guilt" (p. 5). A patient who has formulated beliefs connected with survivor guilt may thus develop masochistic and narcissistic symptoms and traits that serve the function of redressing the imbalance perceived by the patient to exist, while separation guilt may result in a passive, dependent personality.

The Patient's Unconscious Motivations During Therapy

Despite the prominence attributed to unconscious guilt in generating neurotic suffering, Weiss (1986d) stresses that patients do not enter treatment merely to gain symptomatic relief from guilt and anxiety. Nor are patients solely motivated to gratify infantile wishes. Pathogenic beliefs are not wishful fantasies that the patient would like to gratify, but grim, crippling beliefs. Although the patient may find some gratification in his symptoms or character distortions, his strongest desires lie not in maintaining these secondary gains, but in ridding himself of his pathogenic beliefs. Patients thus go into therapy with the primary unconscious motivation to change their behavior by mastering their unconscious conflicts, and they have an unconscious "plan" for how they intend to achieve their objectives. Specifically, the patient wishes to overcome unconscious pathogenic beliefs that underly his neurotic conflicts by disconfirming them in the relationship to the therapist.

According to this thesis, the patient enters treatment with a set of adaptive goals for change which exist on varying levels of

consciousness. These goals refer to potentially achievable activities and states, and usually represent a developmentally higher level of behavior. Caston (1977) characterizes the patient's goals as "represented by some significant behavior, attitude, affect, memory, mood state, objective within an interpersonal relation, or a group of such, which the patient wishes to enjoy, employ, achieve, renounce at will, or render innocuous, but at present is unable to do so" (p. 15).

Weiss (1986b) describes the plans, purposes and goals which guide the patient in his work in therapy as typically tentative and flexible. Some goals will be of immediate concern, and thus will appear as a focus of the patient's work, while other goals will be identified as more long-term in their priority. Curtis and Silberschatz (1986) refer to the patient's plan as a "broad direction or series of directions in which the patient wishes to go" (p. 16). Just how the plan unfolds will depend on such factors as the therapist's reactions to the patient, life events, and the patient's unconscious assessment of his own immediate needs, strengths and weaknesses, or limitations imposed by the amount of time available.

Patients are thus seen to be highly motivated to gain insight into unconscious beliefs because such insight assists them in their efforts to disconfirm these beliefs. They will strive to gain insight into pathogenic beliefs as part of their struggle to overcome their crippling effects, and may do so unassisted by others -- including a therapist. Their efforts, however, are hampered by powerful psychological impediments, such as unconscious guilt and anxiety, which are very difficult to surmount by oneself, and which actually help to per-

petuate pathogenic beliefs (Bush, 1984; Friedman, 1985; Modell, Weiss, & Sampson, 1983). One of the most fundamental functions of psychotherapy, therefore, is to provide a setting which enables the patient to overcome such obstacles to examining and disconfirming pathogenic beliefs.

The Concept of Testing the Therapist

Acquisition of insight into pathogenic beliefs is facilitated by two overlapping types of interventions by the therapist -- passing tests, and making pro-plan interpretations. Testing of the therapist is a complex, principal activity carried out by the patient throughout the therapy as part of the patient's unconscious plan for achieving therapy goals (Weiss, 1986e; Sampson, 1980). The patient unconsciously tests the therapist by behaving in ways which allow him to evaluate, from the therapist's response, whether the expectations of danger inherent in his belief system are operable in the relationship with his therapist.

There are two main ways that the patient unconsciously tests the therapist: (1) by turning passive into active, and (2) by expressing transferences. In the first way, the patient treats the therapist as he had been treated as a child, and unconsciously hopes the therapist will not feel traumatized too. The therapist's lack of reaction would challenge the patient's pathogenic beliefs associated with his earlier traumatic experiences. Gassner (1986) provides the following example of how a patient would work to overcome a pathogenic belief by turning passive into active:

> Suppose a patient comes into treatment who has a childhood history of having felt repeatedly humiliated by his parents. We would assume that such a person would be likely to develop the unconscious pathogenic belief that he would hurt his parents and others, were he to feel proud and dignified. He would also be likely to feel that he would hurt his parents and others, were he to be relatively unaffected by their expressions of contempt...[If the patient] tests the analyst by humiliating him, the therapist would pass such a test by showing that he is not upset. The therapist's lack of reaction to ridicule challenges the patient's pathogenic belief that he should treat ridicule as deserved, and feel humiliated. (p. 6)

The other way that the patient tests is to unconsciously express transferences. The patient acts toward the therapist in the ways which he believed provoked traumatizing responses from his parents. By transfering, the patient unconsciously tests to see if the therapist will respond the same way his parents did. For example, the above patient might become boastful of his accomplishments to see if the therapist needs to humiliate him by criticizing his behavior or pointing out his shortcomings.

The therapist may pass tests in a number of ways that can range from remaining silent to making a highly specific interpretation. What's important is that the therapist does not impede the patient's efforts at mastery by confirming an expectation of danger based on a pathogenic belief. For example, a therapist may confront a patient for missing or being late to sessions by interpreting his behavior along the lines of passive-aggressive expression of anger. The patient's behavior may have been related to a long-standing belief that he must remain compliantly dependent on parental figures in order to maintain their love. Missing sessions may have been part of a testing process to determine, from the therapist's reactions, whether it

was safe for him to begin to defy the therapist's expectations and to begin to explore independent strivings. Should the therapist act in a way that confirms pathogenic beliefs -- in the above example, by focusing on the patient's anger in such a way that makes him feel scolded or causes him to infer that the therapist can't tolerate the patient's defiance or separation -- the patient will probably experience an increase in anxiety, guilt and defensive constriction, and be less likely to explore his beliefs. On the other hand, should the therapist interpret the patient's concern that his defiance and independent actions will destroy the therapeutic relationship, the patient might well feel reassured that he could begin to safely explore his independent and defiant strivings with the therapist.

When tests are passed, the patient's expectations of being impeded or traumatized by the therapist are diminished. He may then experience increased feelings of safety, feel less anxious, lift his defenses, and begin to experience more of the warded-off memories, impulses, feelings or ideas connected to the problem that he is trying to solve, and to gain insight into his pathogenic beliefs (Sampson, 1976).

In addition to passing tests, the second principal way the therapist helps the patient to examine pathogenic beliefs is by making pro-plan interpretations. Pro-plan interpretations foster insight into unconscious pathogenic beliefs and therapy goals either because they help the therapist pass a critical test, or because they supply information that helps the patient in his efforts to better understand his unconscious conflicts.

In responding to patient's tests, the therapist's behavior is more important than the content of what he says. In general, the therapist's style remains non-accusatory, non-judgmental, neutral and exploratory. The therapist's interpretations may implicitly or explicitly reassure the patient against some perceived danger in the transference, but not suggest the content of insight. At other times, the therapist may offer specific explanations of the patient's behavior based on the therapist's empathy and clinical experience. However, if the therapist persists in forwarding ideas which are irrelevant, incorrect, or which confirm pathogenic beliefs, the patient will be less likely to begin developing insight into his pathogenic beliefs. Should the patient adopt false propositions from the therapist, his functioning will not improve, and in fact it may worsen.

Insight into pathogenic beliefs during therapy is thus not simply the result of an interaction wherein ideas are put forth by the therapist and adopted by the patient. Insight into pathogenic beliefs that the patient has held for years implies that they are being re-examined in the light of more mature cognitive functioning and broader interpersonal experience, and in the context of a facilitative therapeutic setting.

The Relationship of Control Mastery Theory to Object Relations Theory

To briefly summarize, Control Mastery Theory attributes therapeutic progress to a process wherein the patient tests out unconscious

pathogenic beliefs in the relationship with his therapist. The therapist's main task is to understand the patient's unconscious goals, and to create conditions of safety that allow the patient to lift defenses, and begin to experience and resolve repressed conflicts. The therapist accomplishes this primarily by passing the patient's tests -- that is, the therapist responds to the patient's behavior differently than had earlier parental objects, whose responses had traumatized the patient. As discussed above, the idea that a patient can lift his own defenses to allow unconscious material to come into awareness is rooted in Freud's signal theory of anxiety, and has been further developed by later analysts.* In addition, Control Mastery ideas of how the patient-therapist interaction promotes change are consistent with ideas found in Object Relations theory.

Loewald (1960), for example, suggests that the patient is able to become aware of and to re-experience his childhood anxieties and conflicts only when the analyst "makes himself available for the development of a new object-relationship between the patient and the analyst" (p. 17). This new object relationship begins when the patient reveals his "true form" that is hidden behind neurotic distortions:

> The patient, by revealing himself to the analyst, provides rudiments of such an image through all the distortions--an image which the analyst has to focus in his mind, thus holding it in safe keeping for the patient to whom it is mainly lost. It is this tenuous reciprocal tie which represents the germ of a new object-relationship. (p. 18)

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*See Chapter 2, "New Psychoanalytic Perspectives on Insight."

Referring to Freud's use of an artistic metaphor by Leonardo da Vinci, Loewald states that analysis does not produce change by adding something to the patient, as when a painter adds oils to canvas. Rather, the analyst works more like the sculptor to create a figure by taking something away; analysts "bring out the true form by taking away the neurotic distortions" (p. 18).

Loewald thus strongly implies that the patient does not enter treatment solely to gratify infantile impulses, or to avoid awareness of his unconscious trends. Rather, he suggests that the patient, from the very beginning, holds an image of who he would like to become, and that the therapist's task is to become aware of that image and to assist the patient in removing the neurotic distortions that inhibit its development. Such a point of view is consistent with the Control Mastery idea that the patient has unconscious goals of what he would like to accomplish during his treatment, and that therapeutic success is dependent on the therapist correctly empathizing with and facilitating attainment of those goals.

Key elements of Kohut's (1977) description of the therapeutic process are also similar to Weiss's ideas concerning the etiology of pathology, unconscious planning, and testing of the therapist. Like Weiss, Kohut argues that pathology stems from faulty parenting and other traumas that distort a person's sense of self and compel him to abandon developmental goals and aspirations. Although Kohut does not refer to the patient having an "unconscious plan" for therapy, he clearly believes that the disruptions of the patient's developmental sequences caused by early trauma predetermine the course of treatment.

The therapist's interventions must be based on empathy with indications from the patient of where he needs to go, and must facilitate the patient's progress, which will begin to unfold along predetermined lines if not inhibited or blocked:

> The specific course [analysis takes] and the specific remedial solution ultimately reached by it [are] pre-determined. The essential transference (or the sequence of essential transferences) are defined by preanalytically established internal factors in the analysand's personality structure, and the analyst's influence on the course of the analysis is therefore important only insofar as he - through interpretations made on the basis of correct or incorrect empathic closures - either promotes or impedes the patient's progress on his predetermined path. (p. 216)

According to Kohut, transference essential for cure centers on the reactivation of developmental goals that were left unattained as a result of early trauma. Kohut characterizes the patient-therapist interaction as one where the therapist strives to recognize and support aspirations of the nuclear self that were abandoned because of early trauma and that are re-expressed in the analytic situation. The reactivated parts of the self are kept alive largely in the person of the analyst who confirms their existence in the patient's own mind by communicating both his awareness of the patient's aspirations, and of the traumatic effect of early failures to have them validated. The therapist thus becomes a "self-object" for the patient:

> The precariously established self of the child (as revived in the analytic situation) depends for the maintenance of its cohesion on the near-perfect empathic responses of the self-object. In harmony with the developmental stage of its self, the child demands total control over self-objects' responses; it demands perfect empathy, both in the content of the understanding that is offered and with regard to the perfect intuness with the traumatic effect produced by deviations from

the optimum which for early self is the expected norm. (p. 91)

Both Weiss and Kohut thus emphasize that the therapist must respond empathically to the patient's attempts to overcome the effects of early trauma on developmental strivings. For Kohut, the therapist confirms the patient's re-emerging aspirations (and thus advances the treatment) by becoming the "idealized self-object" who keeps the patient's visions alive by mirroring them, and who does not re-traumatize the patient by acting like past objects. Weiss also stresses how important it is for the therapist both to demonstrate understanding and empathy when the patient strives to validate inhibited aspirations, and to avoid recapitulating early traumas, but construes the therapist's behavior in terms of failing or passing the patient's tests. Both theorists conceptualize the patient as presenting his developmental visions (or, as Loewald puts it, revealing his "true form") in a systematic, although mostly unconscious, manner.

Kohut (1977), like Weiss, stresses that the drive-defense model of mental functioning does not account for what transpires during therapy. He argues that the unconscious knowledge about which the patient strives to become aware relates to repressed aspirations of the nuclear self, rather than to repressed infantile impulses:

> When the analysand becomes enraged in consequence of our attack on this resistance, he does so, not because a correct interpretation has loosened defenses and has activated the aggressive energy that was bound up in them, but because a specific genetically important traumatic situation from his early life has been repeated in the analytic situation. (p. 90)

For both Kohut and Weiss, resistance to treatment is equated with anxiety of being re-traumatized by the therapist:

> [The] roots of resistances reach into the most deeply buried unconscious layers of the personality; the resistances are the activities of the archaic nuclear self, which does not want to re-expose itself to the devastating narcissistic injury of finding its basic mirroring and idealizing needs responded to, i.e., the resistances are motivated by disintegration anxiety. (Kohut 1977, p. 136)

In summary, both Object Relations theory and Control Mastery theory conceptualize pathology as stemming from early traumatic situations that either actively inhibit or, at minimum, fail to adequately facilitate development of one's sense of self or the ability to pursue developmental strivings. While Object Relations theory seems to focus more on the effects of trauma on pre-verbal cognitive structures, the two theories are similar both in their conceptualization of the etiology of pathology, and in their treatment implications. Both theories emphasize the clinical consequences of therapist behavior on pathological sequelae to trauma.

Empirical Research of the Mt. Zion Research Group

Many of the hypotheses advanced by Control Mastery Theory have been investigated in a series of interrelated empirical studies. Horowitz, Sampson, Seigelman, Wolfson, and Weiss (1975) demonstrated that previously warded-off mental contents (i.e., thoughts, perceptions, wishes, memories or impulses), emerged during a therapy and that it was possible to identify them. He also showed that previously warded-off contents were accompanied by anxiety when they were first

articulated in treatment, but that the patient's anxiety decreased after the therapist passed tests.

Horowitz et al. (1975) identified 12 statements in hours 41-100 of an analysis that contained contents not found in the first 40 hours (warded-off contents, or W items). Episodes containing the W items and episodes containing non-warded off themes (N items) were assigned a discomfort quotient (DQ), which reflected the amount of anxiety present based on assessment of semantic characteristics and discontinuities in patient speech. Horowitz found that W items were accompanied by higher DQ than N items, and that hours containing W items manifested a higher mean DQ than hours with N items. However, when W and N items were located in the therapy with respect to therapist neutrality in response to patient challenges, a different pattern emerged: Horowitz found that when the patient openly disagreed with, expressed anger at, or made a demand of the therapist, and the therapist responded in a neutral manner, that the DQ decreased. Horowitz considered the patient's challenges to be tests, and the therapist's neutrality to be passing the tests. He showed that hours containing such challenge/neutral-response episodes were much more likely to contain W themes, and that hours where the therapist responded in a non-neutral manner (e.g., the therapies seemed anxious or defensive, or he insulted or disagreed with the patient) contained predominantly N items. These results suggest that warded-off mental contents tend to occur following passed tests, and that passed tests tend to decrease anxiety that may be associated with bringing forth unconscious material.

Gassner, Sampson, Weiss and Brumer (1982) replicated the Horowitz study by having judges reliably identify warded-off contents in hours 41-100 of a second analysis. They also wanted to determine if the patient could bring forth warded-off contents on his own. The analyst's behavior was studied, and it was found that his interpretations referred to difficulties in talking rather than to the content of what the patient was saying. Twelve of 13 instances of warded-off contents appeared "without any previous interpretation which pertained directly or indirectly to the ideas expressed in the contents judged previously warded off." Gassner et al. (1982) then applied three concurrent measurements of anxiety (the Speech Disturbance Ration, Mahl, 1956; the Gottschalk-Gleser content analysis scale, Gotschalk and Gleser, 1969; and clinical ratings) to the 12 contents that emerged without interpretations. Gassner et al. (1982) found that the contents appeared without signs of anxiety.

Other studies also investigated immediate patient functioning in response to therapist behavior. Silberschatz (1978; 1986), examining transcripts of an analysis, was able to show that a patient became less anxious and more flexible, spontaneous, bold and positive following instances of the analyst passing the patient's test. He followed methodology utilized in psychotherapy research by Luborsky and others (cited by Silberschatz, 1978), in which an incident considered to be critical to the therapeutic process is isolated. The patient's behavior prior to the event is then compared to his behavior following the event.

Silberschatz first had two judges independently locate instances where the patient made transference demands (i.e., attempts by the patient to elicit reassurance, approval, affection, encouragement, punishment, more active participation by the analyst, or permission to be critical or angry). In all, the judges isolated 87 transference demands. A separate group of three judges idependently read the 87 segments containing transference demands, and selected a subsample of 46 segments as examples of key tests. Four psychoanalysts trained within the Control Mastery model then rated on a six-point scale (the "CM Analyst Scale") the extent to which the analyst passed or failed the patient's test; that is, the degree to which the analyst's response was consistent with the patient's "plan." Finally, the effects of the analyst's interventions on immediate patient functioning were assessed utilizing four separate patient measures: The Experiencing Scale, a boldness rating scale, a relaxation scale, and measures of eight different affects. Pre- and post-intervention segments containing approximately six minutes of patient speech were randomly presented to different groups of judges, each of whom blindly rated the patient on the above measures.

Residualized gain scores -- the variance in the post-score not predicted by the pre-score -- were calculated for each of the process variables. These residualized gain scores were then correlated with the ratings of the analyst passing or failing the patient's tests (CM ratings). The CM ratings correlated significantly ($p < .05$) with changes in Experiencing, Boldness, Love, Relaxation, Fear and Anxiety.

Silberschatz was able to to guide judges in making discriminations concerning the analyst's passing or failing the tests by utilizing a case formulation inferred during a previous study of the same case. The concept of a case or "plan" formulation was developed by the Mount Zion Research Group in order to provide clinical judges with reference points relevant to Control Mastery theory for rating segments of therapist and patient behavior on a case-specific basis. (Caston, 1977; 1986; Rosenberg, Silberschatz, Curtis, Sampson & Weiss, 1986; Curtis, Silberschatz, Sampson, Weiss & Rosenberg, 1985). Plan formulations were derived by having a number of judges who were blind to the course of treatment or to therapy outcome read the verbatim transcripts of the intake interviews and the first two therapy hours for each patient. Each judge independently made diagnostic inferrences about the patient and generated a list of the patient's goals for therapy, obstructions to achieving those goals, insights that would probably be helpful to the patient in reaching his goals, and the kinds of tests the patient would likely pose to the therapist. These broad propositions were then organized into an array of items. A second team of experienced judges reviewed the same therapy material and the lists of the first group of judges, and rated the pertinence of each item for the patient under study. Interrater reliability ratings were in the .7 to .9 range (Caston, 1986; Rosenberg, et al., 1985; Curtis et al., 1985).

