

CHANGES IN THE PATIENT'S LEVEL OF INSIGHT IN BRIEF PSYCHOTHERAPY: TWO PILOT STUDIES

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In a pilot study of four brief psychotherapies the level of insight in each session was determined. Patients initially demonstrated insight but during the course of therapy their insight decreased, and toward the end, again increased. The pattern that emerged in each case was fit by a quadratic (parabolic) curve, and was statistically significant. The average level of insight across each therapy was found to be related to outcome. In a second pilot study, a fifth case was found to have a similar pattern of insight, fit by a parabolic curve that approached significance, after the data were smoothed. Based on Control Mastery

Theory, the results were interpreted as reflecting patients' unconscious plans for working in therapy by testing their pathogenic beliefs in order to change them.

This article reports the findings of two studies of insight in brief time-limited psychotherapy. The first study examined changes in the level of insight in four sixteen-session therapies, and the relationship between the level of insight in psychotherapy and treatment outcome.¹ Unexpected changes in the patients' level of insight over the course of the treatment was found in all four cases. In each case insight went down to zero in the middle of treatment. A hypothesis based on control mastery theory, discussed below, was tentatively developed to account for this drop in insight. A second pilot study of one case was then conducted and a similar pattern was found. This report will discuss each pilot study and present our tentative explanation of the findings.

The development of insight during therapy is thought to be an important component of successful psychoanalytic therapy (Abrams, 1971; Bibring, 1954; Hatcher, 1982; Wallerstein, 1975; Wolberg, 1982), both long- and short-term (Davalo, 1980; Jones, Parke & Pulos, 1992; Malan, 1976; Sifneos, 1992; Strupp & Binder, 1984). It has been assumed by many since Freud

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The results of part of the first pilot study described in this article were presented by Joseph Weiss, M.D., at the Meetings of the Society of Psychotherapy Research, Summer, 1992, Berkeley, California. These results are also to be reported in brief, in a broad article by Joseph Weiss, M.D., in the *Journal of the American Psychoanalytic Association*, in press, and in *How Psychotherapy Works: Process and Technique*, by Joseph Weiss, M.D., Guilford Press, 1993. The results of the second study described in this manuscript are mentioned in a footnote in the upcoming article in *JAPA*, and the book. This present article is the only written description containing the methodological details of any of these two pilot studies.

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¹ Some of the data used in this study were collected as part of Susan Edelstein's Dissertation, "Exploration of the Relationship between Insight and Outcome in Four Brief Psychotherapies". This dissertation was conducted under the supervision of Andrea Morrison, Ph. D., The Wright Institute, Berkeley, California.

that patients develop insight in therapy and that it is an essential component of cure. There has also been an implicit assumption that insight develops in a slow and consistent manner throughout the course of therapy. There have, in fact, been few empirical studies to test this, and in most reports the results have been inconclusive (Luborsky et al., 1988) or have not demonstrated the expected pattern. One exception is a recent study reporting an increase in insight in brief psychotherapy (Jones, Parke & Pulos, 1992). In an analysis of 30 patients in brief 16-sessions psychodynamic therapies, Jones, Parke & Pulos (1992) examined three hours out of the 16. The patients, analyzed as a group, demonstrated an increase in new understandings and insights from hour 1 to hour 5 to hour 14.

There has been much controversy over the definition and measurement of insight (Gill, 1963; Ludvig, 1966; Marrott, 1981; Wheelis, 1969). One problem in earlier studies of insight that may have led to confusing and contradictory findings is that the conceptualization and measurement of insight or self-understanding was developed without regard for a particular patient's unique set of problems and goals (Coleman, 1989; Crits-Christoph, Barber, Miller, & Beebe, 1993; Linsner, 1987; Luborsky et al., 1988).

