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LEARNING FROM WELL-TRAINED AND EXPERIENCED DYNAMIC PSYCHOTHERAPISTS: RESEARCH ON THE EFFICACY OF DYNAMIC PSYCHOTHERAPY AND ITS MECHANISMS OF CHANGE

Abstract. Is psychodynamic therapy (PT) an evidence-based practice? What makes PT work? In the present article we shall discuss empirical evidence for these as well as other vital questions. First, we shall examine the existing findings concerning two of the most widespread myths about PT: (1) PT is not an evidence-based therapy; (2) PT is not directed at and, therefore, not effective at alleviating symptoms. Second, we shall examine some of the existing findings regarding what it is that actually enables change in PT. The aim of the article is to provide some access to the knowledge accumulated from numerous studies on PT treatments, conducted by dozens of therapists, with the hope that it will benefit clinicians.

Keywords: psychotherapy research, evidence-based practice, effectiveness, mechanisms of change, alliance, adherence

Freud strongly believed in the importance of a scientific grounding in classical psychoanalytic theory. A scientific observer at heart and by training, he regarded psychoanalysis as a branch of science and the

Because the editor asked us to write a summary of our own research, we have overemphasized our work and have not been as comprehensive as we could have been in reviewing other researchers' work.

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psychoanalytic situation as a kind of laboratory environment (Freud, 1933). Since then, psychoanalytic literature has been filled with heated debates over the best ways to think about this field as both a clinical treatment and an intellectual discipline (e.g., Mitchell & Black, 1995; Mitchell, 1997).

In Freud's time, the scientific world lacked the tools to systematically investigate psychoanalytic hypotheses. At that time, an attempt to restrict clinical work to an evidence-based scientific approach may have damaged the development and proliferation of the field of psychoanalysis. This has changed, however, and the time for *rapprochement* has arrived. Scientific investigation now has the tools to perhaps innovate and contribute to the extensive literature of psychotherapy. Like other clinicians-researchers (Lampropoulos et al., 2002), we suggest that building a bridge between these two parts of the same field, clinical practice and research, holds tremendous opportunities for psychoanalysis and psychoanalytic therapy (e.g., Barber, 2009). In this article, we will examine some of the existing empirical literature on psychodynamic therapy (PT) in order to examine how empirical findings may help clarify important issues both in clinical theory and in practice.

We start by examining the up-to-date contributions of research to discuss two widespread myths about PT: (1) PT is not an evidence-based therapy, and (2) PT is not directed at and, therefore, not effective at alleviating symptoms. In the second part of this article, we delve into one of the core questions of psychotherapy research and practice: What is it in PT that actually enables the patient to change?

Myth 1: Psychodynamic Therapy (PT) Is not an Evidence-Based Practice

In the 1950s, strong criticism was voiced concerning the effectiveness of psychotherapy in general. For years it had been asked whether we honestly do better than we could do by flipping pennies (Meehl, 1954; see also Eysenck, 1952), and some criticism still exists. Such criticisms are especially noticeable in regard to PT. The question of whether PT is effective has important consequences, not only theoretically, but also practically, when it comes to policy makers and budgets allotted for treatments by governments, insurance companies, and HMOs. In addition, therapists are interested in the welfare of their patients and do their best to provide effective treatment. Thus, answering the question of the efficacy of our treatment has an ethical implication for our work.

A popular comparison is between medicine and psychotherapy. If we assume that both physical and emotional well-being are important and that malpractice (even unintentionally) may have adverse consequences in both, one may ask: Will you give your relative a drug for his or her heart that is not evidence based? What about psychotherapy for his or her soul? Inside (i.e., ethical, wish to know) and outside (i.e., policy makers and budgets allotted) forces are now tipping the scales toward evidence-based psychotherapy.

Given the recent trends toward evidence-based psychotherapy, is PT obsolete and ineffective, as some may argue? Overall, and perhaps unsurprisingly to its practitioners, the answer remained a definite “no” throughout studies, with accumulated findings showing that PT indeed helps patients feel better as reviewed recently by Barber, Muran, McCarthy, and Keefe (2013) in the sixth edition of Bergin and Garfield’s *Handbook of Psychotherapy and Behavior Change*. Empirical evidence supports the efficacy and effectiveness of these treatments. Moreover, its efficacy (as assessed by statistical effect size) was found to be as substantial as that reported for other treatments that have been labeled “empirically supported” and “evidence-based” (e.g., Shedler, 2010; Barber et al., 2013). Prior meta-analyses have shown similar results for both short-term PT (average of 21 sessions; e.g., Leichsenring, Rabung, & Leibing, 2004) and long-term PT (average of 150 sessions; de Maat, de Jonghe, Schoevers, & Dekker, 2009), with patients continuing to improve long after the therapy ends. For example, Abbass, Hancock, Henderson, and Kisely’s (2006) meta-analysis of 23 randomized controlled trials, which included 1,431 patients with a range of psychiatric disorders who received short-term PT (fewer than 40 hours), showed a very large effect size estimating PT patients’ improvement (.97) in comparison to control patients (who were on a waiting list, received minimal treatment, or treatment as usual, i.e., a treatment patients generally receive in a community clinic). It is interesting that the effect size increased (1.51) at long-term follow-up (more than nine months posttreatment), suggesting that patients may have learned lasting tools and a more adaptive view of the world that led to ongoing change, even after therapy has ended. Another meta-analysis, which included 17 randomized control trials of short-term PT (average of 21 sessions), also reported a very large effect size (1.17) for PT compared to controls, which become even larger (1.57) at long-term follow up (an average of 13 months [Leichsenring et al., 2004]).

