

# Does insight mediate treatment and enhance outcome?

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## **Abstract**

*According to psychoanalytic and psychodynamic theory, insight is an important mechanism which may lead to better interpersonal functioning. In the present paper we have summarized empirical studies attempting to shed some light on insight as a putative mediator of treatment effects. Two case examples illustrate how improved insight might lead to clinical change.*

The term insight has been used in general psychiatry to describe patients' recognition of the abnormality of their own symptoms. However, the psychodynamic use of the word refers more generally to the patients' understanding of their internal conflicts and maladaptive relationship patterns. Insight in dynamic psychotherapy has a more complex meaning which involves both cognitive (intellectual) and emotional aspects of self-understanding. Increased insight and integration of external and internal realities are expected as effects of psychodynamic treatment. Self-understanding gained through psychotherapy is presumed to lead to reconciliation with disowned aspects of oneself, and to symptom change (Crits-Christoph, Connolly-Gibbons, and Mukherjee, 2013).

## **Working-Through, Insight, and Transference**

In psychotherapy the patient is offered the possibility to revise past events and accept the hitherto unacceptable (*nachträglich*). The understanding and insight acquired during dynamic therapy needs to be emotional as well as cognitive for change to occur. The patient's symptoms and defenses have to be explored, understood and worked through (Laplanche, and Pontalis, 1973). Working-through is a process where the therapist's interpretations help the patient to overcome resistance and repetition of behavior and emotional reactions. One assumption in dynamic psychotherapy is that the therapeutic and healing process will develop when old dysfunctional emotional and behavioral patterns have been experienced and resolved repeatedly in relation to the therapist. In-session new relational experiences and working-through permit the patient to pass from rejection or intellectual acceptance to increased ability to understand and describe his own vulnerability, reactions to stress, and coping abilities in relationships with others outside therapy. Working-through and gaining insight pave the way for reintegration and maturation as well as improvements in interpersonal functioning. When defenses are understood and modified they are less necessary and the patient may function more flexibly. (Laplanche, et al., 1973; Bateman, Brown, Pedder, 2010; Messer, 2013 ).

Transference has been a core concept in dynamic psychotherapy (Freud, 1905). The ongoing interaction between patient and psychotherapist is heavily influenced by the patient's past relationships and affective experiences. To focus on the themes and conflicts that arise in the therapeutic relationship by interpreting the transference may have an immediate affective resonance and illuminate the true nature of problems in the patient's relationships outside of therapy (Kernberg et al., 2008). According to psychodynamic theory; this may increase insight which again may lead to better interpersonal functioning (Strachey, 1934; Gabbard, and Westen, 2003; McGlashan, and Miller, 1982; Messer, and McWilliams, 2007; Kernberg et al., 2008). Insight gained through the therapist's interpretation of transference and the

subsequent working through is assumed to be particularly valuable since it facilitates integration of cognition and affect more effectively than when the therapist focuses exclusively on relationships outside of therapy, which may invite more intellectual speculation (Strachey, 1934; Messer, and McWilliams, 2007; Kernberg et al., 2008;).

Historically, there has been a general agreement in the psychodynamic tradition that transference interpretations aim to establish connections, by cause or analogy, between internal conflicts, past or present objects and the relationship to the therapist. More recently theorists have relied on broader definitions of transference and transference work interventions and emphasized how transference also might be originating from recent relationships as well as influenced by the therapist's style and behavior (Høglend, 2004; Gabbard, 2010; Høglend, and Gabbard, 2012; Høglend, 2014).

### **Quantitative Studies on Insight as a Mediator**

Patient variables that influence treatment outcomes are either predictors, moderators, or mediators of outcome. Both predictors and moderators are pre-treatment variables that affect the strength or direction of a treatment response. Predictors influence outcome regardless of treatment condition (for example; regardless of type of treatment, outcome will significantly depend on patients' motivation). Moderators are variables (e.g. patient and therapist characteristics) present at baseline. They differentially influence outcome within different treatment conditions and alter treatment response. Moderator analyses provide a test of for whom therapy works. Mediator analyses, on the other hand, provide a test of the mechanisms that putatively explain treatment effects (Baron, and Kenny, 1986; Kraemer, et al., 2002; Kazdin, 2007; Johansson and Høglend, 2007). "Studying mediators..... means attempting to understand what it is that brings about change, rather than merely asking "does it work for the average patient?" (Johansson and Høglend, 2007). It may be the case that

different forms of psychotherapy work through common mechanisms. On the other hand, different therapy modalities may work through different processes and mechanisms, e.g. insight may be a mediator in one therapy mode while not in another.