In an effort to deal with this problem, several studies have been conducted by Luborsky and also by investigators from the San Francisco Psychotherapy Research Group, each using their own case-specific approach to the definition and measurement of insight. The studies presented below utilized the case-specific method of assessing accurate insight, developed by the San Francisco group. The work of this group is based on a particular model of psychopathology and therapy, developed by Joseph Weiss (Weiss, Sampson, & The Mount Zion Psychotherapy Research Group, 1986) and sometimes referred to as Control Mastery Theory. In the following, Weiss' theory will be described briefly, the related studies of the research group will be reviewed, and the two recent studies on insight will be presented.

Background

Overview of Weiss' Theory

Weiss' theory is a theory of the mind and of psychotherapy, researched by the San Francisco Psychotherapy Research Group, co-directed by Weiss and Harold Sampson. This theory states

that people are able to think and plan unconsciously, that people are always striving for health and normal development, and that psychopathology is derived from traumatic events which lead to pathogenic beliefs. According to Weiss, all people have an inherent wish to overcome their problems, and to achieve success in work and in relationships. Psychological problems that interfere with the achievement of these goals occur as the result of traumatic childhood experiences with parents, siblings, or other care givers. From these experiences children develop grim pathogenic beliefs about themselves and their interpersonal world. Pathogenic beliefs are often unconscious; they predict great dangers and cause guilt, shame, fear, and inhibitions. For example, people may develop the belief that if they are assertive they will be rejected, or if they are sexual they will be shamed, or if they are successful they will make siblings feel inferior. Because pathogenic beliefs cause pain, a person is motivated both consciously and unconsciously to change them. According to Weiss, people do not want to hold on to their psychological symptoms, but are always working to find a way to overcome their problems. They look for situations in which they may safely attempt to resolve their problems by testing their pathogenic beliefs so as to modify them.

Weiss' theory proposes that people are able to think and plan unconsciously, as they do in their conscious mental life, and that they unconsciously plan the course of their treatment in therapy (Curtis, Silberschatz, Sampson, Weiss & Rosenberg, 1988; Fretter, 1984; Silberschatz & Curtis, 1986; Silberschatz, Fretter & Curtis, 1986; Weiss, 1990a,b; Weiss, 1993; Weiss, & Rosenberg, 1988; Weiss, Sampson & the Mount Zion Psychotherapy Research Group, 1986). Patients in therapy develop specific though often unconscious plans to have experiences by which they may disprove their pathogenic beliefs and master their problems. One of the ways they do this is by a process of testing their pathogenic beliefs in relation to the therapist. For example, a patient who was rejected by his or her parents in childhood may have developed the belief that s/he deserves to be rejected and that s/he will inevitably be rejected in significant relationships. In the course of therapy the patient may test this pathogenic belief by providing the therapist with the opportunity to reject him or her. This might take the form of the patient threatening to quit therapy. Or the patient might behave in an offen-

sive manner to evoke scorn or rejection from the therapist. If the therapist does not reject the patient, s/he may begin to change these beliefs. Another example of testing occurs when the patient overtly states pathogenic beliefs, such as the belief that s/he is lazy, or overly competitive, or stupid, or harmful. S/he hopes that the therapist will directly refute these beliefs, verbally as well as by attitude. In testing the therapist, the patient is unconsciously concerned with avoiding danger. The patient is reluctant to give a test which, if failed, would put him or her in jeopardy. Thus an important task of the therapist is to make it safe for the patient to carry out his or her testing.

According to this theory, the development of insight may be an indication of the process of cure. In some instances self-understanding occurs as the result of therapist interpretations. In other instances it results from a therapist passing the patient's tests, thereby providing a corrective emotional experience and helping the patient to disconfirm his or her pathogenic beliefs. Insight is case specific, and relates to a patient's particular pathogenic beliefs and goals. For example, a patient who feels inhibited from pursuing a successful career because of a childhood belief that the patient's success in school caused a sibling to feel inferior, may from both therapist's interpretations and passed tests, come to have insight about this issue and be freed of inhibition at work.