Using mostly pre/post studies, rather than controlled studies, de Maat et al. (2013) reported that patients who received psychoanalysis demonstrated change from intake to treatment termination on a range of measures. It is not surprising that the study of long-term therapies, especially psychoanalysis, using randomized clinical trials involves numerous methodological difficulties (see de Jonghe et al., 2012). However, there is some evidence from controlled studies suggesting that long-term dynamic therapy is effective. For example, based on eight controlled studies, Leichsenring and Rabung's (2008) meta-analysis suggested that long-term PT yielded significantly larger outcomes compared to other shorter forms of psychotherapy (e.g., CBT, dialectical behavioral therapy).

Barber et al. (2013) reviewed and meta-analyzed multiple, disparate, and randomized clinical trials to test the efficacy of psychodynamic psychotherapy for different disorders, irrespective of treatment length. They showed that PT is equivalent to alternative therapies (e.g., CBT) and superior to control conditions at termination and follow-up in the treatment of many types of psychopathology, including depression (across the 15 studies reviewed) and personality disorders (across the 13 studies reviewed). It is especially interesting to mention the research on the efficacy of PT on anxiety disorders because their treatment is commonly viewed as a stronghold of CBT. Barber et al. (2013) reviewed eight randomized clinical trials examining the efficacy of PT for anxiety disorders. For almost all anxiety disorders that were empirically examined, psychodynamic techniques are as effective (and for anxiety disorders other than generalized anxiety disorder [GAD], PT is more effective) than other alternative therapies. However, at short-term follow-up, there is preliminary evidence that for GAD alternative treatment (mostly CBT) may be more effective than PT (Barber et al., 2013). It might be suggested that CBT components need to be implemented during the acute phase of therapy to decrease symptoms and to prevent relapse. Nevertheless, it has been argued that the lack of sufficient attention to interpersonal problems may partly explain the limitations of CBT treatments for GAD (Borkovec, Newman, & Castonguay, 2003). Support for this argument can be found in a study showing that the degree of remaining interpersonal problems after CBT was predictive of failure to maintain follow-up gains (Borkovec, Newman, Pincus, & Lytle, 2002). Newman et al. (2011) have added an experiential/interpersonal component to CBT for GAD in their attempt to improve the efficacy. Unfortunately, their results were

not promising, perhaps because the treatments were not integrated (e.g., were administered at separate sessions).

A patient once shared with one of us: “When I was less occupied with the symptoms and the terrible anxiety that any moment I was going to have another attack was diminished, I had room to start to understand in therapy what really caused my symptoms, so I can treat the real problems in my life.” Indeed, studies indicate that improvement in acute symptoms may happen early in therapy, whereas improvement in defensive functioning may occur only later in the therapeutic process (e.g., Hersoug, Sexton, & Høglend, 2002).

As a final note to this section on therapy outcome, we want to emphasize two points:

1. We believe that no form of psychotherapy is going to work with every patient and not even with a specific class of patients. We have conducted research where we have explored for which subgroup of patients PT is effective. Barber, Barret, Gallop, Rynn, and Rickels (2012) have shown, for example, that minority male depressed patients improved more following PT than following either antidepressant medication or placebo, and another study showed that patients who are characterized as more dominant in their personality showed greater improvement in PT, compared with patients who are characterized as more submissive (Dinger, Zilcha-Mano, McCarthy, Barrett, & Barber, 2013). This research emphasis on what works for whom should be strengthened and more widely adopted as we try to develop more personalized forms of interventions.
2. Outcome research needs to focus on specified samples to ensure that we can replicate our findings and to ensure that we know for which kind of patients we are successful. However, this does not mean that we need to use DSM or any other classification system. We are, for example, suggesting that PT should be studied on patients with “commitophobia!”

Myth 2: Psychodynamic Therapy Is not Directed at, and Therefore not Effective at, Alleviating Symptoms

Another widespread myth is that PT does not alleviate symptoms because it does not strive directly in this direction. An old joke demonstrates this

common claim: “I’m still wetting, but now thanks to therapy I know why I am doing it.” What does the available research on this issue show? Studies demonstrate the efficacy of PT regarding a variety of outcome measures, including traditionally expected outcomes of PT, such as positive changes in intra-psychic structures (e.g., quality of object relations and ego functions; Vinnars, Thormählen, Gallop, Norén, & Barber, 2009), improvement in family/social problems (e.g., Crits-Christoph et al., 2008), in well-being and quality of life (Zilcha-Mano, Dinger, McCarthy, Barrett, & Barber, 2014), and in personality pathology (e.g., Vinnars, Barber, Noren, Gallop, & Weinryb, 2005).

However, PT efficacy is not restricted to those outcomes, and also results in a decrease in symptoms, as detailed in the DSM for many types of mental disorders. For example, PT was found to alleviate depressive symptoms (Hilsenroth, Ackerman, Blagys, Baity, & Mooney, 2003), panic symptoms (Milrod et al., 2007), agoraphobic symptoms (Alstrom, Norlund, Persson, Harding, & Ljungqvist, 1984), GAD symptoms (Crits-Christoph, Connolly, Azarian, Crits-Christoph, & Shappell, 1996; Crits-Christoph, Connolly Gibbons, Narducci, Schamberger, & Gallop, 2005), traumatic symptoms (Brom, Kleber, & Defares, 1989), somatic disorders (Abbass, Kisely, & Kroenke, 2009) and cocaine abuse (e.g., Crits-Christoph et al., 1999), as well as borderline personality disorder symptoms (Bateman & Fonagy, 2009), avoidant personality disorder (PD) symptoms and obsessive-compulsive PD symptoms (although better at reducing the latter than the avoidant PD symptoms; see Barber, Morse, Krakauer, Chittams, & Crits-Christoph, 1997).