In order to empirically investigate a theoretical phenomenon one needs to operationalize the construct. Operationalization is to define a theoretical concept and to make it measurable in terms of empirical observations. How can we clearly define and reliably measure a multidimensional construct such as insight, including both cognitive and emotional aspects? A variety of measures has been developed. Two examples are the Insight scale of the Achievement of Therapeutic Objectives Scale (ATOS; McCullough et al., 2003) and the Insight sub-scale of the Psychodynamic Functioning Scales (PFS) (Bøgwald and Dahlbender, 2004). In ATOS, insight is defined as 1) the degree of clarity and depth of verbal descriptions of maladaptive behavior (cognitive and defensive), including the gaining of awareness of unconscious motivations and feelings. 2) the ability to state how, why, and with whom the maladaptive patterns began. 3) the ability to identify how, why, and with whom these patterns are occurring in the present, including secondary gains.

The Insight sub-scale of the Psychodynamic Functioning Scales (PFS) (Bøgwald, and Dahlbender, 2004) (Table 1), covers cognitive and emotional understanding of the main dynamics of inner conflicts. It measures to what degree the patient is able to understand interpersonal patterns and repetitive behaviors, and make connection to past experiences. Also the patient's ability to understand and describe his/her own vulnerabilities, reactions to stress, and coping abilities are measured, as well as whether the patient has a tolerant and realistic sense of self and others in interpersonal disputes.

Are there any empirical findings supporting the theoretical assumption that insight is a mediator (mechanism of change) in dynamic psychotherapy? If insight is a mediator it must be expected that insight changes during dynamic psychotherapy, change in insight occurs

before there is a change in symptoms, and improved insight enhances outcome. Repeated measures of insight, with reliable assessment tools before, during, and after treatment, as well as during follow-up are desirable for more precise conclusions to be drawn. For example, measuring insight repeatedly throughout treatment might indicate whether insight precedes or follows symptom reduction (Woody, and Ollendick, 2006).

As far as we know, eight studies have evaluated change in insight during psychodynamic therapy (Crits-Christoph, et al., 2013). All except one demonstrates significant change (increase) in insight. The studies include a variety of patient samples: mixed diagnostic outpatients (Høglend, et al., 1994; Grande, Rudolf, Oberbracht, and Pauli-Magnus, 2003; Connolly-Gibbons et al., 2009; Johansson, et al., 2010), generalized anxiety disorder (Connolly, et al., 1999), Cluster C personality disorder (Kallestad et al., 2010), and relationship problems (Kivligham et al., 2000). The one study which showed no significant change measured insight from session 3 to 5 (Crits-Christoph, et al., 2013). Hence, studies suggest that there is an increase in insight during psychodynamic psychotherapy.

Three studies indicate that changes in insight may be specific to dynamic psychotherapy. Connolly and co-workers (Connolly, et al., 1999) compared psychodynamic psychotherapy and medication in patients with generalized anxiety disorder. Connolly-Gibbons and co-authors (Connolly-Gibbons et al., 2009) evaluated change in insight in psychodynamic therapy, cognitive therapy and supportive therapy. Kallestad and colleagues used the ATOS (Kallestad, et al., 2009) to examine the role of insight in short-term dynamic psychotherapy (STDP) and cognitive therapy (CT) for Cluster C personality disorders. All three studies found that patients in dynamic psychotherapy improved more in insight than the patients in the comparison treatment modes. These results support the theoretical assumption that insight may be a factor in the change process in dynamic psychotherapy.

Some studies have explored the link between insight and outcome. Five studies have reported a significant association between increased insight and outcome across the course of dynamic psychotherapy (Høglend, et al., 1994; Kivligham, Multon, and Patton, 2000; Grande et al., 2003; Connolly-Gibbons et al., 2009; Johansson et al., 2010). The First Experimental Study of Transference Interpretations (FEST) linked the use of specific techniques (transference interventions) to gains in insight and subsequent improvement in interpersonal functioning. (Johansson et al., 2010). For the purposes of describing how these factors are studied we will describe the FEST in greater depth.

### **The First Experimental Study of Transference Interpretations (FEST)**

#### **Method**

The First Experimental Study of Transference Interpretations (FEST) (Høglend et al., 2006; Høglend et al., 2008) is a randomized controlled trial (RCT) designed to test the effects of Transference Interventions (TI) in psychodynamic psychotherapy. Insight was the primary mediator chosen a priori.