Review of Previous Research

Using Weiss' theory of the mind and of psychopathology, a series of related studies examining interpretations, insight, and psychotherapy outcome have been conducted by the San Francisco Psychotherapy Research Group. Insight in these studies has been defined as statements made by patients in which they demonstrate useful explanations or knowledge about themselves and their experiences. Useful explanations are those that they will find helpful in their efforts to move toward their specific goals. This case-specific approach to the definition of insight differs from most prior research other than Luborsky's (Crits-Christoph et al., 1993; Luborsky, Crits-Christoph, Mintz & Auerbach, 1988), in that it distinguishes between statements about the self that are valid and helpful and those that are not.

A number of prior studies related to the present study were carried out using psychotherapy transcripts collected by the Mount Zion Brief Psychotherapy Research Project co-directed by George

Silberschatz and John Curtis. In a study of three brief psychotherapies (Fretter, 1984; Silberschatz, Fretter & Curtis, 1986), the immediate effects of interpretations on a patient's level of experiencing was examined. All interpretations were extracted from the sixteen-session therapies, and categorized according to Malan's typology as either transference interpretations or nontransference interpretations. The interpretations were rated for the degree to which they supported a patient's unconscious plan for therapy. A method of determining the patient's plan was developed in prior research and was found to be reliable (Caston, 1977; Curtis, Silberschatz, Sampson, Weiss & Rosenberg, 1988; Curtis, Silberschatz, Sampson & Weiss, in press; Silberschatz & Curtis, 1986). Those interpretations which were judged to be supportive of the patient's unconscious plan were categorized as "pro-plan", and rated for the degree to which they were planful (pro-plan). The investigators then extracted segments of patient speech preceding and following the extracted interpretations. Judges rated the level of experiencing in these segments, using the Experiencing Scale (Klein et al., 1970). The investigators found no significant difference between the transference interpretations and nontransference interpretations in their effect on the patients' levels of experiencing. They demonstrated, however, that the planfulness of interpretations was significantly correlated with shifts in patients' level of experiencing. Furthermore the data showed that in these three cases, the higher the proportion of plan compatible (or pro-plan) interpretations, the better the treatment outcome.

Broitman (1985) studied the relationship between insight and interpretation, asking raters to evaluate insight in segments of patient speech preceding and following the interpretations previously identified (Fretter, 1984). Raters employed the Morgan Patient Insight Scale (revised by Broitman [1985]), a generic insight measure. In all three cases studied, the greater the compatibility of the therapist's interpretations with the patient's unconscious plan as measured through the plan-compatibility method (Silberschatz & Curtis, 1986), the greater the increase in insightfulness.

Norville (1989) expanded the study of the effects of interpretations on therapy outcome and showed a relationship between the average level of planfulness of the interpretations given to the patient, and therapy outcome.

Based on the results of these studies, it was hypothesized that patients who receive pro-plan interpretations may, during therapy, develop increasing insight into their pathogenic beliefs. Therefore, by utilizing case-specific measures, a significant relationship between insight and outcome may be demonstrated.

The concept of pro-plan insight makes it possible to predict which insights will be of use in the therapy of a specific patient. Using the Plan Compatibility of Insight Rating Scale (PCIRS), a case-specific scale designed to measure the degree to which an insight is pro-plan, Linsner (1987) studied a single short-term psychotherapy. In segments following the therapist passing the patient's tests, the patient showed an immediate increase in pro-plan insight.

Coleman (1989) employed a revised version of the PCIRS to study the role of insight in several brief psychotherapies. All statements of self-understanding were rated on a single scale. These included self-statements that contained pro-plan insights, that is, insights that the patient could use to pursue his or her unconscious therapy plan, and self-statements that were anti-plan or obstructive to the patient pursuing his or her plan. These segments were rated on a scale ranging from strongly anti-plan to strongly pro-plan. Coleman hypothesized that the degree of pro-plan insight that the patient demonstrated during therapy would correlate with outcome. However this was not supported by the findings. Coleman offered several methodological reasons for his results. Since he selected random segments and not the entire therapy, he may have missed important insight statements. Also, Coleman's scale was used to rate both pro-plan and anti-plan statements. Often in rating the self-statements the raters assumed that pro-plan self-statements canceled anti-plan self-statements, so the statements were rated near to zero. Thus the scale failed to detect a number of pro-plan self-statements. In addition to these methodological issues, Coleman hypothesized a substantive reason for his findings. He hypothesized that the concept of testing may explain his results. When testing, patients may appear to lose insight. They may refrain from making pro-plan statements of self-understanding for it is not possible for patients to give the therapist certain kinds of tests and at the same time reveal much insight. Moreover, as part of testing, patients may make false statements about themselves in the hope that the therapist will refute these statements.

