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A Systematic Review of the Association Between Interpretations and Immediate, Intermediate, and Distal Outcomes

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Interpretations are a hallmark of psychodynamic treatment and a method used in other theoretical orientations as well. Therapists use interpretations to increase patients' insight concerning unconscious and preconscious elements in their lives, with the ultimate aim to reduce mental pain and suffering and improve mental health. This systematic review focuses on the association between the therapists' use and accuracy of interpretation and immediate (within-session), intermediate (between-session), and distal (end-of-treatment) outcomes. This synthesis of the research literature is based on 18 independent samples of 1,011 total patients in individual psychotherapy. The results suggest that the use and accuracy of interpretations were associated, in half the studies, with patient disclosure of emotions and increased insight at the immediate, moment-to-moment enfolding of the session. At the intermediate postsession outcome, the use of interpretations was associated with a stronger alliance and greater depth, in half the studies. At the end of treatment, however, while there is some evidence for a positive effect of the use of interpretations on treatment success, there are also neutral effects and even evidence that interpretations have the potential to be harmful in some particular situations. The article concludes with training implications and therapeutic practices based on the integration of clinical experience and research evidence.

Clinical Impact Statement
Question: Does a synthesis of the literature support the utility of providing interpretations for improving immediate, intermediate, and distal outcomes in adult psychotherapy? ***Findings:*** In many of the studies, the use and accuracy of interpretation were related to various positive outcomes. ***Meaning:*** The use of interpretations, especially those that accurately capture the origins of the patient's suffering, contributes to adaptive therapeutic in-session processes and to better treatment outcome, although potential adverse effects of interpretations have also been documented. ***Next Steps:*** More studies are needed to determine the type of interpretations that should be used and the optimal, responsive way of delivering them to individual patients, based on their strengths, characteristics, and needs.

Keywords: interpretations, psychodynamic, transference, alliance, process-outcome research

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Interpretations are a fundamental component of most psychodynamic treatments and a common feature of other forms of psychotherapy. In psychodynamic work, interpretations address a central conflictual theme that the therapist believes is likely responsible for the pain and suffering of the individual (Crits-Christoph et al., 1988). Therapists use interpretations to increase patients' insight concerning unconscious and preconscious elements in their lives (Nunberg, 1948), and many theorists consider them to be at the top of the hierarchy of psychodynamic methods (Bibring, 1954). Repeated use of interpretations is expected to bring lasting ("structural") change in the individual through a process of uncovering unconscious themes and increasing self-understanding

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("aha" moments) and result in improved mental health and reduced symptoms (Horwitz, 1974).

The process of raising awareness and understanding of recurring maladaptive patterns is transtheoretical, although manifesting differently across theoretical orientations (Wampold et al., 2007). For example, in cognitive treatments, identifying and challenging automatic thought distortions and their underlying negative personal schemas (Beck, 1976; Leahy, 2017) have some similarities to psychodynamic interpretations. The same is true regarding schema therapy, in which the therapists and the patients may engage in identifying and exploring the origin of maladaptive schemas, which are self-defeating emotional and cognitive patterns established in childhood and repeated throughout life (Young et al., 2003).

Despite the importance of interpretation, both in theoretical and clinical literature, research studies in this area have been more limited than one would expect for such a key method. To the best of our knowledge, this is the first systematic review to synthesize the research evidence on the association between psychotherapists' interpretations and outcomes at three time frames: immediate (in-session), intermediate (measured after sessions), and distal (symptom reduction at the end of treatment).

Definitions and Clinical Description

In the context of psychodynamic treatment, *interpretation* refers to a psychotherapist skill in which the psychotherapist recognizes, and then seeks to raise, the patients' awareness and understanding of recurrent maladaptive patterns (Gabbard, 2009; Summers & Barber, 2010). A broader, transtheoretical definition of *interpretation* is "a statement that goes beyond what the patient has overtly stated or recognized and gives a new meaning, reason, or explanation for behaviors, thoughts, or feelings so that the patient can see problems in a new way" (Hill, 2020, p. 255). Awareness of such maladaptive patterns, when it is not only intellectual but also emotionally involved, is expected to raise insight, which in turn is expected to result in cognitive and behavioral change, symptom reduction, and an increase in well-being (Kuncewicz et al., 2014).

Some interpretations focus on *intrapersonal*, others on *interpersonal* conflicts or maladaptive recurring patterns. From the ego psychology perspective, intrapersonal conflict commonly refers to a conflict between the ego and the superego, and between the ego and the id. For example, therapists may recognize and interpret the patient's use of less mature defenses to handle internal and external stressors, viewing defenses as expressions of unconscious conflicts, needs, and motivations (Freud, 1955). From a relational perspective, intrapersonal conflict commonly refers to aspects of the self or "inner voices" that have different and at times conflicting needs (Bromberg, 2003). By contrast, from an object relations theory perspective, interpersonal conflict commonly refers to a conflict between the individual's interpersonal wishes (what the individual wants and needs in interpersonal relationships) and the response of the others to those wishes (Luborsky, 1984). Interpretations focusing on interpersonal conflict and maladaptive patterns can be divided into those concerning the patients' interpersonal relationships outside of treatment and those concerning enactments of these patterns in the relationship with the therapist, also referred to as *transference interpretations* (Foelsch & Kernberg, 1998). Interpretations also differ in the extent to which they are viewed either as objective information that the therapist delivers to the patient, as a hypothesis to consider or prompt for further reflection, or as a collaborative task that both the patient and the therapist engage in, with the result of patients understanding the therapist's subjectivity and feeling understood by the therapist (Aron, 1992).

According to some psychodynamic perspectives, therapists are advised to start with an empathic statement, move to a tentative hypothesis regarding the identified maladaptive pattern, then conclude again with empathy (Summers & Barber, 2010). For example, a therapist may say:

> You feel so alone, with no one being there for you. I think that maybe you are so afraid of being left alone that you are clinging to those who mean so much to you, in a way that may make it hard for them to stay, then at the end you really find yourself alone. All this makes you feel that you will not get the help and intimacy that you want so much from others no matter what.

After an interpretation is provided, the therapist can carefully explore the patients' reaction: Does it lead to greater emotional openness and greater disclosure of emotions (Basch, 1980)? Does it lead to rupture in the alliance (Milbrath et al., 1999)? Clinical experience and a few research studies (e.g., Leibovich et al., 2020) advise offering interpretations as a tentative hypothesis to facilitate further explorations, rather than as an objective truth (Leibovich et al., 2020; Wachtel, 1993). It has also been suggested that it is advisable to be flexible in use of interpretations, to make the rationale on which they are based clear and their content close to the surface of consciousness (Katz et al., 2019; Owen & Hilsenroth, 2014; Speisman, 1959). When offering interpretations that go beyond what the patient is saying and presenting new perspectives, therapists should be aware of the patients' cultural background and worldview, and be careful not to impose their own worldview on the patient.

Other clinical suggestions, requiring empirical support, indicate that the recommended number of interpretations is generally not high, especially for transference interpretations. The rule of thumb is about one or two transference interpretations per session (Høglend et al., 2008). Another rule of thumb concerns the timing of interpretations, and states that it is generally more advisable to provide the interpretation in the middle of the session. Providing it at the end of a session may preclude the opportunity to work through its potential meanings, and providing it too early may prevent establishing a strong enough alliance to serve as a supportive environment for the interpretation (Gabbard, 2006; Leibovich et al., 2020). The same is true about offering interpretations too early in the course of treatment before a sufficiently strong alliance has been formed (Summers & Barber, 2010).