The effects of therapist interpretations on in-session patient productivity during brief (16-session), dynamic psychotherapy has begun to be assessed in a series of quantitative process studies at

Mt. Zion. In a study focusing on the effects of therapist interpretations in brief psychotherapy, Fretter (1984; Silberschatz, Fretter & Curtis, 1986) identified therapist interpretations in three completed therapies. The interpretations were rated according to how compatible they were with the patient's "plan," as diagnosed by a group of independent judges who read the intake and first two hours of treatment. Fretter then measured patient progress before and after each interpretation using the Experiencing Scale (Klein et al.,1970; 1986). Fretter found that the patient's progress, as measured by the Experiencing Scale, improved as a function of the therapist making plan-compatible interpretations.

Broitman (1985) rated the segments isolated by Fretter on a generic insight rating scale (The Morgan Patient Insight Scale), and found a significant correlation between plan-compatible interpretations and global increase in insightfulness. Broitman also found a highly significant correlation between the Experiencing Scale and the Morgan Insight Scale (r ranged from .6 to .8 across three cases), suggesting that the two scales may be measuring the same variables.

Silberschatz, Curtis, Sampson, Weiss and Kelly (1987) instructed a group of judges to identify patients' tests on transcribed recordings of three psychotherapies. A second group of judges read the tests and the therapist's response to them. They rated the tests on a seven-point scale (Key Patient Test Scale, or KPT), and identified 125 tests which represented key attempts by the patient to advance his plan. The same judges then rated the degree to which the therapist passed or failed the patients' tests on the seven-point, Therapist

Passing Patient's Test (TPPT). Judges referred to a plan formulation for case-specific referents when utilizing the two scales. Patient functioning immediately following the test segments was then measured on the Experiencing Scale. In two of three cases, a significant positive correlation was demonstrated between improved patient functioning and the therapist passing the patient's tests.

In two related studies, Bugas (1986) and Kelly (1985) rated the patient's functioning on two additional process variables. Bugas presented the pre- and post-test sequence segments to judges who made blind ratings of ego functioning on the Adaptive Regression Scale (Holt, 1977). In all three cases he was able to demonstrate a significant positive relationship between the therapist passing tests and immediate increase of adaptive regression. Kelly utilized an electronic measurement of stress, Long-Term Voice Spectrum (LTS), to investigate the immediate effects of the therapist's passing or failing tests on patient functioning on three cases. He found a significant negative correlation in two of the three cases, while the third case barely failed to reach significance. His results suggest that patients experience a decrease in anxiety following passed tests.

The empirical studies carried out by the Mount Zion Research Group contribute to the development of methodology for conducting psychotherapy research on a case-specific basis, and provide guidelines for conceptualizing a clinically useful model of insight. The studies demonstrate that: (1) It is possible for clinical judges to reliably infer a patient's plan for therapy; (2) A plan formulation can reliably predict how a patient will work to achieve therapy goals;

(3) Clinical judges can reliably identify tests and determine whether a therapist has passed or failed a test; and (4) Therapist behavior (i.e., passing/failing tests) significantly affects immediate patient functioning: Following passed tests, the patient will tend to bring forth unconscious material, and to explore it in an engaging, reflective manner.

The Relationship of This Study to Previous Research

One of the purposes of the proposed study is to extend the Mount Zion studies by demonstrating that patient material following passed tests will show an immediate increase in pro-plan insights, and that pro-plan insight will tend to occur in the context of other indications of therapeutic progess, such as reduced anxiety and increased adaptive regression. The construct of "pro-plan" insight provides an important conceptual tool for defining and identifying insight. First, by focusing on the therapeutic usefulness of insight, it is possible to isolate instances where the patient is adopting false beliefs or dwelling on unpleasant weaknesses or shortcomings for masochistic or punitive purposes. Second, the idea of "pro-plan" makes it possible to predict specific insights that will be of varying therapeutic usefulness to a specific patient and to identify those insights as the therapy proceeds. The logical circularity involved in construing insight as "emotional" or "intellectual" can thus be avoided.

In addition, this study will demonstrate that it is possible to use a plan formulation to assess the clinical significance of the patient's insights in any given segment of material. This study will

attempt to show that pro-plan insights are associated with signs of improvement in immediate patient functioning, while anti-plan insights are associated with signs of lack of improvement.

CHAPTER 4

METHOD

Introduction

An overarching aim of this study is to demonstrate a model for assessing the therapeutic relevance of insight. Three primary objectives are pursued: First, this study attempts to measure the extent to which a patient's associations following instances of the therapist passing or failing key patient tests* reflect insights predicted to advance the patient's inferred plans, goals and purposes during therapy (pro-plan insight), or whether the patient's productions suggest insights predicted to impede his therapeutic work (anti-plan insight).** Second, shifts in pro-plan and anti-plan insight are assessed for the degree to which they are associated with signs of a concommitant increase or decrease in level of immediate patient functioning. Finally, an attempt is made to demonstrate that the case-specific insight scale constructed for this study is more sensitive to the immediate therapeutic effects of passed and failed tests, as defined in this dissertation, than a generic measure of insight.

A case-specific scale for rating plan compatibility of insight (Plan Compatibility of Insight Rating Scale-PCIRS) was developed for this study. Independent clinical judges applied the PCIRS to segments

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*The concept of testing is discussed in Chapter 3, pages 58-61.

**The patient's unconscious "plan" for treatment is discussed in Chapter 3, pages 56-58; the concepts of a "plan formulation," by which the patient's plan is inferred, and "pro-plan" and "anti-plan" insight are discussed below.

of patient speech immediately preceeding and following key patient tests and the therapist's response to them. Once segments of patient speech were rated on the insight scale, the insight scores were correlated with independent measures of in-session patient functioning and therapist behavior that were obtained during previous studies.

The research was carried out on transcribed recordings of a completed short-term (16 sessions) dynamic therapy ("Fran") in which the patient's tests, therapist's responses, and resultant patient functioning were identified and rated in previous research conducted at Mount Zion Hospital. These studies are described below. This study rates the plan compatibility of insight immediately following key tests in a case studied by Silberschatz, Curtis, Sampson, Weiss and Kelly (1987), Bugas (1986) and Kelly (1985).

The case was randomly selected from patients being studied in an investigation of brief psychotherapy by the Mount Zion Research Group. All patients were randomly assigned to psychologists or psychiatrists with three to five years experience in private practice. They were instructed to conduct treatment as they normally would. All therapists had been trained in psychoanalytic programs, and adhered to a psychodynamic orientation. Although no attempt was made to measure the degree to which the therapists did in fact employ psychoanalytic techniques, a careful reading of the transcripts of the treatment used in this study gave the impression that the therapist did follow psychoanalytic principles; the therapist appeared to guide interventions according to manifestations of transference, to encourage reflection upon and expression of feelings and thoughts, and to

refrain from giving advice (Luborsky, 1984).

Previous Research on the Case Studied ("Fran")

Silberschatz et al. (1987) had groups of independent clinical judges evaluate therapist and patient behavior along several dimensions, guided by a dynamic case formulation, or "plan formulation" that was inferred by a separate group of judges. The plan formulation consists of the psychodynamic formulation of goals for therapy, possible obstructions to achieving those goals, tests the patient might use and insights which would be helpful to the patient in overcoming obstructions.*

A group of judges identified tests posed by the patient on transcribed recordings of the treatment. Transcript segments containing these tests, and the therapist's responses to them, were given to a second group of judges, who rated the tests on a seven-point scale (Key Patient Test Scale, or KPT-Appendix C). The same judges also rated the therapist's responses to these key tests on the seven-point, Therapist Passing the Patient's Test Scale (TPPT -Appendix D). Interrater reliability (r_{kk}) was .78 for KPT and .83 for TPPT (Interrater agreement for KPT, TPPT, EXP and ARS is presented in Table 1). Five-minute segments of patient speech immediately preceeding the tests and five-minute segments immediately following the tests were then isolated. These segments were coded, randomized and rated for patient

*The prodecure for inferring a plan formulation is described in Chapter Three.

Table 1. Interrater Agreement for Key Patient Tests, the Degree to Which the Therapist Passed the Patient's Tests, Experiencing and Adaptive Regression (Silberschatz et al., 1987; Bugas, 1986)

Rating scale	Number of judges	r_{11}	r_{kk}
Key Patient Tests (KTP)	5	.42	.78
Therapist Passing vs Failing Pt. Tests (TPPT)	5	.49	.83
Experiencing (EXP)	5	.44	.70
Adaptive Regression (ARS)	3	.76	.89

functioning on the Experiencing Scale (Silberschatz, et al., 1987). A significant positive correlation was not obtained between immediate patient functioning (EXP-Appendix F) and the therapist passing the patient's tests (TPPT), although in other cases significant correlations have been obtained between EXP and TPPT.

In a subsequent study, Bugas (1986) presented the pre- and post-test segments to judges who made blind ratings of adaptive regression, utilizing a version of Holt's Adaptive Regression Scale (ARS-Appendix E) modified for application to a discursive or narrative format. Bugas found a significant positive relationship between ARS residualized gain scores and ratings of the therapist's passing or failing the patient's tests (TPPT) ($(r_{\underline{x}(\underline{yz})}) = .54$).

Bugas also assessed convergent validity between ARS and the Experiencing Scale, and found that, while the two did not correlate significantly on this case, they did correlate on two additional cases. He concluded that although the two measures may tap constructs which at times overlap, they are not related to the same variables,

and that both the Experiencing Scale and ARS are valuable therapy process measures.

In a third study, Kelley (1986) applied an electronic measurement of anxiety (Long-Term Voice Spectrum, or LTS), to audio tapes containing the same pre- and post-test segments studied by Bugas and Silberschatz. He found a significant negative correlation between TPPT and LTS ($r_{x(yz)}$ = -.62), suggesting that the patient experienced a decrease in anxiety following passed tests. Table 2 summarizes the correlations between TPPT and EXP, ARS and LTS.

Table 2. Semi-Partial Correlations Between Therapist Behavior, Experiencing, Adaptive Regression and Voice Anxiety: N=32 (Silberschatz, et al., 1987; Bugas, 1986; Kelley, 1985)

	Experiencing	Adaptive Regression	Voice Anxiety
Therapist Passing vs Failing Patient Tests	.08	.54*	-.62*

*$p < .05$, two-tailed test.

New Research on "Fran"

Although results from previous studies on "Fran" supported the hypothesis that the patient would experience increased adaptive regression and decreased anxiety following passed tests, and decreased adaptive regression and increased anxiety following failed tests, they were not able to demonstrate the effects of therapist behavior (passing or failing tests) on the patient's insight, as measured by the Experiencing Scale. It is postulated that the Experiencing Scale (which is considered to measure the degree to which a patient is able

to freely explore relevant ideas and feelings resulting in increased self-awareness and insight) did not reveal clinically significant shifts in insight because it is predicated on generic criteria for evaluating insightful behavior.

This study developed a case-specific insight scale (The Plan Compatibility of Insight Rating Scale), which was applied to the pre- and post-test segments of the case. The insight ratings were then correlated with ratings of therapist behavior (TPPT), ARS scores, voice anxiety scores (LTS) and scores on the Experiencing Scale.

It was felt that the development of a patient-specific insight scale would require extensive pilot testing, and would thus be best carried out as an exploratory study on a single case. The case of "Fran" offered the advantage of providing a generic measurement of insight that could be contrasted with the case-specific measurement developed in this study.

Hypotheses

The following hypotheses were tested:

(1) The mean PCIRS residualized gain score will show a significant positive relationship with the mean TPPT score.

(2) The mean PCIRS ratings will show a significant positive relationship with the mean ARS ratings.

(3) The mean PCIRS ratings will show a significant negative relationship with with the mean LTS ratings.

(4) The mean PCIRS ratings will not show a significant relationship with the mean EXP score.

Limitations of the Study

One of the main shortcomings of this study is limitations on generalizability of findings. The phenomena under investigation are demonstrated to exist in one case. It would take many replication studies to reach an N large enough (perhaps 20 to 30) to allow findings to be generalized beyond this case. In addition, the clinical case studied was a neurotic, non-institutionalize patient, and the type of treatment conducted was short-term dynamic therapy. Findings therefore cannot be extended to patients with other types of pathology, or to different treatment settings.

Conceptualization of Insight

Traditionally, the generic term insight has been assigned multiple meanings related to various aspects of patient behavior, including self-awareness, problem-solving, or the truth value of what is being reported. The vagueness of the term has diluted its clinical usefulness. This study attempts to conceptualize insight in terms of therapeutic relevance.

In this study, insight is conceptualized to describe a certain type of self-awareness. The patient is viewed to be in conflict between two major belief systems. The first is adaptive, more responsive to current reality and linked to positive unconscious goals. The

second set of beliefs is maladaptive, derives from traumatic experiences and centers around pathogenic beliefs. The patient's insight is construed to be an expression of the dynamic balance of the two belief systems, and the insight scale developed for this study attempts to directly assess the degree to which one set of beliefs gains ascendancy over the other.

The patient's work, in large part, consists of an on-going struggle to replace maladaptive beliefs with adaptive beliefs -- a task that he is highly motivated to pursue. One of the principle ways in which patients attempt to accomplish this work is by testing the therapist in order to garner evidence that will disconfirm their pathogenic beliefs and support the development of more realistic beliefs. When the therapist passes the patient's tests, the patient will relax defenses and lift repressions, and begin to become conscious of goals or pathogenic beliefs, awareness of which facilitates the patient's ability to implement his inferred plan for attaining therapy goals. Conversely, when the therapist fails the patient's tests, defenses will not be relaxed, and the patient will focus on pathogenic beliefs and other false, distorted ideas to characterize himself or explain his behavior. Such awareness will not be helpful and in fact may prevent the patient from achieving inferred therapy goals.

Pro-plan and Anti-plan Insight

"Pro-plan" insight implies increased conscious awareness of formerly unconscious anti-plan beliefs, recognition of the degree to which the patient is dominated by anti-plan beliefs, or awareness of the

irrationality of anti-plan beliefs. Pro-plan insights may call attention to experiences which contradict the patient's pathogenic beliefs, or show awareness of the patient's efforts to overcome their pathogenic beliefs through testing the therapist or through other behavior.

Patient productions that run counter to or are incompatible with the patient's plan for therapy are referred to as "anti-plan" insights. Anti-plan insights derive from the patient's irrational pathogenic beliefs and in turn support those beliefs.

Because the generic term "insight" often implies the patient has discovered a "truth" about himself, it is recognized that the term "anti-plan insight" may seem confusing. For the following reasons, however, it seems warranted in the present instance: First, "anti-plan insight" is part of the terminology of Control Mastery theorists, and therefore possesses a specific referent. Second, patients may use accurate discoveries about themselves in a punitive or masochistic manner to obstruct their therapeutic advances. Finally, both patients and therapists may phenomenologically experience awareness of anti-plan material as if it were insight.

Evaluating Insight

The term insight has commonly been used to refer to psychological understandings of oneself and others which are ostensibly valid and which are thought to facilitate positive therapeutic change. A "valid" insight traditionally refers to one that is consistent with the therapist's theory about the patient's psychopathology. Patient ideas that do not agree with the therapist's view of the case may be

treated as pseudo insights that function as defensive rationalizations or resistances. Insights which, from their content, appear to be valid but which are not associated with signs of therapeutic progress are usually considered to be intellectualizations, i.e., apparent understandings, that are defensively isolated and lack emotional conviction.

In the past it has been difficult, if not impossible, for therapists to specify in advance when a patient's verbalizations constitute insights which should be associated with other indications of therapeutic progress, and when they constitute empty intellectualizations or defensive rationalizations that should not be associated with therapeutic progress. From the perspective of Control Mastery theory, the patient's work in therapy can be viewed as an ongoing effort to replace irrational pathogenic belief systems by more realistic adaptive belief systems. In other words, the patient's therapeutic work can be conceptualized as a continual struggle to replace anti-plan insights with pro-plan insights.

Rather than contrasting pro-plan insights with patient cognitions which represent defensive intellectualizations or rationalizations, as has traditionally been done in the clinical literature, they are instead contrasted with patient cognitions which impede progress towards reaching therapy goals and reinforce pathogenic beliefs. In other words, the crucial distinction focused on here is not whether an apparent insight is being used in the service of mastery or resistance, but whether the patient's cognitions are conducive to or obstructive of his efforts to carry out his unconscious plan for

therapy.

This study focuses on subprocesses related to self awareness, and on microscopic shifts in insight associated with the patient's advances and retreats during individual therapy sessions. Insight is conceptualized to be a continuous variable, rather than as a sudden, dramatic awareness of previously unconscious material, and therefore can be rated on almost any section of patient speech.

Insight is conceptualized as an expression of the degree to which the patient is able to form cognitions that help him to overcome pathogenic beliefs and become aware of goals and positive developmental strivings. In this scheme, the central, overriding feature of a patient production in determining its status as insight is the degree to which it represents knowledge, or the attempt to acquire knowledge, which could facilitate the patient's ability to achieve his therapy goals.

In a given episode of speech, a patient will typically express both pro-plan and anti-plan ideas. The various elements may be dynamically influenced by opposing elements, or by other factors arising from the patient-therapist interaction. Pro-plan ideas may be subject to repression should they be accompanied by guilt or anxiety; anti-plan material may be sustained or used to undo pro-plan ideas if the patient feels unsafe in the therapeutic situation. The overall level and direction of insightfulness of patient productions represent a global evaluation of the content and relative salience of the various elements.

When evaluating the overall clinical significance of a segment, such factors as the degree to which the patient sustains and develops an idea, the amount of conflict he manifests about it, or the extent to which his statements seem ego-syntonic or dystonic are assessed. For example, the patient may make pertinent pro-plan statements, and then go on to elaborate on them (a strong pro-plan rating). Or, he may retreat by undoing his initial pro-plan statements, thus weakening the pro-plan rating, perhaps to the point where the segment warrants an anti-plan rating. The patient may make anti-plan statements without hesitation or conflict, resulting in a strong anti-plan rating. Conversely, he may express anti-plan material not so much in the sense of "this is me," but rather with an objective quality that suggests he is moving toward becoming aware that he has held a particular pathogenic belief about himself, or of the irrational nature of the belief. Depending on how ego-dystonic the anti-plan material seems, such a segment could receive an insight score ranging from mildly anti-plan to pro-plan.

