

ACTIVE INGREDIENTS IN INDIVIDUAL PSYCHOTHERAPY

Searching for Common Factors

Carsten René Jørgensen, PhD
University of Aarhus

Every serious school of psychotherapy has its own theory—often only vaguely formulated—concerning the active ingredients in psychotherapy. Many of these theories are presented as mutually exclusive. The author presents an overview of some of the important, primarily psychoanalytically founded, theories of the factors in individual psychotherapy that are responsible for inducing change. It is impossible to pinpoint any single factor that is crucial in every therapy. What is needed is a nondogmatic, multiple-factor model that successfully incorporates the knowledge obtained from the many existing theories of psychotherapy-induced change. In practice, it is often difficult to maintain the traditional distinction between specific and nonspecific factors, just as it is difficult to distinguish the roles played by purely therapeutic factors—relating to the technique of the therapist—and by extratherapeutic factors. The author also addresses the epistemological status of the various claims put forward, by the many different theories of psychotherapy, concerning the active ingredients in psychotherapy.

Today it is generally accepted that psychotherapy works for most forms of psychopathology. However, there is still considerable disagreement as to what makes psychotherapy effective: What are the active ingredients in psychotherapy, or what factors in the therapy are responsible for effecting change? In his classic contribution to the understanding of the therapeutic elements in psychotherapy, Jerome Frank (1971; Frank & Frank, 1991) lists four general factors that are essential, in his view, to every form of psychotherapy: (a) a particular kind of emotionally charged relationship between the patient and the therapist that supports the patient's confidence in the therapist's competence and in his desire to help; (b) the fact that psychotherapy and its institutional context are socially sanctioned and legitimized, which in itself enhances the patient's expectations of help; (c) the immanent rationale or myth behind any given therapy, which offers an explanation of the

Correspondence concerning this article should be addressed to Carsten René Jørgensen, PhD, Department of Psychology, University of Aarhus, Nobelparken, Jens Chr. Skous Vej 4, DK-8000 Aarhus C, Denmark. E-mail: carsten@psy.au.dk

patient's problems and methods for eliciting change; and (d) specific tasks and procedures that demonstrate the therapist's competence and give the patient an alibi for change. In addition, Frank argues, most therapies provide the patient with successful experiences that in themselves enhance her sense of mastery, interpersonal competence, and capability, thus helping her to overcome her sense of demoralization and alienation from others. The patient discovers that her problems are not unique and that others are able and willing to understand and help her.

This conceptualization of the therapeutic factors in psychotherapy arguably has much in common with social constructionist ideas (Gergen, 1994). According to Frank, it is primarily the social and relational processes within and surrounding the therapy and the various psychotherapeutic theories that are responsible for eliciting change, rather than "objective" factors or factors relating to specific therapeutic techniques, that are traditionally cited by most theories of psychotherapy. In Frank's view, then, the various psychotherapeutic theories are important not primarily because they are "true" in the traditional sense but rather because they offer certain culturally legitimized myths about the nature and treatment of psychopathology. A radical social constructivist reading of Frank would present the various theories of psychotherapy as culturally founded narratives that in themselves contribute to the therapeutic process. Such narratives, it may be argued, help the therapist and the patient jointly to generate meaning and coherence in the patient's life—a process that is probably essential in eliciting change. By contrast, most of the existing theories concerning the therapeutic factors in psychotherapy conceptualize the active ingredients from a "realistic" point of view and thus aim to identify the "objective" factors in a successful therapy.

In their efforts to understand the active ingredients in psychotherapy, theorists have tended to focus on different levels of the therapeutic experience, while not necessarily making that focus sufficiently clear or explicit. Certain theories, for example, concentrate primarily on specific therapeutic strategies and techniques such as confrontation, interpretation, or validation. Others put emphasis on the preconditions for a positive therapeutic outcome, for example, the correctness of the therapist's understanding of the transference (Luborsky, 1996, p. 258). Still others are primarily interested in patient-related factors that influence patients' ability to profit from treatment: factors such as general psychological health, degree of social support, ego strength, psychological mindedness, and general intelligence. Finally, certain theories have a more global focus, seeking to reveal general or common therapeutic factors that are active in most forms of therapy and across different forms of specific interventions. The focus of this article is primarily on theories that implicitly or explicitly seek to articulate general or common therapeutic factors.

In his classic work "The Necessary and Sufficient Conditions of Therapeutic Personality Change," Carl Rogers (1957) argued that constructive personality change is based on six factors: (a) psychological contact between patient and therapist, where (b) the patient is in a state of "incongruence" (i.e., is vulnerable and anxious) and (c) the therapist appears as a congruent, integrated, and genuine person. Further, (d) the therapist experiences unconditional positive regard for the patient, and (e) he has an empathic understanding of the client's internal frame of reference. Finally, (f) the therapist is able to communicate his empathic understanding and unconditional positive regard to the patient—and the patient perceives the therapist's acceptance of and empathy for her. Rogers has been criticized for being too narrow in his understanding of the therapeutic factors in psychotherapy, and there is only modest empirical evidence in favor of the hypothesis that the facilitative conditions he enumerates are significantly related to therapeutic outcome (Lambert &

Barley, 2002). Although these factors may be *necessary* for successful psychotherapy, in most cases they are not in themselves sufficient to bring about the desired changes. Elaborating on Rogers's insights, Strupp (1974) hypothesized that the art of psychotherapy consists in "knowing when and *how* to communicate interest, respect, understanding, empathy, etc., and, perhaps even more important, when *not* to" (p. 251). Moreover, the "therapist's response to the client's needs must be genuine" (p. 251). It is also widely recognized as important for the psychotherapeutic process and outcome that the therapist recognizes and validates the patient's experience and the patient as a person. Sufficient focus and structure are also essential elements in all successful therapies (Hubble, Duncan, & Miller, 1999, p. 422). Finally, the reassurance and support that psychotherapy offers the patient, and the opportunity it gives her to obtain information about her problems and learn new skills to handle them, all have some bearing on the outcome of the therapy.

Most schools of psychotherapy involve intimately related conceptions of four important and closely related questions: (a) What is the nature of psychopathology? (b) What are the crucial therapeutic techniques? (c) What is the nature of therapeutic change (i.e., what are the essential criteria for determining and evaluating therapeutic success)? And finally, (d) What are the active or essential ingredients in psychotherapy? Manifestly, the answers one gives to these four questions will be interrelated. If, for example, one takes the view, as Freud (1914/1958) did, that psychopathology is the result of suppressed, repressed, or conflicting inner drives, or of the ego's inability to find the necessary compromise between the demands of the id, the superego, and external reality, it follows that the essential task of therapy must be to strengthen the ego and help the patient to find better ways to handle her drives. Freud assumes that the patient must be helped in gaining insight into her inner mental life—with its drives and conflicts—by way of analytic interpretations of her associations, dreams, and transferences. The insight derived from these interpretations—according to Freud—will strengthen the ego's position in the battlefield between the id, the superego, and external reality. If, on the other hand, one takes the cognitive therapist's view that the origins of psychopathology lie in the patient's maladaptive and erroneous basic assumptions and ways of thinking about herself and the surrounding world, it follows that therapeutic techniques must focus primarily on correcting these ways of thinking (or cognitive schemas) by testing the patient's basic assumptions against reality. In the eyes of the cognitive therapist, effective therapy consists not in an analytic exploration and interpretation of the patient's early history and inner conflicts but rather in a Socratic questioning (and following revision) of her erroneous basic assumptions (about the self, others, and own past, present, and future life) and an exploration of the relation between her dysfunctional thinking and the psychopathological symptoms she shows.