Core Question: What Makes PT Successful?

To refine our knowledge about treatment efficacy and to improve future treatments, it may be helpful to know: What is it, precisely, that makes change possible in PT? Studying the mechanism of change raises complex questions. As a way of answering this complex question, we will address the interventions that are associated with good therapeutic outcomes. For the purposes of this article, we focus on what is perhaps a simplistic dichotomy and the question we would ask, therefore, is this: What has the research shown about which of two possible components—the *therapeutic alliance* or the *technique*—underlies this change (e.g., Barber, 2009). We focus on these two components of therapy because they have received considerable attention in theory, practice, and research,

and because the question of which one really matters is, perhaps, as old as psychotherapy itself and of great interest to clinicians.

Claim 1: A Good Alliance Is Highly Important for the Success of Therapy

The therapeutic alliance, also referred to as the helping alliance, the therapeutic bond, the therapeutic relationship, and the working alliance, has had a long and controversial history in psychoanalysis (Messer & Wolitzky, 2010). Whereas some see this concept as a distracting shift of focus away from the nuclear analytic technique of interpretation (e.g., Brenner, 1979; H. C. Curtis, 1979), others, like Freud himself in some of his writings, see it as a necessary vehicle for success that should not be analyzed, serving as a precondition for the curative aspect of therapy to take place (e.g., Freud, 1912). There are others who see the alliance as therapeutic in its own right (Zetzel, 1966), and even as the very essence of the change process (Safran & Muran, 2000). Cutting across the realm of PT, is it useful to think in alliance terms? To what extent does the alliance contribute to the success of therapy? How might research in psychotherapy contribute to this lively discussion?

Over the last few decades, many studies have been conducted on the therapeutic alliance (e.g., Muran & Barber, 2010). One of the reasons for the interest in such research was likely the alliance's relative importance in many psychodynamic theories. Another reason is the consistency of empirical findings in demonstrating the similarities of different therapies in their effectiveness in producing therapeutic gains (*The Dodo Bird Verdict Effect*¹; Luborsky, Singer, & Luborsky, 1975; Smith & Glass, 1977; Stiles, Shapiro, & Elliott, 1986). These consistencies may suggest that variables common to different psychotherapies may account for a large part of patient improvement. Many researchers and theorists concluded that this was due to the therapeutic alliance and thus, research on the alliance began to flourish. This trend was supported by three decades of empirical research that have consistently linked the quality of the alliance between therapist and patient with therapy outcomes. For example, Horvath, Del Re, Flückiger, and Symonds (2011) have shown

¹ Borrowed from *Alice in Wonderland*, the dodo's verdict announcement at the end of the race, that "everybody has won, and all must have prizes," has been commonly used to demonstrate that there were few differences that significantly distinguished among various brands of psychotherapy (Rosenzweig, 1936; Luborsky, Singer, & Luborsky, 1975).

that the correlation between alliance and psychotherapy outcome across 14,000 treatments is moderate but reliable (.285 explaining 8% of the variance). Barber et al. (2013) have shown that the average correlation is similar in PT. Based on these findings, many scholars have posited that the alliance is an active ingredient in therapy, meaning it is therapeutic in and of itself, and predicts, or accounts for, at least part of the therapeutic change (e.g., Flückiger et al., 2012).

However, a methodological analysis and review of the existing literature depict a more complicated picture. While reviewing the empirical literature that demonstrated that alliance predicts outcomes, researchers (e.g., DeRubeis & Feeley, 1990; Barber, Crits-Christoph, & Luborsky, 1996; DeRubeis, Brotman, & Gibbons, 2005) became concerned that these studies might have missed something important in relation to time sequence. In order for A to predict B, A needs to precede B. In other words, causes must temporally precede the effects and outcomes; demonstrating a timeline between a cause and an effect is important. Likewise, in order for the alliance to be responsible for changes in symptoms, it must be observed before these changes. This, however, was not the rule in many studies. Most studies examined the changes in symptoms from the first session to the last, whereas the alliance was observed in session 5 or 10. Is this only a methodological glitch or a more essential one?

Due to the failure to establish the required temporal relation, it can be argued that the alliance is actually a product of the decrease in symptoms and not a predictor of it. Patients who realize therapy sessions make them feel better (e.g., due to insight gained from successful interpretations) may come to see their therapists as more competent and helpful, and thus the therapeutic relationship benefits. Indeed, empirical findings show that the level of early alliance can be the product of previous symptomatic changes (e.g., Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000), and previous symptomatic changes can predict later symptomatic changes (Crits-Christoph et al., 2001). Is it possible that what we currently identify as an indication of a good alliance are simply aspects of early therapeutic progress resulting, for example, from a qualified use of interpretations? Does a prior lessening of symptoms predict both the alliance and the subsequent change in symptoms? Or is it the alliance that predicts sequence changes in symptoms? Perhaps both are correct. How may one correct the time sequences in order to test the alliance's power to predict symptomatic improvement? One option is shifting the time of observation to an earlier point, before a change

in symptoms has taken place. Although it is interesting to examine the alliance before therapy has begun (see Iacoviello et al., 2007), or during the first session, it may not capture the full concept of alliance as a relationship established between the therapist and the patient *throughout* therapy.