The two studies to be reported below attempt to correct the problem in Coleman's scale by examining case-specific pro-plan insights only, that is, statements of self-understanding that are directly helpful to patients' progress toward their goals. An example of a pro-plan insight from one case in this study, the case of Rachel, is as follows: "I felt very guilty about being me, uhm—I have a very, very bad image of myself as I thought I was as a child. But that image was given to me by those who spoke about it—my father, my mother, and my sister mostly. And of course when you're young, their opinions count for everything in the world. I mean that's gospel truth, something you never question. I never questioned their negative—you know, feelings about me, until now." This insight is pro-plan because Rachel could use it in her effort to change her belief in her "bad image" of herself.

The studies to be reported here improved on Coleman's study by using all insight statements rather than random segments, and by using only pro-plan statements of self-understanding. In the first study of insight in four brief psychotherapy cases, all insight statements from all sixteen sessions as well as the initial intake interview, the posttherapy interview, and the six-month follow-up, were extracted and rated for degree of insightfulness to explore the pattern of insight over the course of therapy. Also, the relationship between mean level of insight and therapy outcome was examined. In the second study, another case of a sixteen-session therapy was examined to determine the pattern of insight, using a revised insight scale. As in the first study, all sessions as well as the initial intake interview, the posttherapy interview and the six-month follow-up interview were included.

Study One

Method

Subjects. The method employed was a series of single-case research designs. The cases studied were selected from the 43 cases collected by the Mount Zion Brief Psychotherapy Research Project co-directed by John Curtis and George Silberschatz. These psychotherapies were carried out by a variety of psychodynamically oriented therapists. The data consisted of the verbatim transcripts of audio-recorded treatments. This included transcripts of each session in 16-session therapies, as well as transcripts of an initial intake

by an independent evaluator, an immediate post-therapy interview, and interviews six months and one year following termination, also by an independent evaluator.

The four cases used in this study were chosen because of availability of the plan formulation and the variability of outcome. The sample included cases with good, moderate, and poor outcomes. This judgment was based on a comprehensive outcome assessment which included standardized measures in addition to evaluations made by the therapist, the patient, and an independent evaluator (Nathans, 1988; Silberschatz et al., 1988).

Patients were included in the project after demonstrating during an intake interview with an independent evaluator that they had 1) a history of positive interpersonal relationships; 2) no evidence of serious substance abuse; 3) no evidence of psychosis, disorganization, or mental deficiency; and 4) no evidence of suicidal or homicidal ideation. The patients, who were all self-referred, were from diverse socioeconomic and cultural backgrounds. They agreed to have their therapy sessions recorded and all signed informed-consent forms. All patients involved in the project were treated by therapists who had a minimum of three years experience in psychodynamic psychotherapy and had specialized training in brief therapy. The patients and therapists used in the studies presented here were as follows: Rachel was a 54-year-old European-American woman, who was treated by a 30-year-old European-American man. Robert was a 34-year-old European man who had come to the United States in order to attend school; he was treated by a 30-year-old European-American man. Irene was a 58-year-old European-American woman treated by a 30-year-old European-American man. Hilde was a 30-year-old European-American woman who was treated by a 41-year-old European-American man. Diane was a 34-year-old European-American woman who was treated by a 33-year-old European-American man.