In summary, insights are construed to be complex thought processes which typically reflect both pro-plan and anti-plan elements. However, each episode of patient speech under investigation manifests a global, overall clinical significance which can be rated on a continuum ranging from pro-plan to anti-plan. Exceptions occur if the segment is dependent on preceeding material to make sense, in which case it may appear ambiguous or meaningless. In addition to establishing whether content is pro- or anti-plan, it is also necessary to assess the dynamic relationship among the various elements

that contribute to whether the segment as a whole represents cognitions that are likely to help advance or to obstruct the patient's work in therapy.

The Plan Formulation makes it possible for this study to use a content-oriented approach to identify insight. Insight is identified and categorized by comparing the content of what the patient says to the content of therapy goals and pathogenic beliefs inferred in the Plan Formulation. Once the content of the various elements is established, the segment is rated on a five-point ordinal scale, The Plan Compatibility of Insight Rating Scale (PCIRS), which was developed to rate patient productions on a continuum that ranges from "Strongly Anti-Plan" (-2) to "Strongly Pro-Plan" (+2). The PCIRS is used in conjunction with inferred goals and obstructions specific to the case, and delineated in the Plan Formulation, to help raters make qualitative and quantitative judgments regarding the content and dynamics of each segment. The PCIRS directly attempts to assess the dynamic balance of the two belief systems, and to measure the degree to which pro-plan insight gains ascendency over anti-plan insight.

In this study, considerations of whether an insight is intellectual or emotional are not considered to be reliable signs for evaluating patient productions, and in fact may be misleading and confusing. Traditionally, intellectual insight implies a defensive isolation of emotion in order to avoid awareness of a wish or fantasy, the gratification of which is unconsciously desired.* Pathogenic beliefs are not

*From the Control Mastery frame of reference, defensive use of isolation by the patient may be therapeutically progressive, depending on the context. For instance, the patient may isolate affect in order to

wishful fantasies, but function as inhibitions that the patient would like to be rid of.

A patient's emotional reactions to or during productions of insight may vary according to a number of interrelated factors. A patient may, following a series of passed tests, express an insight, and, in the context of increased feelings of trust and safety, do so in a bold, confident manner. On the other hand, the patient may express an insight in the context of testing the therapist, and therefore appear more constricted, anxious or tentative. A patient may express a range of emotional responses in the context of expressing either pro- or anti-plan insights, since his affective state is governed by a number of factors, and is not necessarily related to the content of the patient's cognitions. In general however, the patient will tend to be less anxious and more involved with material when manifesting pro-plan insight, and more anxious and constricted when producing anti-plan insights.

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protect himself from the negative therapeutic effects of an anti-plan intervention by the therapist. Or, he may utilize isolation in order to help him begin to accept insight into trauma, that is, an intellectual understanding may present the idea in an attenuated form that allows the patient to titrate the experience (M. Bush, personal communication, April 5, 1987).

Similarly, the fact that a patient says the right things but manifests only small signs of improvement, would not be construed as an "intellectual insight," in the traditional sense. Assuming the plan formulation for the case was correct, such an event would likely be attributed to the patient being too guilty to allow himself to benefit from pro-plan insights and to have a better life. This situation would be analyzable and the guilt would have to be worked through. Another patient who has experienced extreme hypocrisy might not trust the therapist's pro-plan behavior, assume he has ulterior motives, and expect eventually to be undermined by him; this patient might also experience little benefit from pro-plan insights until issues of trust were further worked through.

Procedure

The procedures for implementing research proposed by this study involved the following steps: (1) pilot-testing the PCIRS, (2) writing and field-testing a manual of instructions for judges, (3) preparing experimental segments and presenting them to judges for rating on the PCIRS, (4) establishing reliability and validity of the PCIRS, (5) correlating PCIRS ratings with TPPT, ARS and LTS and (6) comparing PCIRS correlations with results obtained utilizing a generic measurement of insight, the Experiencing Scale.

Pilot Study

A pilot study was conducted by this experimenter on the case to be investigated. After studying the intake and the Plan Formulation, the pre- and post-test segments were randomly rated on the PCIRS. All ratings were made blind to TPPT scores and to corresponding pre- or post-segment insight score. A high significant correlation was found between post-test PCIRS scores and TPPT scores (r = .581) and with the Adaptive Regression Scale (r = .565). A semi-partial correlation (residual gain score), which gives a more direct measurement of the effects of therapist behavior on insight by partialling out the effects of the pre-PCIRS score, yielded even more highly significant results ($r_{x(yz)}$ = .654). In addition, a significant negative correlation was found between post-test PCIRS scores and Kelly's measurement of voice anxiety (r = -.476). All correlations were significant at the .001 level. Finally, no significant correlation was found between PCIRS and EXP (r = -.086). These correlations are summarized

Table 3. Pilot Study: Post-test Pearson Product-Moment Correlations Between Insight, Therapist Behavior, Adaptive Regression, Experiencing and Voice Anxiety, and Semi-Partial Correlation Between Insight and Therapist Behavior (N = 32)

	TPPT	ARS	EXP	LTS
Insight (PCIRS)	.58*	.56*	-.09	-.48*
Insight shift (residualized)	.65*			

*$p < .001$, two-tailed test.

in Table 3. Results of the pilot study supported the hypotheses to be tested, and demonstrated the feasibility of having judges rate segments for plan-compatibility of insight using the PCIRS and a plan formulation.

Writing the Manual for Rating Plan Compatibility of Insight

The manual of instructions includes the case history, a plan formulation, guidelines for rating insights, sample and practice insights, rating sheets and therapy segments. The Plan Formulation, was diagnosed by the Mount Zion Research Group from the intake hour and first two therapy hours. Judges inferred the Plan Formulation without having read the transcripts of the remaining therapy, and were unaware of the course or outcome of treatment. A description of the process by which the plan was inferred is found on page 70.

The case history included with the Plan Formulation was considered too brief to adequately acquaint judges with case characteristics that would enable them to make complex insight ratings. It was therefore expanded using information from the intake hour. The Plan Formulation was then elaborated by adding categories of pro- and

anti-plan insights. These insight themes were generated to assist judges in rating plan compatibility of insight during the 16 therapy hours. In addition, 14 insight episodes were identified in the intake hour and used in the manual as sample insights that illustrate pro- and anti-plan ratings, and to provide practice insights on which judges could become more familiar with case material and gain experience rating insight. The manual of instructions for "Fran" is included in Appendix A.

Initial Field Testing of the Manual and Scale

The manual was initially field tested by having an experienced clinician read it and rate the nine practice insights. The experimenter then met with the tester and discussed his ratings. In this phase, the focus was on soliciting the tester's reactions to using the manual and doing the rating task. Particular attention was given to evaluating whether the Plan Formulation helped the judge to establish referents which facilitate consistency in making ratings. Such topics as possible ambiguities in the Plan Formulation or insight categories, unclear instructions, and other difficulties in performing the rating task were discussed.

Next, a more objective assessment of the manual and the PCIRS was undertaken. After revisions suggested during the initial phase were incorporated into the manual, two new judges were asked to repeat the steps above, and then go on to rate the 58 experimental segments. The results were mixed: The two judges correlated with other (r = .631); neither judge correlated significantly with the mean TPPT score (r = .095 and .225, respectively), but they both correlated with the mean

Adaptive Regression Scale ratings obtained by Bugas (1985) at $p < .05$ ($r = .471$ and .392, respectively). In addition a raw change score was calculated by subtracting the pre-test segment insight scores from the post-test segment scores, which was then correlated with the mean TPPT score. Judge #1 obtained a correlation of -.051, while judge #2 correlated at .106. These results suggested either that no relationship existed between the therapist failing or passing the patient's tests and plan compatibility of insight, or that the manual, scale or aspects of the training did not provide adequate guidelines for rating insight.

In order to evaluate the adequacy of the manual and scale, each judge was interviewed. Particular attention was given to discussing ratings that were discrepant from the pilot ratings, but on which the two judges had shown agreement. Several possible sources of confusion were identified during these discussions.

Revising the Manual and Scale

First, it was discovered that while the manual emphasized that judges evaluate the content of what the patient said, it did not provide adequate guidelines for helping judges to evaluate the relative weight that pro- and anti-plan elements lent to a global insight score for a given segment. Although they were instructed to use their reading of the Plan Formulation to guide them in determining the "clinical significance" of the various elements, the manual left them unclear on how to accomplish this. Judges typically resorted to making a simple count of pro- versus anti-plan elements.

It was also discovered that judges had difficulty discriminating between instances where the patient was becoming aware that she held certain beliefs about herself (e.g., she is dependent, confused, unable to cope), and statements that suggested such beliefs were ego-syntonic. A related problem concerned discriminating between the patient's functioning outside therapy and how she observed her behavior within session as she reported it. For example, she may describe having been depressed, confused and making mistakes with her daughter, and then realize that her upset disrupts her ability to be a good mother and that she feels impatient with feeling depressed. The point is that she is not merely complaining of being helpless and depressed, but that she is observing those feelings with distance and objectivity and, in the latter case, becoming aware of important goals (i.e., that she wants to be a good mother), and moving toward awareness of important beliefs (i.e., that she feels guilty and tends to use feeling depressed for punitive purposes). The Introduction to the manual was therefore revised to state that insight is identified and rated according to content and considerations about the relative importance of pro-plan and anti-plan elements within a given segment, instead of emphasizing the single dimension of content. The Guidelines section of the manual and the PCIRS were then revised to make more explicit dynamic factors that were previously only alluded to in the phrase "clinically more significant." The original and revised scales are presented in Table 4.

A second major source of difficulty was located in the examples of pro- and anti-plan insights the patient might express in the Plan

Table 4. Comparison or Original and Revised PCIRS Items

ORIGINAL SCALE		REVISED SCALE	
+2.0	Material is almost completely pro-plan.	+2.0	Material is almost completely pro-plan. Patient is able to sustain or build upon pro-plan insight. No attempt is made to undo or reverse pro-plan material. Asserts pro-plan insight without conflict.
+1.0	Both pro- and anti-plan elements present, but pro-plan material is clinically more significant than anti-plan elements.	+1.0	Both pro- and anti-plan elements may be present, but pro-plan material is clinically more significant. Patient is moving in direction of pro-plan insight. Pro-plan elements show ascendancy over anti-plan elements, but some signs of undoing or discomfort are evident.
0	Anti-plan and pro-plan material are present with equal salience, or absent; Patient is not floundering, but no clear purpose or direction is evident; material appears too ambiguous to allow judgment.	0	Anti-plan and pro-plan material are present with equal salience, or absent; Patient is not floundering, but no clear purpose or direction is evident; material appears too ambiguous to allow judgment.
-1.0	Both anti- and pro-plan elements present, but anti-plan material is clinically more significant than pro-plan elements.	-1.0	Both anti- and pro-plan elements may be present, but anti-plan material is clinically more significant. Pro-plan elements are significantly undone. Patient is moving in direction of anti-plan insight.
-2.0	Material is almost completely anti-plan.	-2.0	Material is almost completely anti-plan. Patient asserts anti-plan elements without questioning them. Anti-plan material appears ego-syntonic.

Formulation, and in the instructions on how to relate the lists to the clinical material. Judges frequently misinterpreted the meaning of the insights, or applied them too literally. For example, the pro-plan insight "She would like to leave her husband" was meant to imply gradations of awareness and resolve on the part of the patient, including such thoughts as "She begins to have doubts that she wants to go back with him." After reviewing ratings with the judges, however, it became apparent that such themes as "She wants to leave him" were applied concretely, and that judges did not link the insights to variations in the case material.

The lists of insights seemed to impart a sense of definitiveness, and did not help judges to recognize movement toward or away from an insight. For instance, judges did not connect statements by the patient that she was beginning to become aware that she "didn't like many qualities" in her husband to the pro-plan insight "She recognizes her husband is immature, unmotivated and emotionally unavailable," which is stated in a much stronger, more definitive form.

The fact that insights were not always listed in both pro- and anti-plan forms also caused difficulty. For example, the pro-plan insight "She recognizes she feels responsible for her husband's moods" is not adequately expressed as an anti-plan insight in terms of her being "hopeful" that the relationship might work if she would only change her behavior. Judges failed to interpret such feelings of hopefulness as an expression of a belief that her failings were the primary cause of her marital difficulties, despite the fact that the Plan Formulation states that her "primary goal for brief therapy is to

overcome her irrational feelings of responsibility for her husbands bad moods, inadequacies, and rejecting behavior towards her, so that she can be free to reject him...and to replace him with someone better."

It was thus decided to revise the list of insights as an attempt to insure that the Plan Formulation was more fully and accurately reflected in the insight lists. This was done in a way that did not introduce new material, but rather reworded pro- and anti-plan insights so as to present the content in both concrete and more generalized terms. In all instances, the revised insights were either (1) originally expressed or strongly implied in the Plan Formulation, or (2) extrapolated by the experimenter when applying the original lists to practice and sample insights. It had been assumed that judges would extrapolate from the insight lists as the experimenter had. After discussing ratings with them, it became clear that it was necessary to spell out variations in advance. In revising the lists, pro-plan insights were juxtaposed next to a central, opposite anti-plan insight. However, no attempt was made to list all the possible pro- and anti-plan variations of a theme. Instead, an attempt was made to illustrate how insights could overlap, and judges were alerted to the problem in the Guidelines section. Examples of the original and revised list of pro-plan and anti-plan insights is presented in Table 5.

A third source of unclarity was found in the sample insights provided to illustrate use of the scale in the Guidelines Section. The purpose of the sample insights was to illustrate pro- and anti-plan

Table 5. Examples of Original and Revised Insight List

Original List	Revised List
PRO-PLAN INSIGHTS	
1. She would like to leave her husband.	1. She realizes she has doubts about wanting to get back together with her husband; part of her wants to leave him.
2. Her anger at her husband is justified by the way he has victimized the patient and her baby.	2. She begins to recognize that she feels compelled to suppress her anger; she may become aware that she believes her anger has driven her husband away; she may begin to understand that much of her anger at her husband is justified by the way he as treated the patient and their baby.
ANTI-PLAN INSIGHTS	
1. She is ill-tempered, and her anger drives others away as it has driven her husband away.	1. She feels that she should suppress her anger; she may believe her anger is primarily responsible for her husband leaving her.
2. She feels her husband's departure is a traumatic, irreplaceable loss. She loves her husband very deeply and feels a strong, spiritual bond with him.	2. She misses her husband; she feels his departure is a traumatic loss; she loves him very deeply.

ratings. Since selection of sample insights was limited to intake material, it was impossible to locate segments that adequately represented the full range of the scale. In order to achieve this end, what appeared to be a good example of a neutral segment was excerpted from the intake and altered to illustrate how the same

material might hypothetically appear as neutral, pro- and anti-plan. In addition, the initial examples from the intake were annotated to enhance their instructive value.

Finally, it was felt that many of the experimental segments were ambiguous because they lacked context, and that one possible strategy for helping judges to maintain their concentration would be to provide brief, parenthetical clarifications of pronouns. Such inclusions referred directly to concrete references made by the patient immediately preceeding the segment (e.g., "he" = "her husband;" "it" = "her feelings of anger").

In summary, after interviewing the first two judges, attempts were made to remove possible sources of ambiguity by (1) revising the Introduction to the manual to provide a clearer theoretical orientation, (2) revising the pro-plan and anti-plan insight lists to make them less extreme and more representative of variations in the concreteness of themes, (3) revising the Guidelines for Rating Insight section of the manual to better explicate the steps involved in determining the "clinical significance" of pro- and anti-plan elements within a segment, (4) revising the scale to reflect points in the Guidelines, (5) hypothetically altering a segment excerpted from the intake to illustrate the full range of the scale, (6) annotating all sample insights in order to illustrate how the Plan Formulation and the PCIRS were applied to arrive at ratings, (7) clarifying pronouns within the segments, and (8) reorganizing material in the Plan Formulation to emphasize the narrow focus of short-term treatment.

Final Field Testing of the Manual and Scale

The revised manual and scale were given to two new judges, an experienced Control Mastery therapist, and a clinical graduate student who was unfamiliar with the theory and who held a contemporary, but more traditional Freudian point of view. The Control Mastery judge correlated significantly with the process variables: His raw change score correlated .393 ($p < .05$) with TPPT, and the post-test PCIRS score correlated .539 with TPPT and .592 with ARS ($p < .01$,). The judge who was naive to the theory obtained insignificant correlations: The raw change score correlated .080 with TPPT, and the post-test PCIRS score correlated .155 with TPPT and .336 with ARS. Neither judge correlated with the Experiencing Scale (-.058 and -.265, respectively), which was predicted. The two judges ratings correlated with each other at .502.

The results obtained with the revised scale suggested that the study was feasible. Although the naive judge did not produce significant correlations, his results were in the predicted direction. More importantly, the mean scores of the two raters produced favorable correlations: The mean raw change score correlated .307 with TPPT, and the mean post-test PCIRS ratings correlated .411 with TPPT and .542 with ARS ($p < .05$ and .01, respectively). Since from eight to ten judges were to be used in the study, it was expected that their mean PCIRS ratings would correlate significantly with the other process variables. The product-moment correlation of .502 indicated that an acceptable intraclass correlation could be expected from a pool of ten judges.

Rating Segments on The PCIRS

Experimental segments were prepared for rating according to steps described in the materials section (Transcripts and Test Sequences). Fifty-eight pre- and post-test segments of patient speech isolated by Silberschatz et al. (1987) were randomly presented to ten judges. Each judge independently rated the segments for plan relevance on the PCIRS. Before rating the experimental segments, the judges discussed their rating of the practice insights in the manual with the experimenter. This step served as a training exercise to insure that judges understood the rating task, and to establish guidelines to help reduce measurement error stemming from rater bias.

Reliability and Validity of PCIRS

Reliability of the scale is established by the intraclass correlation. The validity of the scale involves two questions: (1) Is the scale a valid measurement of insight as defined in the study? and, (2) Is the conceptualization of insight used in the study a valid one?

Since the PCIRS is based on the Plan Formulation, the first question overlaps with the issue of whether or not the Plan Formulation is therapeutically valid. To the degree that the empirical findings support what the Plan Formulation predicts about the patient-therapist interaction, both the Plan Formulation and the insight scale have demonstrated predictive power. A measure of construct validity has been obtained in that pro- and anti-plan insight, as defined in the study, correlate positively and significantly with the Adaptive Regression Scale, which measures cognitive functioning widely reported

in the clinical and theoretical literature to be a necessary concommitant of insight.