How can we overcome this difficulty without the risk of an inappropriate use of the concept of alliance? First, one needs to make sure that one is measuring change in outcomes after the measure of the alliance has occurred. Second, one needs to “clean up,” statistically, the symptomatic change occurring before the alliance is observed. When we consider only results from studies that have used the correct temporal relation between alliance and outcomes, we find the result to be more surprising than one may expect. Let us now examine some of these findings.

It seems that the first to employ correct temporal relations were DeRubeis and Feeley (1990; replicated in Feeley, DeRubeis, & Gelfand, 1999), who studied 25 depressed patients receiving cognitive therapy. They found that symptomatic change that had occurred prior to alliance measurements predicted the alliance. However, the alliance itself did not predict subsequent changes in depressive symptoms.

In addition to the methodological shortcomings (e.g., small sample size) that may diminish the capacity to detect significant findings in these studies, it can also be argued that, theoretically, it is reasonable to assume that alliance may play a far more important role in PT than in other therapies. If this assumption is correct, we might expect to find that the alliance does, in fact, predict subsequent change within PT. Two studies with substance-dependent patients receiving PT may shed some light on this issue.

Based on the findings from a sample of 252 cocaine-dependent patients receiving a variety of therapeutic interventions (cognitive, dynamic therapy, or drug counseling, Barber et al., 1999), the researchers did not find a significant relationship between alliance and subsequent change in drug use, after taking into account early symptomatic improvement. Similar results were obtained in the subsequent randomized clinical trial of the National Institute of Drug Abuse cocaine collaborative treatment study (Barber et al., 2001). Here, as well, researchers did not find a significant relationship between alliance and subsequent change in symptoms. Though PT was used in these two studies, it may be postulated that the alliance with a population of substance-dependent patients is less apt to be a predictor of outcomes as it is with other “neurotic” patients (see also

Barber et al., 2008), a population more frequently seen in psychodynamic clinical practice. In order to examine this more elaborate assumption, it may be more expedient to study a neurotic population receiving PT.

In a sample of “neurotic” patients, Barber et al.’s (2000) showed that alliance at session 5, for example, was predicted by earlier change in symptom (from intake to session 5). Nevertheless, the therapeutic alliance in PT with patients who were not substance-dependent was a predictor of subsequent change in symptoms, even while taking into consideration the fact that the alliance itself was strengthened by the patient’s prior symptomatic improvement. In other words, the study showed that alliance predicted subsequent symptomatic change well beyond the improvement that had occurred prior to the assessment of the alliance (Barber et al., 2000; Crits-Christoph, Connolly Gibbons, & Mukherjee, 2013).

Similar findings have been shown by Klein et al. (2003), who also studied a population more frequently seen in psychodynamic clinical practice: 341 chronically depressed patients. The patients received cognitive behavior analysis system of psychotherapy, an integrative CBT with psychodynamic interpersonal components, in which the patient identifies a recent, distressing interpersonal situation and examines it with the therapist (McCullough, 2000). This study also found the alliance between the patient and therapist to be highly significant in determining outcomes. Although the last two studies reviewed show promise that alliance can predict subsequent symptomatic change in DT regardless of previous symptomatic improvement, the findings are still inconsistent (e.g., Barber, 2009; Crits-Christoph et al., 2013).

One potential way to address this question and the mixed results reported by Crits-Christoph et al. (2013) is the use of an analytic method that enabled us to assess the alliance-outcome relation at more than one time point throughout therapy and therefore facilitate the examination of reverse causality between alliance and symptoms (Zilcha-Mano, Dinger, McCarthy, & Barber, 2013). Our findings showed that the alliance was the predictor (and not the product) of subsequent symptomatic levels in a sample of depressed patients receiving PT or supportive management with either medication or placebo. These findings lend some support to the theoretical view of the alliance as a curative factor (Rogers, 1951; Norcross, 2002) that precedes therapeutic change. At this point, more studies are needed in order to understand how the type of therapy (PT vs. other therapies) and the type of population (neurotic vs. other patient

populations) influence the causal relationship between alliance and outcomes, because the matter seems to be far more complicated than it first seemed. Another interesting direction for future studies is the question of *how* the alliance influences the success of therapy, i.e., what is the mechanism involved in this process?

Until more studies follow, some suggestions may be offered at this point about additional factors that may contribute to our understanding of the poor correlations between alliance and outcome when focusing on some of the studies that have employed the appropriate sequence of measurement and statistical analysis. First, early dropout rates of patients who had formed a negative or weak alliance with their therapist may considerably restrict a fuller range of alliance levels in statistical analyses performed later in the therapy, as they may only be performed on patients with more satisfactory alliances with their therapists, resulting in a lack of correlation (or a smaller correlation compared to the relation that may exist in reality) between alliance and outcome.

Second, when examining the relation between alliance and outcomes it is also important to refer to potential confound variables. For example, the projected parts of the alliance formed long before the treatment began may be responsible for both the symptomatic change prior to report of the alliance as well as the alliance's association with subsequent change. Some of these projected parts can be expressed in the patient's pretreatment expectations about the success of therapy and about the quality of the alliance to be formed with the therapist, which has been found to influence the actual alliance in therapy (Gibbons et al., 2003; Zilcha-Mano et al., 2013; Barber et al., 2014). Other possible related variables, which would predict both the assessed alliance and symptomatic change, and therefore account for the association between them, may include the initial "chemistry" between patient and therapist, and the therapist's ability to become a self-object (Kohut, 1984), or a secure base (Bowlby, 1988), for the specific patient.