Although the suffering experienced by each patient is an "objective" fact, our specific theoretical understanding of the nature of the individual patient's psychopathology is in part a social construction from one of several possible perspectives. The patient's symptoms and maladaptive behavior are interpreted as signs of certain pathological syndromes, interpersonal conflicts, or some "inner" dysfunction. The way we classify, interpret, and construct the patient's problems will in part determine how we handle these problems and how we conceptualize therapeutic change. But how significant, in terms of outcome, is our choice of one or another of the widely recognized theories of pathology and psychotherapy? On the one hand, our general inability to find significant differences in outcome among the commonly recognized forms of therapy (Asay & Lambert, 1999, p. 28) suggests that in many cases, the therapist's theoretical approach and consequent choice of therapy are not especially crucial. For most forms of psychopathology, the success of intervention appears in practice not to depend on such choices, provided that the work of

the therapist is grounded in a coherent and sufficiently valid clinical theory or narrative and that the therapist is able to attune his interventions to the problems and needs of the individual patient. On the other hand, authoritative voices from the empirically validated or supported therapy movement (Task Force on Promotion and Dissemination of Psychological Procedures, 1995) have used the fact that some forms of therapy have been shown to be more efficient for some forms of pathology (cf. cognitive-behavioral therapy for anxiety and depression and interpersonal therapy for major depression; Nathan & Gorman, 2002) to argue that the choice of theory and specific techniques has significant importance for therapy outcome.

Discussions of therapeutic factors often rest on the implicit assumption that most patients (especially patients in the same diagnostic category) have the same needs and that the outcome of most therapies, broadly speaking, depends on the same (specific and technically driven) agents of change, regardless of individual differences in the nature, attitude, and expectations of patients. As Donald Kiesler (1966, 1995), among others, has noted, this is probably not the case. Kiesler (1995) coined the term “the myth of patient uniformity” (p. 94) in referring to the belief, prevalent in psychotherapeutic theory and research, that most patients in a given diagnostic category at the outset are more alike than they are different and thus require more or less the same treatment. As has been shown by aptitude-treatment interaction research (Beutler et al., 1991; Shoham-Salomon & Hannah, 1991; Snow, 1991), which looks at the interrelationship between patient and therapy, this idea is untenable. In principle, each individual patient needs a unique form of treatment, adapted to her individual problems, needs, and style. This demands a high level of therapeutic flexibility, which most competent therapists are, however, able to offer.

Psychoanalytic theorists (Killingmo, 1989) have drawn a general distinction between what they call “conflict” or “oedipal” pathology and “deficit” or “pre-oedipal” pathology. The basic idea is that patients suffering from conflict pathology (which is usually less severe) need a therapy aimed at recovering (repressed) meaning and at changing an already established internal psychological structure, whereas deficit pathology (which is generally more severe) calls for a more structured and supportive therapy aimed at constructing meaning and building up an internal self-structure that the patient lacks. In this sense, the essential agents of change depend on the level or nature of the patient’s pathology. Thus, good and successful treatments vary, depending on the patient’s pathology and current level of functioning. Furthermore, in each individual case the selected goals of therapy—be they removing target complaints and symptoms or changing the patient’s character structure—will have some bearing on what the crucial therapeutic factors are deemed to be. As noted by Gabbard (2000), “the mode of therapeutic action depends in part on the goals of the treatment. Hence, views of change mechanisms often vary according to these treatment goals” (p. 104). Finally, it is probable that positive immediate, intermediate, and ultimate outcomes (Muran, 2002) will be related to different active ingredients within the therapy.

Common Versus Specific Factors

The vast majority of theories concerning psychotherapeutic mechanisms of eliciting change are embedded in a medical model of psychotherapy. In this medical model,

theoretical explanations for disorders, problems, or complaints are formulated, treatments contain specific ingredients that are theoretically purported to be necessary for change, the therapist focuses on these specific ingredients, and researchers attribute the benefits of psychotherapy to those ingredients. (Wampold, 2001, p. xii)

According to this model, therefore, specific disorders—or patients in specific diagnostic categories—require specific interventions and specific active ingredients. The prevailing research on psychotherapy, much of which focuses on identifying empirically supported treatments, almost always embarks from this medical model. Bruce Wampold (2001), however, argues that this model should be replaced with what he calls a “contextual model” of psychotherapy, focusing primarily on the common factors in different forms of therapy. The common-factors movement, as it has been called, seeks to determine the core ingredients shared by most therapies, with the goal of developing efficacious treatments based on these components (Grencavage & Norcross, 1990; Norcross, 2002). Thus, as we become better able to formulate and understand the common or nonspecific factors in psychotherapy, they can to some extent become part of the specific or more technical factors within psychotherapy.

Garfield (1995) believes that most of the many existing psychotherapies “use a number of similar procedures or interactions that have an impact on the client, although they are not particularly emphasized in the formal descriptions of the therapy” (p. 135). A distinction is commonly made between specific and nonspecific agents of change in psychotherapy. The term *specific* refers to theoretically specified factors that have a theoretically or empirically supported effect in the treatment of specific problems or disorders and implies therefore that it is possible to distinguish “specific factors or procedures that are of particular value in treating specific kinds of problems” (Garfield, 1995, p. 138). The term *nonspecific* refers to theoretically unspecified agents of change, the effects of which are not limited to particular problems or disorders. It is especially among these nonspecific factors that the common factors of psychotherapy may be found: those that are not specific to any particular form of therapy (or hitherto acknowledged as specific only by a single theoretical school) but are common to most or all forms and are effective in treating different kinds of problems, although to different degrees, depending on especially pathological severity. The current emphasis on “branding” the various schools of psychotherapy, for economic reasons and reasons related to the prevailing cultural zeitgeist, has meant that therapists themselves have tended to put greater weight on specific factors—that is, on those techniques and ingredients that distinguish their particular school from others—even though the common or nonspecific factors probably play a greater role in the outcome of any given therapy.

Although the distinction between specific and nonspecific factors is important from a theoretical point of view, it is quite difficult to apply in clinical practice, where it is extremely complicated to distinguish specific factors relating to particular techniques from those that are nonspecific and more subjective. As stated by Ogles, Anderson, and Lunnen (1999), “the distinction between specific and common factors used to distinguish the crucial components of different therapies is a convenient yet artificial heuristic device” (p. 218). It is a problem inherent to the nature of psychotherapy that it is almost impossible to isolate specific factors and relate these directly to changes in the patient. Moreover, the endeavor to identify specific, active ingredients often implies a decontextualization of parts of therapy, removing them from the essential interpersonal context of the therapy (Samstag, 2002).

According to Michael Lambert’s (1992) important but also controversial analysis of outcome studies, only approximately 15% of the differences in improvements obtained through psychotherapy are due to (specific) factors uniquely relating to specific therapies. Another 15% can be attributed to patients’ expectations—the client’s trust in a particular treatment and its rationale. As the group therapist Irvin Yalom (1995, p. 4) has argued, instilling and maintaining hope is crucial in any psychotherapeutic treatment and will help

to keep the patient in therapy. Moreover, the patient's trust in the treatment can in itself be effective. According to Lambert, a further 40% of the demonstrated differences in improvement must be attributed to factors relating to the client and his environment. In the past decade, this finding has resulted in numerous substantial contributions focusing on how to utilize the patient's own resources in therapy (Duncan & Miller, 2000; Hubble et al., 1999). Finally, Lambert argues that up to 30% of the differences in improvement resulting from therapy are due to (mainly nonspecific) common factors: factors to be found in most therapies regardless of the therapist's theoretical orientation. Many of these common factors have to do in various ways with the nature of the therapeutic relationship and the ongoing interaction between the individual patient and the therapist. Traditionally, they include a wide range of relationship-mediated factors such as empathy, warmth, acceptance, affirmation, and recognition, qualities to be found in most therapies regardless of the therapist's theoretical persuasion. Distinguishing specific techniques from other, more nonspecific parts of the therapy is especially problematic when it comes to interpersonally oriented forms of psychotherapy, where factors such as empathy, acceptance, affirmation, and the systematic use of the relationship are part of the therapeutic technique proper. Therapist, patient, and relationship variables are intimately related.