Some theorists have argued that transference and nontransference interpretations have different recommended timing. That is, it is advisable to first increase the patients' curiosity about maladaptive patterns outside the relationship with the therapist, as well as their insight into such patterns, and only then interpret them as part of the transference toward the therapist (Book, 1998). Others, however, have noted the importance of offering transference interpretations early in treatment (Davanloo, 2000; Kernberg, 1975). The rationale here is that interpreting defenses early in the process of therapy will create pressure that will allow warded-off feelings to be experienced and processed quickly and completely (Davanloo, 2000).

There is an ongoing debate regarding the characteristics of the patients who may benefit most from interpretation. Some studies suggest that the use of transference and nontransference interpretations

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is related to better treatment outcomes for patients with more, rather than fewer interpersonal problems (e.g., Høglend et al., 2008; Keefe et al., 2019). Other studies report an opposite pattern of findings, with a greater number of transference and nontransference interpretations being related to better treatment outcomes in patients with fewer, rather than more interpersonal problems (e.g., Connolly et al., 1999; Jacobs & Warner, 1981; Ogrodniczuk et al., 1999). A potential explanation for these mixed research reports is that, similarly to the interaction between interpersonal problems and therapeutic alliance (Zilcha-Mano & Fisher, 2022), the effect on the outcome of the interaction between interpretations and the patients' interpersonal characteristics may run in opposite directions for between-patients versus within-patient effects. The *between-patients* level refers to differences between patients in the extent to which their therapists generally tended to use interpretations in their treatments. In contrast, the *within-patient* level refers to changes in the use of interpretations in sessions with the same patient. Thus, for individuals with more severe interpersonal problems, the association between interpretations and outcome may be positive at the between-patients but negative at the within-patient level. At the between-patients level, a general use of a low–intermediate amount of interpretation over the course of treatment may be more beneficial than a high amount. By contrast, at the within-patient level, a gradual increase in the amount of interpretation may be more beneficial than a stable amount of interpretations or a reduction in the amount.

Assessment

Measures assessing the occurrence of interpretations in an entire session can be divided into those estimating the extent to which interpretations were a characteristic of the session (e.g., McCarthy et al., 2016) and those focusing on the frequency of interpretations used in a session (e.g., Crits-Christoph et al., 1988). Measures assessing the occurrence of interpretations within each therapist sentence or speaking turn in sessions can be divided into those measuring whether interpretation occur or did not occur (e.g., Piper et al., 1991) and to those assessing the accuracy and quality of the interpretations (e.g., Silberschatz et al., 1986).

In within-sessions' measures of interpretations, researchers code the occurrence of interpretation in each therapist's speech turn. An example is the revised Hill Counselor Verbal Response Modes Category System (HCVRMCS; Hill, 1986), which includes nine pantheoretical, nominal, mutually exclusive therapist verbal response modes, including interpretation. Judges code the response modes using transcripts of sessions and calculate the proportions of response modes (the number of interpretations divided by the total number of therapist verbal response modes used in the session). In the Helping Skills System (Hill, 2020), a revision of the HCVRMCS, interpretations (and the other response modes) are coded by judges both on video and transcripts of sessions. The Psychodynamic Intervention Rating Scale (PIRS; Cooper et al., 2002) includes codes for interpretative interventions (which includes defense and transference interpretations) and noninterpretive interventions (which includes direct questions, clarifications, supportive and work-enhancing statements, associations, acknowledgments, reflections, and contractual arrangements). Judges code both on the basis of video and transcripts of the sessions.

Measures assessing outcome can be divided into those focusing on immediate in-session outcomes, such as the extent to which the patient becomes more open and collaborative (e.g., Hill et al., 2020); intermediate or postsession outcome (e.g., depth of experience in the session; Stiles & Snow, 1984); and distal treatment outcome, such as end of treatment symptom change (e.g., Gaston et al., 1994). Regarding measures of immediate outcome, based on the theoretical assumptions that interpretations aim to foster patients' insight, previous researchers explored whether patients exhibited greater insight following therapists' interpretation. Insight in this regard was coded using the following definition: "Client expresses an understanding of something about him/herself and can articulate patterns or reasons for behaviors, thoughts, or feelings" (Hill et al., 2020). Another study coded the maturity of patients' defense mechanism as the immediate outcome based on the idea that some of these insights involve increased clarity regarding the use of maladaptive defense mechanisms, which may result in patients adapting more mature defense mechanisms (Drapeau et al., 2008).

Clinical Examples

The example below is based on a composite clinical case; informed consent was obtained from the patients (P) and therapists (T). The first interpretation refers to an interpersonal conflict outside the therapy room whereas the second refers to a transference interpretation. Interpretations are italicized.

Example 1 (Interpersonal Interpretation—Outside the Therapy Room)

T: *From what you tell, it seems you really needed her support.*

P: *That's interesting. I didn't think of it that way. What do you mean?*

T: *I noticed that with your friend, too, like what you said about your partner, you felt you really needed her support, but at the same time you felt that she was too busy with herself, not paying attention to you, and not seeing how much you were in need. In response, you are not sure what to say to her and eventually decide that there's no point in trying at all, then withdraw into yourself and feel lonely.*

P: *I didn't think of that. Hearing you saying that, it sounds right to me … and that loneliness is so painful. The loneliness of being without hope (crying). That there's no chance that it will ever be different.*

T: I think that we are identifying together a pattern that manifests in various relationships that are important to you, and this pattern appears to hurt you. *I think it makes sense for us to try to understand it, where it comes from, and how it can be changed.*

Example 2 (Transference Interpretation)

T: *A moment ago you were telling me in great detail about what happened yesterday, and suddenly you seem to be inert, distant. I'm asking myself what happened between us now. Did I do something to drive you away?*

P: *I don't know. Suddenly I feel like I don't have much to say.*

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T: *How do you feel?*

P: *I don't know. Suddenly I get, like, a distressing feeling. What's the point of talking about all this?*

T: *I hear the distress you feel, and you suddenly seem to me closed and alone. I wonder if it has anything to do with the fact that I just looked at the clock?*

P: *Don't know. Maybe.*

T: *Maybe you felt like I was not interested in you? That when you need my support so much, I'm preoccupied with how much time of the meeting is left, and I'm not available to be with you?*

P: *It was so important for me to tell you what happened yesterday, and I was really offended when I saw you looking at the clock.*

T: *I wanted to make sure we had enough time to work on the important things you are revealing. This is why I looked at the clock. I understand now that it hurt you and gave you the impression that I don't see you and don't understand how much you need me. I'm sorry about that. I ask myself whether what happened between us now is related to the things you and I talked about, that sometimes happen to you in relationships with people who are important to you?*

P: *I kind of understand, but I'm not sure I completely understand. Can you say more?*

T: *I wonder maybe you felt like you felt with your parents. Like them, I am too busy with other important stuff to listen to you. Immediately you felt unimportant as you described you felt with your father.*

Previous Reviews

Several reviews have evaluated the association between psychodynamic skills assessed directly from therapy process ratings and treatment outcome. Crits-Christoph et al. (2013) and Crits-Christoph and Gibbons (2021) found that higher frequency of psychodynamic interpretations in general predicted better treatment outcome and that higher frequency of transference interpretations predicted poorer treatment outcomes for subsets of patients. They also found that higher levels of accuracy in interpretations significantly predicted outcome but they could not demonstrate a causal pathway. Further, they concluded that the adverse effect of transference interpretations is more pronounced for patients with a low quality of object relations. Relatively more favorable treatment outcomes were obtained when therapists accurately addressed central aspects of patients' interpersonal dynamics.