A third explanation suggests that we are focusing on the wrong outcomes. It might be the case that the formation of a good alliance in therapy will most likely result in improvements in the patient's abilities of perceiving and relating to others, or in personality change, rather than in symptomatic change (e.g., depression or drug abuse), which will be only secondary to the interpersonal and intrapersonal alteration.

Even if the alliance indeed maintains a central role in predicting therapeutic outcomes, one may wonder whether a good alliance is sufficient for successful psychotherapy. Given the empirical evidence that the

largest portion of therapeutic change cannot be explained by the alliance (even when focusing on specific studies that found a strong effect for the alliance), we are suggesting that therapeutic interventions might also have an important influence on therapeutic outcome.

Claim 2: Good Technique Is Highly Important for the Success of Therapy

Although many clinicians consider the alliance to be the most important ingredient across different therapies, others consider the unique core techniques that characterize each therapeutic orientation to be the most important components in facilitating therapeutic change, thereby putting therapy-specific factors ahead of common factors (e.g., the alliance; Brenner, 1979; H. C. Curtis, 1979) as the major agents of change.

As clinicians, many of us spend a significant and precious part of our professional lives developing and enhancing our repertoire of techniques, through reading professional literature and working on developing our clinical skills. Some aspire to expand their toolbox to include many techniques, from which they will choose the most appropriate ones for any specific patient who may seek their help. Others seek to continue deepening their knowledge and competence in a selected therapeutic orientation in order to become more professional in delivering it. Whatever the choice may be, most of us invest many hours of our lives, from graduate school through our ongoing professional development, improving our professional techniques, due to the assumed importance of skill and professionalism in implementing psychotherapeutic techniques. Our impression is that we do the same as teachers and supervisors.

Implementing therapeutic techniques forms the foundation of each therapist's professional activities, and has been argued to play a core role in the profession of psychology, which directs much of what psychologists do (e.g., Barnett, 2007). But the question remains: Is the implementation of a therapeutic technique during treatment really what generates our patients' progress? Given that technique is such a broad concept, before addressing these issues, elaboration on some of the ways technique is measured in research is warranted.

From the extensive literature on the effect of technique, this article will cover some of the research focusing only on two complementary concepts of therapist proficiency: adherence and competency. Adherence includes the extent to which the techniques that a therapist uses are theory-specific and not proscribed according to a specific treatment manual. For example, in supportive expressive therapy for depression (a

type of PT developed by Lester Luborsky [1984] that can be time-limited), therapists are expected to provide support. An example of a supportive technique is captured in the adherence measurement by an item such as: "The therapist conveys a sense of supporting the patient's wish to achieve the goals of treatment." In addition, they are also expected to use expressive techniques. Items representing expressive techniques include: "The therapist focuses attention on similarities among the patient's past and present relationships"; "The therapist relates the way the patient feels about the therapist to the way the patient feels about significant others (e.g., friends, boss, or parent)" or "the therapist *relates* the appearances of symptoms during the session to the various components of the relationship problem or conflict" (Barber et al., 1996).

Although adherence ignores to some extent the context in which a technique was implemented, competence is context-specific and includes the extent to which the therapist uses the technique skillfully in the appropriate context (in the appropriate time, with responsiveness, and congruence with the patient's characteristics and needs; e.g., Barber, Sharpless, Klostermann, & McCarthy, 2007; Sharpless & Barber, 2009a). Although adherence and competence are theoretically distinct, there is much overlap in their assessment, with some tools including the same items being rated on adherence and competence (e.g., Barber et al., 1996). Other measures have focused on either adherence or competence (e.g., DeRubeis & Feeley, 1990). Both adherence and competence are typically assessed through observations by at least two independent experts or trained raters who code these variables from videotaped, audiotaped, or transcribed therapy sessions. These methods are labor intensive and time consuming (for exceptions that did not require external experts' rating, please see McCarthy & Barber, 2009; Paivio, Holoway, & Hall, 2004).

What were the empirical findings using these tools? Is technique a primary vehicle for change? Webb, DeRubeis, and Barber's (2010) recent meta-analysis combining the results of many studies show that the studies are actually inconsistent and reveal high heterogeneity among them. Even the varied type of therapy was not able to explain this inconsistency. However, most surprising, there was no association between adherence or competence and outcome.

Specifically, some of the studies in this field failed to find any relation between adherence to the specific therapy's techniques and therapy outcomes. For example, a study with bereaved patients given time-limited

PT showed that actions by the therapist were not significantly related to outcomes (Horowitz, Marmar, Weiss, DeWin, & Rosenbam, 1984). Similar findings were found by Gaston, Piper, Debbane, Bienvenu, and Garant (1994), who showed that neither exploratory nor supportive interventions had an impact on outcomes for either short-term or long-term PT with a neurotic population. Likewise, in a study of PT for depression, Barber et al. (1996) did not find any significant relation between adherence and change in depression.

However, in other studies, different trends than those described above have been found. For example, in Paivio et al.'s (2004) study, adherence was significantly related to one of the outcomes measured (i.e., improved abuse resolution) but not with the others (e.g., change in interpersonal problems, change in trauma-related symptoms, and a general checklist of symptoms). Even more promising are findings regarding a positive association between adherence and outcome, which emerged from DeRubeis and Feeley's (1990) study. The authors found that adherence to the specific techniques of cognitive therapy predicted subsequent change in depression.