Instruments

Plan formulation. A plan formulation developed in prior studies was available for each patient to be studied. The plan formulation is an individualized psychodynamic formulation based on Weiss' theory, that focuses on the patient's goals for treatment, the patient's pathogenic beliefs, the tests that a patient may pose to the therapist in an attempt to disconfirm his or her patho-

genic beliefs, and the insights the patient may achieve during the course of treatment, that will help him or her move toward his or her goals. For example, in the case of Rachel used in this study, the plan formulation includes a list of goals such as: To overcome feelings of paralysis and indecision and regain a sense of direction and purpose in her life; to find employment; to feel less like a terrible, bad, unworthy person. Examples of pathogenic beliefs in Rachel's plan formulation include: she does not deserve to be admired and loved; she believes that she should give to others and not accept help; she believes that her love can cure her husband's despair. Rachel's plan formulation also includes the following likely tests: she will act helpless and incompetent to see if the therapist expects or needs her to be that way; she will describe selfish behavior to see if the therapist will criticize her for it.

Prior studies have described the method and shown that the formulations derived from it are reliable (Caston, 1977; Curtis et al., 1988; Curtis et al., in press; Rosenberg et al., 1986). These plan formulations were derived in the following manner. Four experienced raters read transcripts of the intake and the first two sessions of the therapies to be studied. Each rater independently generated a list of the patient's goals, pathogenic beliefs, tests, and insights. From these independent evaluations, a master list was developed. The same raters read the extended list of goals, pathogenic beliefs, tests and insights and were asked to judge the pertinence of each item for the patient being studied. Those goals, pathogenic beliefs, tests, and insights receiving a sufficiently high rating constitute the patient's plan. Interrater reliability has been demonstrated to be in the high range (alpha coefficient .7-.9). (Rosenberg et al., 1986; Silberschatz & Curtis, 1986).

Pro-plan Insight Rating Scale (PIRS). This scale is a case-specific insight scale, designed to measure insight that is pro-plan, that is, statements of self-understanding likely to help the patient pursue his or her goals and plans as these are described in the plan formulation (Edelstein, 1992; Grebel, 1992). This scale is a six-point ordinal scale, ranging from 0 to 5. Raters were asked to make qualitative judgments regarding the planfulness of the content of previously identified insight segments. It was demonstrated that the scale could be used reliably by three judges; intraclass correlations ranged from .60 to .88.

Outcome measures. The outcome of each case was assessed through composite outcome scores based on five outcome measures utilized by the Mount Zion Brief Psychotherapy Project. These measures include the Symptom Checklist (SCL-90), Target Complaints, the Overall Change Rating (OCR), the Global Assessment Score (GAS), and the Brief Psychiatric Rating Scale (BPRS). The measures were first administered prior to beginning therapy to provide a measure of baseline functioning. The measures were readministered immediately after therapy and at six-month follow-up. Data immediately posttherapy was collected from the patient, the therapist, and an independent evaluator who conducted an interview with the patient. Data at the six-month follow-up was collected from the patient and the independent evaluator after a follow-up interview with the patient. Residualized gains scores were calculated from the pre- and posttest batteries as an index of treatment success.

Procedure

The research design in this study required the investigators: 1) to utilize the patient's plan for therapy as formulated by the method developed by Curtis & Silberschatz and used in prior studies (Curtis et al., 1988; Curtis et al., in press; Fretter, 1984; Silberschatz, Fretter & Curtis, 1986; 35) in order to select all possible pro-plan insight statements from the transcripts; 2) to rate the planfulness of each insight statement; 3) to sum the insight rating in each session including the intake, posttherapy interview and six-month follow-up interview; 4) to examine the pattern of insight established by the summed level of insight; 5) to establish in each case, the mean of the insight ratings for each sessions; 6) to analyze the relationship between the mean insight over all sessions in each case with patient's composite outcome score.