Research Review

We conducted a search in May 2021 of the Pubmed, PsycINFO, and MEDLINE databases between January 1970 and May 2021, with the following search terms: psychotherapy, therapy or treatment, and technique, intervention or interpretation, psychodynamic or psychoanalytic or dynamic or supportive–expressive or insight-oriented, and psychotherapist or therapist. We excluded studies that measured adherence to psychodynamic treatment, rather than focusing only on interpretations. If studies used the same data in multiple reports, we included their data only once.

The criteria for inclusion in the research review were as follows: (a) the authors referred to the therapy method or skill as interpretation, or to psychotherapeutic treatment that specifically included interpretations; (b) the authors provided data on outcome (immediate, intermediate, and/or distal) measures; (c) the data reported were such that it is was possible to evaluate the association between interpretations and outcome; (d) the treatment was individual psychotherapy, rather than group, couple, or family therapy; (e) the patients were adults (age >18 years); and (f) reports were written in English.

We identified 53 studies in which interpretations were measured and their associations with outcome (immediate, intermediate, distal) assessed. Of these 53 articles, 18 met the criterion of interpretation provided by the therapist during a psychotherapy session and tested its association with outcome. Tables 1 and 2 summarize these studies. The total number of patients was 1,011, and the total number of psychotherapists was about 316 across the 18 studies.

The small number of studies in each of the outcome categories (6 immediate, 4 intermediate, 12 distal; some studies addressed more than one level of outcome) and their diversity precluded conducting a quantitative meta-analysis. Thus, we conducted a box score analysis of the association between interpretations and outcomes. We employed our judgment based on the reported effects in the original studies to aggregate the effects across the 18 studies. We gave each effect a box score in terms of positive associations (positive score), neutral association (neutral score), or negative associations (negative score).

Measures of interpretations in psychotherapy varied. In the studies included in the current research review, the majority of the studies (38.89%) assessed the degree to which interpretations were a characteristic of the session based on postsession self-report ratings or ratings by trained judges. Other studies (27.78%) assessed the frequency of interpretations used in a session as coded by trained judges, and two studies (11.11%) assessed the accuracy and quality of the interpretations (Crits-Christoph et al., 1988; Silberschatz et al., 1986).

The perspective of the assessor also varied. The vast majority of research (77.78%) focused on the perspective of an external observer (e.g., Drapeau et al., 2008), 11.11% on the therapists' perspective (e.g., Hendriksen et al., 2011), and only 5.55% on the patients' perspective (e.g., Glock et al., 2018). One study (6.5%) focused on both patients' and therapists' perspectives (Ogrodniczuk et al., 2000).

Of the six studies assessing immediate in-session outcome (Table 1), two (33.33%) focused on patients' collaboration or alliance, two (33.33%) on the quality of the patients' therapeutic work (such as elaborating on important topics), and two (33.33%) on improved emotional processing. Additional types of in-session outcomes were patients' maturity of defense mechanism, insight, and emotional processing, with a single study focusing on each. Some of the studies used several outcomes. All four studies focusing on intermediate session outcome assessed the alliance (e.g., Datz et al., 2019). In addition, one study assessed session depth (e.g., Lingiardi et al., 2011).

Of the 12 studies assessing distal treatment outcome (Table 2), 41.67% assessed severity of depression (e.g., Connolly et al., 1999), 33.33% general symptom severity (e.g., Levy et al., 2015), and 41.66% general life satisfaction and level of functioning (e.g., Bush & Meehan, 2011) or problem improvement (e.g., Jacobs & Warner, 1981) as the outcome. The types of assessment do not amount to

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Table 1
Summary of Studies on Immediate and Intermediate Outcomes of Psychotherapist Interpretations

Study	Sample	Measures of interpretation, outcome, and moderators	Results
		Immediate outcome	
Drapeau et al. (2008)	First session of Brief Psychodynamic Intervention (Gillieron, 1989) for 32 (17 female) adult patients nested within six (two female) therapists. One licensed psychologist; the others were licensed psychiatrists.	Measure of interpretation: interpretation category of PIRS (Cooper et al., 2002). Defense and transference interpretations were folded into one category ("Interpretations"). Measures of immediate outcome: DMRS (Perry, 1990) Measure of moderators: none	No significant sequence was found for therapist interpretations followed by change in the patients' level of defensive functioning. Box score: one neutral
Hill, Helms, Spiegel, et al. (1988)	Multiple case studies of eight adult females presenting symptoms of depression, anxiety, self-esteem, and relationship problems. Patients underwent 12-session psychotherapy with eight experienced therapists (four male) from a range of theoretical orientations.	Measure of interpretation: category in HCVRCS (Hill, 1978) as coded by trained judges from transcripts. Measures of immediate outcome based on a postsession videotape review: (a) helpfulness was rated by therapist and patient on a 9-point scale (1 = *extremely unhelpful*, 9 = *extremely helpful*); (b) Patient Reactions System (Hill, Helms, Spiegel, et al., 1988): supported, therapeutic work, challenged, negative reactions, no reaction; coded by patients. Measures of immediate outcome based on ratings by trained coders: patients' emotional experience as rated on EXP (Klein et al., 1986). Measures of moderators: none	1. For helpfulness, compared to other skills, interpretation was rated as most helpful by therapists and second most helpful by patients. 2. For patient reactions, interpretation was more often followed by therapeutic work reactions (better understanding of thoughts and feelings and new ways to behave) than expected by chance. Interpretation was associated with higher levels of patient emotional experience. Box scores: four positive
Hill et al. (2020)	Case study of 18 sessions of 192 with middle-aged, White man paired with three doctoral student therapists in psychodynamic psychotherapy. Six sessions with the highest postsession therapist-rated patient insight for each of the three cases.	Measure of interpretation: category in the Helping Skills System (Hill, 2014) as coded by trained judges from videotapes and transcripts. Therapists' interpretations were compared to therapists' probe for insight intervention (i.e., open questions that invite patients to think about different meanings for their thoughts, feelings, or behaviors). Measures of immediate outcome: (a) patient collaboration rated by trained judges using UTIS (Allen et al., 1990); (b) patient insight was rated by trained judges using the Judge-Rated Insight Scale (Hill et al., 1992). Measures of moderators: none	For patient collaboration, probe for insight was associated with more gains in collaboration than were interpretations, although only tending toward statistical significance ($b = -0.47$, $p = .059$). For patient insight, controlling for antecedent patient collaboration and insight, no significant differences were found between interpretations and probe for insight ($b = -0.15$, $p = .69$). Box scores: two neutral
Locati et al. (2019)	Three first sessions of 24 patients (17 female) nested within 12 therapists (eight female) in psychodynamic supportive therapy.	Measure of interpretation: category in PIRS (Cooper et al., 2002). Measures of immediate outcome: therapeutic alliance was measured using CIS (Colli & Lingiardi, 2009). Measures of moderators: none	Positive alliance was not associated with defense interpretation (adj = .32; $p = .75$) or transference interpretation (adj = −1.26; $p = .21$). Neutral alliance was negatively associated with defense interpretations (adj = −3.25; $p < .01$) and with transference interpretations (adj = −4.4; $p < .01$). Negative alliance was positively associated with defense interpretations (adj = 5.18; $p < .01$) and with transference interpretations (adj = 9.62; $p < .01$). Box scores: four negative, two neutral; the authors suggest that neutral alliance can be seen as positive process "the grounds for establishing a more positive alliance" (p. 119).