#### **Treatment and Participants**

100 patients in FEST were randomized to two groups, either to dynamic psychotherapy with low to moderate use of TI or to dynamic psychotherapy of the same kind but without TI. The treatment consisted of once a week sessions of 45 minutes, over one year, with a maximum of 40 sessions. How was it determined when treatment ended? Prior to the study it was decided that patients who came to less than 15 sessions were considered to be a dropout. Treatment length, without the dropouts, was equal in the transference and comparison groups; 34 [SD 6.1] and 33 [SD 6.6] sessions on average (Høglend et al., 2006). However, all patients (also the dropouts), were included in the statistical analyses.

#### **Assessment in FEST**

The patients had a semi-structured psychodynamic interview at pre-treatment, post-treatment, 1- and 3-year follow-ups. Based on the interview, independent clinicians rated the Psychodynamic Functioning Scales (PFS) (Høglend et al., 2008), one measure of global functioning, the Global Assessment of Functioning Scale (GAF) (American Psychiatric Association, 1987), and at pre-treatment only the Quality of Object Relations (QOR) (Azim, Piper, Segal Nixon, Duncan, 1991).

When designing FEST none of the available instruments for measuring clinician-rated psychodynamic changes were considered sensitive enough to capture statistically significant changes during one year of therapy. Therefore, the FEST research group developed PFS. The 6 sub-scales have the same format as the GAF (rated on a scale from 1 – 100), and measure psychological capacities over the previous 3 months. The scales are: Quality of Family Relationships; Quality of Friendships; Quality of Romantic and Sexual Relationships; Tolerance for Affects; Insight; and Problem Solving Capacity. Aspects of content validity (define), internal domain construct validity, interrater reliability, discriminant validity from symptom measures, and sensitivity for change in brief dynamic psychotherapy have been established. (Høglend, et al., 2000). The subscales of the relations to family and friends as well as romantic relationships, together constitutes a measure of interpersonal functioning used in FEST.

For the PFS and GAF, no normative data exist, but a score of  $\geq 71$  is defined in the descriptive levels of the scales as normal functioning. The Quality of Object Relations (QOR) (Azim et al., 1991), was chosen a priori as the primary moderator, as we hypothesized that patients with lower QOR would be less responsive to TI (?). The QOR measures the patient's life-long tendency to establish relationships with others, ranging from mature to primitive, using three 8-point scales. The three scales are; Quality of interpersonal relationships, Quality of sexual and intimate relationships, and Recent friendships. The cutoff score we chose for

differentiating high versus low QOR patients in this study was 5.1, the mean score of all 100 patients. QOR scores above the cutoff indicate evidence of at least one stable and mutual interpersonal relationship in the patient's history. Scores below the cutoff indicate a life-long history of less gratifying relationships characterized by less stability, less emotional investment, and a need for dependency or over control. Sixty percent of the patients with low QOR scores had one or more personality disorders in this study. In FEST there was a moderated treatment effect (the treatment effect was significant for low QOR patients).

In FEST, TI was operationally defined as interventions with explicit reference to the patient's ongoing relationship with the therapist. Five categories of TIs combine the relational (modernist) construction of transference, with the more traditional construct of transference in relationship to genetic (historical) origins (Gabbard, 2010; Høglend, et al., 2012; Ulberg, et al., 2014; Høglend, 2014).

In the following, the five categories of TIs are presented and illustrated by examples. In the examples, patients respond by reflecting and searching for self-understanding of their own feelings and reactions, and presumably, their insight improved. In the examples TIs are written in *Italic*:

**TI Category 1) The therapist addresses transactions in the patient-therapist relationship:**

Therapist: *After all, you and I talk when you come here. (Category 1)*

Patient: Yes. It's good even though I think it's hard. I'm learning about myself.

*Comment:* Even after a simple TI of category 1, the patient responded by commenting on the value of gaining insight.

**TI Category 2) The therapist encourages patients' exploration of thoughts and feelings about the therapy and the therapist's style and behavior:**



Therapist: *One way of understanding what you just said is that maybe you have chosen ahead of time to interpret what I say as if it doesn't mean anything. (Category 2)*

Patient: We are just sitting here playing with thoughts so it doesn't mean anything. There is a big difference between being here and meeting possible boyfriends.

Therapist: Maybe you would see things differently if you had experienced having a boyfriend who was also a true friend.

Patient: No. That just hurts more because I can't have a relationship like that anyway. This weekend I thought about how I have never had a relationship to a mentor or father figure and I have never been seen as a woman. I've been put down instead of being helped in a positive direction. Ever since I was a child I've been rejected over and over. But I never manage to say that I feel rejected. I can't manage to say: "Now you really disappointed me."

*Comment:* The patient responded to the TI by describing emotional material and an increased understanding of the historical origins of her problems.