Lambert (1992) concludes his analysis of psychotherapy outcome studies with the assertion that "although there are a large number of therapies, each containing its own rationale and specific techniques, there is little evidence to suggest the superiority of one school or technique over another" (p. 103). Lambert's conclusion has been questioned by the empirically supported therapy movement (Crits-Christoph, 1997; Nathan & Gorman, 2002; Roth & Fonagy, 1996). But his basic point, that the common factors have significant influence on therapy outcome, is still valid. And the Dodo Bird verdict—all have won and all must have prizes—is still true for most bona fide therapies and forms of psychopathology.

Two points may help us in understanding the remarkable fact that relatively few of the studies have found significant differences in outcome among the various schools of psychotherapy. First, the difference between therapists is probably significantly smaller in practice than in theory. The individual therapist may subscribe to a particular theory and school of psychotherapy, but in practice, every "good enough" therapist (cf. Winnicott's, 1971, concept of the good enough mother; Jørgensen, 2000) is flexible and able to adapt his approach and techniques to the needs and current condition of the individual patient. In this sense, most therapists are to a certain extent eclectic, and when it comes to treatment outcome, the particular differences between most individual therapists are substantially greater than the overall differences between the various theoretical schools of therapy. Therefore, we should put more effort into empirically validating each individual therapist rather than continuing the ongoing horse race between the well-established schools of therapy. Second, the common factors—those that are common to most forms of psychotherapy—are probably more important for therapeutic outcome than specific technical factors. Furthermore, Asay and Lambert (1999, p. 29) have suggested that different therapies may be able to achieve similar goals through different processes. Alternatively, it is possible that different outcomes actually do occur more often but have not been detected by the research strategies until now.

Therapists are not interchangeable, and psychotherapy—even within particular schools or forms of therapy—is not a homogeneous form of treatment. Detailed manuals and intensive training in the conduct of therapy do not eliminate the complex elements of the therapeutic encounter, nor do they reduce the therapist to a technician who merely has to apply certain standardized treatments for specific and clearly delineated symptoms.

Thus, it is problematic to assume that the active ingredients in psychotherapy can be reduced to a series of individual, easily definable therapeutic techniques.

Although most theories claim the opposite, a substantial part of the essential active ingredients in each of the various schools of psychotherapy is probably much the same. "Much of what is effective in psychotherapy is attributable to pantheoretical or common factors, those shared by many schools of therapy" (Asay & Lambert, 1999, p. 23). As Luborsky and his colleagues concluded in their study of the factors determining therapeutic success, "the therapist's ability to form an alliance is possibly the [single] most crucial determinant of his effectiveness" (Luborsky et al., 1985, p. 610), even though most studies have found only a moderate correlation between alliance and outcome. Similarly, Bohart and Tallman (1999) argue that "the client's abilities to use whatever is offered surpass any difference that might exist in techniques or approaches" (p. 95). Most patients will use whatever resources are offered and made available to help them change. Nevertheless, there is probably a strong correlation between the severity of the patient's symptoms and the patient's ability, or otherwise, to form an alliance and to benefit from therapy. As the patient's problems become more severe, specific and technical factors become relatively more important for therapy outcome (Crits-Christoph, 1997; Stevens, Hynan, & Allen, 2000). Thus, client-related factors interact with relationship factors and with the patient's expectations of the therapist.

Focusing on the common factors in therapy does not necessarily entail arguing for a non-model-based or "technique-less" form of therapy. However, the various models or techniques that provide a structured rationale for different kinds of therapy in many cases appear to offer equally viable paths to achieving change. If we agree that the common factors are important for therapy outcome, it is relevant to ask such questions as What do we know about these common factors? Do we have well-established theories to account for the efficacy of therapeutic factors common to most forms of psychotherapy?

In the following, I outline some of the most important, primarily psychodynamic theoretical accounts of how the therapist and the therapy contribute to the development of the patient in individual psychotherapy. In this connection it is important to distinguish between, on the one hand, the therapist's conscious theory of change, therapeutic strategies, selected interventions, and so forth, and, on the other hand, what actually elicits change in each individual therapy. The point is that these two "levels" are not necessarily identical. As stated by Rosenzweig (1936, p. 412), the factors alleged to be operating in a given therapy are not necessarily identical with the factors that actually are operating. For example, a therapist who identifies with a cognitive-behavioral clinical theory and uses primarily cognitive-behavioral interventions could have good results for reasons other than the ones stated in his clinical theory. Even though he is convinced that eliciting changes in the patient's basic assumptions through Socratic questioning is of utmost importance, his way of interacting with the patient—giving her an opportunity for correctional emotional experiences, and so on—might be the most important agent of change. As therapists, we are sometimes efficient for more and/or other reasons than we believe and are immediately able to articulate. Furthermore, some of the many existing theories about technical interventions and mechanisms of change related to these interventions contain articulations of active ingredients that are valid for most forms of psychotherapy, and some of our theories about specific technical interventions in reality articulate important common factors. Even though they are not an explicit part of the therapist's clinical theory and training, these common factors are important agents of change in most psychotherapies.

Emotional Abreaction: Catharsis

In the early years of psychotherapy, Freud and Breuer (1895/1955) hypothesized that an emotional abreaction of “dammed up” affects or emotions was a crucial agent in effecting psychological change. In accordance with the classical psychoanalytic theory of drives, they claimed that psychological disturbance and especially hysterical symptoms were the result of blocked or suppressed drives or affects. This understanding of the nature of psychopathology meant that one of the main objectives of hypnosis, and later the talking cure, was to help the patient find new and better ways of releasing her blocked affects and drives (Jørgensen, 1997). Freud and Breuer (1895/1955) observed that their patients’ symptoms disappeared when they had

succeeded in bringing clearly to light the memory of the event by which it [the symptom] was provoked and in *arousing the accompanying affect* and when the patient had described that event in the greatest possible detail and had *put the affects into words* [italics added]. (p. 255)

When the strangulated affect is allowed to find a way out through speech, the symptoms will disappear.

Although current theories of psychotherapy—especially those that are more experientially oriented—still refer to blocked emotions and the inability to express emotion (in word and deed) as principal causes of psychopathology, it is no longer assumed that emotional abreaction, or catharsis, is in itself sufficient to bring about durable changes. Abreaction alone has no permanent curative value. However, in many cases the cathartic effect of releasing blocked emotions and finding better and socially more acceptable ways of expressing emotions—ways that do not have the same negative impact on the patient’s interpersonal relations and ability to adapt—will contribute to a positive healing process.

Exposure, Desensitization, and Changing Passive Into Active

The techniques of desensitization and exposure were first introduced by behavioral therapy as treatments for phobic conditions (Wolpe, 1969). The basic idea is that if the patient is systematically and repeatedly confronted, in an anxiety-reducing context, with feared situations—either in imagination or in vivo—the accompanying anxiety, which in this case is seen as the core of psychopathology, will gradually disappear. As the patient repeatedly discusses his problems and repeats his concerns in a therapeutic climate of acceptance, these problems will gradually become less threatening and anxiety provoking (Garfield, 1995, p. 109). Systematic desensitization involves the creation of a hierarchy of progressively more anxiety-provoking stimuli or situations, which are then imagined or experienced by the patient under the safe conditions of therapy. As most patients will be inclined to avoid such anxiety-provoking situations, the therapist must keep the treatment focused and block the patient’s attempts to flee from anxiety-provoking themes. Formulated from a psychoanalytically oriented frame of reference, the therapist must confront the patient with her more or less unconscious attempts to flee anxiety-provoking themes. Finally, in the course of therapy the characteristic helplessness and passivity that most patients exhibit in relation to their pathological symptoms will gradually be replaced by a more active attitude and an experience of self-efficacy. Gradually, in other words, the patient will develop a sense of being able to deal with her own problems and will cease to feel like a passive victim of inner or outer forces that are beyond her control. This will contribute to her increased self-confidence and sense of her own effectiveness. Similarly,

the social behaviorist Albert Bandura (1977) argued that “psychological procedures, whatever their form, serve as means of creating and strengthening expectations of personal efficacy” (p. 193). The patient acquires an increased sense of personal mastery and greater conviction that she will be able successfully to execute the forms of behavior required to cope with stressful situations. This sense of efficacy is intimately related to a change in the patient’s understanding of her own problems, which she no longer sees as being beyond her control.