Selecting insights. Twelve experienced clinicians were instructed in a training session and in written instructions on how to identify pro-plan insight using the plan formulation for each case to be studied. For this study, pro-plan insight is defined as insight or self-understanding that will help patients to move toward their goals as defined by the plan formulation. More specifically, judges were instructed to regard insight as any statement that indicates awareness into the meaning of thoughts, feelings, and/or behavior that will help the patient prog-

ress toward their goal as defined by the plan formulation. After initial training, three judges read the verbatim transcripts of each case independently, selecting all possible pro-plan insight statements. In those instances in which all three judges did not identify the same insights, they discussed their differences and reached agreement. From this selection process, a master list of insights was generated.

Rating insights. A second group of three experienced clinicians were given written instructions for how to use the pro-plan insight scale (PIRS) and the plan formulation, in order to rate the pro-plan insight statements already selected by the judges. The segments were presented to the raters in random order. The raters were asked to determine the strength of the pro-plan insight in each statement, using the PIRS, a six-point ordinal scale. Intraclass correlations were used to determine interrater agreement (Shrout & Fleiss, 1979). Intraclass correlations for the three rater insight ratings across all four cases was .6 to .84. Scores on the Pro-plan Insight Scale were associated with outcome measures as described below.

Results

The sums of the insight ratings for each of the sixteen sessions, the initial intake interview, the posttherapy interview and the six-month follow-up interview were plotted in sequence (see Figure 1). In each case, the patient was far more insightful in the posttherapy interview than in the 16th session of therapy, during which three of the patients showed a low level of insight. The fourth patient had terminated before session 16.

Given the roughly parabolic pattern of insight in all four cases, standard quadratic regression procedures were applied to the data (see Table 1; in statistical tables, X denotes the session variable). In each case, the quadratic term of the regression was statistically significant at the .05 significance level, indicating that a parabola fit the data in all four cases. Durbin-Watson statistics indicated no significant autocorrelation in the residuals of these regression models. As an additional check on the adequacy of the parabolic model, simple linear regressions were calculated for each to determine whether a linear fit to the data might provide a parsimonious approximation to the observed pattern of insight. None of the linear regressions was statistically significant; and Durbin-Watson statistics indicated substantial