**TI Category 3) The therapist encourages patients to discuss how they believe the therapist might feel or think about them:**

Therapist: *When I ask you a question about what you said, could it be you feel I don't accept you? (Category 3)*

Patient: Yes, it makes me think "now I have to find a good explanation."

Therapist: *When I ask you questions like this, sometimes I am curious, but I also want to understand you. Mostly I am interested in knowing how you*

*think, so that we can look at your thoughts and feelings together. For example the fact that you are constantly troubled by a bad conscience.*

**(Category 2)**

Patient: Yes, I don't understand why I go around beating myself up for everything, that I don't take enough care of my mother and my brother, because I do take more care of my mother than most people.

*Comment:* After identifying his reaction to the therapist's intervention the patient gains new self-understanding about repetitive patterns with people outside therapy.

**TI Category 4) The therapist includes him-/herself explicitly in interpretive linking of dynamic elements (conflicts), direct manifestations of transference, and allusions to the transference:**

Therapist: *What can I say that will help you? (Category 1)*

Patient: You can say it's OK.

Therapist: *So if I would agree with you that you should leave therapy, it would be helpful. Then you could leave with a clear conscience. Is that how it is? (Category 4)*

Patient: Yes, that's it.

Therapist: *So, it's important how I feel about it? (Category 3)*

Patient: I guess the main problem is that I let others take control. I'm always worried what other people might say about me.

Therapist: *Others have to decide or you have to decide. What do you think I think you should do? (Category 4)*

Patient: I do want to talk about the problems I have with other people. But right now I'm sitting here, being nice, just so that your study will work out well.

Therapist: *My study as it pertains to you? (Category 2)*

Patient: Yes, and it's often like that with others as well. I very rarely speak my mind if there's a chance it might hurt someone. I hate it when I can't say what's bothering me.

Therapist: *Recently, you said it annoys you that I don't say much and that you feel obliged to come here. Are there other situations that annoy you that you can't tell anyone about? (Category 4)*

Patient: Yes, it happens on a daily basis.

Therapist: For example?

Patient: If I think that a friend has done something good, and then someone else says something negative about it. I can completely change my mind about what I thought to begin with.

Therapist: *It's almost as if you have an antenna that constantly picks up what you think other's including me, might mean. (Category 4)*

*Comment:* In this example, TIs of different categories, including category 4, are used. The patient responds with increased insight about his lack of assertiveness.

**TI Category 5) The therapist interprets repetitive interpersonal patterns (including relationships with parents/genetic interpretations) and links these patterns to transactions between the patient and the therapist.**

Patient: He says he's very fond of me and could see us having a relationship

Therapist: And you're afraid of being let down, that he will lose interest in you or something like that?

Patient: Mm mm.

Therapist: *You also believed I didn't have any interest in you. (Category 5)*

Patient: Yeah, I know logically speaking, that you do care, but I still felt it wasn't true. I don't know .... It's just sort of a feeling I get.

Therapist: This fear that people that mean something to you won't care; have you always felt that way or did it start more recently?

Patient: I think I have had it for a long time, but I never actually thought about it before.

*Comment:* In this example of category 5, the therapist interprets repetitive patterns and points to the relation with the patient's boyfriend. The therapist also opens up for an exploration of the patient's past relationships. The patient seems to gain new emotional insight through the transference work.

Since insight was the primary putative mediator in FEST, the question was: Does insight act as a mediator and a true mechanism of change for the long-term effects of TIs? In addition, we wanted to identify the interrelationship between QOR, TI's and insight (Høglend et al., 2008; Johansson et al., 2010).

### **How to prove that insight is a mediator of outcome?**

Methodologically the strongest case for mediation in randomized clinical trials is made when five conditions are satisfied. Establishing mediation is a step-wise procedure, involving statistical demonstration of four associations, as well as demonstration that the mediator changes before outcome (Baron, and Kenny, 1986; Muller, Judd, and Yzerbut, 2005; Kazdin, 2007; Kraemer et al., 2002).

In FEST this step-wise procedure was applied in order to establish that there was a mediation by insight of the moderated treatment effect (that is treatment effect of transference intervention) for low QOR patients:

**I. Was transference intervention significantly related to a change of interpersonal functioning (direct treatment effect of transference intervention)?**

In the whole study sample, there was no overall difference in long-term outcomes between the two treatments. However, contrary to common expectation, patients with a life-long pattern of low quality of object relations and/or personality disorder pathology profited more from therapy with TI than from therapy with no TI. Patients with long-standing interpersonal difficulties improved more on interpersonal functioning from pretreatment to the 3-year follow-up in the transference group compared to the comparison group (Høglend et al., 2008) (Figure 1, Figure 2).