(*table continues*)

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Table 1 (*continued*)

Study	Sample	Measures of interpretation, outcome, and moderators	Results
Milbrath et al. (1999)	The fourth session of 20 patients in a psychotherapy for pathological grief reactions, treated by nine therapists (five female). Four therapists were clinical psychologists, three were psychiatrists, and two were psychiatric social workers.	Measure of interpretation: category in PIRS (Cooper et al., 2002). Measures of immediate outcome: measure of patient's elaboration and dyselaboration (Horowitz et al., 1993). Elaboration includes convey facts, convey emotionality, convey significance. Dyselaboration includes peripheral talk and distort significance. Measures of moderators: none	Defense interpretations were followed by disclosure of emotion (Lag 1: $Z = 8.34$, Lag 2: $Z = 5.01$, Lag 3: $Z = 3.30$). Defense interpretations were also followed by conveying significance and making connections between different topics and the self for Lags 1 and 3 (Lag 1: $Z = 3.27$, Lag 3: $Z = 2.11$). Defense interpretations were followed by a decrease in conveying facts (Lag 1: $Z = -9.71$, Lag 2: $Z = -5.30$, Lag 3: $Z = -4.05$, Lag 5: $Z = -2.16$). Transference interpretations were followed by conveying significance and making connections for up to five sequences after the therapist's intervention (Lag 1: $Z = 7.96$, Lag 2: $Z = 4.32$, Lag 3: $Z = 3.29$, Lag 4: $Z = 4.07$, Lag 5: $Z = 4.36$). Transference interpretations were followed by a decrease in conveying facts (Lag 1: $Z = -2.24$, Lag 4: $Z = -2.00$, Lag 5: $Z = -2.23$). Box scores: five positive
Silberschatz et al. (1986)	Three patients diagnosed with depression or dysthymic disorder were randomly selected from a larger sample. Case 1 showed an excellent outcome, Case 2 showed a moderately good outcome, and Case 3 showed a poor outcome. The therapists were all experienced psychologists and psychiatrists with a psychodynamic orientation.	Measure of interpretation: the typology devised by Malan (1963), which distinguishes between interpretation and transference interpretation. The accuracy of interpretation was measured using PCIS (Caston, 1986). Both were measured by clinical judges. Measures of immediate outcome: EXP (Klein et al., 1986). Measures of moderators: none	No significant differences were found between transference and no-transference interpretations on the residualized EXP scores (Case 1: $t = -3.41$, $p < .05$; Case 2: $t = 1.03$, *n.s.*; Case 3: $t = 0.62$, *n.s.*). The accuracy of interpretations was positively associated with increased EXP score (Case 1: $r = 0.54$, $p < .001$; Case 2: $r = .28$, $p < .01$; Case 3: $r = .25$, $p < .01$). Box scores: one positive, one neutral
		Intermediate outcome	
Datz et al. (2019)	Twenty clients at various stages of their respective therapeutic journeys were interviewed. For each patient, one session was recorded; two of the 20 patients were recorded during two sessions; in total, 22 psychotherapeutic sessions were analyzed.	Measure of interpretation: the interpretive techniques category of PIL (Gumz et al., 2014) as coded from transcribed sessions. Measures of outcome: WAI-SR (Munder et al., 2010) as rated by the client.	Interpretative forms of intervention were associated with higher WAI scores than were supportive forms (Mann–Whitney $U = 2283.5$, $p = .000$, $d = 0.67$). Box score: one positive
Lingiardi et al. (2011)	About 60 clients (40 female), treated by 60 (28 female) therapists (experienced psychiatrists and psychologists). All clients were treated with three theoretical approaches: psychodynamic ($n = 35$), cognitive–behavioral ($n = 17$), and integrative ($n = 8$). Patients and sessions were chosen randomly.	Measure of interpretation: PQS (Jones, 1985) as coded by trained judges from videotapes and transcripts. Measures of outcome: (a) WAI-O (Horvath & Greenberg, 1989) as coded by trained judges from videotapes and transcripts; (b) SEQ-D (Stiles & Snow, 1984) as coded by trained judges from videotapes and transcripts.	1. The following PQS items were positively correlated to the WAI-O: "Therapist makes connections between the therapeutic relationship and other relationships" ($r = .40$, $p < .05$) and "Therapist identifies a recurrent theme in the patient's experience or conduct" ($r = .36$, $p < .05$). 2. The following PQS items were correlated to the SEQ-D: "Therapist identifies a recurrent theme in the patient's experience or conduct" ($r = .61$, $p < .05$); "Therapist points out patient's use of defensive maneuvers (e.g., undoing, denial)" ($r = .42$, $p < .05$); and "Therapist interprets warded-off or unconscious wishes, feelings, or ideas" ($r = .33$, $p < .05$). Nonsignificant correlations were not reported. However, at least eight potential correlations (four reported items and two outcome measures). Box scores: five positive and three neutral

(*table continues*)

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Table 1 (*continued*)

Study	Sample	Measures of interpretation, outcome, and moderators	Results
Ogrodniczuk et al. (2000)	One hundred forty-four clients (61% female), treated by eight therapists (five female), three psychologists, two social workers, two occupational therapists, and one psychiatrist. Each patient received either interpretive or supportive therapy.	Measure of interpretation: PTS as rated by the client and the therapist. Measures of outcome: Therapeutic alliance, as rated by the client, defined as the working relationship between the patient and the therapist. An overall alliance scores was derived by calculating the average of the six items, and a summary of the entire course of therapy was used.	In interpretive therapy, there was a significant correlation between alliance and the patient-rated interpretive subscale of the PTS ($r[68] = 0.54$, $p = .00$), and between alliance and the therapist-rated interpretive subscale of the PTS ($r[70] = 0.30$, $p = .01$). These associations were not significant in supportive therapy. Box scores: two positive, two neutral
Piper et al. (1991)	Sixty-four clients (62% female), treated by eight therapists (three psychiatrists, one psychologist, and four social workers). All clients received dynamically oriented treatment.	Measure of interpretation: TIRS (Piper et al., 1987), as coded by trained judges from videotapes. Measures of outcome: Therapeutic alliance, defined as the nature of the working relationship between the client and therapist, rated separately by the client and the therapist. Four items rated the immediate impression, and two items rated the reflective impression. An overall score of the six items was calculated.	The proportion of transference interpretations was negatively correlated with the client-rated alliance ($r = -.21$, $p < .10$), with the therapist-rated immediate impression of the alliance ($r = -.33$, $p < .10$), and with the therapist-rated reflective impression of the alliance ($r = -.32$, $p < .10$). Box scores: three negative

Note. EXP = Experiencing Scale; PQS = Psychotherapy Q-sort; WAI = Working Alliance Inventory; WAI-O = Working Alliance Inventory–Observer; SEQ-D = Depth scale of the Session Evaluation Questionnaire; PTS = Perception of Technique Scale; PIRS = Psychodynamic Intervention Rating Scale; DMRS = Defense Mechanisms Rating Scale; HCVRCS = Hill Counselor Verbal Response Mode Category System; UTIS = Use of Therapist Interventions Scale; CIS = Collaborative Interaction Scale; PCIS = the Plan Compatibility of Interventions Scale; PIL = Psychodynamic Interventions List; WAI-SR = Working Alliance Inventory-Short Revised; TIRS = Therapist Intervention Rating System.

100% because three studies included more than one outcome measure. For example, one study assessed the severity of anxiety, the severity of depression, and the level of self-concept as outcomes (Hill, Helms, Spiegel, et al., 1988).