Analysis of Data

Statistical analysis of judges' ratings was accomplished in four steps. First, judges' PCIRS ratings were correlated to establish interrater agreement and reliability of the scale. Since insight is conceptualized to be a continuous variable, reliability data was assessed using the intraclass correlation (Ebel, 1951; Guilford, 1954; Shrout & Fleiss, 1979) with the residual mean square as the error term. The estimated reliability of k judge's ratings (r_{kk}) was reported.

Second, the relationship between the effects of the therapist passing or failing the patient's tests and plan compatibility of insight were assessed by computing the mean residualized PCIRS gain score, which was then correlated with the mean TPPT score. The residualized gain score reflects the change in insight ratings between the pre- and post-test segments, and provides a measurement of the variance of the post-test insight score not predicted by the pre-test insight score. This procedure is referred to as a semi-partial correlation ($r_{x(yz)}$): Cohen & Cohen, 1975; Beutler & Hamblin, 1986). The semi-partial correlation measures the extent to which each type of therapist behavior (i.e., passing or failing the patient's tests) facilitated, inhibited, or had no apparent effect on production of insight.

The relationship of plan compatibility of insight to other measures of immediate patient functioning was accomplished by correlating the mean PCIRS scores of the judges with the mean ratings on the two process variables; a Pearson product-moment correlation was computed between PCIRS and the Adaptive Regression Scale, and between PCIRS and Kelly's measurement of voice anxiety (LTS).

Finally, the increased power of the patient-specific PCIRS in measuring insight over a generic insight scale was tested. Correlations involving TPPT, ARS and LTS obtained using the PCIRS were contrasted with those obtained using the Experiencing Scale, and EXP was correlated with PCIRS.

Data are illustrated on plots and graphs that were generated utilizing a data analysis and graphics software system (Becker & Chambers, 1984), and plotted on a Calcomp Model 1051 Drum Plotter.

Subjects and Therapists

Patients

Research subjects were selected from patients applying for psychotherapy at the outpatient clinic of Mount Zion Hospital and asked to participate in a brief psychotherapy research project (N.I.M.H. Grant 35230). Potential subjects were screened by an independent evaluator for suitability to brief, dynamically-oriented psychotherapy according to minimal acceptance criteria (Silberschatz, Fretter & Curtis, 1986) in order to avoid selection of only highly motivated, optimal cases. Selection criteria included history of

positive interpersonal relationships, no evidence of psychosis, organicity, mental deficiency, chronic substance abuse, or suicidal or homicidal ideation. In diagnostic terms, patients accepted for therapy suffered from neurotic and character disorders (including DSM III diagnoses of dysthymic and cyclothymic disorders, anxiety disorders, somatoform disorders, and psychosexual disorders). Subjects represented diverse socioeconomic and cultural backgrounds. All therapies were audio-recorded.

Therapy outcome was assessed by measures taken at several time intervals (pre-therapy, post-therapy, six month follow-up, one year follow-up). The following outcome measures (as cited by Silberschatz, et al., 1986) were employed: Target Complaints (Battle, Imber, Hoen-Saric, Stone, Nash & Frank, 1966); Symptom Checklist 90R (Derogatis, Lipman, Rickele, Uhlenhuth, & Covi, 1974); Global Assessment Scale (Endicott, Spitzer, Fleiss, & Cohen, 1976); Brief Psychiatric Rating Scale (Overall & Gorham, 1962); and a global scale that assesses overall degree of improvement or deterioration.

Case Investigated

Fran was a 28-year-old married woman who sought therapy because of her upsetting reaction to her husband having left her and their three-month-old baby. She was shocked that he would leave their child which he had said he wanted, angry that he wouldn't try to work things out, and deeply hurt. She feared that part of the reason he left her was her bad temper. She also felt that whatever she did put him in a bad mood, and that despite her best attempts she could never alter his unpleasant disposition. She felt disappointed in him because he was

very passive, unmotivated, unexpressive and unable to take any initiative in their sexual relationship. The patient entered therapy with the expectation that the therapist would challenge her "rationalizations," and help her "deal with the pain and the anger."

The "plan diagnosis" for this case formulated the patient's primary goal for brief therapy as overcoming her irrational feelings of responsibility for her husband's bad moods, inadequacies, and rejecting behavior towards her, so that she could feel free to reject him, enjoy being a good mother, replace him with someone better, and get on with her life. Her core conflicts centered on feelings of guilt at surpassing and being happier than her mother.

It should be noted that the plan for this case was formulated with individual therapy in mind. It therefore does not approach treatment goals from a systems perspective. However, this does not imply that Control Mastery theory undervalues the importance of how two people can co-determine dynamics in a relationship. Gassner (1986), for example, gives this account of how the humiliated patient discussed earlier (page) could become caught up in an interplay with parents that would perpetuate their neurotic patterns:

> It is quite possible that such a patient has a distorted or exaggerated view of his parents' motives. Whereas his parents may have been trying to provide guidance to help him develop his strengths, the patient may have assumed that they were getting pleasure out of saying things which resulted in his feeling small. Often there are misunderstanding between parents and children which perpetuate neurotic dynamics. If such a patient unconsciously believes that it makes his parents feel important to have opportunities to correct him, he may continue to have an unconscious need to make himself look foolish. This may heighten the parents' efforts to call attention to and correct their child's foolish behavior. From case to case, the relative importance of reality factors and

> projections will vary as contributing determinants leading to the patient's experience of his subjective reality. (p. 6)

A complete case formulation is presented in the Plan Formulation, which is located in the Manual of Instruction to Judges, Appendix A.

Therapists

The therapists used in the Mount Zion studies were psychologists and psychiatrists who had at least three years of private practice experience, including brief psychotherapy, and who worked from a psychodynamic orientation. They were given no information about the patients other than that they had been screened and accepted for brief therapy. The case reported was studied after completion of treatment.

Materials and Judges

Transcripts and Test Sequences

Transcribed recordings of a completed brief therapy of 16 sessions plus an intake hour, and 58 pre-test/test/post-test sequences were made available for this study by the Mount Zion Research Group. The test sequences were received on floppy diskettes and transferred onto a mainframe computer (VAX 11/750 running UNIX 4.2). Once transferred, the segments were sequenced by assigning numbers from a random number table, coded and printed.

Judges

Raters were recruited primarily from clinical psychologists, psychiatrists and advanced graduate students associated with the Mount Zion Research Group.

Discussion of Instruments

Adaptive Regression Scale (ARS)

The Adaptive Regression Scale (ARS) was developed by Holt (1977) to measure the extent to which a person can experience and integrate unconscious material for problem-solving purposes. The scale accomplishes this in two steps: (1) It rates the degree to which unconscious material (manifestations of libidinal and aggressive impulses, and condensations, displacements and symbolizations) compels the subject to take defensive measures to make the response socially acceptable (Defense Demand); and (2) It rates the effectiveness with which the subject regulates anxiety while remaining involved in the therapeutic task (Defense Effectiveness) (Bugas, 1985). These two elements are then assigned a global score (ARS). At one end of the scale, the person is rated as having large amounts of primary process and good control, while at the other level, subjects have large amounts of primary process and poor control.

Bugas (1986) adapted the Holt measure to therapy transcripts, and had three clinical judges independently apply the ARS to 90 five-minute segments of patient speech. Reliability coefficients for Defense Demand and Defense Effectiveness ranged from .72 to .82.

Experiencing Scale (EXP)

The Experiencing Scale (Klein et al., 1970, 1986) is among the most widely-used psychotherapy process rating scales. Derived from a Rogerian client-centered framework, this seven-point scale is thought to tap such constructs as insight, patient involvement, lack of resistance and free association.

The Experiencing Scale measures the extent to which the patient attends to inner referents, as opposed to being concerned with data about phenomenon external to the therapy or to the patient's own feelings. The scale consists of seven "stages" that define different levels of patient involvement with inner referents (Appendix F): At stage one the patient's manner of expression or content is impersonal, abstract, general or journalistic. At stage two the patient is more involved with inner referents, but at a superficial level. Externalized or limited references to feelings are made in stage three. Stage four is seen to mark a crucial transition point where content and focus shift from external events or abstractions, to giving a clear personal presentation of feelings about the self. Stages five to seven define the progressive elaboration, exploration and expanding awareness of feelings and internal processes.

The patient's level of experiencing is indicated by grammatical, stylistic, paralinguistic and content cues. Judges are directed to assess cues such as pronouns (first person versus personal), tense (past versus present), manner of expression (remote and intellectual versus declarative and affirmative), speech fluency, affect indicators (laughs and sighs) and content (impersonal versus subjective

experiences and associations) in making judgments about the patient's functioning.

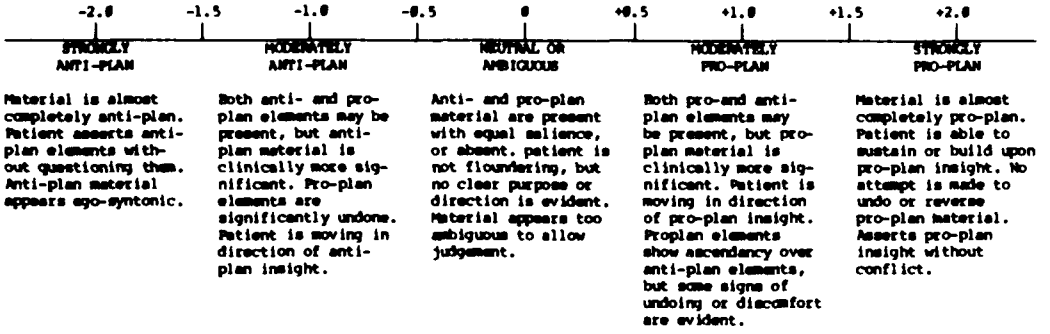
The Experiencing Scale has consistently been associated with ratings of self-disclosure, problem-expression and free association. Details of diagnoses, the patient's specific presenting complaints and the clinical or dynamic relevance of content are purposfully excluded from scale definitions and rater instructions.

Plan Compatibility of Insight Rating Scale (PCIRS)

The Plan Compatibility of Insight Rating Scale is a five-point ordinal scale that ranges from -2 to +2 (Table 6). It was developed for this study, and designed to allow raters to assign each segment a numerical value, placing the segment on a continuum from Strongly Anti-Plan (-2) to Strongly Pro-Plan (+2). At the low end of the scale, anti-plan material predominates, while at the upper end material is weighted towards pro-plan elements. Neutral or ambiguous material will fall between the two end-points of the scale. A segment could receive a rating of "0" in two ways: (1) The segment is neutral -- anti-plan and pro-plan material are either both present with equal salience, or both absent, or; (2) The segment is ambiguous. For example, a segment may appear ambiguous or meaningless because the segment is particularly dependent on the preceeding context in order for it to make sense.

The PCIRS enables judges to make quantitative judgments about segments; it is used in conjunction with the Plan Formulation which helps with qualitative judgments based on patient specific clinical

Table 6. The Plan Compatibility of Insight Rating Scale (PCIRS)



material. Reliability was established by intercorrelating the judges' ratings.

Judges were instructed to use the PCIRS in tandem with the Plan Formulation to make ratings. Judges first compared the content of a segment with the categories of pro-plan and anti-plan insight to determine the presence of pro- and anti-plan insight themes. (These categories are not definitive, but are used as a point of departure; judges were instructed to make ratings based on their reading of the case formulation provided to them.)

After getting an idea of the material contained in the segment, judges referred to the PCIRS to assign the segment a global insight score. Assigning a segment a scale value required integrated clinical judgment to determine the relative weight that the various pro-plan and anti-plan elements carry. For instance, a segment could contain three pro-plan and one anti-plan elements, but be rated as anti-plan if the rater feels that the anti-plan material is clinically more sig-

nificant than the pro-plan elements. The central, overriding criterion for rating insight is how directly what is being said relates to the goals and obstructions inferred in the Plan Formulation. Rated sample insights are found in the Manual of Instructions to Judges located in Appendix A.

Therapist Scale of Passing Versus Failing the Patient's Tests (TPPT)

This is a seven-point scale that measures the degree to which the therapist has passed or failed the patient's test, (i.e., the degree to which the therapist's behavior is linked to the patient's unconscious treatment plan). The low end of the scale is defined by an explicit, clear-cut example of failing the patient's test (Appendix D). The high end of the scale is defined by a clear-cut, explicit example of the therapist passing the patient's test. This scale has been used in previous studies, with high interrater reliabilities (Silberschatz, 1978; Silberschatz et al., 1985). Interrater reliability figures are reported in Table 1. A segment rated on the TPPT as passing the patient's test is presented in Appendix G.

Voice Anxiety: Long-Term Voice Spectrum (LTS)

The Long-Term Voice Spectrum provides a procedure for evaluating aspects of vocalizations not governed by rules of the language code, such as intonation, voice quality, rhythm and pausing. These nonlinguistic aspects of speech are considered to phylogenetically predate language, and function as a nonverbal signaling system that modulates the linguistic code and communicates emotional states (Scherer & Ekman, 1982). LTS systematically analyizes acoustic

components of speech that correlate highly with stress, emotion and psychopathology (Scherer & Ekman, 1982; Scherer, 1979, 1981a, 1981b). It is considered to be a valuable research tool for measuring stress because it is simple to implement, reduces the need to know exactly which utterances to analyze, and provides several independent parameters such as frequency and power measures (Kelly, 1985).

Voice segments are sampled 1024 times a second. A spectrum is then computed for every two-second epoch, from which the frequency and power are obtained for the highest and second-highest peaks. These four measures are then averaged over all two-second epochs for the entire segment. The frequency of the highest peak and the power of the second-highest peak tap different aspects of the power distribution. These two variables are standardized and averaged to obtain a measure of LTS for each baseline and effect segment (Kelly, 1985).

CHAPTER 5

RESULTS

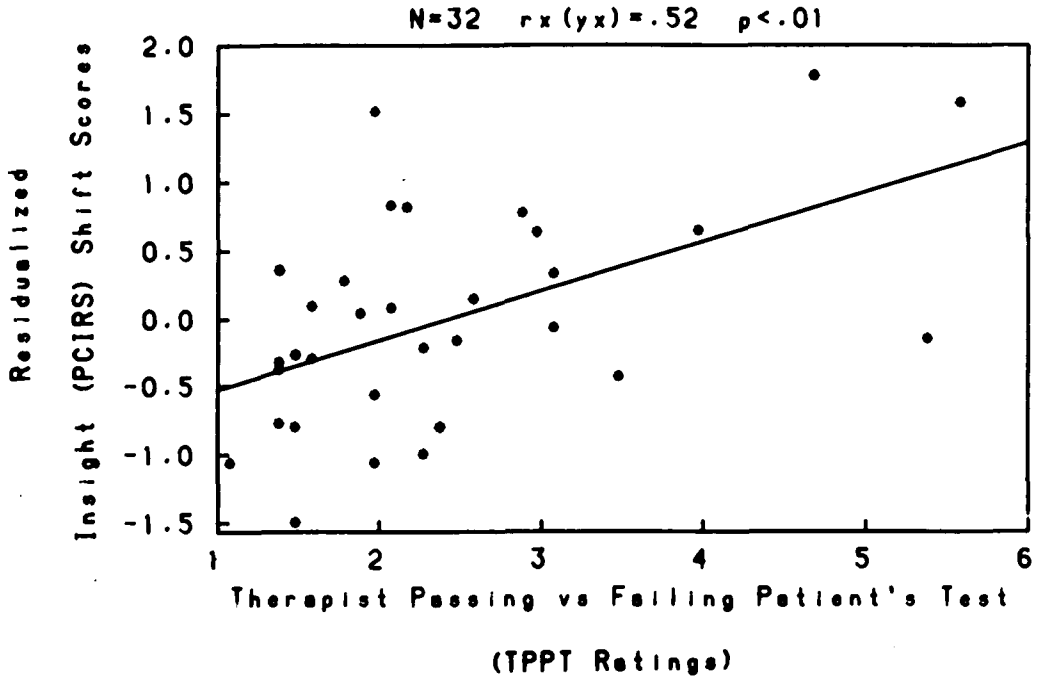
The Plan Compatibility of Insight Rating Scale is a continuous scale that was applied by judges who were interested in participating in psychotherapy research. Interjudge reliability was thus assessed through an intraclass correlation that uses a two-way analysis of variance with the residual mean square as the error term (Shrout & Fleiss, 1979).

Two indices of reliability are reported: r_{11}, which gives the estimated reliability of the average judge; and r_{kk}, which represents the estimated reliability of k judges' ratings (the equivalent of an alpha coefficient; Shrout & Fleiss, 1979). Since the mean differences in judges' ratings were not regarded as error, all data analysis utilizes the mean of the judges' ratings, and r_{kk} is the appropriate reliability index (Ebel, 1951; Guilford, 1954). The reliability for the PCIRS was high: $r_{11} = .45$ and $r_{kk} = .89$ for ten judges.

To assess the relationship between plan compatibility of insight and the therapist passing or failing the patient's test, a residualized gain score was calculated for PCIRS. This statistical procedure calculates the variance in the post-test insight score not predicted by the pre-test score (Cohen & Cohen, 1975). It yielded a semi-partial correlation ($r_{x(yz)}$) between PCIRS and TPPT of .52 ($p < .01$, two-tailed test). Shifts in scores of the plan compatibility of insight thus correlated significantly with ratings of the degree to

which the therapist passed or failed the patient's tests (Figure 1).

Figure 1. A scatter plot of mean insight (PCIRS) shift scores (residualized) and ratings of Therapist Passing Versus Failing Patient Tests (TPPT) with regression line.



When evaluating these results, it is important to keep in mind the fact that this therapist did not function well according to Control Mastery criteria: The median TPPT score was 2.1 (example of mildly failing the patient's test), and only four, or 12.5%, of key patient tests obtained a score of 4 or higher (Figures 2 and 4). None of the therapist's responses were rated as passing the patient's tests in a clear-cut manner (i.e., none received a score of 6 or higher).

Figure 2. Barplot of TPPT. A TPPT score of 3 means the therapist's behavior is either ambiguous or falls midway between passing and failing a test; scores less than 3 denote degrees of failing a test, and a score of 4 means a test was mildly passed.