LEVEL OF INSIGHT

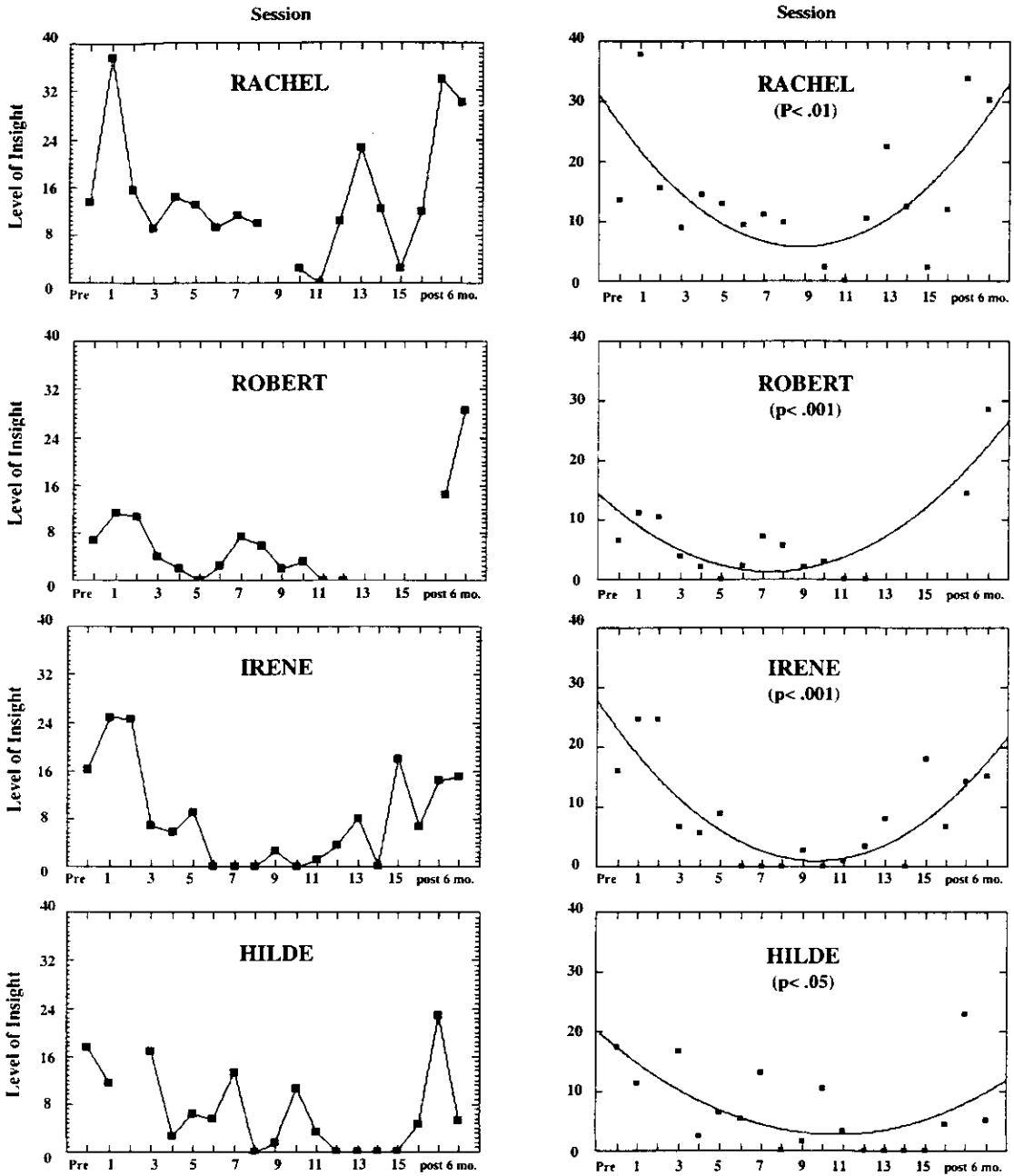


Figure 1.

TABLE 1. Results of Polynomial Regressions of Insight over Therapy

Analysis of Variance					
Case	DF Regression	DF Residual	R	F	
Rachel	2	15	.65	5.48*	
Irene	2	16	.81	15.24***	
Hilde	2	15	.59	3.99*	
Robert	2	12	.86	17.35***	
Beta Coefficients					
Case	Parameter	Value	SE	β	t
Rachel	X	-4.86	1.55	-2.70	3.15**
	X ²	.25	.08	2.83	3.30**
Irene	X	-5.04	.91	-3.42	5.52***
	X ²	.24	.04	3.31	5.35***
Hilde	X	-2.99	1.11	-2.34	2.71*
	X ²	.13	.05	2.11	2.44*
Robert	X	-3.13	.74	-2.26	4.21**
	X ²	.19	.04	2.78	5.18***

* $p < .05$ ** $p < .01$ *** $p < .001$

auto correlation in the residuals of the linear models. These results indicate that in all four cases a parabolic curve provided a statistically significant and parsimonious fit to the observed pattern of insight.

Scatterplots of the sum of the insights by session with the quadratic line of fit are also shown in Figure 1.

The relationship between mean insight and therapy outcome was analyzed next. The mean insight across sessions was determined by averaging the mean insight in each session. Because of a lack of independent data points an analysis of variance using case as the grouping variable could not be performed. Instead a permutation test based on ranks of the insight levels was performed (Levin, Marascuilo & Hubert, 1978). It was hypothesized that the rank of the mean insight per case would follow the rank of the outcome measures at the follow-up. Based on the ranks of treatment outcomes, it was hypothesized that the mean insights would be ordered as follows: Rachel > Robert > Irene > Hilde. The observed ranking of mean insight was as predicted: Rachel ($M = 2.475$), Robert ($M = 1.569$), Irene ($M = 1.464$), and Hilde ($M = 1.347$). All possible

orders of insight segments were permuted. The permutation test was significant, $p < .05$.