The perspective of the assessor in all outcome measures varied, with 27.78% focusing on the patients' perspective (e.g., Pesale & Hilsenroth, 2009) and 33.33% on the perspective of the external evaluator coding the session (e.g., Lingiardi et al., 2011). Other studies focused on more than one perspective, with 27.78% focusing on patients' and therapists' perspectives, 11.11% focusing on patients' and external evaluators' perspectives, and 6.25% combining all three perspectives into one factor.

Associations Between Interpretations and Immediate Outcomes

There were six studies with 88 patients, testing the association between the use of interpretations and a variety of immediate outcomes. In terms of positive immediate outcomes, Hill, Helms, Spiegel, et al. (1988) compared the patient- and therapist-rated helpfulness of interpretations with other types of interventions, such as closed or open questions, self-disclosure, and direct guidance. Based on a sample of eight patients, they found that interpretations were rated as most helpful by therapists and second most helpful (after self-disclosure) by patients. Further, following the use of interpretation, patients indicated a therapeutic work reaction, that is, achieving better understanding of their feelings and thoughts and adopting new ways to behave. Similarly, patients presented greater emotional processing following interpretations (Hill, Helms, Spiegel, et al., 1988; Silberschatz et al., 1986). In addition, the frequency of defense interpretations (i.e., therapists' interventions on patients' defense mechanisms) in a sample of 20 patients was followed by greater disclosure of emotions, conveying significant information about oneself and making new connections between important themes, and by a decrease in conveying factual statements that do not facilitate the therapeutic work (Milbrath et al., 1999). The use of transference interpretations was also followed by conveying significant information about oneself and making new connections, and by a decrease in conveying factual statements (Milbrath et al., 1999). We thus assigned 10 positive box scores in this section (Table 1).

In terms of negative immediate outcomes, some potential adverse effects of defense and transference interpretations were found in the only study that tested the association between interpretations and alliance (Locati et al., 2019). In that study, both defense and transference interpretations were positively associated with immediate negative alliance and negatively associated with aspects of good alliance, as indicated by coding of direct and indirect rupture markers. We thus assigned four negative box scores in this section.

In terms of neutral immediate outcomes, other studies found no significant effects of interpretations on patients' defense mechanisms (Drapeau et al., 2008), and interpretation was not followed by greater patients' collaboration or insight than in the case of open questions inviting the patient to explore their thoughts, feelings, or behaviors (Hill et al., 2020). Furthermore, interpretation was not followed by some positive aspects of alliance (Locati et al., 2019). We thus assigned six neutral box scores in this section (Table 1).

In sum, there were 10 positive, six neutral, and four negative box scores. Thus, in half of the studies, the associations between

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Table 2
Summary of Studies on Distal Treatment Outcomes of Psychotherapist Interpretations

Study	Sample and methods	Measures of interpretations and outcome	Interpretation–outcome association	Moderator results
Crits-Christoph et al. (1988)	Forty-three patients (30 female) were treated by 28 therapists. Accuracy was assessed based on therapists' interpretations of two early in-treatment sessions of dynamic therapy.	Measure of interpretation: CCRT (Luborsky, 1977) coded by trained judges from transcribed sessions. Measures of outcome: (a) residual gain (general adjustment ratings made by the patient and a clinical observer, which were obtained pre- and posttherapy and were statistically adjusted for the effects of the patient's initial level of functioning) and (b) therapy benefits (ratings by the patient and the therapist assessing actual change).	The accuracy of the wish and a response from the CCRT "other" were significantly associated with residual gain ($r = .44$, $p < .01$) and with rated benefits ($r = .38$, $p < .05$). The accuracy of the response of the CCRT "self" was not related to residual gain ($r = .07$, n.s.) and was not associated with rated benefits ($r = .16$, n.s.). Box score: two positive, two neutral	
Connolly et al. (1999)	Twenty-nine patients (76% female) underwent brief supportive–expressive therapy. Four PhD-level therapists had at least 5 years of postdoctoral clinical experience with dynamic psychotherapy. Therapist speaking turns from three early sessions (2, 3, and 4) of psychotherapy were coded by three independent judges for each patient.	Measure of interpretation: Each therapist statement was rated as either an interpretation, a clarification, a question, or other statement. Statements that were rated as interpretations by the coders were rated by three other independent coders who decided the type of interpretation (transference/nontransference). Measures of outcome: (a) BDI (Beck et al., 1961); (b) HAMD (Hamilton, 1960). Both measures were completed at treatment intake and termination. Measures of moderators: The quality of interpersonal relationships was assessed using the global rating from HSRS (Luborsky & Bachrach, 1974). A clinician rated each patient before treatment on a scale from 0 to 100 assessing "the quality of the patient's interpersonal relationships."	Average percentage of transference interpretations did not predict posttreatment symptoms controlling for pretreatment symptoms. Box score: two neutral	Significant interaction was found between average percentage of transference interpretations and quality of interpersonal relationships in the prediction of symptom change (both BDI and HAMD). High levels of transference interpretations were significantly associated with poor treatment outcome for patients with poor interpersonal functioning.
Gaston et al. (1998)	One hundred twenty patients (66.67% female), older adults with depression were treated by 10 therapists with at least 1 year of postdoctoral training in the specific therapy. Each patient was randomly assigned to one of four conditions: behavioral therapy, cognitive therapy, brief dynamic therapy, and a delayed treatment control group.	Measure of interpretation: The exploratory interventions subscale of ITS (Gaston & Ring, 1992) coded by trained judges from videotapes. Measures of outcome: (a) Depressive symptoms measured by both BDI (Beck et al., 1961), and HRSD (Hamilton, 1967). Measures of moderators: CALTARS (Marmar et al., 1989) measured the alliance and comprised four scales.	Exploratory interventions across therapy sessions predicted lower posttreatment HRSD scores only in cognitive therapy ($R2$ increment = 12%). Exploratory interventions did not predict posttreatment BDI scores. Box score: one positive, seven neutral	Across sessions, no significant interaction was found between exploratory interventions and alliance. But when sessions were analyzed separately, a significant interaction was found at Session 10 for behavioral and cognitive therapies. Fewer exploratory interventions provided in cases of better alliance were predictive of less depressive symptomatology at termination. Conversely, more exploratory interventions provided in cases of poorer alliance were predictive of less depressive symptomatology at termination.

(*table continues*)

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Table 2 (*continued*)