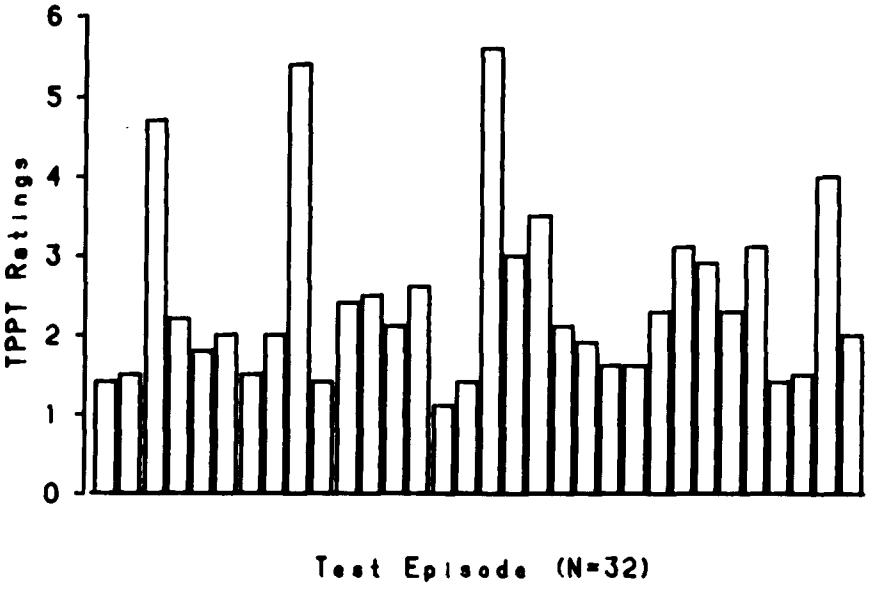


Figure 3. Barplot of PCIRS Shift Scores (residualized). A PCIRS shift score of Ø denotes no change in insight; negative ratings indicate shifts toward anti-plan insight, and positive ratings indicate movement toward pro-plan insight.

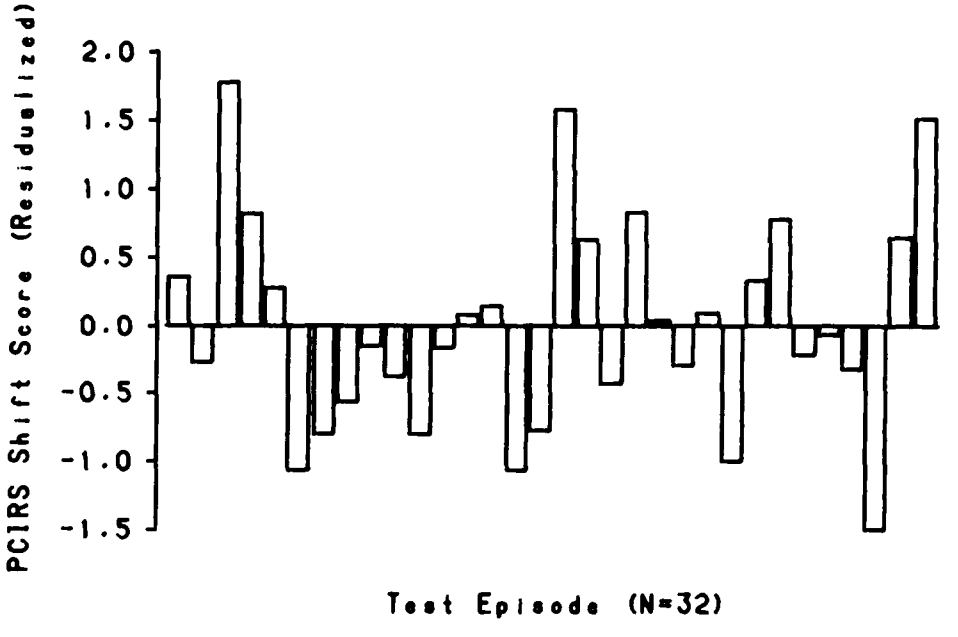


Figure 4. Histogram of TPPT. A TPPT score of 3 means the therapist's behavior is either ambiguous or falls midway between passing and failing a test; scores less than 3 denote degrees of failing a test, and a score of 4 means a test was mildly passed.

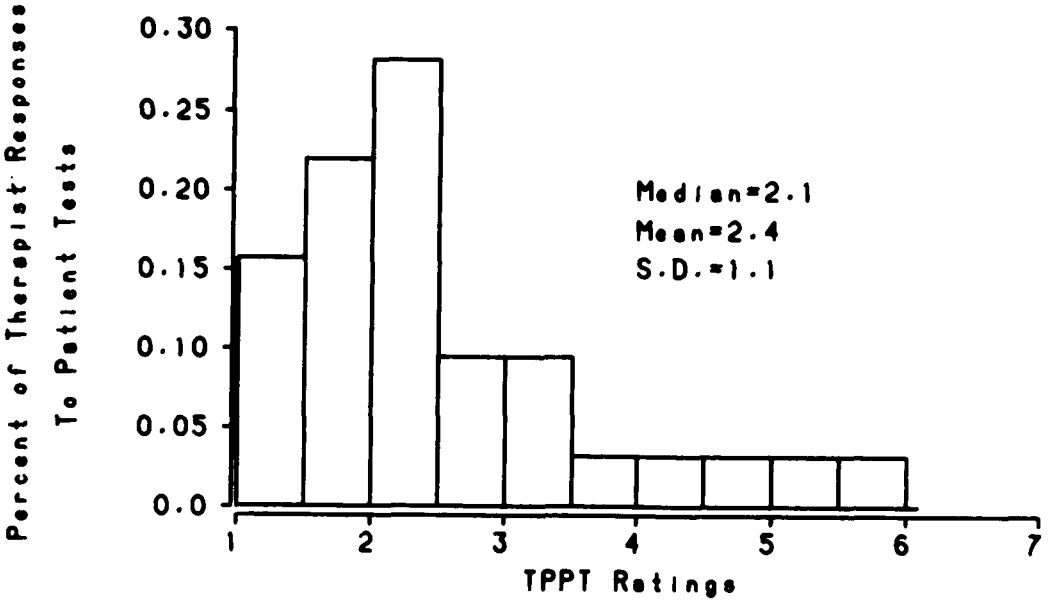


Figure 5. Histogram of PCIRS Shift Scores (residualized). A PCIRS shift score of Ø denotes no change in insight; negative ratings indicate shifts toward anti-plan insight, and positive ratings indicate movement toward pro-plan insight.

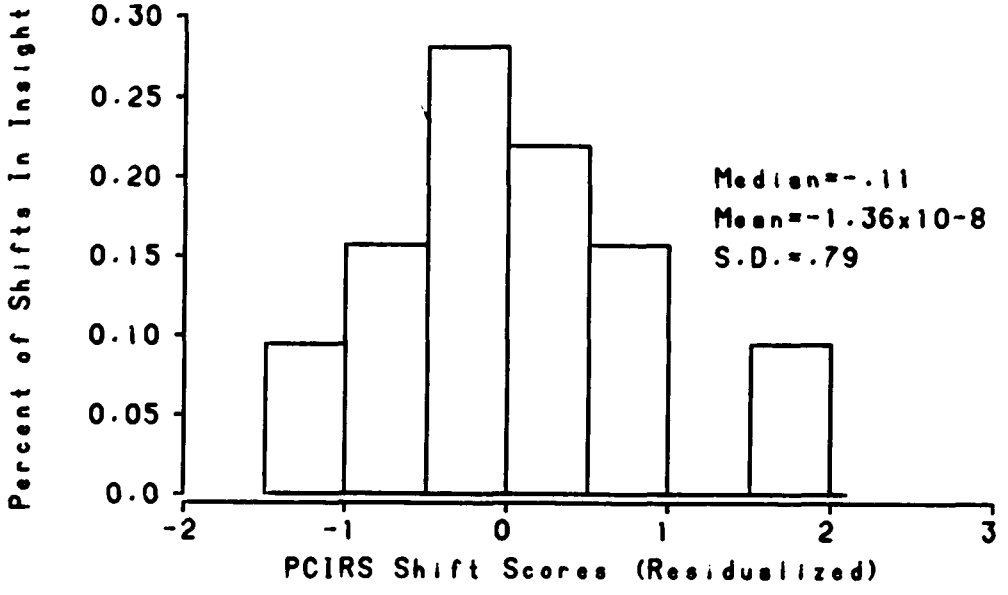


Figure 6. Barplot of PCIRS Ratings. A rating of 0 indicates the segment was neutral or ambiguous. A negative 1 is moderately anti-plan, and -2 is strongly anti-plan; +1 and +2 denote pro-plan ratings. The fist 26 plots refer to pre-test segments (six tests were made during the opening moments of a session, and were thus not preceeded by a pre-test segment), while the final 32 plots pertain to post-test segments.

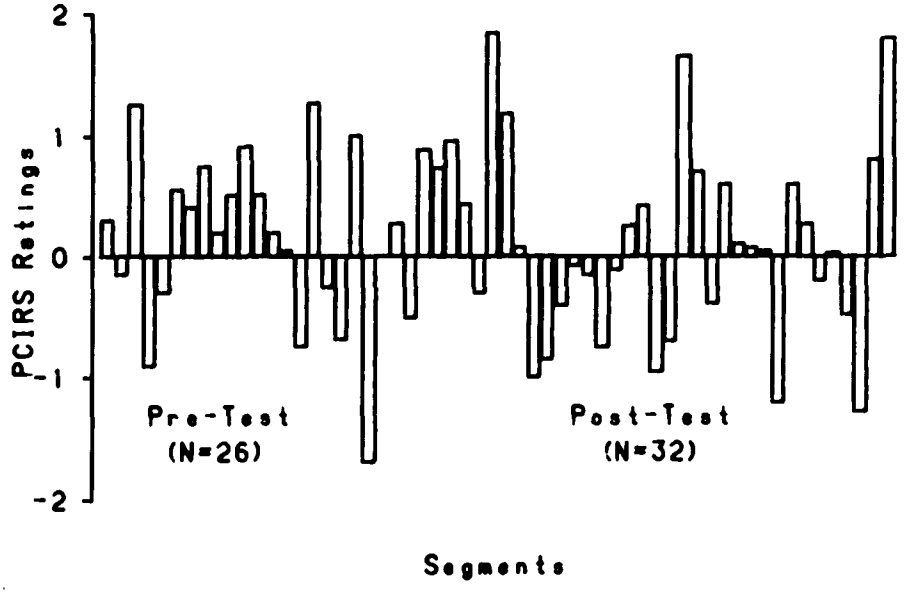


Figure 7. Histogram of PCIRS Ratings.

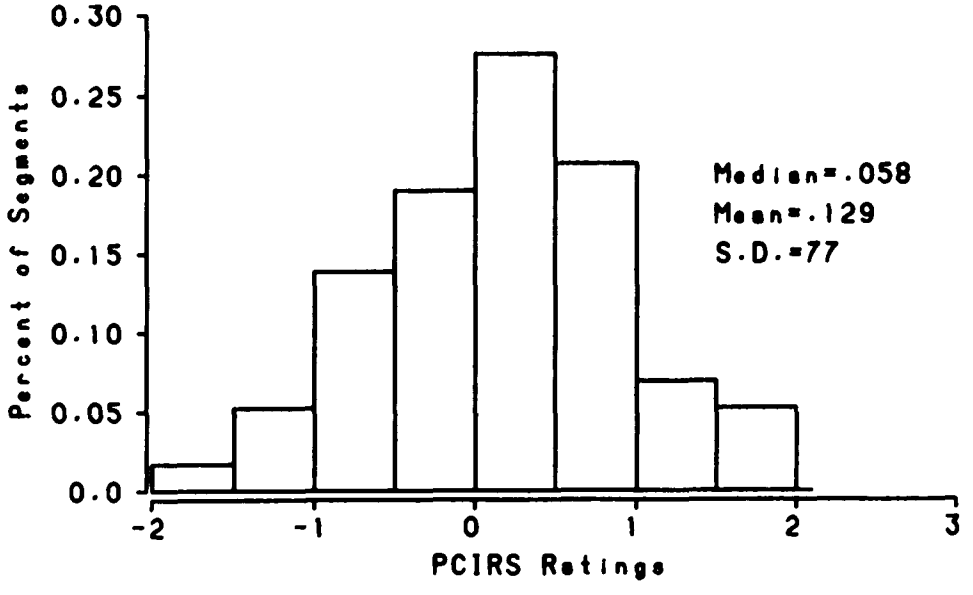


Figure 8. Histogram of PCIRS Pre-Test Ratings.

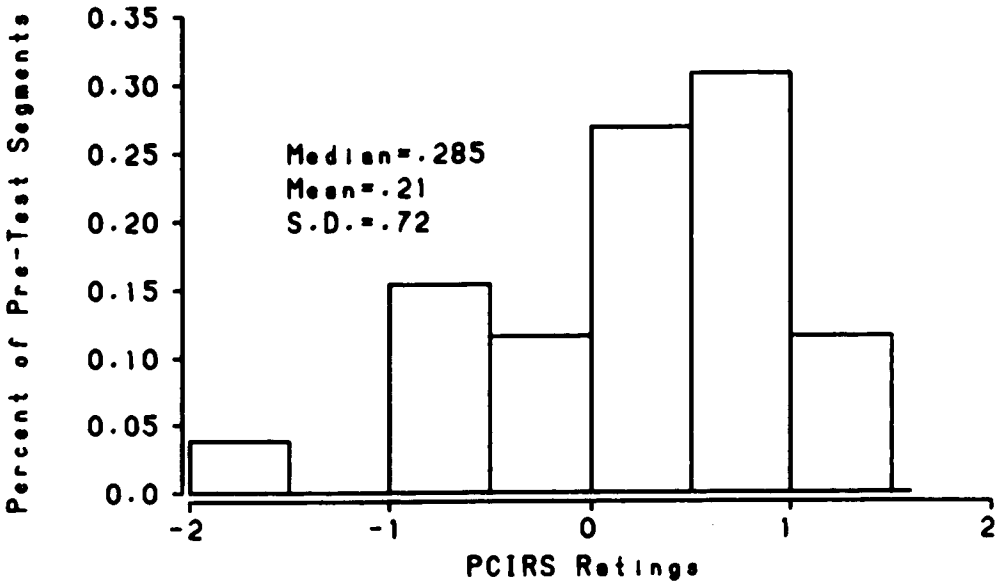
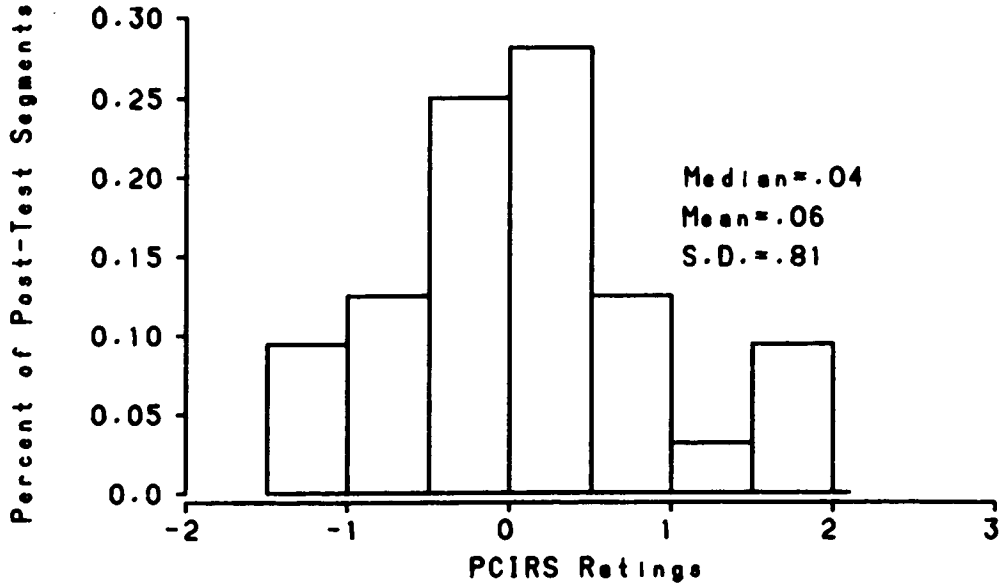


Figure 9. Histogram of PCIRS Post-Test Ratings.



Figures 3 and 5 illustrate that the patient's insight score shifted in the anti-plan direction following 17, or 53%, of the therapist's responses to her tests. The median change score was -.12, and only three, or less than 10%, of the pre- to post-test shifts were rated as moderately pro-plan or higher. Since these figures are based on residualized change scores (which measure that portion of the post-test score not predicted by the pre-test score), the shifts in insight reported here can be directly related to therapist behavior.

One would expect a consistent relationship between the therapist's typical behavior during crucial therapy moments and the patient's overall functioning over the course of the treatment; in this therapy, consistently failed tests should be associated with (at minimum) an overall low frequency and level of pro-plan insights, which indeed is the case. Taken together, pre- and post-test segments had a median PCIRS score of .058 and a mean score of .13. Twenty-three (39.6%) of the segments were rated as anti-plan, four (7%) as neutral or ambiguous, and 24 (41%) were rated as mildly pro-plan; five, or 12%, of the segments were considered to be moderately pro-plan (i.e., 1 to 1.5), and only three came close to being rated as strongly pro-plan. These findings are illustrated in Figures 6 and 7.

The relationships of PCIRS to ARS, LTS and EXP were assessed by calculating a Pearson Product-moment correlation utilizing all pre- and post-test segments; results are summarized in Table 7. As illustrated in Figure 10, the PCIRS significantly and positively correlated with adaptive regression (ARS), suggesting that pro-plan insights occur in the context of increased adaptive regression, while anti-plan

Figure 10. Scatter plots of insight ratings (PCIRS) and ratings of Adaptive Regression (ARS), Voice Anxiety (LTS), and Experiencing (EXP) with regression line.