It might be argued that these therapeutic factors are active only in behavioral therapy for anxiety disorders. However, in one form or another the exposure of the patient to anxiety-provoking situations, the blocking of—or confrontation with—avoidant behavior, and the effort gradually to change the patient’s passive role into a more active attitude toward her own problems and treatment are inherent in most schools of psychotherapy, from the experiential therapist’s persistent focus on suppressed affects to the psychoanalytic and interpersonal therapist’s continual focus on problems and conflicts in the therapeutic relationship. As Linehan (1993) has emphasized, it may be necessary in some cases to use specific techniques to ensure that the new skills acquired during exposure are generalized to everyday life outside therapy.

In “Remembering, Repeating and Working-Through,” Freud (1914/1958) described how transference allows the patient an opportunity to repeat or relive, with emotional immediacy, the core of her pathology. Through repeating, in interaction with the therapist, the basic conflicts behind her problems, the patient—so Freud argues—is able to remember essential elements from the past, which in turn makes it possible to initiate change. In general, the persistent repetition and working through of the patient’s core conflicts in transference are an essential part of psychoanalytic treatment. Moreover, psychotherapists of all schools will in most cases seek, in one way or another, to keep the patient focused on pathological thoughts, behaviors, and emotions in a way that resembles the technique of exposure and the blocking of avoidant behavior. For example, the psychodynamic therapist exposes the patient to emotionally intense situations by continually clarifying, interpreting, and confronting her with her maladaptive social behavior. If the therapist is competent, this will gradually lead to a desensitization of the patient’s relationship to the situations, significant others—and her inner representation of these situations and significant others—that originally gave rise to her pathological behavior, and hence to an improvement in her ability to handle such situations.

The attempt to turn the patient’s passive and helpless attitude into a more active and effective form of behavior is also part of most psychotherapeutic traditions, although it takes somewhat different forms in each case. According to psychoanalytic theory, the human psyche repeatedly stages in vivo repetitions of pathogenic experiences and situations (cf. repetition compulsion) in an effort to process them. Concomitantly, the original passive position is replaced by a more active one. This process is paralleled in therapy as the patient gradually gains control over the recurrent and unpleasurable repetitions or actualizations of painful situations and conflicts. The process of turning passive into active by repeatedly confronting the patient with feared situations and demonstrating that they do not have to issue in the expected catastrophic consequences can be seen as a form of what Alexander and French (1946) called correctional emotional experience in psychotherapy. Similarly, the new client-directed therapies (Duncan & Miller, 2000), with their focus on activating the resources of the client, work systematically to enhance and highlight the patient’s felt sense of personal control—both within therapy and outside of it. The theory is that people who feel and believe that they *can* influence or control the course of therapy

and the course of their own life events will indeed in practice adjust more successfully (Hubble et al., 1999, p. 420).

Correctional Emotional Experience and Internalization of the Therapeutic Interaction

The idea that corrective or correctional emotional experience is an important curative factor in psychotherapy was formally introduced by Franz Alexander and Thomas French (1946) in their influential book *Psychoanalytic Therapy*. Here they conceptualized psychopathology as the outcome of past and present pathogenic interpersonal relations. They hypothesized that in each case a given psychopathology is originally caused by, and is subsequently maintained by and manifested in, dysfunctional interpersonal relationships. Thus, the repetitive maladaptive patterns in interpersonal relationships that block more authentic ways of relating to others play an important role in psychopathology. In therapy, the patient will expect the therapist to act in the same way as other significant persons in her past and present life, and the patient herself will act toward the therapist in ways that are similar to her past and present ways of relating to important others. In this sense, the patient (re)enacts core elements of her pathology in her interaction with the therapist.

By exposing the patient, under more favorable circumstances, to emotional situations that she was unable to handle in the past, the therapist gives her the opportunity to undergo a corrective emotional experience, which will repair or diminish the negative influence of previous pathogenic experiences (Alexander & French, 1946, p. 66). To begin with, the patient continues to act according to the old and outdated relational patterns, whereas the reactions of the therapist (ideally) break those patterns by conforming not with the expected behavior of significant others in the patient's life but with the actual therapeutic situation in the here and now. Gradually, the therapist will "help the patient both to see intellectually and to *feel* the irrationality of her emotional reactions" (Alexander & French, 1946, p. 67). The patient's behavior is revealed as a form of "one-sided shadow boxing" (p. 67). Through the actual experience in the relationship with the therapist, the patient is given the "opportunity to face again and again, under more favourable circumstances, those emotional situations which were formerly unbearable and to deal with them in a manner different from the old" (p. 67). Through the therapeutic relationship, the therapist disconfirms the patient's dysfunctional beliefs about interpersonal relationships and compensates for frustrations and traumatic experiences in her early relationships. "The crucial therapeutic factor is that the [therapist's] reactions are different from those of the parents" (Alexander, 1950, p. 486).

This conceptualization of psychotherapy is related to Sandor Ferenczi's idea of a "new beginning" in psychotherapy and to Michael Balint's (1979) focus on "primary love" as an essential factor in effective psychotherapy, especially with more severely disturbed patients. Their common notion is that positive experiences with the therapist will compensate for deficits in the patient's early relationships and help redirect or restart maladaptive or fixated developmental processes. Seen as a specific therapeutic strategy, the correctional emotional experience has been severely criticized by the psychoanalytic community (Wallerstein, 1990; 1995, p. 55). The critics claim that the therapy of Alexander and French abandons fundamental psychoanalytic notions and principles, that it encourages the therapist to engage in inauthentic role-playing, and that the therapy is not a "real" psychoanalytic and rational therapy directed toward structural change based on insight but rather a suggestive and manipulative behaviorist therapy whose goal is mere

symptom relief and social adaptation. Again, it is important to distinguish between the correctional emotional experience as a thorough-going and dominant therapeutic strategy (where inauthentic role-playing is an inherent danger) and the correctional emotional experience (avoiding the recurrence of pathological interpersonal patterns) as an important (for the therapist often unconscious or not consciously intended) agent of change in most therapies.

From an ego-psychological perspective, Loewald (1960, p. 30) postulated that internalization of the interaction process is an essential element both in the development of the ego in childhood and in the resumption of it through therapy. Similarly, Fairbairn (1958) suggested, from a slightly different perspective, that

the disabilities from which the patient suffers represent the effects of unsatisfactory and unsatisfying object-relationships experienced in early life and perpetuated in an exaggerated form in inner reality; and . . . the actual relationship existing between the patient and the analyst as persons must be regarded as in itself constituting a therapeutic factor of prime importance. (p. 377)

The patient–therapist relationship, he added, “provides the patient with an opportunity, denied to him in childhood, to undergo a process of emotional development in the setting of an actual relationship with a reliable and beneficial parental figure” (p. 377).