Study	Sample and methods	Measures of interpretations and outcome	Interpretation–outcome association	Moderator results
Glock et al. (2018)	About 34 (27 female) patients sought treatment for anxiety symptoms as their primary concern. The time of measurement was not specified. Details on the type of psychotherapy were not provided.	Measure of interpretation: CPPS (Hilsenroth et al., 2005). Item 13 "The therapist suggests alternative understanding not previously recognized by the patient." Patients rated their perceptions on how helpful the interventions were during their treatment. Measures of outcome: overall improvement in psychotherapy. Patients were asked to rate the following item: "Overall, how much did you improve during the therapy?"	The interpretation item had the highest group mean ($M = 6.9$), that is, it was rated as the most helpful intervention. This item was marginally associated with the measure of overall improvement ($r = .320$, $p = .065$). Box score: two positive.	
Hendriksen et al. (2011)	One hundred forty-seven patients with depression (70% female) were allocated to short-term psychoanalytic supportive psychotherapy or combined therapy (psychotherapy and medication).	Measure of interpretation: TEF assessed the therapist's appraisal of the applied technique during treatment (five categories from only supportive to only expressive), as rated by the therapists. Measures of outcome: HAM-D (Hamilton, 1960). Measurement of moderators: the patient's defense style based on Vaillant's hierarchy of ego defense mechanisms (immature, neurotic, or mature; Vaillant, 1971).	Expressive techniques were associated with a decrease in posttreatment HAM-D controlling for pretreatment HAM-D ($B = -2.38$, $p < .01$). Box score: one positive	No significant interaction effect was found between expressive techniques and maturity of defense style on HAM-D.
Hill, Helms, Spiegel, et al. (1988)	Eight (all female) patients over 25 years of age with self-esteem and relationship problems were treated by eight therapists (four female). Type of treatment was not provided.	Measure of interpretation: HCVRCS (Hill, 1986) as coded by trained judges from transcribed sessions. Measures of outcome: (a) the Anxiety and Depression scales of SCL-90-R (Derogatis et al., 1976); (b) the Depression scales of the Symptom Checklist–90–Revised; and (c) TSCS (Fitts, 1965), all rated by the patients. Change was determined by using squared difference scores and retaining the signs between pre- and postadministrations.	Interpretation on the HCVRCS did not correlate significantly with the SCL-R Anxiety scale ($r = .17$, n.s.), the SCL-R Depression scale ($r = .38$, n.s.), or the TSCS ($r = .55$, n.s.). Box score: one positive two neutral	
Jacobs and Warner (1981)	One hundred sixty-one patients (66.66% female) were treated by 21 therapists (77% female). All patients were treated with dynamic oriented psychotherapy.	Measure of interpretation: the uncovering subscale of the staff attitudes and therapeutic style, a therapist self-report questionnaire developed for this study. This subscale consists of scores for recognizing feelings and connecting temporal associations (clarifications and interpretations). Measure of outcome: GIS, answered on a 7-point scale ranging from *very much worse* to *very much improved*, as rated by the patient. Measurement of moderators: severity of clinical diagnosis. Clinical diagnoses represented four main categories: neuroses (49%), personality trait disorders (25%), borderline conditions (15%), and psychoses (11%). Based on severity, the first two categories reflected a group of mild to moderate disorders, whereas the second two characterized the seriously disturbed group.	The association between the uncovering subscale and the GIS was insignificant ($F = 1.96$, n.s.). Box score: one neutral	There was a significant interaction effect with the severity of clinical diagnosis ($F = 4.19$, $p < .05$). High levels of uncovering appear to have been associated with poor outcomes on the GIS in the more seriously disturbed group ($r = -.36$; p was not reported).

(*table continues*)

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Table 2 (*continued*)

Study	Sample and methods	Measures of interpretations and outcome	Interpretation–outcome association	Moderator results
Levy et al. (2015)	Seventy-six patients (55 female) were treated by 26 therapists with psychodynamic psychotherapy at a university-based outpatient clinic. Therapists were advanced doctoral students (13 female).	Measure of interpretation: Item 13, "The therapist suggests an alternative understanding not previously recognized by the patient" from CPPS (Hilsenroth et al., 2005) as coded by trained judges from videotapes. Measure of outcome: GSI is an index of global distress derived as a summary score from BSI (Derogatis, 1993). Measurement of moderators: alliance was measured with CASF-P (Hatcher & Barends, 1996) as rated by the patient; (b) object relatedness was measured with SCORS (Westen, 1995). Independent raters completed the measure based on narratives told during assessment and the first two treatment sessions.	In multilevel model accounting for therapist effects, and including patients' personality disorder, insight, alliance, object relations, and GSI at pretreatment evaluation, early session use of interpretation ($b = 0.81$; $SE = 0.28$; $p = .01$) was significantly related to a reliable change in GSI. Box score: one positive	There was no significant interaction between interpretations and alliance or interpretations and object relatedness on GSI.
Lilliengren et al. (2019)	Ten good and 10 poor outcome cases were obtained from a randomized trial comparing cognitive therapy and short term psychodynamic psychotherapy (STPP) for Cluster C personality disorders. Each outcome group included five cases from the cognitive therapy (CT) group and five from the STPP group.	Measure of interpretation: PQS (Jones, 1985), which yields ipsative scores. After watching a treatment session (or reading a session transcript), the rater sorts the 100 items into nine piles according to how characteristic of the session they are. Item 67: "Therapist interprets warded-off or unconscious wishes, feelings or ideas" refers to interpretation. Measure of outcome: successful and unsuccessful cases were defined based on their respective amount of change in self-reported psychiatric symptoms, as assessed with SCL-90-R (Derogatis et al., 1973).	Therapists in the unsuccessful cases showed significantly greater use of interpretations (successful: $M = 5.41$, $SD = 0.73$; unsuccessful: $M = 6.35$, $SD = 0.88$, $t = -2.703$, $p = .015$). Box score: one negative	
Milbrath et al. (1999)	Twenty bereaved patients (all female), ranging from normal to pathological grief reaction, were treated by nine therapists (five female), four clinical psychologists, three psychiatrists, and two psychiatric social workers. All patients were treated with brief dynamic psychotherapy for stress response symptoms. Process variables were derived from Session 4, and the outcome was measured from pre- to posttreatment.	Measure of interpretation: PIRS (Cooper & Bond, 1992) as coded by trained judges from transcribed sessions. Measure of outcome: depression subscales of BSI (Derogatis & Melisaratos, 1983).	The defense interpretation score was associated with lower symptoms, controlling for pretreatment symptoms ($r = -0.48$, $p < .05$). Box score: one positive	
Ogrodniczuk et al. (2000)	One hundred forty-four patients (61% female) were treated by eight therapists (five female), three psychologists, two social workers, two occupational therapists, one psychiatrist. Each patient received either interpretive or supportive therapy.	Measure of interpretation: PTS as rated by the patient and the therapist. Measures of outcome: A set of outcome measures was reduced to three factors: (a) general symptomatology and dysfunction, (b) social-sexual maladjustment, and (c) nonuse of mature defenses and family pathology.	Patient ratings on the interpretive subscale of the PTS-P were associated with poorer outcomes in the area of social-sexual functioning ($r[64] = 0.34$, $p = .01$). No other significant associations were found. Box score: two neutral, one negative	

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interpretations and immediate outcome were positive, indicating that clients in those studies tended to react positively to therapist interpretations in that immediate session.

Associations Between Interpretations and Intermediate Outcomes

In four studies with 288 patients, researchers examined the association between the use of interpretations and a variety of intermediate outcomes, such as alliance strength and session depth (as measured after or between sessions).

Of the four studies that examined the relation between the use of interpretations and alliance, three studies found a favorable effect on alliance strength, two for patient-rated alliance (Datz et al., 2019; Ogrodniczuk et al., 2000), and one for alliance as rated by external judges based on the videotapes and transcripts of the sessions (Lingiardi et al., 2011). We thus assigned five positive scores in this section (Table 1).

A negative relation between frequency of interpretations and postsession alliance strength was found in only one study (Piper et al., 1991). That study found that a greater proportion of transference interpretations (of all the methods used in the session) was associated with poorer alliance as rated by both patients and two aspects of alliance rated by the therapists. We thus assigned three negative box scores in this section (Table 1). One potential post hoc explanation is that transference interpretations may have an adverse effect when provided in a high dose. However, given that no causality can be established between transference interpretations and alliance in this study, it is also possible that higher levels of negative transference resulted in both poorer alliance and greater use of transference interpretation by the therapists.

Lingiardi et al. (2011) focused on session depth as coded by judges based on session videotapes and transcripts, and found that greater use of interpretations was associated with the session being coded as deeper. We assigned three positive box scores for this study (Table 1).

In summary, there were eight positive, five neutral, and three negative box scores. Thus, half of the associations between the frequency of interpretations and intermediate outcomes were positive.

To the best of our knowledge, no study investigated the existence of moderators of the effect of interpretations on intermediate outcome.