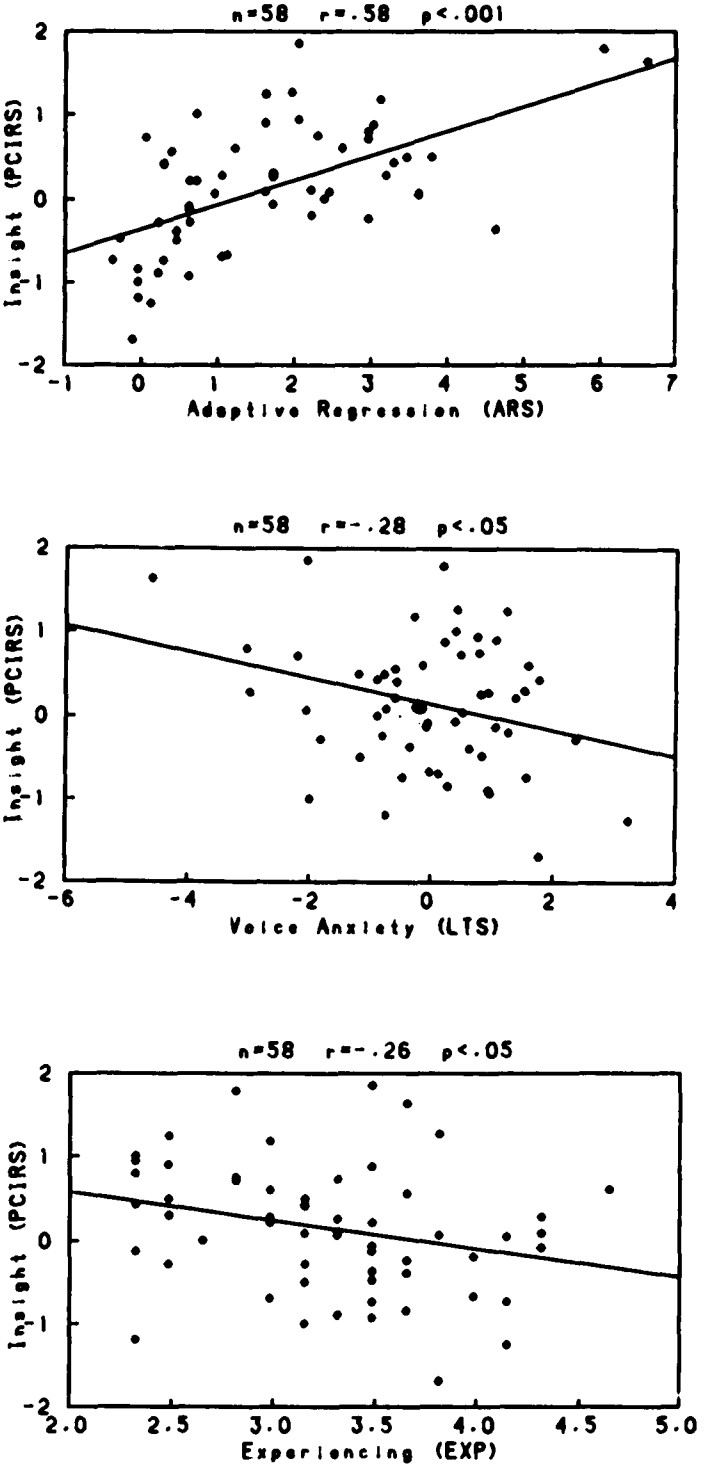


Table 7. Pearson Product-Moment Correlations Between Insight, Adaptive Regression, Voice Anxiety and Experiencing[a]

	N	Adaptive Regression (ARS)	Voice Anxiety (LTS)	Experiencing (EXP)
Pre-Test Segments Insight (PCIRS)	26	.434*	-.0003	-.383
Post-Test Segments Insight (PCIRS)	32	.711***	-.447**	-.160
Pre/Post-Test Segments Insight (PCIRS)	58	.584***	-.284*	-.264*

[a]Two-tailed test of probability

*$p < .05$
**$p < .02$
***$p < .0001$

insights are associated with decreased adaptive regression. A significant negative correlation was obtained between PCIRS and Voice Anxiety (LTS), indicating that pro-plan insight is accompanied by low levels of of anxiety, while higher levels of anxiety are manifested during the production of anti-plan insight.

A significant negative correlation was also obtained between EXP and PCIRS. Although it was predicted that PCIRS would correlate with TPPT when EXP did not, it was not thought that a significant relationship would be found between PCIRS and EXP.

At first glance, the inverse relationship between PCIRS and EXP could be interpreted to mean that when PCIRS indicated an increase in patient functioning, EXP recorded a decrease, and vice versa. However a more informative picture that underscores the relative power of a case-specific scale is revealed when the raw PCIRS and EXP scores are

examined and viewed in the light of the clinical nature and course of the case studied, and the primary constructs that EXP taps.

Of the nine segments that received a score of 4 or above on EXP, five were rated on the PCIRS as anti-plan, two were essentially neutral and two were very mildly pro-plan (Table 8). Moreover, the segments with the 11 lowest (most anti-plan) PCIRS ratings received a mean EXP score of 3.5, and none of the eight highest (most pro-plan) segments were rated on EXP as 4 or above.

Table 8. Comparison of Corresponding PCIRS and EXP Ratings

EXP*	PCIRS	PCIRS**	EXP	PCIRS***	EXP
4.0	-0.68	-0.90	3.3	0.90	2.5
4.3	0.27	-0.75	3.5	1.27	3.8
4.2	-0.75	-0.68	4.0	1.0	2.3
4.3	-0.10	-1.70	3.8	0.95	2.3
4.3	0.07	-1.0	3.1	1.85	3.5
4.6	0.60	-0.85	3.6	1.18	3.0
4.0	-0.20	-0.75	4.2	1.65	3.6
4.2	0.03	-0.95	3.5	1.80	2.8
4.2	-1.28	-0.70	3.0		
		-1.20	2.3		
		-1.28	4.2		

*Nine highest EXP scores. A score of 4 or greater is considered to be the crucial turning point for psychotherapy, where subject begins to focus on internal referents.

**Eleven lowest (most anti-plan) PCIRS ratings ($\leq$ 1 S.D. below patient's mean PCIRS score).

***Eight highest (most pro-plan) PCIRS ratings ($\geq$ 1 S.D above patient's mean PCIRS score).

Keeping in mind the fact that Stage 4 in the EXP is considered to mark a crucial transition point where the patient is clearly involved with internal referents, these findings suggest that EXP correctly

revealed that the patient was experiencing anti-plan insights. In other words, EXP did what it was supposed to do -- to identify self disclosure and ownership of feelings, which, in this treatment, meant that it registered the patient's primary involvement with anti-plan material. As will be discussed below, although the generic constructs employed by EXP were able to account for about 5% of the variance in detecting anti-plan insights, the lack of case-specificity did not allow for discriminating between content having positive and negative therapeutic value.

Table 7 also shows that the correlations between PCIRS and the other process variables differed between the Pre- and Post-test segments. The correlation between PCIRS and ARS, for example, changed from .434 on the pre-test segments to .711 on the post-test segments, suggesting that the relationship was more robust in the latter segments. Similar shifts occurred with LTS and EXP (although a reverse trend was seen between PCIRS and EXP.) It was hypothesized that these differences were related to the impact of therapist behavior on this particular patient's functioning. As illustrated in Figure 6, the patient's functioning tended to be less variable just prior to testing the therapist than it was immediately following the therapist's response to her tests; during pre-test segments, only eight out of 26, or 31%, of the segments were rated anti-plan, while 15 out of 32, or 47%, of the post-test segments were anti-plan. This difference in variability is also expressed below (Table 9) in terms of increased variance between ratings of pre- and post-test segments.

The post-test segments were thus characterized by greater variability than the pre-test segments. The size of the correlations

Table 9. Variance of Pre- and Post-Test Patient Measures

	PCIRS	ARS	LTS	EXP
Pre-Test	.518	1.26	1.49	.341
Post-Test	.661	3.17	2.39	.369

between insight and other patient measures was affected by the change in the degree of variance between pre- and post-test segments. These findings suggest that the patient was working on developing pro-plan insights immediately preceeding testing the therapist, and the main effect of the therapist failing her tests was to reverse the patient's movement.

CHAPTER 6

DISCUSSION

This study demonstrates a new model for assessing the therapeutic relevance of insight. A scale that rates the plan compatibility of insight (PCIRS) was developed and applied by clinical judges to segments of patient speech. It was predicted that pro-plan insights would be more likely to appear following passed rather than failed tests, whereas anti-plan insights would be more likely to appear following failed rather than passed tests. It was also predicted that pro-plan insights would tend to be associated with signs of decreased anxiety (LTS) and increased adaptive regression (ARS), whereas anti-plan insights would tend to be associated with signs of increased anxiety and decreased adaptive regression. Finally, it was expected that a significant relationship between insight and TPPT would be demonstrated using the patient-specific PCIRS, whereas in past research the generic constructs used in the Experiencing Scale to measure insight did not correlate significantly with TPPT on this case.

Interjudge agreement on the Plan Compatibility of Insight Scale was high ($\underline{r_{kk}} = .89$). It is thus demonstrated that judges can reliably rate patient productions on a case specific measure of insight, as defined in this dissertation. Validation of the PCIRS is based on construct-related considerations, including empirical evidence of its predictive power. Construct validity is established by the fact that the scale was able to empirically test hypotheses derived from the theoretical constructs used to conceptualize insight (Cronbach, 1970).

In addition, the PCIRS is convergent with ARS (r = .58, p < .001); the ability to engage in controlled regression is widely reported in the theoretical and clinical literature to be a necessary concommitant of insight.

The results support the hypothesis that, following passed tests, the patient will tend to experience increased feelings of safety, relax defenses, and bring forth pro-plan insights; conversely, the patient will tend to be more anxious and constricted, and to manifest anti-plan insights following failed tests. It could be argued that since the PCIRS focuses on the content of what the patient says, a positive correlation between PCIRS and TPPT could reflect patient compliance with the therapist's interventions. However, the therapist was unaware of the Plan Formulation when he carried out the treatment, and a reading of the test sequences indicate that, with only a few exceptions, the content of the therapist's interventions do not introduce, either directly or indirectly, new material to the therapist-patient exchange (See Appendix G for a sample of a test that was rated as being passed by the therapist). This suggests that the overall clinical significance of the therapist's behavior, rather than the content of what the therapist said, determined the TPPT rating.

A pro-plan PCIRS rating on the post-test segments would therefore be unlikely merely to represent compliance with the therapist's suggestions, interpretations or comments. Whereas it is acknowledged that the patient may produce material in accord with the the therapist's expectations, these findings suggest that the patient's ideas are not shaped solely by the therapist, but that the patient can

bring forth new material on his own based on considerations of safety. This hypothesis has been demonstrated in other studies (Gassner et al., 1982; Shilkret et al., 1986). The question of compliance in this case could be addressed more systematically by examining therapist behavior outside of the testing episodes to determine if topics following tests were previously introduced by the therapist.

Pro-plan insights were accompanied by signs of decreased anxiety and increased adaptive regression, while anti-plan insights were related to signs of increased anxiety and decreased adaptive regression. The hypothesis that pro-plan insights would be related to other indices of therapeutic progress while anti-plan insights would not be is supported.

It might be argued here that the therapist interventions which were rated as passing the patient's tests reassured the patient, either in tone or content, and thereby lessened anxiety and guilt. This argument, however, would not be able to convincingly account for pro-plan insight ratings following passed tests, since PCIRS measures very specific content related to the patient's conflicts, and does not directly measure lessened guilt or anxiety.

These results suggest that an insight scale which takes case-specific information into account can reveal important relationships between therapist behavior, patient insight and patient functioning which a generic insight scale may not detect. Two findings provide evidence that lend support to this position. First, the PCIRS correlated significantly with TPPT ($\underline{r}$ = .58), while no relationship was demonstrated between EXP and TPPT ($\underline{r}$ = .08). Secondly, a significant

negative correlation was obtained between EXP and PCIRS ($r = -.26$, $p < .05$).

Shifts in insight from pre- to post-test segments were largely in the anti-plan direction, and the patient was primarily involved with anti-plan material. The data suggest that EXP correctly revealed that the patient was experiencing anti-plan material, but did not register that fact in terms of negative therapeutic movement.* Generic concepts did not take into account this patient's particular conflicts, and thus did not discern the clinical significance of the material. It was important for this patient to overcome excessive, irrational feelings of responsibility for the failure of her marriage, and to repudiate feelings of helplessness and depression that represented guilt about wanting to leave and pathological identifications with her husband. While the EXP gives positive weight to signs that the patient is "owning" ideas, feelings and mood states, it explicitly avoids consideration of the clinical or dynamic significance of content (Klein et al., 1986). The PCIRS, on the other hand, takes case-specific content into account, and thus was able to discriminate (1) which material would be associated with signs of therapeutic progress, (2) which material would be associated with signs of lack of progress, and (3) how different material would relate to therapist behavior.

In past studies, EXP has been shown to correlate significantly with therapist behavior. This case differs from the others in that

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*It is not clear to what extent the patient's involvement with anti-plan material represented the strength of her guilt or the effects of the therapist's consistently failing her tests, or how the two behaviors may have co-determined the patient's productions.

the patient tends to focus on anti-plan material. Pro-plan insights were expressed tentatively, but still with some involvement. In other words, the patient was involved with both anti-plan and pro-plan material. Generic indicators of involvement utilized by EXP measured both anti-plan and pro-plan insights to be therapeutically positive; hence, the relationship to therapist behavior was attenuated. At the same time, EXP, which apparently was not able to distinguish between compliance and enthusiasm, rated the patient higher in experiencing when involved with anti-plan than with pro-plan material, and thus manifested a negative correlation with PCIRS.

To summarize, the relationship of PCIRS to EXP discussed above provides an important clinical illustration of how generic measures can be highly related to insights that are ineffective. These data are consonant with clinical experience that the assessment of patient's associations in terms of "emotional" or "intellectual" insight may or may not bear a relationship to patient improvement. On the other hand, and as this study demonstrates, case-specific criteria (plan compatibility) have an increased capacity to discern clinically significant cognitions (both positive and negative).

These results support the position suggested by Silberschatz et al. (1987) that the therapeutic significance of therapist and patient behavior should be evaluated according to case-specific criteria. Silberschatz concluded that a measure of the suitability (plan compatibility) of therapist interventions yielded results that were consistently more clinically useful than general catagories of behaviors such as transference versus non-transference interpretations, or

empathic versus non-empathic comments. Significant positive correlations between plan compatibility and signs of in-session patient progress have also been reported by others (Bush & Gassner, 1986; Caston, Goldman & McClure, 1986; Silberschatz, 1978; 1986; et al., 1987; Bugas, 1986; Kelly, 1985; Fretter, 1984)

Conceptualizing insight in terms of the patient's unconscious plan for therapy cuts across traditional concepts of insight as "intellectual" or "emotional". By linking indices of patient functioning to insights defined by a plan diagnosis formulated independently of measures of patient functioning, this study is able to identify therapeutically relevant insight while avoiding having to define insight retrospectively according to therapy outcome measures. Although it may be possible to identify therapeutically relevant insight without a plan formulation, the plan formulation allows one to do so systematically across all cases. Since the concept of a plan formulation that delineates the patient's unconscious plan for treatment is an application of Control Mastery theory, it has therefore been shown that the theory provides a clear conceptual framework for identifying clinically significant insight.

By demonstrating the relevance of pro-plan and anti-plan insights to the therapeutic process, this study bears on the concepts of unconscious planning and testing. First, the concept of an unconscious plan is supported by the fact that unconscious goals inferred in the Plan Formulation helped to provide insight categories. Moreover, since pro-plan insight is linked both to improved patient functioning, as indicated by decreased anxiety and increased adaptive regression,

and to passed tests, and anti-plan insight is associated with decreased patient functioning and with failed tests, the concept of testing is confirmed to be a valuable construct for evaluating the patient-therapist interaction.

Finally, these results are pertinent to the question of the relationship of process to outcome. Shifts in insight during the course of treatment were predominantly in the anti-plan direction, while therapist behavior in this case was rated as primarily non-facilitative; follow-up measures indicated a negative outcome. This study is exploratory and does not investigate a large enough number of cases to provide systematic results concerning the relationship of in-session patient functioning to therapy outcome. However, these results are commensurate with the process studies cited earlier in this chapter.

In conclusion, this research was an exploratory study that attempted to test hypotheses concerning the process of insight during psychotherapy. The concept of plan compatibility was shown to provide a clinically useful model for identifying characteristics of therapeutically relevant insight, for describing the conditions under which it arises, and for assessing the patient's progress. The increased efficacy of utilizing case-specific information over generic constructs to evaluate subprocesses related to insight was also demonstrated. Results also suggested a relationship between process and outcome; over the course of the therapy the patient's overall direction of insight was anti-plan, and the outcome of the treatment was negative. The hypotheses and methodology utilized in this study

appear to provide a productive approach to investigating the patient-therapist interaction.

Appendix A

Manual for Rating Plan Compatibility of Insight

(Edited to Protect Confidentiality)

PREFACE

The following pages contain segments from the transcribed recordings of a completed short-term (16 sessions) dynamic psychotherapy. After reading a brief history of the patient and a formulation of the case you will be asked to rate each segment on a measure of insight. The criteria for rating insight will be described and illustrated with sample insights excerpted from the transcripts.

This manual consists of five parts:

Part I. Introduction

Part II. Presenting Problems and History

Part III. Criteria and Scale for Rating Insight

- A. Plan Formulation
- B. Plan Compatibility of Insight Rating Scale (PCIRS)

Part IV. Guidelines for Rating Insight

- A. Sample Insights
- B. Practice Insights

Part V. Instructions and Case Segments

The rating task requires becoming acquainted with the case material. First, read the Introduction to obtain a conceptual overview. Then read "Presenting Problems and History" for an orientation to the patient. Next read about the criteria and the scale for rating insight; this section provides a framework for making quantitative and

qualitative judgments about the patient material in each segment. The Plan Formulation presents a formulation of the case and patient-specific information for assessing transcripts. The PCIRS assigns each segment a global insight score.

After familiarizing yourself with the patient, the plan formulation and the scale, read the guidelines for rating insight. In addition to offering suggestions and guidelines for making ratings, this section presents several rated and annotated sample insights to illustrate use of the scale. It also provides segments on which to practice making insight ratings. Please discuss your practice ratings with the experimenter before going on to rate experimental insights.

PART I. INTRODUCTION

This study attempts to measure the degree to which a patient's associations reflect a certain family of insights, to be described below. In general, insight is treated as an expression of the system of beliefs patients hold about themselves, others and the world--beliefs that frame their reality and guide behavior. This study focuses on subprocesses related to self awareness, and on microscopic shifts in insight gain associated with the patient's advances and retreats during individual therapy sessions. Insight is considered to be a continuous variable and therefore rateable on almost any section of patient speech. It is classified and rated according to (1) content, and (2) directness of expression.

The process of identifying and rating insights begins by comparing the content of what the patient says to the content of therapy goals and pathogenic beliefs delineated in a "plan formulation." The plan formulation was inferred by a group of independent clinical judges from intake material. It describes inferred goals the patient will want to achieve during therapy, and predicts how the patient unconsciously and consciously "plans" to work in the relationship with the therapist to attain those goals (hence the term "plan formulation"). The plan formulation also describes pathogenic beliefs that can obstruct movement toward therapy goals, insights that will be helpful to the patient in overcoming obstacles, and insights that will not be helpful and in fact may prevent the patient from achieving therapy goals.