Although these studies provide evidence that in some instances a higher level of adherence brings better outcomes, there are also findings showing precisely the opposite: There is some evidence showing that higher adherence results in less favorable outcomes. In clinical work this might be equivalent to the surprise one feels when realizing that his or her patients (or supervisees' patients) respond to the interventions in a way that is totally different from what one expected. Let us look at an example from research. In a study with a cocaine-dependent population Barber et al. (2008) found that greater adherence to psychodynamic techniques significantly predicted worse subsequent outcome as assessed by cocaine use. In other words, patients did worse when therapists were generally adherent to psychodynamic techniques related to cocaine abuse.

Based on the mixed results, it might be suggested that overall adherence and outcome are simply not related and the only significant relations that were found are due to random errors. However, the heterogeneity of findings, as indicated in the Webb et al. (2010) meta-analysis, suggest that the picture is complex, and that we shall benefit from directing our attention to additional variables in attempting to explain why this relation was found in some studies/situations but not in others.

Several explanations have been suggested thus far to explain the lack of a positive relation between adherence to specific therapeutic orientation and outcomes (see Webb et al., 2010). One explanation suggests that other unintended therapeutic orientations might “sneak” into the therapy room and have an influence on outcomes. Therapists in clinical trials are requested to use only a specific predefined therapeutic orientation, so the specific orientation’s effectiveness (in its “prototype” version) can be compared to other therapeutic orientations. Studies show that although different kinds of therapy orientations differ from one another in the techniques used, it seems that slippage among them does exist, and more often than one may think (Ablon & Jones, 2002). Therapists use a variety of interventions with their patients, some of which are perhaps inconsistent with their prescribed treatment orientation. For example, when examining the adherence of psychodynamic therapists to psychodynamic tools, the adherence indeed was satisfactory. However, while examining the adherence of psychodynamic therapists to other interventions, such as individual drug counseling, it was not negligible at all (Barber, Foltz, Crits-Christoph, & Chittams, 2004; Barber et al., 2008). In other words, studies have shown that the therapists in those studies were perhaps more eclectic in orientation than they intended to be (see also Ablon & Marci, 2004).

Barber et al. (2008) used adherence scales of different kinds of therapies to rate the use of different kinds of techniques in PT for cocaine dependence. They showed that as adherence to individual drug counseling increased and adherence to supportive-expressive dynamic therapy decreased, patients’ outcomes improved. One may therefore conclude that there are advantages to using active directive methods of interventions as part of PT in the first stages of working with a cocaine-dependent population, instead of trying to help patients understand the reasons for their use during these early phases of treatment (i.e., while they still use the drugs). Indeed, for those patients who achieved abstinence in the early stages of therapy, PT became more effective and produced outcomes comparable to one of the most effective treatments for this population—individual drug counseling (Crits-Christoph et al., 2008). One may speculate that as we move away from the stereotyped population of PT (drug abuser, patients with panic disorder), the more that slippage may occur (Barber et al., 2004, 2008; Ablon, Levy, & Katzenstein, 2006). In brief, the use of these extra-therapeutic interventions is perhaps one of the reasons for

the lack of a consistent relation between adherence to specific therapeutic orientation and outcomes, and that these “sneaking” therapeutic interventions act as active ingredients that are responsible for promoting positive patient change (Ablon & Marci, 2004).

Another possible explanation is that we have focused on measures of treatment packages, rather than on specific interventions. For example, one could study the impact of transference interpretations on patients’ outcomes rather than the impact of the delivery of the entire package of PT on outcomes. Some PT techniques have already received empirical support for their beneficial influences on patients. For example, exploration of affect has been consistently linked to positive outcomes (for a meta-analysis, see Diener, Hilsenroth, & Weinberger, 2007). However, not all PT techniques examined have been found to be beneficial. For example, although many therapists believe that good interpretations are the vehicles of change in psychotherapy, more frequent uses of interpretations were found to be related to worse therapeutic outcomes (for review, see Barber et al., 2014). These findings may suggest that a few targeted interpretations are better than frequent uses of interpretations (e.g., the “high risk-high gain” role; Gabbard et al., 1994). Another possibility is that interpretations are only useful for a subset of patients, such as those with strong alliances with their therapists. Further research is needed in order to thoroughly understand the relation between specific PT techniques and outcomes.

An additional possible explanation for the lack of consistent positive relations between adherence and outcomes is that a different kind of relation exists between adherence and outcome than the one that has typically been searched for in this field. Although many studies examined whether more adherence leads to better outcomes (a linear relation), Piper, Azim, Joyce, and McCallum (1991) and Barber et al. (2006) suggested that therapists who are too rigid (high adherence) or too amateur (low adherence) may not be as effective as those with a moderate level of adherence (curvilinear relation). Barber et al. (2006) reported that moderate adherence had a positive effect on outcomes in a sample of cocaine-dependent patients (for similar findings of a curvilinear relation see also Huppert et al., 2001). Although it needs to be directly examined in future studies, it is possible that a moderate amount of adherence implies therapist flexibility or responsiveness; two additional variables that might be of great importance and relevance to clinicians.

A related aspect, the competence with which the therapist delivered the treatment, may also help us understand the inconsistent findings regarding the association between adherence and outcomes. Two therapists, who adhere to the same therapeutic orientation at the same level, may practically perform very differently in the therapy room. One may do it with responsiveness to patients' needs (Stiles, Shapiro, & Elliott, 1986; Stiles, 2009), in the right time and the appropriate context, whereas the other may do it rather robotically and rigidly. Therefore, it can be speculated that a competent therapist might have better treatment outcomes than a noncompetent therapist, even when both adhere to the same therapeutic orientation and at the same level. Regardless of how intuitive it may seem, is it important to refer to the appropriateness in which the techniques were implemented?