More recently, Jeremy Safran and Christopher Muran (2000) have focused on the working through of alliance ruptures as the core of effective psychotherapy. Safran hypothesizes that the ongoing exploration of subtle elements in the patient–therapist interaction and the working through of alliance ruptures “provide a learning experience through which the client gradually develops an interpersonal schema that represents the other as potentially available and the self as capable of negotiating relatedness even in the context of interactional ruptures” (Safran, 1993, p. 19). The therapeutic relationship helps the patient to correct dysfunctional cognitive schemes and provides a new positive experience in a wholesome interpersonal relationship. Moreover, ruptures in the alliance are typically related to an activation and repetition in the here and now of core interpersonal conflicts and dysfunctional patterns in the patient’s habitual ways of interacting with others, because the patient tends to reenact his maladaptive patterns of behavior with the therapist. The therapist’s success in demonstrating another—healthier—outcome to the interpersonal conflict reenacted in therapy will contribute significantly to the patient’s positive development. Thus the breaking, or nonrepetition, in therapy of maladaptive interpersonal patterns represents an important agent of change. According to Kohut (1984), therapeutic impasses or alliance ruptures are typically related to failures of empathy on the part of the therapist, and the process of working through these (nontraumatic) empathic failures in itself has important therapeutic potential. Theoretically, the technique of healing alliance ruptures is also related to the classic psychoanalytic conception of working through negative transferences. Similarly, Marsha Linehan (1993, p. 110) emphasizes that doing therapy is a highly complex and difficult task and that it is inevitable that mistakes are made. Good therapy consists of rectifying these mistakes in a way that contributes to the process of healing.

Joseph Weiss and Harold Sampson (1986) have argued that the core of psychopathology lies in pathogenic beliefs about the self and its relation to other people and that the patient constantly tests these beliefs in his interaction with the therapist in the hope that the therapist will act and react in ways that will disconfirm his beliefs (Weiss, 1993). These beliefs, acquired in early childhood, impede normal psychological and interpersonal

functioning. Weiss (1994) argues that in therapy the “patient works unconsciously by planful testing of the therapist and the analyst may help the patient by passing his test” (p. 236). By carrying out trial actions, the patient is testing his pathogenic beliefs on the therapist, hoping that the analyst will not act and react as his beliefs would lead him to predict. Weiss and Sampson suggest that the effectiveness of any intervention should be understood in terms of its impact on the patient’s sense of safety—an idea related to Bowlby’s (1988) concept that the therapist must provide a secure base for the patient—and that psychotherapy basically works to the extent that it disconfirms the patient’s pathogenic beliefs and enables him to feel safe (Rappoport, 1997).

Experiential therapists emphasize the process of learning through direct experiential feedback in the patient–therapist interaction. They focus especially on what more psychoanalytically oriented theorists would call the “real” relationship (Greenson, 1967, p. 216): that is, the realistic and genuine parts of the patient–therapist encounter. It is assumed that this genuine relationship contains important elements in inducing change. Similarly, in trying to specify those elements that represent “something more than interpretation” in psychodynamic therapy, Daniel Stern and his colleagues (1998) point to the so-called “moments of meeting” between patient and therapist as important elements in the curative process. They suggest that these moments of meeting are events that rearrange the patient’s implicit relational knowledge, that is to say, his representations of non-symbolic and nonverbalized interpersonal events and experiences (Stern et al., 1998, p. 906). In other words, these moments, according to Stern et al., change the unconscious representational preconditions for the patient’s experience and behavior in interpersonal situations.

Sullivan (1953) hypothesized that the individual learns to treat himself or herself in a manner that corresponds to the way that he or she is treated in interpersonal interactions with significant others. Interactions with significant others become internalized as part of the individual’s personality structure, and this will subsequently determine the person’s self-understanding and behavior toward the self (Benjamin, 1993). Thus, psychopathology in interpersonal theory is conceptualized as the result of the individual’s internalization of maladaptive interpersonal interactions with significant others.

The interpersonal theory put forward by Strupp and Binder (1984, p. 261) suggests that internalization is one of the crucial routes to intrapsychic change and that the effect of internalization—the process of replacing early (maladaptive) patterns with new (more adaptive) ones—is an achievement unique to psychotherapy. In psychotherapy the patient will internalize the positive attitude and behavior of the therapist and will replace maladaptive behaviors toward the self with more adaptive and less pathogenic ones. Moreover, the patient will incorporate or internalize many of the techniques and problem-solving strategies of the therapist.

Development of Affect Regulation

Affect regulation is the process “by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions” (Fonagy, Gergely, Jurist, & Target, 2002, p. 93). The ability to regulate affects is not an inborn quality. Normally it is developed in the course of early relationships with significant others. A dyadic regulatory system is evolved in which the infant’s signals of moment-to-moment changes in her state are understood and responded to by the caregiver. This process both helps the child to achieve immediate affect regulation and supports the

development of her independent affect regulation (Fonagy, Target, & Gergely, 2000, p. 104). “The infant learns that arousal in the presence of the caregiver will not lead to disorganization. . . . The caregiver will be there to re-establish equilibrium” (p. 104). Moreover, the caregiver’s repeated external representations of the infant’s displays of affect will gradually sensitize the infant to relevant cues of internal states in herself and others (Fonagy et al., 2002, p. 161). In normal development “the caregiver’s emotional expression, congruent with the child’s state, is internalized and becomes its representation” (Fonagy et al., 2002, p. 349). Through her ongoing interaction with significant others, the child learns how to identify and verbally represent her emotional states. The development of affect regulation and the self-regulation that goes with it is thus a product of coregulation.

Essential parts of this process are paralleled in psychotherapy when the therapist helps the patient to regulate and construct relevant verbal representations of internal states, emotions, and ways of relating to the therapist in the here and now. The patient’s understanding of her affects is not arrived at by introspection alone. Rather, she internalizes the therapist’s emotional and verbal expressions, which are more or less congruent with her internal states. Thus, all forms of psychotherapy offer a safe and containing context in which to experiment with the experience and expression of affect, and the patient’s experience of this will again support her in developing a more mature and subtle way of regulating her emotions. It has been argued that a more affirmative attitude on the part of the therapist and more affirmative interventions in general might have an activating and revitalizing effect on frozen or immobilized affects, particularly in more severely disturbed patients (Killingmo, 1995).

More severe forms of psychopathology, in particular, have been linked to substantial problems in the regulation of affect (Fonagy et al., 2002) and emotional dysregulation (Linehan, 1993). In the theoretical model outlined in her *Cognitive–Behavioral Treatment of Borderline Personality Disorder*, Marsha Linehan (1993) emphasized the development of the patient’s affect regulation as one of the active ingredients in treating personality disorders.

Development of Mentalization, Self-Reflexivity, and the Ability to Handle Interpersonal Interaction

Inspired by the American philosopher Daniel Dennett’s (1987) influential book *The Intentional Stance*, Peter Fonagy et al. (2000) have argued that it is an important part of normal psychological development to learn how to understand oneself and others in terms of mental states, that is, thoughts, feelings, beliefs, and desires. According to Fonagy et al., the development of a theory of mind, or what the authors prefer to call a capacity to mentalize, is the basis for the ability to understand, make sense of and anticipate the behaviors and reactions of others. By attributing thoughts, feelings, and intentions to others, a person is able to understand and make sense of their behavior. At the same time the individual develops the capacity to separate inner and outer realities and to acknowledge surface and depth as potentially separate worlds. All of these capacities are essential for the establishment of normal interpersonal relations. Mentalization enables the person to “read,” understand, and make sense of other people’s minds and to “predict and explain other people’s actions by inferring and attributing causal intentional mind states to them” (Fonagy et al., 2002, p. 347), which is an essential part of social reality-testing.

Mentalization is the capacity to think in terms of mental causation, and this is especially important for the ability to handle interpersonal conflicts, traumatic experiences,

and complex realities in general. It allows us to interpret the reactions and behaviors of others as a result of their mental states and to understand that they do not always represent realistic reactions to the self. Rather, we see that the behavior of others often reflects their current states of mind—states of mind that do not necessarily emanate from their feelings about or objective appreciation of the self. We learn how to construct contextual understandings of the behavior of others and how circumstances in other people's lives or their immediate states of mind may affect the behavior they manifest toward the self. Not only does this reflective function allow us to step beyond our immediate experience of others' behavior and identify the possible mental states that could have elicited it, but it is also an important precondition for empathy. Moreover, it enables us to understand our own mental states, fantasies, and emotional reactions as possible ways of communicating elements of the present reality and our own position within this reality. Finally, it is an important foundation of the capacity to discover the subjective meanings of one's own feelings. It could be argued that the reflective function is a version of the traditional psychoanalytic notion of insight (Holmes, 2001, p. 28).