Associations Between Interpretations and Distal Outcomes

Twelve studies with 866 patients investigated the association between the frequency or accuracy of interpretations and distal outcome (changes in symptom severity throughout treatment).

In terms of positive associations, seven out of 12 studies found positive association between higher frequency or accuracy of interpretations and better outcome (Crits-Christoph et al., 1988; Gaston et al., 1998; Glock et al., 2018; Hendriksen et al., 2011; Hill, Helms, Spiegel, et al., 1988; Levy et al., 2015; Milbrath et al., 1999). For example, Levy et al. (2015) found that a greater use of interpretations early in treatment was associated with greater likelihood of the patients showing reliable change on a global severity index. A similar association was found in a study correlating the frequency of defensive interpretations and reduction in symptom severity in a sample of 20 bereaved patients (Milbrath et al., 1999).

Table 2 (*continued*)

Study	Sample and methods	Measures of interpretations and outcome	Interpretation–outcome association	Moderator results
Piper et al. (1991)	Sicty-four patients (62% female) were treated by eight therapists (three psychiatrists, one psychologist, and four social workers). All patients received dynamically oriented treatment.	Measure of interpretation: TIRS (Piper et al., 1987) coded by trained judges from videotapes. Measures of outcome: A set of outcome variables was reduced to four factors: (a) interpersonal functioning, (b) psychiatric symptoms, (c) self-esteem, and (d) life satisfaction, as rated by the patient, therapist, and an independent assessor. Measurement of moderators: Quality of Object Relations, assessed before the start of therapy by an unstructured interview by a trained interviewer, other than the therapist.	The proportion of transference interpretations on the TIRS was positively correlated with higher patient-rated general symptoms and dysfunction (r = .34, p < .01). Nonsignificant correlations were found between the TIRS and the three other factors: psychiatric symptoms (r = .17, p < .18), self-esteem (r = .09, p < .48), and life satisfaction (r = .08, p < .50). Box score: one negative, three neutral	The proportion of transference was significantly (or near significantly) correlated with poorer interpersonal functioning and psychiatric outcome for high-quality of object relationship (QOR) patients. None of the correlations for low-QOR patients were significant.

Note. CCRT = core conflictual relationship theme; BDI = Beck Depression Inventory; HAMD = Hamilton Rating Scale for Depression; HRSD = Hamilton Rating Scale for Depression; HCVRCS = Hill Counselor Verbal Response Mode Category System; SCL-90-R = Symptom Checklist–90–Revised; TSCS = Tennessee Self-Concept Scale; GSI = Global Severity Index; GIS = Global Improvement Scale; *SE* = standard error; PTS = Perception of Technique Scale; TIRS = Therapist Intervention Rating System; HSRS = Health-Sickness Rating Scale; ITS = Inventory of Therapeutic Strategies; CALTARS = California Therapeutic Rating Scale; CPPS = Comparative Psychotherapy Process Scale; TEF = therapist evaluation form; BSI = Brief Symptom Inventory; CASF-P = Combined Alliance Short Form—Patient Version; SCORS = Social Cognition and Object Relations Scale; PQS = Psychotherapy Process Q-Set; PIRS = Psychodynamic Intervention Rating Scale.

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A tendency toward a significant beneficial of interpretations on outcome was also found in Glock et al. (2018), where 34 patients were asked to rate the extent to which they found the therapists' use of interpretations to be helpful. Interpretation was rated as the most helpful intervention. In addition, there was a marginally significant association, with patients who rated their therapist's use of interpretations as more helpful also showing better treatment outcome. We thus assigned nine positive box scores in this section (Table 2).

In terms of neutral or negative associations between the frequency of interpretation and distal outcome, Jacobs and Warner (1981) found neutral results between the frequency of interpretation in psychodynamic treatment and patients' ratings on the global improvement scale (GIS). Ogrodniczuk et al. (2000) found no significant association between interpretation and symptom reduction but an adverse association on social and sexual functioning. Piper et al. (1991) found an adverse effect of interpretations, but this time on general symptom reduction, whereas the effect on psychiatric symptoms, social and sexual functioning was not significant. Similarly, Lilliengren et al. (2019) found a greater use of interpretations in 10 cases with a poor outcome than in 10 cases with a good outcome. Overall, we assigned 19 neutral box scores (seven of them drawn from one study) and three negative box scores (Table 2).

In summary, we assigned nine positive, 19 neutral, and three negative scores. Thus, the results linking the frequency of interpretations to distal outcome are mixed.

Moderators of Distal Outcomes

Although most of the associations reported in the studies demonstrated a neutral association (19 of 32 box score; see Table 2), findings did show considerable variability as a function of the type of interpretations; type of distal outcomes; and type of treatment, patients' symptoms, and object relations. With regard to type of interpretation, Crits-Christoph et al. (1988) found that a greater accuracy of interpretations focusing on the individual's interpersonal unmet wishes and perceived responses of the others to these wishes was associated with greater symptom reduction by the end of treatment. But that was not the case with respect to the accuracy of the therapists' interpretations regarding the individual's own responses to others, which did not have a significant association with outcome.

With regards to variability in the type of outcome, Hill, Helms, Spiegel, et al. (1988) found no significant relation between interpretations on changes in symptoms of anxiety and depression in a sample of eight patients. Nevertheless, the authors found a nonsignificant but moderate ($r = .55$) association with changes in patient-rated self-concept (one's thoughts and feelings about the self that contribute to a sense of identity).

With regards to variability in type of treatment, a study that examined the effect of interpretations in different types of psychotherapy found that interpretations had a significant association with therapist rated outcome in cognitive therapy but not in psychodynamic therapy (Gaston et al., 1998).

We located one study that found a moderating relation of the severity of clinical diagnosis (Jacobs & Warner, 1981). Patients with more severe clinical diagnosis who received more interpretations, as rated by the therapists, reported poorer outcomes than those with a less severe clinical diagnosis.

Three studies focused on the patients' maturity and style of object relation. Levy et al. (2015) focused on clinician-rated affective and cognitive aspects of an individual's object relations and found no significant moderation. Connolly et al. (1999) found that high levels of transference interpretations were significantly associated with poor treatment outcome for patients with poor interpersonal functioning. By contrast, Piper et al. (1991) found that the proportion of transference interpretations was significantly correlated with poorer interpersonal functioning and psychiatric outcome in patients with a high quality of object relation, where no significant effect of interpretation on outcome was found for those with low quality of object relation.

Neither of two studies examining a potential moderation of alliance strength (measured postsession) on the interpretation–outcome association found a moderating effect in psychodynamic treatment (Gaston et al., 1998; Levy et al., 2015). In one of these studies, such a moderating effect was tested at Sessions 5, 10, and 15 and found only for cognitive therapy and only in a particular session (Gaston et al., 1998). One study focused on the ability of the level of maturity of defense style to moderate the interpretations–outcome association, and found no significant effect (Hendriksen et al., 2011).

In summary, individual studies have found greater effect of interpretation on distal outcome when interpretations focused on the individual's interpersonal unmet wishes and perceived responses of the others to these wishes (one study), when the outcome was self-concept rather than symptoms (one study), in cognitive therapy rather than psychodynamic therapy (one study), and when patients' showed a less severe clinical diagnosis (one study). None of these patterns have been replicated in any published studies to date, to our knowledge. In addition, mixed results were found in regard to patient object relations.