Barber et al. (1996) reported that it was the relatively competent delivery of expressive (interpretative) PT techniques rather than their frequency of use (i.e., adherence) that was critical in predicting patients' subsequent symptomatic improvement, even after taking into account other variables such as the quality of the alliance and symptomatic improvement early in treatment. Using a similar population of patients diagnosed with depression, Shaw et al. (1999) found similar results in cognitive therapy. They showed that competent delivery of cognitive therapy was associated with good outcomes among depressed patients. However, therapist competence may differentially influence therapeutic change depending on the specific population being treated (Webb et al., 2010), with competent delivery of treatment being an important contributor to outcomes among depressed patients, but not with a cocaine-dependence population (Barber et al., 2008).

It may seem reasonable that with some populations the therapist's competence level will have more influence than with other populations. In considering possible reasons for the inconsistency found in the literature dealing with adherence and competency, some methodological factors should be taken into account as well (for a full discussion on this matter see Barber et al., 2007). To name only a few, the characteristics of the therapists in the studies might mask the influence of adherence and competence on outcomes. More specifically, in order to increase the chance of finding a relation between those concepts and outcome, one needs to include therapists with a range of abilities. Therefore, having only inexperienced or very experienced therapists may lead to a restriction of range and, therefore, to a lack of relation between competence

and outcome. Indeed, the therapists in carefully conducted randomized controlled trials were highly experienced and competent (for an exception that focused on changes in professionals' competence, see Milne, Baker, Blackburn, James, & Reichelt, 1999). In those studies, great care was taken to select and train therapists and monitor the delivery of therapy, especially with regard to adherence and competence (Webb et al., 2010). This may explain, at least to some extent, the lack of a clear relation between adherence and outcomes.

Another explanation for the lack of a clear relation between adherence and outcomes may be that we are focusing on the wrong outcomes. As was the case with studies on the alliance, it may be that a better match is needed in future studies between the techniques (and the mechanism of change underlying it) and the outcomes on which research should focus. For example, although it makes sense that high adherence to a symptomatic-focused approach might result in better outcomes when examining short-term cocaine use, it might be that greater adherence to a psychodynamic orientation would result in profound and prolonged personality and interpersonal change. This was suggested by Crits-Christoph et al.'s (2008) study, which showed that DT was superior to individual drug counseling on change in family/social problems a year after therapy ended. Clinicians in the field may help sharpen and clarify the desired outcomes of DT research, as well as the expected association between specific psychodynamic techniques and desired change, based on their accumulated experience.

Claim 3: In Reality, Technique and Alliance Are Intertwined and Cannot Be Separated

When comparing the ability of technique and alliance to produce therapeutic change (i.e., comparing effect sizes), it seems that alliance has a larger contribution to outcomes (e.g., Martin, Garske, & Davis, 2000; Webb et al., 2010; Flückiger et al., 2012). If these findings are replicated in more studies, overcoming statistical, methodological, and conceptual shortcomings, it may affect the future of training in psychotherapy. Specifically, it might suggest that more emphasis should be placed on alliance in the selection process, training, and examination for professional practice of the future generations of clinicians (e.g., Sharpless & Barber, 2009b).

However, before deeming the alliance as more important, it could be argued that alliance and techniques are intertwined and both may be necessary to describe a successful therapy (Barber, 2009). From a theoretical

perspective, the alliance may facilitate the responsiveness of the therapist to the patient's need while implementing the techniques, and therefore facilitating more efficient realization of techniques (Gaston, Thompson, Gallagher, & Gagnon, 1998). In turn, the patient might be more or less reluctant to engage in this process depending on his or her alliance with the therapist. Some argue that a positive alliance is not, in and of itself, curative; rather, the alliance might be seen as the ingredient that makes it possible for the patient to accept and follow the treatment's techniques faithfully (Bordin, 1980). Over the years, therapists have expanded their technique to building and maintaining the therapeutic alliance and to addressing problems that interfere with an effective alliance (e.g., Crits-Christoph, Crits-Christoph, & Connolly Gibbons, 2010).

Some direct examination of the reciprocity between technique and alliance in determining outcome comes from Owen, Quirk, Hilsenroth, and Rodolfa's (2012) study, which examined the interactions between the patients' views of their therapists' technique and the alliance in predicting postsession gains in brief naturally occurring therapies (where therapists may be more integrative in the use of techniques, compared to RCTs). They found that patients who reported that their therapists used more PT techniques had higher postsession gains when reporting strong alliances with their therapists, as compared with patients who reported that their therapists used more PT techniques, but reported weaker alliances. Another study by R. Curtis, Field, Knaan-Kostman, and Mannix (2004) demonstrated the importance of both alliance and techniques in a sample of psychoanalysts reporting on their own experiences in analysis. Consistent with the clinical wisdom, these findings suggest that adherence to technique and the therapeutic alliance are interdependent and interrelated in predicting the success of therapy. However, the specific pattern of connections between technique and alliance in predicting outcomes may differ depending on the specific patient population. For example, Barber et al. (2008) found that in a sample of cocaine-dependent patients, strong alliance combined with the use of lower levels of PT techniques (as opposed to moderate or higher levels) was associated with better outcomes.

Concluding Remarks

Throughout the years, researchers have worked tirelessly to facilitate the study of psychodynamic constructs, by translating them into operational

concepts that can be tested. We now face the no less important challenge of translating back what we have learned from these studies to a practical enrichment of clinical work. This special volume is certainly another step in the joint effort to create a common language between practice and research, with the common goal of benefitting the patients.