**II. Was transference intervention significantly related to change in insight during psychotherapy (treatment effect on the mediator)?**

During treatment a significant positive effect of TI on insight also emerged in some patients. The effect of TI on insight showed a significant increase in patients with lower scores on QOR (more disturbed relationships). The effect of TI on insight during treatment for high QOR patients was non-significant (Johansson et al., 2010) (Figure 1, Figure 2).

**III. Was the change in insight during treatment associated with long-term change in interpersonal functioning?**

There was a significant effect of an increase in insight during treatment on long-term improvement of interpersonal functioning among the patients with low QOR (Johansson et al., 2010) (Figure 1, Figure 2).

**IV. Was the direct treatment effect weakened or eliminated when insight was accounted for in the analysis?**

The direct treatment effect for low QOR patients was no longer significant when insight was added to the model in step I (not clear what this means). Sixty percent of the direct effect of transference interpretation on outcome variance for the typical low QOR patient was accounted for by the indirect effect of insight. Step I x Step II was statistically significant (Figure 1).

#### **V. Occurred change in insight prior to improvement in interpersonal functioning?**

In the transference group 69% of the patients with difficult interpersonal relationships changed more on the Insight scale than on the Interpersonal scales during the 1-year treatment period and an increase in insight preceded change in interpersonal functioning. After treatment interpersonal functioning continued to improve and insight did not (Figure 2).

#### **Conclusion I-V.**

The long-term positive treatment effect was mediated by an increase in the level of insight during treatment with TI? for patients with difficult interpersonal relationships. These analyses from FEST support the assumption that insight is a key mechanism of change in dynamic psychotherapy in these patients.

#### **Case examples demonstrating how insight may mediate clinical change**

In order to shed light on the impact of change of insight during treatment on subsequent interpersonal functioning, two patients were chosen from FEST as examples. Both patients were women with difficult interpersonal relationships. They were randomized to dynamic therapy with TIs. Both showed improvement on insight during therapy as well as interpersonal functioning and GAF up to the three year-follow-up. Two different therapists conducted the therapies. Both therapists were psychiatrists and dynamically trained therapists with more than 20 years of clinical experience.

Examples from the dialogue in sessions from each of the two patients illustrate the therapy processes promoting insight.

## **Case 1**

### *Presenting Problem and Patient Description*

A 40 year old female secretary wanted psychotherapy because of depression and binge-eating that developed after her divorce 7 years ago. She described her husband as a notorious adulterer. She had three teenaged children and was concerned about her lack of stability in her relationships with men. She was living with her fourth partner since the marriage ended. When she had disagreements with her partner, instead of being angry or sad, she ate huge amounts of waffles with jam and sour cream alternating with a very strict low-calorie diet. She contemplated leaving her partner.

The patient defined her primary problem as the eating disorder. If the eating problems disappeared, she thought that the depression, sleeping- and concentration difficulties would become less prominent. She also hoped psychotherapy could help her to feel more independent.

She was the youngest of four children with a domineering and verbally aggressive father and a depressive, negative mother who was also an alcoholic. The family had limited ability to verbalize emotions. She was given little attention and empathy by her parents. During childhood her talent in music provided self-esteem. She was competitive and disliked losing competitions for young musicians. At the time of therapy, she had a tendency to be envious of other people, for example her partner's children. She wanted to be the center of attention. She also had difficulties in expressing her feelings, especially anger, and acted out with binge-eating. She was diagnosed with depression and eating disorder and had long-standing interpersonal problems (QOR 4.9). Her treatment was 16 sessions in length

### *Course of Treatment*

In the initial phase of the therapy the patient felt that the therapist understood her and no disagreement occurred between the two of them. Using TI, the therapist focused on her dependency needs:

Patient: I'm not sure what I can ask of others, like with my children, and wonder what other people would do

Therapist: *Any ideas what I might have done in your situation? (Category 3)*

Patient: If I can think of what you would do? I don't get any answers here.

Therapist: How do you feel about that?

Patient: I'm not sure.

Therapist: No, but maybe you feel hurt or disappointed and then withdraw or overeat instead of realizing you are irritated or angry about not feeling responded to.

Patient: That's possible. I'll have to consider that.

As therapy progressed, the patient more often expressed her own point of view:

Therapist: *How do you feel about me, when I say that you aren't telling me what you really think? (Category 2)*

Patient: I'm not sure how I feel. I believe that I've changed and got pretty opinionated. I'm not sure I agree with you.