Therapist Effects on Distal Outcomes

Whether some psychotherapists are better than others in their interpretations has seldom been studied. Some evidence suggests that more interpretations are associated with a reduction in the patients' maladaptive defense only for those therapists who experienced good parental care and negative introjection (Hersoug, 2004). Moreover, a negative relation between frequency of transference interpretations and outcome was found when therapists experienced an increase in feeling inadequate and disengaged during therapy (Dahl et al., 2016, 2017).

The few studies in the current review that accounted for therapist effects suggested that the interpretation–outcome association remained statistically significant even after accounting for the therapist effect; that is, interpretation in these studies was effective regardless of who provided the interpretation (Katz et al., 2019; Keefe et al., 2019; Levy et al., 2015). Still, some therapist variables may affect the interpretation–outcome association.

With regard to the professional background of the psychotherapist, a potential explanation of the negative interpretation–outcome association found in two studies (Ogrodniczuk et al., 2000; Piper et al., 1991) is the training of the therapists. The therapists in these studies varied in their professional background (e.g., social workers, occupational therapists), compared to the relatively more homogenous training in the other nine studies, where participating therapists received training mostly as clinical psychologists or psychiatrists. If future studies support such an explanation, it may point to the need to systematically investigate how the type of training received may affect the competence and manner in which interpretations are delivered and their subsequent outcomes.

Summary of the Research Review

Half the findings suggest a positive association between interpretation and in-session immediate outcomes (10 positive, six neutral, four negative box scores) as well as intermediate outcomes (eight positive, five neutral, three negative box scores). By contrast, the associations between interpretations and distal treatment outcomes were mixed (nine positive, 19 neutral, three negative box scores), with findings varying according to the type of interpretation and the type of outcome.

The few available studies which tested moderators of the association between the frequency of interpretations and distal outcome suggest that the patients' object relation may be of importance on who benefits most from interpretations. However, based on the literature, the direction of this association is not consistent. Some studies showed that individuals with better object relations benefit more from interpretations, whereas others found the opposite, or did not find any association. The only study that used an experimental design in which individuals were randomized to receive a treatment with or without interpretations, found that individuals with poorer object relation benefited more from interpretation than did those with high-quality object relation.

An interesting pattern of results was found for the few studies focusing on the effect of interpretation on alliance for the immediate versus intermediate outcomes. For immediate in-session outcome, measured at several time points during the session, interpretations were associated with poorer alliance. By contrast, for intermediate end-of-session outcome, most of the studies found that interpretations were associated with stronger alliance.

Limitations of the Research

The greatest advantage of the research literature is also its greatest limitation: the great diversity of measures (various aspects of the skill from different informants), designs (randomized controlled trials, effectiveness studies), treatment types and durations (e.g., long-term psychoanalysis vs. short-term psychodynamic treatment), and statistical methods (e.g., disentangling between- and within-therapist as well as between- and within-patient variances vs. using raw scores). This great variability has the potential to serve as a rich source for identifying who may benefit most from each type of interpretation for each type of outcome. However, the small number of studies makes it difficult to study the effect of any single moderator.

An important limitation of the current findings is the reliance, in most studies, on the correlation between frequency (rather than accuracy or quality) of interpretations and outcome. More is not necessarily better, and in fact, it could be that psychotherapists use more interpretations when the patient is not receptive or understanding of the interpretations. Moreover, most of the available research on intermediate and distal outcomes are based on between-individuals associations, most commonly being limited to a single time in treatment when the interpretations were evaluated. Therefore, most of the available findings mix the general levels of interpretation provided by the therapist to a given patient with deviations from this general level in a given session. Disentangling within- from between-patients effects is of critical importance because within-patient effects (rather than between-patients effect) can indicate the ability of interpretations to serve as a mechanism of change in treatment (Zilcha-Mano, 2021). Between-patients effect may indicate that patients who generally received more interpretations than other methods showed better outcomes. But this association may be a product of therapists' responsiveness: the tendency to provide more interpretations to some patients than to others.

One of the main factors contributing to the focus on a single session per patient is the labor-intensive process of coding in-session processes for each session, which limits dramatically the number of sessions that can be coded. Thus, some studies have focused on patients' and therapists' self-reports, which can be administered repeatedly throughout treatment, even on a session-by-session basis. Self-report measures have their own limitations, however, including their subjectivity and their restriction to what the patients and therapists are aware of and interested in reporting.

One direction for future research is the development of artificial intelligence algorithms that can mimic observer coding (Imel et al., 2019) based on videotaped sessions or transcripts. Automated coding of interpretations can be especially instrumental in providing therapists with real-time feedback on their methods. Similarly, automatic measures can be collected during the session to provide insight into patients' and therapists' moment-to-moment experiences before, during, and after the therapists provide an interpretation (e.g., facial microexpressions; Arango et al., 2019).

To enhance clinical practice and research, it is important to move from context-free questions of whether interpretations are effective to questions of for whom, when, and in which manner interpretations can be effective. Such questions can be addressed in many ways, including data-driven machine learning for identifying the optimal use of interpretation for each individual or subpopulation of individuals (Cohen et al., 2021). Additionally, theory-driven moderated mediation models can identify between-individuals moderators (the patients who benefit most) and within-individual ones (the optimal timing of interpretations) in a within-patient mediation model of the effect of specific therapists training or type of treatment on the methods used, which in turn predicts treatment outcome. There has been limited research to date on the effectiveness of interpretations as a function of the individual's gender, race/ethnicity, sexual orientation, and socioeconomic status. As a result, there are no research-based guidelines on how to implement interpretations across diverse patients, except for the general guideline of acting in a responsive and sensitive manner.

Training Implications

Numerous clinical training resources are available for offering skillful interpretations (e.g., Book, 1998; Malan, 1979; McCullough et al., 2003; Safran & Muran, 2000; Summers & Barber, 2010; Wachtel, 2011). Based on the clinical and theoretical knowledge, to skillfully implement interpretations, we recommend that trainees: (a) be familiar with the theoretical models for each type of interpretation (intrapersonal conflict, interpersonal transferential, and non-transferential repetitive patterns); (b) master concrete procedures to formulate patients' problems and deliver interpretations addressing those issues (such as the core conflictual relationship theme guidelines for constructing and delivering interpretations); and (c) receive supervision with detailed feedback on the manner in which they deliver the interpretations. In supervision, it is possible to teach how to take into account the many factors that may affect the effectiveness of the interpretations, including the patient's quality

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of object relation, strength of therapeutic alliance, and phase of therapy (Spiegal & Hill, 1989). Preferably, videotaped sessions will be used to enable supervision that takes into account the moment-to-moment unfolding of the session. In the future, automatic feedback about the skillful implementation of interpretations within the sessions may also become available (Weck et al., 2021).

Therapeutic Practices

Although it is too early to formulate research-based guidelines for the skillful use of interpretations, the following practices can be recommended based on a synthesis of clinical experience and empirical research.

- Observe the immediate and intermediate outcomes of an interpretation (do the patients reject the interpretation, accept it passively and not act on it, or embrace it and make it their own, using it to deepen the therapeutic work?)
- Check with patients about how they feel about the interpretation and be responsive to patients' verbal and nonverbal reactions.
- Prioritize the accuracy and experience-nearness of your interpretations over their simple frequency.
- Take into account the patient's sociocultural context, psychological history, and readiness for interpretation.
- Monitor the strength of the alliance before, during, and after you provide interpretations and repair any alliance ruptures resulting from the negative effects of interpretations.
- Attend to patients' quality of object relations when considering whether to use interpretations. Patients with poorer object relations may benefit more from interpretations compared to patients with high quality of object relations.
- Be aware that interpretations may not be beneficial, and in some occasions, may prove harmful if not provided at the right time and if not attuned to the patient.

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