We believe that even though much remains to be learned, clinicians can use research findings combined with their theoretical knowledge and their clinical experience as a compass at junctions of decision making in treatment. For example, as mentioned above, while working with substance-dependent patients, clinicians may consider using active techniques at the early phase of treatment (i.e., while patients still use the drugs) in order to reduce substance use, thereby creating the conditions needed for profound work toward emotional insights as well as intrapersonal and interpersonal change (Barber et al., 2008). This is only one example of how empirical findings, based on the experiences of numerous therapists, patients, and external observers, could be used to facilitate therapeutic change. Pragmatic books and articles presenting the state-of-the-art research-based psychodynamic practice guidelines that clinicians can use to further optimize the welfare of their patients are now available (e.g. Summers & Barber, 2009; Weiner & Bornstein, 2009).

In addition to the implementation of empirical findings in practice, research tools could also improve clinical work by being integrated into the education and training process of clinicians-to-be and experienced clinicians (Sharpless & Barber, 2009b). Existing research tools might have an important role in the process of individual and supervisory self-reflection. For example, given the empirical findings demonstrating that therapists tend to include unintended techniques in the therapies they conduct (Barber et al., 2004), a systematic self-reflective tool on the specific techniques being used in each session, such as the recently developed Multi-theoretical List of Therapeutic Interventions (MULTI; McCarthy & Barber, 2009), may highly contribute to our life-long training and learning processes. The MULTI assesses interventions from eight different psychotherapy orientations (behavioral, cognitive, dialectical-behavioral, interpersonal, person-centered, psychodynamic, process experiential, and common factors). Therapists are invited to experience this reflective process by following the link below and anonymously answering questions regarding a specific session, and receiving immediate feedback about the specific techniques being used in the session. Furthermore, given

that the language used is not technical, patients are also invited to use this tool.²

Although there have been great developments in recent decades in the study of PT, much more work remains to be done. It is reasonable to expect that the development of advanced methodological and analysis methods will enable researchers to reach deeper and more accurate levels of understanding. These changes are already taking place, as can be seen, for example, from the prevalent use of advanced quantitative statistical methods, as well as experience-near methodologies, such as narratives in psychotherapy research (e.g., Goncalves & Stiles, 2011). Also, it seems that there will be a tighter connection between new models of pathology and specific interventions directed to them.

However, the most substantial contribution to the future of psychotherapy research may depend on you, fellow readers. Even though the studies that have been accomplished so far show very promising support for the efficacy of PT, more studies may be necessary for PT to become a well-established treatment. In addition to randomized control trials, examining effectiveness, as well as the mechanism underlying therapeutic change, in large sample of treatment in which naturalistic DT is delivered, is important (e.g., Barber, 2009). Each and every one of this journal's readers can contribute to accomplishing this goal through participation in naturalistic research in psychotherapy by contacting the authors.

As psychodynamic therapists who reflect on the studies presented in this article, we are curious about many further questions: First, which psychodynamic technique results in more favorable outcomes for different types of patient problems, needs, and personality characteristics? Are there patients who will benefit more from therapy based on a self psychological perspective, and others who will benefit more from an object-relations or relational perspective (see Summers & Barber, 2010)? And perhaps, along with the possibility that PT versus CBT therapies may lead to different results, it may be that different PT orientations will vary in their influence on the patient's intrapsychic and, therefore, interpersonal life. Second, similar questions of elucidation and expansion might be applied to the therapeutic alliance. When asked to rank themselves on capability in forming a therapeutic alliance, many (or even

² The link for therapists: http://idc.qualtrics.com/SE/?SID=SV_b195XJu7GGU52ol; the link for patients: http://idc.qualtrics.com/SE/?SID=SV_9nN3BMbovCBqb5z.

most) therapists may reply that they are better than average. However, if we look into the composition of the alliance using Bordin's (1979) conceptualization (which was used in building some of these tools), we can ask how good a therapist is in building shared goals or in creating accepted recognition of the therapeutic tasks. We might further ask how good a therapist is in explicitly discussing patients' nonverbal communications, in interpreting patients' core conflicts, or in repairing the inevitable ruptures and discussing patient-therapist relationship issues. We might also ask whether these abilities have different influences on outcome. The practical implications of these questions to training and the professionalization process are clear. Third, delving into the concept of the alliance, the reader may notice even more clearly the interconnection between alliance and technique, and it may seem hard to separate them. Undoubtedly, more exciting work in PT remains to be done. To further examine these complex and rich concepts, more studies are necessary, and naturalistic studies following the treatments of clinicians in practice may shed much light on these issues.

Following Stricker (1992), we concur that science and practice share a mutual dependence on a systematic body of knowledge to which we are all obligated to contribute, as we all share the common aim of improving patients' lives and well-being. If science fiction has succeeded in influencing science (e.g., Verne, 1886), is it fiction to believe that therapy can facilitate effective research and effective research can contribute to more effective therapy?

In this article, we have raised central and clinically practical questions related to the effectiveness of PT and to its mechanisms of change. We have also described a few of our contributions to the discussion of these questions, with the hope that it will create a growing desire to increase knowledge among the readers. The studies mentioned were used to illustrate the contributions that research in psychotherapy offers clinicians, rather than to provide a comprehensive review of the respective literatures, or even a representative part of it.

Many of us have internal supervisors, be it specific figures who mentored us in the past, or a mosaic of our experience combined with the experience of influential others. Imagine that at any point of time in therapy, in addition to your own conceptualization of the case, you will also have the clinical experience of dozens of well-trained and experienced psychodynamic therapists to consult with. This seems to be one of the contributions of research in psychotherapy and its promise for clinicians.

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