When asked at treatment termination whether or not she had learned something new about herself, she said that before therapy, she had not been aware of how much she automatically disavowed her own feelings, especially negative ones. Prior to treatment, she was to some extent aware of a connection between stress and binge eating. After treatment, she was able to give a much more detailed account of the associations between specific stressors, negative emotions and binge eating, and the way this interfered with her daily life.



During treatment she improved on insight (from 62.6 to 73.3). From being anxious and dependent, she was more aware of own vulnerability, stress reactions and coping abilities. Under stress she might partly forgot the connections between her behavior patterns and earlier experience. However, she could account for her most important inner conflicts, related problems and repetitive and personal attitudes. She showed realistic expectations about the future.

During the study period she improved on interpersonal functioning (from 63.5 at baseline to 76.3 at 3-years follow-up). The improvement on GAF was from 60.0 at baseline to 85.3 at 3-years follow-up. At the 3 year follow-up the patient emphasized that the focus on exploring how she repeated her feelings towards parents in her relationship with the present partner and also towards the therapist had been helpful. She no longer found herself dependent on advice from others, was no longer depressed and the binge eating had stopped. The relationship with her partner was much improved although she sometimes withdrew after disputes.

## **Case 2**

### *Presenting Problem and Patient Description*

A 37 year old pharmacy technician wanted psychotherapy because she was depressed and desperate after her adulterous husband wanted to leave her. However, she let him move back in because she loved him. She had three children aged four to nine.

### *Case formulation*

The patient grew up with mother, father and a three year younger brother with cerebral palsy. Her mother was preoccupied with her brother and the patient had a close relationship with her father. She was afraid of losing her father. During her teens, she was defiant, opposing her parents and at times using drugs. However, she was also member of a religious youth

organization. The patient defined her present problem as being too dependent and insecure and she wished to be able to make decisions by herself.

Her understanding of inner conflicts and links to past and present experience and behavior was limited, and she was less emotionally integrated. She showed vulnerability and defensive attitudes towards her husband and his behavior. The patient was diagnosed with anxiety, depression and dependent personality disorder and had long-standing interpersonal problems (QOR 4.7). Her treatment was 35 sessions in length.

### *Course of Treatment*

The therapist found it difficult to use transference interventions in the early phase of therapy. The patient was reluctant to explore conflicts and repetitive interpersonal patterns. In the late phase of therapy, she was more able to understand and describe her own vulnerability, reactions to stress, and coping abilities. Below are some examples from the dialogue in the late phase of therapy:

Therapist :    When you meet other people can you just say "Hi" or do you have to say more?

Patient:        No, I feel those situations are very unpleasant so therefore I avoid contacting others. Also when I sit with somebody, then I get that bad feeling of it being my fault that it's quiet. That she or he thinks I'm stupid because I don't have anything to say.

Therapist:     Mm mm.

Patient:        When I sit there with others then I feel that they think that I'm silly and stupid.

Therapist:     *Yes, and that I also think so? (Category 3)*

Patient: Yes. Perhaps not so much, but the feeling is the same. When I meet others, I feel I don't have anything to say and often when I get here I don't know what to start with.

Therapist: *Exactly. That's interesting because you describe situations where it's two of you, and here we are the two of us talking together. So how was it when you came here today? Did you experience a similarity?*  
**(Category 2)**

Patient: It's very unpleasant when I get here and you don't start, but I have to start.

Therapist: *But apparently not too unpleasant today. (Category 2)*

Patient: No, I started today. I had something I wanted to discuss with you. Perhaps my feelings are changing.

At treatment termination, she no longer met criteria for Axis I or Axis II diagnoses. Insight improved during treatment (from 59.7 to 76.0). At pretreatment she struggled with an inadequate judgment of self and others. Her judgment was poor. She was anxious and dependent with a feeling of being silly. At post-treatment she was more aware of own vulnerability, stress reactions and coping abilities. Sometimes she could blame herself or others too much in interpersonal disputes but observed own reactions and learned from it (integration). She showed realistic expectations about the future. The interpersonal functioning and GAF improved during the four year study period (Interpersonal functioning from 63.2 to 69.7; GAF from 60.5 to 72.5).

At post-treatment and at 3-year follow-up, she reported that the therapist's emphasis on interpreting how she expressed herself and how she behaved with others, including the relationship with the therapist, was helpful. She also valued the therapist's effort to help her

make connections between childhood and present situations and relationships. Exploration of repetitive patterns in relations to parents, husband, friends and the therapist had been helpful.

## **Discussion**

An extensive body of theoretical literature and narrative case studies emphasize insight as a mechanism of change in psychodynamic psychotherapy. Empirical research investigating the role of insight in dynamic psychotherapy has been scarce. However, there has been some evidence that an increase in insight may be associated with positive treatment outcome in psychotherapy (Crits-Christoph et al., 2013).