Many of the more severe forms of psychopathology in particular have been conceptualized as the result of poor impulse and affect regulation. The symptoms and problems manifested by these patients are seen to result from deficits in mentalistic functioning and in the self as an active agent (Fonagy et al., 2002, p. 251). More severely disturbed patients, in particular, are unable to understand the more subtle parts of other people's behaviors, and their representations of reality function in what Fonagy et al. have termed "psychic equivalence" mode, "where feelings and fantasies are experienced as reality and not as mental states representing reality" (Fonagy et al., 2002, p. 199). Psychotherapy aims at developing what Fonagy et al. call the "pretend" mode, in which mental representations are partly decoupled from external reality. This mode of mental functioning involves an awareness of the representational nature of experiences and an acknowledgment that emotions and fantasies are communications from and to the self. The goal of therapy is to develop this metacognitive capacity: the ability to understand the merely representational nature of our own and others' thinking, to step beyond the immediate reality of our own experience, and to grasp the distinction between that immediate experience and the underlying mental states that may give rise to it. Such abilities, which relate to what McCallum and Piper (1997) refer to as "psychological mindedness," are developed through interpersonal dialogues and through playing with different perspectives on and conceptions of reality.

Every psychotherapeutic process contributes in one way or another to the development of this mentalizing capacity: "Psychotherapy in all its incarnations is about the rekindling of mentalization" (Fonagy et al., 2002, p. 368). The therapist represents the patient as an intentional and mentalizing agent with understandable and acceptable thoughts, feelings, and desires. Thus the patient is able to find, rediscover, or recognize herself in the therapist's view of her and to internalize the therapist's representation of her as a significant part of her own developing self. In this sense, mentalization and self-regulation are intimately related. When the patient finds an image or reflection of her own mental state in the mind of the therapist, what she encounters is a processed version of her mental state, a version that she finds containable and bearable. Melanie Klein (1946) and Wilfred Bion (1963) have conceptualized the essential elements of this interpersonal processing of mental states and parts of the self as a therapeutic use of projective identification (Ogden, 1979, 1982). In the therapeutic use of projective identification, the therapist basically contains and metabolizes strong and negative emotions that the patient is not yet able to contain and process on her own. Akin to this, Winnicott (1971) wrote that the essence of

“psychotherapy is not making clever and apt interpretations; by and large it is a long-term giving the patient back what the patient brings” and “if I do this well enough the patient will find his or her own self, and will be able to exist and to feel real” (p. 117).

The therapist’s verbalizations, clarifications, and interpretations of moment-to-moment changes in the patient’s mental state contribute to the patient’s gradual acknowledgement of her own mental states and help her to develop her mentalizing functions. Most patients are prisoners of inflexible, maladaptive, and painful views of the self and the surrounding world. In a sense, psychotherapy is an ongoing dialogue about the nature of reality. Part of what the good therapist has to offer is different perspectives on the self and reality—perspectives that open up new forms of behavior and new ways of relating to others. The patient is offered the necessary building blocks for constructing the world, and the self that is living in that world, in new ways. In the course of therapy, the behavior and reactions of both patient and therapist are continuously reunderstood and reinterpreted from different perspectives and constructed as manifestations of individual feelings, intentions, and conceptions of reality. This process supports the development of the patient’s self-understanding and self-reflective capacities, and her ability to reflect on and understand her own reactions and behaviors with reference to her personal history, her personal characteristics, and possibly her psychodynamic or cognitive functioning. Classic psychodynamic theory has conceptualized parts of this process in terms of the patient’s gaining insight into her history and intrapsychic function and concomitantly developing the observing ego.

In his mature work, Freud argued that establishing the transference neurosis and resolving it through interpreting and working through it constituted the essential curative factors in psychoanalysis. Similarly, the influential analyst James Strachey (1934, p. 63) claimed that in psychoanalytic therapy the mutative interpretation was the key instrument of change. Analytic interpretation helps to establish and maintain the therapist as a new object, rather than as a transference copy of objects from the past—which is a precondition for the corrective emotional experience described by Alexander and French (1946). From a traditional, realist epistemological perspective, analytic interpretations help the patient to become aware of the distinction between archaic fantasy objects and real external objects in the present; access to and insight into “the truth” about reality are believed to heal and “liberate” the patient. Those who lean to the constructionist view, on the other hand, are more inclined to believe that the effectiveness of interpretation lies in the fact that it offers a new and meaningful way of structuring reality. And the analyst’s interpretive understanding is seen as an important relational event and as part of the particularly analytic form of positive attachment experience (Mitchell, 2000, p. 86).

As Rosenzweig (1936, p. 413) observed, the interpretation of the patient’s problems need not be the only true one, or even necessarily “correct”; it is sufficient for its effectiveness that the patient understand it and be willing to accept it. Early on, even classically oriented analysts such as Strachey (1934, p. 71) and Glover (1931) acknowledged that inexact interpretations may have a therapeutic effect—an effect of a nonanalytic or suggestive nature that they understood with reference to the idea that “many patients derive direct libidinal gratification from interpretation as such” (Strachey, 1934, p. 72). Renik (1993), among others, has argued that the therapist’s activity is constantly determined by his individual psychology. And when we

accept the subjectivity of analytic [or psychotherapeutic] technique, we admit the role of suggestion in a successful analytic process, in as much as suggestion consists of the imposition of the analyst, wittingly or unwittingly, of his or her own views upon the patient. (Renik, 1993, p. 569)

Thus, we should leave the illusionary idea of objective interpretations of reality and acknowledge that one of the best ways to facilitate the patient's self-exploration can be for the therapist to present his interpretation of reality for the patient's consideration (Renik, 1993, p. 567).

Most therapies attempt in one way or another to modify the patient's beliefs and perceptions of the self and the world, and regardless of the particular clinical theory that the therapist may follow, this process initiates cognitive reconstructions in the patient. The therapist "works toward structuring and articulating the material and the productions offered by the patient" (Loewald, 1960, p. 24), and this structuring process contains important healing potential, almost irrespective of the way in which the meaningful narrative is related to nuances in past and present "objective" reality.

Psychotherapy constitutes a potential space (cf. Winnicott, 1971) in which the patient is given the chance to play with reality and with different constructions of it. Patient and therapist play with reality in the potential space between their individual minds. Attention is focused on internal mental states, which are externalized within the safe world of psychotherapy—an "as if" world that is decoupled from everyday reality. Ideally, reality in therapy is experienced in a "pretend" mode in which fantasies, ideas, and thoughts become less dangerous than they are in the real world. The therapist adopts an attitude analogous to that taken in pretend play, acting both as the patient expects *and* in a way that differs significantly from those expectations (Fonagy et al., 2002, p. 407). The patient is thus offered a new experience and an alternative perspective on her self and her state of mind. In psychodynamic therapy, for example, the interaction between patient and therapist has a unique as-if quality, in which the feelings and fantasies that the patient experiences in the transference are conceptualized as both real and yet not real in the ordinary sense. The patient's thoughts and feelings in this pretend mode are related to the therapist's experience of the same situations, interactions, and reality. Patient and therapist conduct an ongoing dialogue about the way they experience one another and about their mutual interaction in the here and now. Many of the essential parts of this dialogue resemble the ongoing metacommunicating dialogue that Safran and Muran (2000) have described in their approach to clinical practice. The focus of therapeutic metacommunication is on the way that the patient and the therapist experience each other and their mutual relationship. These various dialogues about the nature of reality contribute substantially to the development of the patient's mentalizing capacity. The emphasis in brief relational therapy (BRT), developed by Safran and Muran, is on "developing generalizable skills of mindfulness, rather than on gaining insight into and mastering a particular core theme" (Safran & Muran, 2002, p. 254).