In this scheme, the central overriding feature of a patient production in determining its status as insight is the degree to which it represents knowledge, or the attempt to acquire knowledge, that could facilitate the patient's ability to implement his inferred plan for attaining therapy goals. Insight that appears to advance the patient's plan is thus identified and rated as "pro-plan insight", while insight that opposes the patient's plan for treatment is rated as "anti-plan" insight.

Pro-plan insights indicate increased focusing of therapy goals, or awareness of pathogenic beliefs that patients' hold about themselves or others that obstruct attainment of those goals. Pro-plan insights also can call attention to experiences which contradict patients' pathogenic beliefs, or show awareness of patients' efforts to overcome their pathogenic beliefs.

Patient productions which run counter to the patient's plan for therapy are anti-plan insights. Anti-plan insights will express beliefs or strivings that are incompatible with the patient's plan for therapy. At their worst, anti-plan insights will confirm pathogenic beliefs, and inhibit and obstruct the patient's attempts to achieve treatment goals.

In addition to establishing whether content is pro- or anti-plan, it is also necessary to assess dynamic factors that contribute to whether the insight is likely to help advance or to obstruct the patient's plan for therapy. The patient must be able to sustain pro-plan insights and to overcome anti-plan insights; their ability to do so is influenced by a number of factors that determine behavior, such

as defenses, transferences, unconscious motives, convictions and identifications. Pro-plan insights may be subject to repressive forces should they evoke guilt or anxiety. The patient may use knowledge of limitations, shortcomings, mistakes, or other unpleasant facts or events in a masochistic or punitive manner. Anti-plan insights (e.g., false or distorted beliefs a patient has about his motivations) may be sustained or used to undo pro-plan statements out of guilt or anxiety.

In sum, this study attempts to investigate the extent to which pro-plan insights gain ascendancy over anti-plan insights, or vice versa, during a short-term therapy. Rating insight requires concerted clinical judgement of both the plan-compatibility of the content, and the strength or directness with which the insights are expressed.

PART II. PRESENTING PROBLEM AND HISTORY

Case material is organized so as to highlight the key conflicts inferred in the case formulation provided for you. According to this formulation, the patient is profoundly conflicted between her wish to extricate herself from an unsatisfying relationship, and forces which keep her bound to her husband; these include her belief that her bad temper drove him away, her sense of responsibility to take care of him and to minimize his deficits, and her feelings of obligation to struggle to make the marriage work.

Presenting Problem:

DELETED FOR CONFIDENTIALITY

History:

DELETED FOR CONFIDENTIALITY

Events Leading to Presenting Problem:

DELETED FOR CONFIDENTIALITY

PART III. CRITERIA AND SCALE FOR RATING INSIGHT

The rating task requires using the Plan Formulation and the Plan Compatibility of Insight Rating Scale (PCIRS) in conjunction with one another to rate segments. The Plan Formulation provides case-specific content, including two catagories of Pro-Plan and Anti-Plan Insight, to be compared with transcripts of patient speech. The PCIRS is a five-point scale that allows each segment to be assigned a numerical value, placing the segment on a continuum from Strongly Pro-Plan to Strongly Anti-Plan. Neutral or ambiguous material falls between the two endpoints of the scale.

The Plan Formulation helps with qualitative judgements, while the PCIRS assists in making quantitative judgements. Both must be used to arrive at a rating.

PLAN FORMULATION

Fran unconsciously believes that her strengths are the source of her husband's problems in the same way that they were the source of her family's problems. She felt that she made her mother feel inadequate, intimidated, insecure, and excluded because of her competence, self-confidence, assertiveness, and close relationships with other people. She believes that she caused the family's unhappiness by being stronger and more successful than her mother and sister, and by refusing to support her father's denials. She submitted to her parents' blame and accepted the idea that she was responsible for the disharmony in the family. She punished herself and restored her mother by identifying with her mother's insecurities. She restored her father by idealizing his passivity, his avoidance of problems, and his romanticized view of life. She restored her sister by envying her and preventing herself from being too popular.

Fran entered treatment with urgent priorities stemming out of her separation from her husband. She may not develop insights into the genetic origins of her conflicts. Rather, she will probably focus on gaining insight into her relationship with her husband, and her reactions to his leaving her and their daughter. Given the patient's immediate needs and the limitations of short-term treatment, the plan formulation thus has a narrow focus. The following goals, obstructions and insights are worded, for the most part, in terms of Fran's

relationship with her husband, although similar issues and conflicts operate in her relationships with others.

Patient's Therapy Goals:

The patient's primary goal for brief therapy is to overcome her irrational feelings of responsibility for her husband's bad moods, inadequacies, and rejecting behavior towards her, so that she can be free to reject him, to enjoy being a good mother, to replace him with someone better, and to get on with her life. She wants to overcome her unconscious guilt about her husband so that she doesn't feel compelled to make their marriage work, or pulled to make their separation into a painful loss and to identify with his depression and feelings of being overwhelmed and unable to cope. To counter her irrational guilt toward her husband, she wants to see him realistically and feel angry about his rejecting behavior towards her and their daughter. In other words, she wants to hold him responsible for failing her as a husband, rather than holding herself responsible for his failings.

Obstructions To The Patient's Goals:

The primary obstructions are the patient's unconscious feelings of responsibility for her husband's shortcomings, and her unconscious guilt at thoughts of wanting to leave the relationship. She feels compelled to deny his problems and his rejecting behavior in the same way her father denied her mother's problems and rejecting behavior towards him. She also feels compelled to idealize her relationship with her husband and to deny her dissatisfaction with him in the same way her father idealized his marriage and denied his dissatisfaction

with her mother.

The unconscious guilt that the patient feels toward her husband compels her to undo her realistic appraisals of his impaired functioning by attempting to find excuses for his behavior or to find fault with herself. Along the same lines, she will need to feel assured her husband does not intend to return before she can begin to feel optimistic about managing without him. Whenever her husband is ambivalent about leaving, the patient will feel increased responsibility for him and more strongly compelled to make the relationship work.

Insight Goals:

During the course of a brief therapy, the patient will be primarily concerned with her immediate marital problems, and will want to gain insight that will facilitate her overarching goal of extricating herself from the relationship with her husband. She wants to recognize that she is not responsible for her husband's problems and his rejecting behavior towards her and their daughter. She wants to recognize that she has justifiable reasons for being angry at her husband and for rejecting him. She wants to see her husband critically and realistically, without feeling guilty. She wants to recognize that she is a good mother and that she loves her child. She wants to recognize that she likes and feels satisfied with herself and her child.

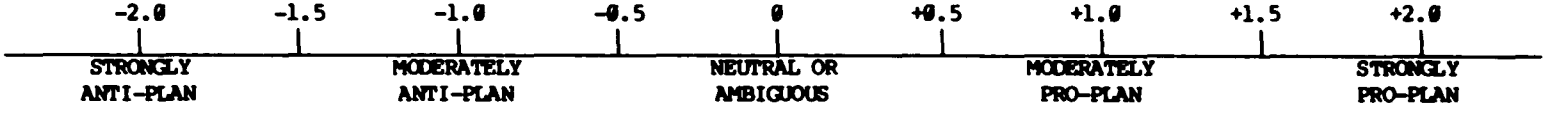
The following are examples of pro-plan and anti-plan insight themes, but they are not exhaustive lists of insights that the patient might express:

PRO-PLAN INSIGHTS	ANTI-PLAN INSIGHTS
1. She begins to recognize that she feels compelled to suppress her anger; she may become aware that she believes her anger has driven her husband away; she may begin to understand that much of her anger at her husband is justified by the way he has treated the patient and their baby.	1. She feels that she should suppress her anger; she may believe her anger is primarily responsible for her husband leaving her.
2. She begins to become aware of qualities in her husband that she doesn't like; she may recognize that he is immature, unmotivated and emotionally unavailable.	2. She denies her husband's problems and idealizes her relationship to him.
3. She is able to see her husband, and members of her family, critically.	3. She finds justifications for her husband's impaired functioning; she implicitly or explicitly suggests she is largely responsible for her husband's rejecting behavior.
4. She realizes that she can be excessively self-critical and that she tends to blame herself for things that are not her fault; She may realize that she tends to feel overly responsible for other people; she is not responsible for her husband's moods.	4. She believes she is responsible for her husband's moods.

(Continued)

PRO-PLAN INSIGHTS	ANTI-PLAN INSIGHTS
5. She begins to relate some of her vaguely accounted for feelings of depression or unhappiness more directly to her relationship with her husband.	5. She minimizes the impact of her husband's behavior; she does not believe her husband's rejecting behavior to be adequate reason for her wanting to end the relationship.
6. She begins to recognize the disparity between her "intense love" for her husband, and how little she receives from him; her attachment to him is irrational and drains her emotionally.	6. She misses her husband; she feels his departure is a traumatic loss; she loves him very deeply.
7. She realizes she has doubts about wanting to get back together with her husband; part of her wants to leave him.	7. She feels hopeful about the relationship; if she changes her behavior her husband might love her and the relationship could work; she feels compelled to try to make it work.
8. She begins to recognize that being overly upset (dwelling on feelings of pain and depression) about her separation is both maladaptive and a way she punishes herself. She may begin to grow impatient with and to distance herself from being overly upset.	8. She depicts herself as confused or unable to cope with her emotions; she seems to accept the idea that she should become overly upset and depressed about the separation.
9. She feels more positive about herself, and more confident that she has the capacity to be independent and in control of her life.	9. She depicts herself as weak and dependent.
10. She wants to be a good mother; she basically feels positive about her child.	10. She feels she is basically incompetent as a mother.

THE PLAN COMPATIBILITY OF INSIGHT RATING SCALE



STRONGLY ANTI-PLAN	MODERATELY ANTI-PLAN	NEUTRAL OR AMBIGUOUS	MODERATELY PRO-PLAN	STRONGLY PRO-PLAN
Material is almost completely anti-plan. Patient asserts anti-plan elements without questioning them. Anti-plan material appears ego-syntonic.	Both anti- and pro-plan elements may be present, but anti-plan material is clinically more significant. Pro-plan elements are significantly undone. Patient is moving in direction of anti-plan insight.	Anti- and pro-plan material are present with equal salience, or absent. patient is not floundering, but no clear purpose or direction is evident. Material appears too ambiguous to allow judgement.	Both pro-and anti-plan elements may be present, but pro-plan material is clinically more significant. Patient is moving in direction of pro-plan insight. Proplan elements show ascendancy over anti-plan elements, but some signs of undoing or discomfort are evident.	Material is almost completely pro-plan. Patient is able to sustain or build upon pro-plan insight. No attempt is made to undo or reverse pro-plan material. Asserts pro-plan insight without conflict.

PART IV. GUIDELINES FOR RATING INSIGHT

The Plan Formulation and the Plan Compatibility of Insight Rating Scale are used in tandem to make ratings. First, compare the content of a segment with the categories of pro-plan and anti-plan insight in the Plan Formulation to locate pro- and anti-plan insight themes. During this step of the rating task, the emphasis is on evaluating how directly what is being said corresponds to the goals and obstructions delineated in the Plan Formulation.

The categories of pro- and anti-plan insights are intended to provide a reference point for evaluating the plan-compatibility of the content of patient productions. However, the categories are not comprehensive. Insight themes may appear in the segments in different variations or in derivative forms. Or, it is possible pro- or anti-plan insights that are consonant with the Plan Formulation, but not explicit in the list of insight themes, will appear in the transcripts. In addition, the list does not attempt to portray how pro- and anti-plan insights may overlap with one another. For example, the anti-plan insight, "if she changes her behavior her husband might love her and the relationship could work" is listed as the counterpart of the pro-plan insight of having doubts about wanting to get back together with him. Since her hopefulness is predicated on thoughts of changing her behavior, this insight is also a variation of the anti-plan insight that she feels responsible for her husband's behavior. It is therefore important that the lists of pro- and anti-plan insight themes be utilized in the larger context of your reading of the entire case formulation provided for you.

After getting an idea of the pro- and anti-plan material contained in the segment, refer to the ordinal scale to assign the segment a global insight score. Assigning a segment a scale value may require integrated clinical judgement to determine the relative weight that the various elements carry. For instance, a segment could contain three pro-plan and one anti-plan elements, but be rated as anti-plan if you feel that the anti-plan material is clinically more significant than the pro-plan elements.

When evaluating the overall clinical significance of a segment, it may be necessary to assess such factors as the degree to which the patient sustains and develops an insight, the amount of conflict she manifests about it, or the extent to which with her statements seem ego-syntonic or dystonic. For example, the patient may make pertinent pro-plan statements, and then go on to elaborate on them (a strong pro-plan rating). Or, she may retreat by undoing her initial pro-plan statements, thus weakening the pro-plan rating, perhaps to the point where the segment warrants an anti-plan rating. The patient may make anti-plan statements without hesitation or conflict, resulting in a strong anti-plan rating. Conversely, she may express an anti-plan insight not so much in the sense of "this is me," but rather with an objective quality that suggests she is moving toward becoming aware that she has held a particular pathogenic belief about herself. Depending on how ego-dystonic the anti-plan material seems, such a segment could receive a PCIRS score ranging from mildly anti-plan to pro-plan. The sample insights beginning on the next page are annotated to illustrate how content themes and dynamic factors can co-

determine insight ratings.

The scale is annotated at Ø and (+,-)1 and 2, with 1/2 stop values of (+,-) .5 and 1.5 to allow for finer discriminations in making ratings. A segment could receive a rating of "Ø" in two ways: (1) The segment is neutral; anti-plan and pro-plan material are either both present with equal salience, or both absent, or (2) The segment is ambiguous; a segment might appear ambiguous or meaningless, for example, because it lacks context. If you rate a segment "Ø", please indicate on the rating sheet whether your decision was prompted by neutrality or ambiguity of the material.

Sample Insights, Part 1

Below, a segment of patient speech has been excerpted from the intake and hypothetically altered and annotated to illustrate how the material might look at the different full scale stops (+2, +1, Ø, -1, -2). The different versions of the segment are presented in descending order from Strongly Pro-Plan to Strongly Anti-Plan.

SAMPLE INSIGHT #1

Rating: +2.Ø (Strongly Pro-Plan)

And then one night he just told me that he wanted me to go away for awhile, which I did not want do, because I didn't want to take a two-month baby away travelling...but I figured if that's what he needed, I could do that for him, so we flew to the east coast and spent two weeks there...I was pretty mad about that. I'm even madder about it now. I guess I was afraid to get angry at him at the time. That, if I did it would somehow wipe him off the face of the earth. But now...you know, his request was absurd, and he was being so selfish and immature, and I think I felt that if his behavior was that extreme, I must have done something to cause it. So, you know, that also kept me from getting angry.

COMMENTARY

The patient is reporting a past interaction with her husband. The rating is based on her behavior while remembering the event, rather than on her functioning at the time the even took place. She expresses awareness that her husband's behavior was extreme and that she felt compelled to suppress her anger out of irrational feelings of fear and responsibility. No attempt is made to undo her insight, either by justifying his behavior or feeling overly responsible. Although three important insights are expressed (critical appraisal of husband's behavior, awareness of irrational fear of her anger and awarenes of irrational sense of responsibility), development of any one could have resulted in a strong Pro-plan rating (+1.5 - +2.Ø).

SAMPLE INSIGHT #2

Rating: +1.0 (Moderately Pro-Plan)

And then one night he just told me that he wanted me to go away for awhile, which I did not want do, because I didn't want to take a two-month baby away travelling...but I figured if that's what he needed, I could do that for him, so we flew to the east coast and spent two weeks there...I was pretty mad about that. But something made my anger shrink back. I guess I thought it would be worth it if it would make him happier. But I thought that was not right for him to do. I guess I was hoping I could do something to help him. He's going through a tough adjustment with a new baby and all, and I've been tired and snappy and I think my having to give most of my energy to the baby has been hard for him. But, I don't know, he's never been able to handle anything emotional, he's always, you know, run from it, and yet I still have these intense feelings of love and that I could do something different and that would help him to change, and its so crazy to feel that, because I just end up getting walked on, and, I don't know...

COMMENTARY

The patient expresses awareness that she felt compelled to suppress her anger, but stops short of recognizing her irrational fear of her anger. She then starts to move in the direction of realizing she feels responsible for her husband's behavior or moods. At this point, the segment would receive a moderately strong pro-plan rating. However, she quickly undoes her pro-plan movement by finding excuses for her husband's behavior, and by criticizing herself. She ends the segment by beginning to recognize the irrationality of her attachment to him, which she is able to sustain with moderate success.

SAMPLE INSIGHT #3

Rating: Ø (Neutral)

And then one night he just told me that he wanted me to go away for awhile, which I did not want do, because I didn't want to take a two-month baby away travelling...but I figured if that's what he needed, I could do that for him, so we flew to the east coast and spent two weeks there...I was pretty mad about that. I guess, I mean, it would be worth it if it would make him happier, but I thought that was not right for him to do.

COMMENTARY

The patient acknowledges that, at the time, she was angry at her compliance with an unreasonable demand. It is not clear, however, if she is accepting the idea that it was "right" for her to have acted to make her husband happy, or if she is emphasizing that, in retrospect, she realizes her anger was justified. She may be moving in the direction of becoming aware that her anger can be negated by feelings of responsibility for him, but she could also end up feeling she should do whatever she can to try to make the relationship work. The pro- and anti-plan elements appear balanced. The direction of movement is unclear.

SAMPLE INSIGHT #4

Rating: -1.0 (Mildly Ant-Plan)

And then one night he just told me that he wanted me to go away for awhile, which I did not want do, because I didn't want to take a two-month baby away travelling...but I figured if that's what he needed, I could do that for him, so we flew to the east coast and spent two weeks there...I was pretty mad about that. I guess, I mean, it would be worth it if it would make him happier, but I thought that was not right for him to do. I mean, he was acting in a pretty selfish, immature way. I should have gotten angry and said, "no!" But something made me shrink back from that. He just hasn't been able to make the adjustment to Cara. He can be such a baby himself. He just runs away and avoids dealing with things. Yet, I know I haven't been there much for him, I mean, most of my energy has gone to Cara. She's been difficult, and its made me tired and short tempered. So, in some ways he probably felt he had two babies to deal with and it was just too much all at once for him.

COMMENTARY

The patient recognizes her anger was justified by her husband's behavior. She then significantly undoes her pro-plan insight by criticizing herself.