Insight has been described and defined in various ways. Generally, insight includes cognitive and emotional understanding of the main dynamics of inner conflicts, the related interpersonal patterns, and problematic repetitive behaviors. The process of gaining insight includes connecting the present to past experiences, and the ability to understand and describe one's own vulnerability, reactions to stress, and coping abilities. Quantitative studies indicate that insight changes during psychodynamic psychotherapy, and that the change is connected with improved outcome. Three studies evaluating change in insight during psychotherapy indicated that changes in insight may be specific to dynamic psychotherapy (Connolly, et al., 1999; Connolly-Gibbons et al., 2009; Kallestad et al., 2010). FEST extended this work by linking the use of transference work to gains in insight and subsequent improvement in interpersonal and global functioning (Johansson et al., 2010; Høglend, 2014)

In the present paper two clinical vignettes were chosen to illustrate the empirical findings on insight as a mediator of improvement in interpersonal functioning and global functioning. The therapy process for two women illustrates how TIs may enhance insight and improve outcome. Both patients showed a marked improvement on insight during therapy. The improvement on symptom- (GAF) and interpersonal functioning (interpersonal subscales

of PFS) occurred subsequent to the development of insight and continued at three years follow up. However, to gain a better understanding of insight as a mediator, more empirical studies are needed.

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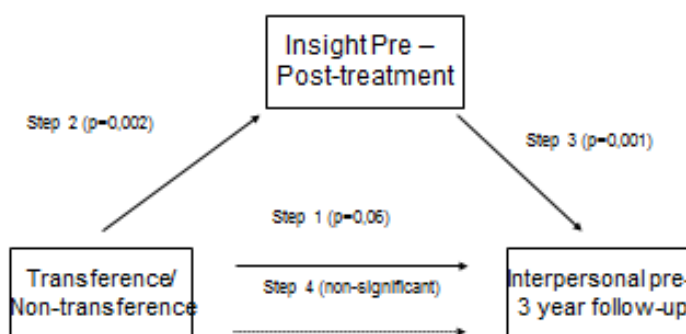


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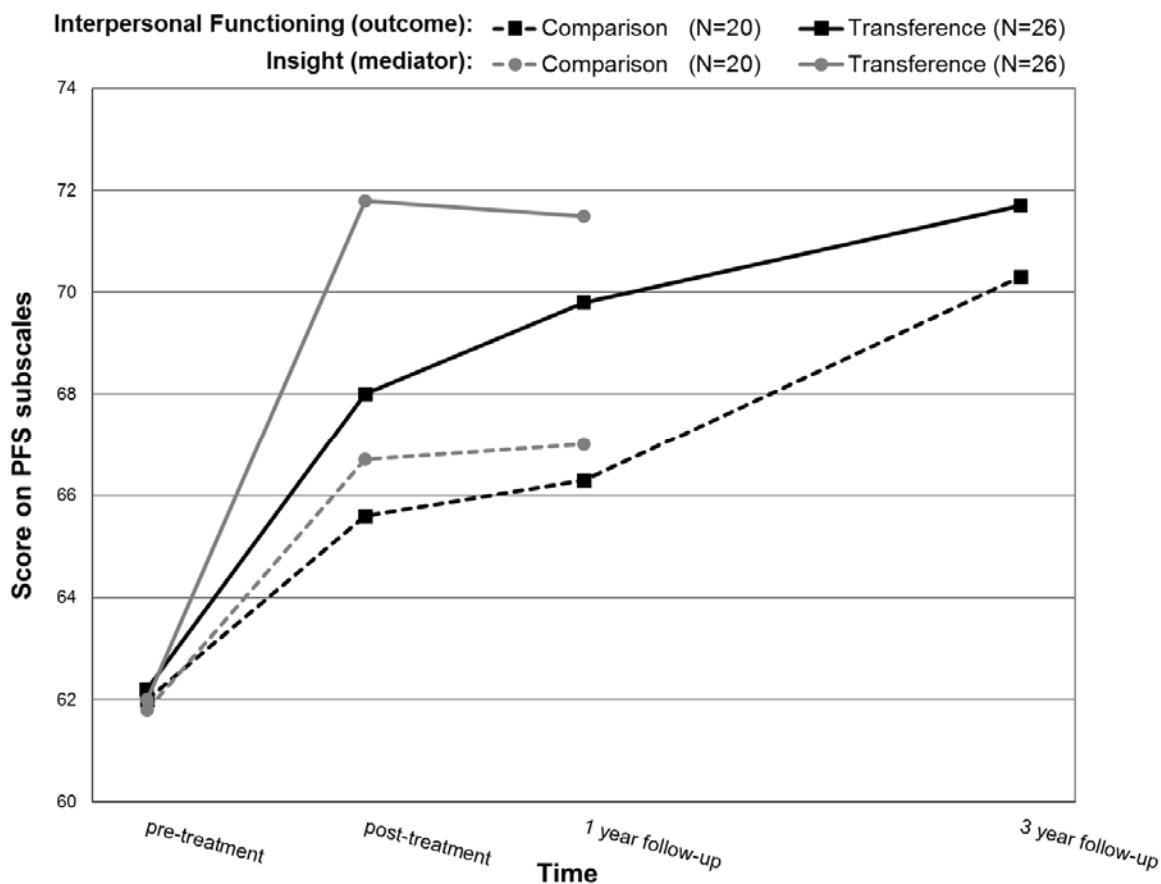
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**Figure 1.** The four statistical steps in the mediation model. Treatment effects studied are the estimated effect of transference interpretation in patients with low Quality of Object Relations (QOR) (Modified after Johansson et al., *J. Consult. Clin. Psychology.*, 2010).