Just as, in the parent-child dyad, the child can develop her mentalizing capacity only if she feels sufficiently secure, so the patient develops that capacity only if she feels secure in the therapeutic dyad. The patient's secure attachment to the therapist is a precondition for emotional and mental development in psychotherapy. Thus, the development of the mentalizing capacity is intrinsically linked with the patient's assurance of safety in her ongoing exploration of the mind of the therapist. Emotional safety is a precondition for the ability to disentangle the feelings and thoughts that might account for the behavior of others, including the behavior of the therapist.

The patient internalizes the mentalizing activity of the therapist and the therapist's implicitly communicated representation of the patient as an intentional human being. On this basis she is able to reach a more mature and subtle conception of the self, others, and reality in general. This enhanced understanding improves the patient's chances of understanding and reacting adequately to the behavior of others, which in turn means that she

is not so easily overwhelmed by emotions and immediate conflicts in her interpersonal relations.

New Narrative About the Self

The leading sociologists Zygmunt Bauman (2000, 2001) and Anthony Giddens (1999) have described how Western societies have changed substantially over the past decades. Under headings such as detraditionalization, individualization, secularization, and globalization, they view the increasingly complex world as lacking coherence and a common sense of meaning. The great religious and political narratives have lost much of their traditional legitimacy, and traditional communities are losing ground. The Canadian philosopher Charles Taylor (1989) argued that the kinds of questions that trouble most people today are centered around concerns about the meaning of existence and about the possibility of achieving a good and happy life.

In an apparently incoherent and meaningless world characterized by increasing individualization, each individual is forced to find or construct his or her own sense of meaning and coherence in his or her own life. Each needs to create a stable, solid narrative about the self and establish a sense of him- or herself as a unified, coherent person. Each is thus forced to find what the German sociologist Ulrich Beck (1986) has called individual biographic solutions to what are at least partly cultural or systemic problems. Failure to deal with these demanding tasks can contribute to the development of various forms of psychopathology such as depression, anxiety, and personality disorders. Some forms of psychopathology can be interpreted as partly the result of an inability to construct a valid narrative about the self and the self's relationship to the world—a narrative that can support the individual's sense of meaning and coherence (Jørgensen, 2002). Most forms of psychopathology involve problems with integrating significant experiences or parts of the self into established coherent and meaningful personal narratives about the self and the world. When it comes to helping people construct or repair these personal narratives, and to finding individual solutions to psychological distress, psychotherapists are among the leading professionals.

Every form of psychotherapy contributes to the construction of a meaning-generating narrative about the individual patient's life and way of being in the world. Therapeutic narratives construct a sense of coherence in the patient's life and psychological functioning, uniting the patient's past, present, and future life in a meaningful way. Similarly, the patient's inner life is connected with past and present interpersonal relationships and with significant parts of outer reality. With the help of rhetorical and narrative strategies, a coherent version of reality and the patient's self and life is constructed—a version that puts less strain on the self than the hitherto dominant narrative.

In the past decade we have witnessed a substantial change of emphasis in psychoanalytic practice, from the former focus on retrieving or gaining insight into (repressed or forgotten) past experiences to the present prevailing focus on creating meaningful narratives that are conducive to change. Increasingly, psychotherapy is conceptualized as a form of retelling or reauthoring the patient's life through dialogue (Schafer, 1992). The patient's pathogenic life story is transformed, and in some instances for the first time, a life story is constructed that encompasses all of the essential parts of the patient's life and gives her a stable sense of meaning and coherence. In narrative therapy (Parry & Doan, 1994; White & Epston, 1990), the deconstruction of the patient's stories—the identification of old stories and the particular, harmful conceptualizations of the self and the world

that they entail, and the construction of new, healthier stories that offer better opportunities for self-realization—is seen as one of the principal mutative factors in therapy. Therapy is seen as fundamentally a process of story re-vision (Parry & Doan, 1994) or reauthoring, in which the patient is given the authority to tell his own story from his own perspective and with his own words. The therapist primarily acts as a catalyst for the patient's construction of a life story.

The narrative psychoanalyst Roy Schafer (1983) has claimed that

people going through psychoanalysis . . . tell the analyst about themselves and others in the past and present. In making interpretations, the analyst retells these stories. In the retelling, certain features are accentuated while others are placed in parentheses; certain features are related to others in new ways or for the first time; some features are developed further. (p. 219)

Schafer describes psychotherapists as people who listen to the narratives of patients and “help them to transform these narratives into others that are more complete, coherent, convincing, and adaptively useful than those they have been accustomed to constructing” (Schafer, 1983, p. 240).

In therapy, the patient gives only one of several possible accounts of her life events. As Schafer (1983) puts it, “one can never have unmediated access to these events, for the events can only exist in narrative accounts” (p. 186). In Schafer's view (p. 191), the patient is a life historian, a maker of sense, and a definer and designer of possible futures, and psychotherapy is understood in terms of two agents, each narrating or telling something to the other in a rule-governed manner. The constructed life history or narrative will always be organized in accordance with—and substantially influenced by—the clinical theory or metanarrative of the therapist. “In interpreting or retelling the analysand's narrative performances, the analyst follows certain storylines of personal [psychological] development, conflictual situations, and subjective experience that are distinguishing features of his or her analytic theory and approach” (Schafer, 1983, p. 187). Each account of the past and the present “is a reconstructing that is controlled by a narrative strategy. The narrative strategy dictates how one is to select, from a plenitude of possible details, those that may be reorganized into another narrative” (p. 193).

Thus, the therapist's clinical theory structures and partly controls the telling and retelling of the patient's life history (cf. Schafer, 1983, p. 239). Through his attitude, interpretations, way of posing questions, and so forth, the therapist represents, communicates, and legitimizes a powerful cultural narrative: one of the psychological theories or conceptualizations of human life and psychological problems. Simultaneously, this narrative is used to construct and order the patient's personal narrative. All clinical meta-narratives contain more or less coherent and more or less valid conceptualizations of psychological development and the development and treatment of psychopathology, which are communicated to—and internalized by—the patient during therapy. According to Frank's (1971) theory of the active agents in therapy, it is not particularly important which of the many well-established and coherent clinical theories the therapist chooses, so long as he has chosen one of them and is able to use it as a solid base for structuring and focusing his clinical work. As Rosenzweig (1936) observed early on, “whether the therapist talks in terms of psychoanalysis or Christian Science is from this point of view relatively unimportant as compared with the *formal consistency* with which the doctrine employed is adhered to” (p. 413).

Even though the conclusions of Frank and Rosenzweig are too radical and call for reservations, we must acknowledge that we have several—equally valid—theoretical

perspectives on human psychopathology and its treatment. In the treatment process the therapist will communicate his theory or metanarrative about the human psychology and psychopathology and its treatment to the patient. Given that this narrative is reasonably valid, coherent, and meaningful (which is partly contingent on already established beliefs in the patient and the narratives legitimized by contemporary culture), it offers an authoritative structure for the patient's new coherent and meaning-generating narrative about the self and the self living with others.

Conclusions

The contextual model of psychotherapy (Wampold, 2001, p. xii), which follows the ideas put forward by Jerome Frank (1971), conceptualizes psychotherapy as an endeavor in which the therapist provides the patient with a rationale for her disorder and administers a procedure that is consistent with that rationale. There is no such thing as a single true theory of psychotherapy and its active ingredients, nor is there one superior technique that can be applied to all forms of pathology, although specific techniques and curative factors may be particularly important in working with certain types of pathology: For example, cognitive-behavioral therapy may be especially appropriate for some forms of anxiety (Nathan & Gorman, 2002). Similarly, dialectical cognitive-behavioral therapy and psychoanalytic psychotherapy are probably more efficient for personality disorders than most other forms of therapy (Bateman & Fonagy, 2000).