SAMPLE INSIGHT #5

Rating: -2.0 (Strongly Anti-Plan)

And then one night he just told me that he wanted me to go away for awhile, which I did not want do, because I didn't want to take a two-month baby away travelling...but I figured if that's what he needed, I could do that for him, so we flew to the east coast and spent two weeks there...I was pretty mad about that. I guess, I mean, it would be worth it if it would make him happier. I thought that was not right for him to do, but I know he just has difficulty with emotional things, so its particularly hard for him to be able to tell me how difficult it's been for him to get used to Cara and her crying. And I've been too involved with her and short-tempered with Stan, and not really there for him. And I think I could help him, I mean, I still have this deep love for him, and I know he's just scared right now. So I think if I show him I understand and give him more room so he won't feel oppressed, he will be able to work things out.

COMMENTARY

The patient has no insight that her anger was justified. She is unconflicted about making excuses for his behavior and criticizing her own behavior. She asserts her attachment to her husband and her sense of responsibility for him and for making the relationship work without question.

Sample Insights, Part 2

In order to further illustrate pro- and anti-plan insight, several additional (unaltered) instances of patient speech have been excerpted from the intake:

SAMPLE INSIGHT #6

Rating: +2.0

---at first I was feeling very sorry for him and all that stuff, and now I'm starting to get angry and feeling a lot of pain and I just want to deal with it in a constructive way.

COMMENTARY

The patient feels angry at her husband without attempting to suppress her feelings. She implies that she no longer feels compelled to make excuses for his behavior (she no longer feels sorry for him), and asserts her wish to overcome feeling overly upset at the separation.

SAMPLE INSIGHT #7

Rating: -2.0

---so,...the depression is like...well, even all the time it's a real pain inside of losing something that...consumed all of me. I mean, I love my husband very deeply and I felt...I felt something very...it wasn't just attraction; it was a deep soulful kind of feeling I felt for him, and he said that he never felt that for me, you know. I always knew that he was the person for me, I felt really good about, and I still feel real deep.

COMMENTARY

She asserts her love for her husband with no indication that she is in conflict with her feelings.

SAMPLE INSIGHT #8

Rating: Ø (Ambiguous)

But I just...my daughter is very demanding and I just feel like especially after that happened -- after her fall -- I just feel like my head's going to be in a different place and it just makes me physically weak and emotionally weak and I just can't deal with it. That's mostly what I'm afraid of. Plus, I just don't want to go through all the pain.

COMMENTARY

It is not clear how she foresees her functioning (her "head's going to be in a different place"), or what the "it" refers to. The meaning of not wanting "to go through pain" is also unclear (i.e., whether she sees it as unavoidable, unnecessary or something else). This segment lacks sufficient context either to know what the patient is talking about, or to infer her meaning.

SAMPLE INSIGHT #9

Rating: +Ø.5

On the one hand I am glad that he's not seeing her unless he really wants to see her because she's just getting to a point where she's happier now and I think that's because there's less tension around her. And on the other hand I just don't understand how somebody can just abandon their child. Then on the other hand I realize he needs space right now and he feels really closed in and he's just trying to escape his obligation.

COMMENTARY

The patient begins to recognize her life is happier without her husband. She views her husband's behavior critically, but then partially undoes her insight by trying to find excuses for him.

SAMPLE INSIGHT #10

RATING: +1.5

And we talked with them (marriage counselors) for two hours and Stan opened up to them a lot, and I was getting in touch with my anger and as soon as we walked out of there it shut off. You know, it was like this protective barrier came down and wouldn't let me feel it anymore, even though at that point I wanted to feel it a little more as I was driving home. I know I wanted to think about it and feel some of those feelings that I had finally gotten in touch with and couldn't...it just went out.

COMMENTARY

The patient is trying to overcome her guilt about her anger, and to see her anger as justified. She is trying to hold on to her anger as a defense against her guilt and the pathogenic belief that her anger will hurt her husband.

Practice Segments:

The following segments have been excerpted from the intake. Rate each segment for plan compatibility utilizing the Plan Formulation and the Plan Compatibility of Insight Rating Scale. After you have rated these practice segments, please discuss your ratings with the experimenter before going on to the experimental segments. Space is provided beneath each segment for notes.

PRACTICE INSIGHT #1

RATING: _____

There's always an ache, but sometimes I'm more optimistic than others, not about us getting back together but just about things going on, life going on.

PRACTICE INSIGHT #2

RATING: _____

He wouldn't even take a one-hour walk with me to the park or any little thing was too much effort for him. I'd say that was one of my main complaints, which is not devastating. I mean it's something, you know I obviously learned to live with. You know, just little things, but nothing to me that would mean breaking up, at least from my point of view.

PRACTICE INSIGHT #3

RATING: _____

I realized I was really catering to his mood, which I swore I'd never do for any man but I wound up doing--if I felt he was in sort of a bad mood, you know, I wouldn't say things, I'd try and be extra nice or something instead of letting him work out his bad mood. It affected me a lot.

PRACTICE INSIGHT #4

RATING: _____

My sister would always side with my parents because she was more obedient on the outside. See, I always laid everything on the line with my parents and I never lied to them, until it seemed like I was a terrible kid, whereas my sister would tell them what they wanted to hear on the outside and go do what she felt like, you know. So because I stood up for myself and expressed my thoughts and my feelings they...you know, they didn't like it. You know, my mother was always so cautious and my dad likes to ignore things and pretend they don't exist, so...here I was putting it in their faces and they didn't like it.

PRACTICE INSIGHT #5

RATING: _____

I have a quick temper and I'm the kind of person who will get mad at something right away, and that's it, it's over. It doesn't...I don't keep anything inside. He's the kind of person who will keep it stored inside and if you see a little bit of temper you know the rest of the iceberg's underneath. So, he always felt like if I was giving out this much, there must be a lot more underneath and I told him that there wasn't...

PRACTICE INSIGHT #6

RATING: _____

Well (pause), I guess our sexual life wasn't too bad, although I had a greater need than him so I was always the one initiating and I was, you know, I always had to ask him and it was never vice versa, but it's been like that since the beginning, so we pretty much worked it out. I mean, I guess it got compromised, so, I mean, you know, that's something that's an ideal but you know we both learned to live with it.

PRACTICE INSIGHT #7

RATING: _____

I just feel like I didn't do anything wrong and I don't deserve this. I'm really mad that he never gave me a chance after seven years he can just say that's it, you know---you know, it's not worth working on. And I just can't understand how he can leave his daughter. He sees her a couple of times a week but there's something missing in their relationship.

PRACTICE INSIGHT #8

RATING: _____

Well, she's (the patient's mother) very cautious and she's---should you do this and should you do that, and...I grew up feeling like I shouldn't. She'd say "You sure you want to try that, you might not be able to do it," and I'm just starting to be able to deal with those feelings now because all through my life I was afraid not only of failure but of success too. I realize that now and I'm starting to be able to put that aside, but for a long time I was so scared of failure that I wouldn't do things.

PRACTICE INSIGHT #9

RATING: _____

So I'm mainly angry that he never gave me a chance, he never tried to work things out, you know. I just see him as taking the easy way out and not facing me and---so I'm angry about that and also all the pain from somebody I loved very deeply, who I -- you know--didn't expect our relationship to be over and it's just sort of ripped from me, you know, not any chance to get used to it slowly.

PART V. INSTRUCTIONS TO JUDGES

1. Before making ratings, please read the intake information on the patient and the plan formulation. For purposes of this task, your assessment of the patient's insight should be based on the formulation of the case provided for you.

2. Read each segment, rating as you go. There are 58 segments.

3. Space is provided below each segment for any comments you may wish to make about the rating.

4. For any segments rated "0", please note whether you feel the material is neutral or ambiguous.

Appendix B

Samples of Segments

SEGMENT #06

It's just really hard for me to receive, even compliments and stuff. You know, I crave them, but yet when I get them I really don't believe them. My mother was never very--we fight about this--she says she was very supportive and I don't think she was very supportive. She was always the kind who would say "Fran, are you sure you can do that?" She never said "You can do it if you try." But she was definitely that was where she was coming from, because she got it worse than that from her father. So--but as far as feeling about what I can achieve as far as a profession goes, I think I've pretty much worked out of that, but as far as my emotional relationships, I don't think I've worked out of that.

SEGMENT #09

Stan? Yeah, he told me that. Of course who knows if that is a lie now? I don't know what to think anymore, I certainly can't put stock in what he says. You know, all the thinking back I did, to wonder if he really wasn't enjoying sex with me all that time and what that meant and da da da, and to find out he didn't even know he said it and it certainly wasn't true, I mean--Stan is such a passive person, he is not capable of giving a lot. Just like in sex, in what I wanted I had to take. He didn't mind if I took it, he just didn't want to give it, so--and that's the way he is with everything--just sort of lies there, here I am you know--

/So if that statement were true than that meant--/

What?

/The statement about you know that he wasn't enjoying sex for the last year--/

If it were true?

/Yeah?/

It meant what? Well, I was just trying to figure out in my mind if I picked up on that at all while it was happening and it certainly didn't seem any different from how our sexual relationship had always been. I mean I always wound up initiating, unless I wanted to wait a month in between and I couldn't do that. I don't know, just the fact of using sex as a sort of weapon, you know. That maybe he was withholding from me for some kind of reason, you know, but I guess that's not true now, I don't know, I don't know what the truth is.

Appendix C

Patient Scale of Key Tests (KPT)

6 -Segment is an EXCELLENT EXAMPLE
of a Key Test

5 -Segment is VERY GOOD EXAMPLE
of a Key Test

4 -Segment is a GOOD EXAMPLE
of a Key Test

3 -Segment is a MODERATE EXAMPLE
of a Key Test

2 -Segment is a WEAK EXAMPLE
of a Key Test

1 -Segment is a POOR EXAMPLE
of a Key Test

Ø -Segment is NOT AN EXAMPLE
of a Key Test

Appendix D

Therapist Scale of Passing Versus Failing the Patient's Test (TPPT)

6 -Therapist's response is an EXCELLENT, CLEAR-CUT EXAMPLE of Passing the Test

5 -Therapist's response is an EXAMPLE OF PASSING THE TEST; it contains the elements described in 6 but less clearly

4 -Therapist's response is an EXAMPLE OF MILDLY PASSING THE TEST; there are no aspects of failing the test in the response, but it is not sufficiently explicit or clear to warrant a higher rating

3 -Therapist's response is either ambiguous or falls MIDWAY BETWEEN PASSING AND FAILING THE TEST; the response may contain elements of both passing and failing the test but these are not explicit enough to warrant a higher or a lower rating

2 -Therapist's response is an EXAMPLE OF MILDLY FAILING THE PATIENT'S TEST

1 -Therapist's response is an EXAMPLE OF A FAILED TEST; the failure is somewhat more subtle than in Ø

Ø -Therapist's response is an EXPLICIT, CLEAR CUT EXAMPLE OF FAILING THE PATIENT'S TEST

Appendix E

Adaptive Regression Scale (ARS)*

The Adaptive Regression Scale is made up of two component scales: The Defense Demand scale (DD), and the Defensive Effectiveness scale (DE). The Adaptive Regression Score is derived by multiplying the Defense Demand rating for each response by the Defensive Effectiveness rating.

DEFENSE DEMAND (DD)

This scale rates the degree to which the response (usually sexual or aggressive content) demands that some defensive and controlling measures be undertaken in order to make it a socially acceptable communication.

Ø -No scorable Primary Process material.

1 -Virtually no apparent need for defense: Here fall responses that contain aspects of the primary process only implicitly, or references to matters that would hardly be noticed if referred to at a polite tea party.

2 -Slight need for defense: The content and structure of the responses rated at this level are only slightly unusual in conversation, and arouse only slight degrees of tension.

3 -Moderate need for defense: The Content and Formal deviations here are at a level that might cause moderate tension or social embarassment if they occurred in conversation.

4 -Considerable need for defense: The level here is set by the example of responses that describe sexual organs: it is possible for most people to refer to such things in a doctor-patient setting, but it is not permissible in ordinary conversations.

5 -Great need for defense: Shocking ideas which could under no circumstances be introduced into a social conversation without extensive controls and defenses.

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*(as cited by Bugas, 1986)

DEFENSE EFFECTIVENESS (DE)

Defense Effectiveness measures the degree of integration and control of primary process material in a verbal response. Three sets of criteria are employed to determine Defensive Effectiveness: (1) Clarity of overall expression, (2) Sense of adequacy, and (3) Control and defensive variables.

Clarity and Organization Rating Scale

+1.5 -A convincing, creative, original verbal communication that synthesizes imagination and reality adaptiveness. The theme is continuous and uninterrupted. No significant deviations of language.

+1.0 -A commonplace or conventional verbal communication that is organized and easily understood, but requires little or no imagination or creative effort. may include disruptions of speech, with recovery.

+0.5 -An acceptable verbal communication with minor disruptions or deviations that are left unclarified and require some stretching to understand.

0 -In this category fall verbal responses that are indeterminant, i.e., unable to discern whether defensive activity around primary process material is effective or not. This rating does not contribute to patient's total score in the direction of either adaptive or maladaptive regression.

-0.5 -Some verbal obfuscation as an apparent defense against primary process material. may include breaks in continuity of theme(s) and/or deviations of language. requires stretching to understand.

-1.0 -A vague, fragmented verbal communication that cannot be understood without inquiry or interpretation.

Control and Defense Variables

Positive variables

1 -Reflection: Constructive introspection, self-observations and critical self-scrutiny (observing ego).

2 -Minimal remoteness: Focus is on patient's own thoughts, feelings, reactions, experiences, ect.

3 -Adaptive modification: Successful recovery.

4 -Clinical Judgment: Overall sense of integration and synthesis, productiviness, involvement, etc.

5 -Successful Negation: the successful disavowal of an impulse, thought or feeling that would otherwise arouse guilt or anxiety.

Negative Variables

1 -Impotence: Inability to explain something when asked.

2 -Self-Depreciation: Inappropriate self-criticism.

3 -Repudiation: Disavowal; attempts to retract a statement, or deny it was ever given.

4 -Vagueness: language used in a vague, fragmented, fluid or otherwise defective way.

5 -Disclaiming of responsibility: Blaming, denying responsibility for an action.

6 -Disruption or grammar: Significant disruptions of grammar, syntax, verbal usage, etc. apparently related to the impact of primary process material.

7 -Evasiveness: Attempts to evade questions refusal to commit oneself; avoidance.

8.-Obsessional defenses: Doubting, vascillation, indecision.

Adequacy Rating Scale

+1.0 -Active willing, exerting effort against obstacles, successfully achieving, attaining some measure of gratification through effort or at least managing to act in such a way as to maintain self-respect by actualizing basic values.

+0.5 -If the patient's activity is indeterminate, not specified, an unclear mixture of some kind, ect., but there is an instance of the above kind of effort or action that is not cancelled out by equal or more impressive indicators of inadequacy.

0 -Not applicable.

-0.5 -Positive effort or action taken by the patient is cancelled out by equal or more impressive indicators of inadequacy. Some kind of gratification or resolution of problem may occur, but only through the intervention of a deus ex machina and without active participation by the patient.

-1.0 -This rating is given when the patient clearly views self as inadequate, failing or being frustrated because of some personal deficiency, overwhelmed and at the mercy of forces outside his control, or makes little or no effort to actively confront or engage problems and conflicts.

Appendix F

The Experiencing Scale (EXP)*

STAGE	CUES
FEELINGS MAY BE MENTIONED	
1- External events, refusal to participate.	No first person pronouns; past or present tense; remote; impersonal; fluent.
2- External events include pt; behavioral or intellectual self descriptions.	Personal pronouns, past or present tense; limted reactions; usually fluent.
3- Personal reactions to external events; limited self-descriptions; behavioral descriptions of feelings.	Personal pronouns; past or present tense; some affect indicators (laughs, sighs).
FEELINGS ARE CORE CONTENT	
4- Descriptions of feelings and personal experiences.	Present or past tense; immediate expressive, focused voice; expressions of affect.
5- Problems or propositions about feelings and personal experiences.	Immediate; groping; tense; tentative; dysfluent; exploratory; hypothetical.
6- Felt sense of emergent felings and their impact.	Present or vivid representations of past; declarative; exclamatory; alternating dysfluency and fluency; pauses.
7- Steady focus on experiencing; elements linked or integrated	Present; affirmative; more fluency than dysfluency.

*Klein, et al. (1986)

Appendix G

Example of Therapist Passing a Patient Test*

THERAPY SEGMENT

(The patient has just visited her husband's parents.)

Yeah, yeah. I know they didn't know what to say (about their son's marital difficulties), but you still gotta try and talk about it. Since we were all thinking about it. So I was kind of depressed when I first went there, you know, because I had been there five other times before with Stan, but actually I had the best time that I ever had this time, you know. You know I decided I was going to have a good time too. I just feel like I'm really in touch now with the power to make things turn out good for myself you know. I mean at first it was sort of an effort to think positively but now it's really kind of easy. I almost feel guilty because I feel so good. And--you know things that go on around me I mean I can sympathize with them but I don't--they don't bring me down, so--I just--

/Why do you suppose you should feel guilty about feeling so good?/

Why should I feel guilty?

/What's the crime?/

(END OF TEST SEGMENT)

(Pause) I don't feel like there's a crime but it's just that I don't know...it's like sometimes people expect you...I just feel so good it's just like...I mean, I don't really feel guilty, but I feel like I should, you know what I mean? I just...I don't know. But everybody I talk to about how good I feel , they are real happy about it. They are real happy for me and they are real supportive of it. Some people might get down on it and think that I was just being egotistical or whatever, but the people that care about me are really glad to see it. And I feel real good because it's not something I'm faking, you know what I mean, I really feel that I have that strength inside and I don't feel like...well, I tend to be a sort of moody person, so I was always afraid...well, I feel good now, but the next mood I'm going to crash you know, but I don't feel that way anyway. I just feel like I can do anything, you know, and I don't feel that other people can necessarily drag me down.

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*Note that the therapist was not attempting to apply a Control Mastery approach to this case, nor was he familiar with the plan formulation. This is therefore not an example of the ideal response to this test. Rather, it is an example of this therapist's behavior having the general effect of passing the patient's test.

COMMENTARY

The patient is posing a transference test that draws on past experiences with her mother. She is reporting an important accomplishment -- that of overcoming her guilt at being better off than her husband -- and is feeling proud of herself. She is testing to see if the therapist will support her attempts to master her guilt, or whether the therapist, like her mother, will be dour and pessimistic about her ability to succeed. Had the therapist remained silent, his intent would have appeared ambiguous and his support for her in question. Had he questioned the lifting of her depression and guilt, for example by interpreting along the lines that her feeling good was a defense against sadness at losing the relationship, he would have recapitulated her mother's lack of confidence in the patient's ability to advance, and confirmed associated beliefs that she must fail (i.e., remain depressed and helpless) in order to maintain the relationship with important parental figures (i.e., the therapist)*.

*The complete diagnostic formulation for this case is located in Appendix A.

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