**Figure 2.** Descriptive mean trajectories of the mediator and outcome scores over time within the subsample of patients with low scores on the Quality of Object Relations Scale ( $n = 46$ ). Interpersonal functioning (black lines) and insight (grey lines) for the transference group (solid lines) and the comparison group (dotted lines). (Modified after Johansson et al., J. Consult. Clin. Psychology., 2010).



**Table 1: Psychodynamic Functioning Scales (PFS). The Insight subscale:**

This dimension covers cognitive and emotional understanding of the main dynamics of inner conflicts, the related interpersonal patterns and repetitive behaviours, and connection to past experiences. Ability to understand and describe own vulnerability, reactions to stress, and coping abilities.

- 100** Unusual ability to describe genuinely personal wishes, fears, defenses and the related behavior and connections to earlier (childhood) experiences. High awareness of own vulnerability, attitudes, and interpersonal patterns, secondary gains. Open and curious about and reflects on the multiple levels and meanings of experience. Realistic judgement of self and others.
- 91** Can account for inner conflicts, the related problems and repetitive behaviours and connections to earlier experience. Aware of own vulnerability and reactions to stress. A tolerant and realistic sense

- of self and others in interpersonal disputes. May feel disillusionment but no bitterness or hopelessness.
- 81**
- 80** Can account for most important inner conflicts, related problems and repetitive behaviour patterns, and personal attitudes. Connections to earlier experience may partly be forgotten. Aware of own vulnerability, stress reactions and coping abilities. May blame self or others too much in interpersonal disputes but reflects freely and observe own reactions and learn from it (integration).
- 71** Generally curious and tolerant. Realistic expectations about the future.
- 70** Recognizes but can not clearly describe the complex association between past experience, inner conflicts and present problems and repetitive patterns. Reasonably aware of own vulnerability and strength and reactions to stress. Tendency to blame self or others too much in disputes. Occasionally behaviour and attitude may be unrecognized, but reflects and observes self in other areas.
- 61**
- 60** Understanding of inner conflicts and associations to past and present experience and behaviour is somewhat unclear, or less emotionally integrated, or "learned". Inadequate judgement of self and others but ability to observe and reflect with time. Vulnerability and stress-reactions sometimes a surprise. Some defensive, unrecognized attitudes and behaviours. Rigid views of rights and wrongs.
- 51** May look for superficial solutions. Recognizes symptoms as sign of disturbance.
- 50** Superficial "learned" or misleading ideas of inner conflicts and past and present experience. Distortions of judgement of self versus others also when no disputes. Painful feelings accompanied by harsh self-blame or incorrectly ascribed to external factors. Little or no reflection on personal motives, unaware of important aspects of attitudes and behaviours (fundamentalism). May deny symptoms as sign of disturbance. Excessive pessimism or optimism.
- 41**
- 40** Does not recognize associations between behaviour and internal dynamic components. Severely distorted perceptions/judgement of self or others. Disavows painful personal reactions. Can describe internal experiences but in stereo typed, confusing or misleading way. Denies signs of mental disturbance.
- 31**
- 30** Great difficulty describing internal experiences. Do not acknowledge associations between internal experiences and own behaviour. Severe distortions/delusional ideas may be present.
- 21**
- 20** Disorganized or fragmented mental functioning. Breakdown of reality testing. Need outside assistance.
- 11**
- 10** Continuously disorganized in need of constant assistance for days.
- 1**