Each of the existing psychotherapeutic rationales and theories is in part a social construction that is embedded in a specific cultural logic and form of society. Each therapeutic rationale allows the patient to order and explain her experiences. Although it may be important in principle to acknowledge the inherent possibility of adhering to "false" or incoherent beliefs and rationales, the patient's acceptance of the rationale provided by the therapist is probably more important to her well-being than the objective truth of this rationale as traditionally construed. For the rationale to be effective, both therapist and patient must accept it; it must be compatible with their view of the world, their attitudes, and their values, but it need not be "true." To a certain extent, but *only* to a certain extent, "the rationale can be a myth in the sense that the basis of the therapy need not be scientifically proven" (Wampold, 2001, p. 25).

Moreover, significant societal changes contribute to the development of new forms of psychopathology, symptoms, and syndromes that call for new forms of psychotherapy offering slightly different mechanisms of change. Social constructionists would argue that psychopathology and psychiatric diagnoses are also prone to "fashion" in various historical periods, because social processes contribute to the construction of certain syndromes and prevalent forms of pathology. The traditional idea that psychopathology and treatment can be detached from their societal and cultural context is an illusion. However, what most patients need—across different cultures and many forms of psychopathology—is provided by those factors that are common to most psychotherapies.

The many bona fide schools of psychotherapy offer varying but (more or less) equally "true" perspectives on psychopathology and its treatment. Most consistent clinical theories and therapeutic rationales support the work of the therapist and will offer the patient helpful therapeutic rituals and coherent and meaning-generating narratives about her self, her past and present life, and her problems. In most therapeutic rationales, much of the possible therapeutic effect is likely to be due to the more or less universal mechanisms of change described above. Specific techniques (or convincing rituals) are necessary for any

effective psychotherapy; however, this does not necessarily imply that these techniques have the important specific effects or are the main causal agents in therapy as claimed by the specific school of therapy. From a postmodern constructionist perspective, most of our clinical theories, treatment rationales, and conceptualizations of the mechanisms that elicit change are narratives that will help the therapist and patient to generate meaningful and coherent narratives themselves—both about the process of therapy as such and about the patient's problems, life, and so forth. Insufficient work has been done on the epistemological status of these narratives. It has been argued (Spence, 1982) that the so-called "narrative truth" of the therapeutically generated narratives about the patient and her problems is more important for the treatment process and outcome than their historical or objective truth. Similarly, it is still unclear to what extent our theories of the active ingredients in therapy reflect the actual mechanisms of change. This article, however, is based on the assumption that our theories and hypotheses concerning the mechanisms of change that are common to all therapies—mechanisms described in the previous pages—reflect objective processes in most successful therapies, whether each individual therapist realizes this or not. To be active, the outlined common factors do not have to be part of the therapist's theoretical understanding of psychotherapy—nor do they have to be a consciously integrated part of his specific interventions.

In modern Western cultures, psychotherapy is acknowledged (and often formally approved by the authorities) as a practice aimed at relieving emotional suffering. This cultural recognition brings the necessary social legitimacy to the therapeutic rituals and to the communicated rationale or myth that offers the patient an understanding of her psychological problems. Simultaneously, this social legitimacy will support the patient's faith in the therapist and the therapy. The active ingredients in every individual psychotherapy involve an emotionally charged relationship between patient and therapist in which the therapist in one way or another communicates empathic understanding and (almost) unconditional positive regard for the patient. The therapist communicates genuine interest, acceptance, warmth, respect, and understanding for the patient. If these communications are to be effective, either the patient must be able to receive them or the therapist must be able to help her become able to do so.

In the process of therapy, basic assumptions about oneself, others, and one's life hitherto are (explicitly and implicitly) explored, questioned, and revised. In interacting with the therapist, the patient will repeat her characteristic and pathogenic interpersonal patterns. And when the therapist manages to heal the resulting conflicts or alliance ruptures and thus help the patient to work through her pathogenic interpersonal patterns, this will in itself give the patient an opportunity to achieve a correctional emotional experience. Pathogenic beliefs are tested and disconfirmed, and healing parts of the interaction with the therapist are internalized by the patient. In most forms of psychotherapy, the therapist will block or confront the patient with her characteristic attempts to flee anxiety-provoking themes. The patient is repeatedly confronted with her core conflicts in an anxiety-reducing context where emotions are both abreacted and symbolized. Gradually, this will bring about desensitization and enable the patient to learn how to symbolize and regulate impulses and affects. On a more general level, the ongoing dialogue about what takes place inside and between patient and therapist will develop the patient's ability to mentalize; it will develop her psychologically vital ability to understand her own self, others, and interpersonal relationships in terms of inner mental or psychological processes. Finally, the therapeutic conversation will contribute to the construction of a (new) narrative about the patient's self and the world, one that supports the patient's vital sense of meaning and coherence.

Implications for Clinical Training and Research

In their review of existing empirical studies, Ogles et al. (1999) concluded that “little evidence substantiates the benefit of technique-based training” (p. 215). If we accept the idea that the common and, to a certain extent, nonspecific factors are more important to the outcome of therapy than the more technical and specific elements applied in particular kinds of psychotherapy, it follows that good clinical practice results not primarily from theoretical training, the study of the clinical literature, and empirical research into psychotherapy, nor from explicit instructions concerning specific therapeutic strategies and forms of intervention, but rather from the clinician’s personality, attitudes, and way of being with his patients. Academic knowledge—or *epistémé* (Aristotle, 1976, p. 207)—is important in building a solid foundation for clinical practice. And the theory has an important holding function for the therapist, which enables him or her to “maintain equanimity in the challenging setting” of the therapeutic relationship (Almond, 2003, p. 131). Similarly, the therapist must acquire a broad range of technical skills—or *techné* (Aristotle, 1976, p. 208). A certain amount of eclecticism is thus a virtue when it comes to tailoring the treatment to the individual patient and her specific problems and needs. However, the essential factor—in the words of Aristotle (1976, p. 209)—is that the therapist has prudence or practical wisdom (*prónésis*); he must be able to apply his theoretical knowledge and technical skills to the individual patient and her particular problems. “Prudence is not concerned with universals only; it must also take cognizance of particulars, because it is concerned with conduct, and conduct has its sphere in particular circumstances” (Aristotle, 1976, p. 213). Prudence involves “knowledge of particular facts, which become known from experience” (p. 215). Consequently, more personal and less specific or technical factors become important, and closely supervised clinical experience with a broad spectrum of patients with different kinds of problems becomes an essential part of clinical training. Training in relationship skills, clinical judgment, and basic clinical skills become crucial.

The individual therapist’s ability to catalyze the common mechanisms of change depends on his having been part of—and having internalized central elements of—a good therapeutic culture. Factors such as good clinical judgment, empathy, social intelligence, relational competence, ability to handle interpersonal conflicts in a sensible and growth-enhancing way, and ability to articulate, organize, and legitimize the patient’s subjective experience—all of which are important elements in good psychotherapeutic practice—are unlikely to be developed significantly by formal technical training alone. Provided that the person training to become a therapist is not himself severely disturbed, practical clinical training and competent supervision will make it possible for him to internalize these qualities and integrate them as parts of his personality. As we become better in articulating these common factors—or in making some of the nonspecific factors more specific—parts of this learning and internalization process can be accelerated. The therapist can learn how to use or take advantage of the common factors more deliberately and can use more specific technical interventions selected for the problems of the individual patient.

It should be noted that most of the existing conceptualizations of the active ingredients in psychotherapy are primarily hypothetical and derived from theory—albeit recognized clinical theory that has been endorsed by practice. Although most of the various theories concerning common mechanisms of change in psychotherapy probably have some validity in practice—depending on the problems, needs, and personality of the individual patient—it is clear that more empirical research is needed to test and validate these conceptualizations and hypotheses. In particular, we need to conduct intensive process and process—

effect studies, looking at possible connections between, on the one hand, specific parts of the therapy process and, on the other hand, other parts of the process and observable changes in the patient (Henry, Schacht, & Strupp, 1986, 1990; Jørgensen, Hougaard, Rosenbaum, Valbak, & Rehfeld, 2000). Our understanding of the active ingredients in psychotherapy, in other words, is still only rudimentary.

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