This suggests that the patient's level of pro-plan insight was related to therapy outcome. It was noted that although mean insight related to psychotherapy outcome, the level of insight session by session and over the course of the therapy did not appear to increase, even in the more successful therapies. It was also noted that insight was lower in the last session than in the first. This was the case whether or not the therapy was considered successful. In the case of Rachel, the most successful therapy, insight appeared to be much lower at the last session of the therapy than in the first session. In the case of Robert, the next most successful, there was no final session at the end of treatment because he dropped out after 12 weeks. In the case of Irene, a mildly successful treatment, insight was much lower at session 16 than at the beginning of treatment. And in the case of Hilde, an unsuccessful treatment, insight was also lower at the end of the 16-session treatment than at the beginning.

Study Two

Method

Subjects and instruments. The second study used a different case selected from the Mount Zion Brief Psychotherapy Research Project archives, the case of Diane. This case was selected because it had been considered by clinicians to exemplify a case in which a patient appeared to develop insight throughout the course of the treatment. The study used a revised pro-plan insight scale. This study included investigation of insight in the initial intake interview, the 16-session therapy, the posttherapy interview, and the six-month follow-up interview.

Pro-plan Insight Rating Scale, Revised (PIRS-R). Like the prior scale, this scale is a case-specific six-point ordinal scale, designed to measure insight that is pro-plan (Edelstein, 1992; Grebel, 1992). However the scale was revised to provide an additional factor to be considered, that is the type of insight in which a person discussed a pathogenic belief with some understanding that it is false. When this type of self-understanding was included in the insight statement, it was to be considered more planful. As with the prior scale, raters were asked to make qualitative judgments regarding the content of previously identified insight segments. It was demonstrated in a

pilot on a case used in the study, that is, in the case of Rachel, that the scale could be used reliably by three judges; the intraclass correlation was .70.

Selecting insights. Three experienced clinicians were provided with the verbatim transcript of the therapy, the plan formulation for Diane developed in a prior study, and written instructions for the definition and selection of insight. These judges then identified pro-plan insight using the plan formulation for this case. The judges read the verbatim transcript of the entire therapy as well as the intake interview, the posttherapy interview, and the six-month follow-up interview, independently selecting all possible pro-plan insight statements. From this selection process, a master list of insights was generated which included all insights selected by each judge.

Rating insights. A second group of three experienced clinicians was provided with the plan formulation for the case of Diane, the master list of pro-plan insights, and written instructions for how to use the PIRS-R. The raters were given the insights in random order. Using the PIRS-R scale, raters were asked to determine the strength of the pro-plan insight. Intraclass correlations were used to determine interrater agreement (Shrout & Fleiss, 1979) and was found to be .65.

Results

In this case, the patient also lost insight during the course of her therapy; however, a parabolic curve did not significantly fit the raw scores, due to greater variability in insight throughout the therapy. The plot of smoothed scores however, indicates that the pattern was also parabolic, though less dramatically so (see Figure 2). The quadratic regression

TABLE 2. Results of Polynomial Regression of Smoothed Insight Ratings over Therapy in the Case of Diane

Analysis of Variance					
DF Regression	DF Residual	R	F	p	
2	14	.62	4.26	.03	
Beta Coefficients					
Parameter	Value	SE	β	t	p
X	-1.13	.67	-1.83	1.69	.12
X ²	.06	.03	2.30	2.12	.05

closely approached significance ($p = .052$) for the quadratic term in the regression (see Table 2). Unlike the prior cases studied, the mean rating of insight per session in the Diane case showed a linear trend, going up significantly throughout the therapy ($p < .01$), and also unlike the prior cases, the patient completed treatment with greater insight than she had in the beginning.

Discussion

The finding that all patients appear to lose insight during the course of their therapy and to regain at least some insight toward the end, with greater insight after termination, is intriguing and calls for explanation. We suggest that the parabolic pattern shown in these five cases may result from the unconscious plan for therapy described by Weiss (Weiss, 1993; Weiss, Sampson & The Mt. Zion Psychotherapy Research Group, 1986). Based on Weiss' theory, we propose that patients who know in advance the length of their therapy

LEVEL OF INSIGHT

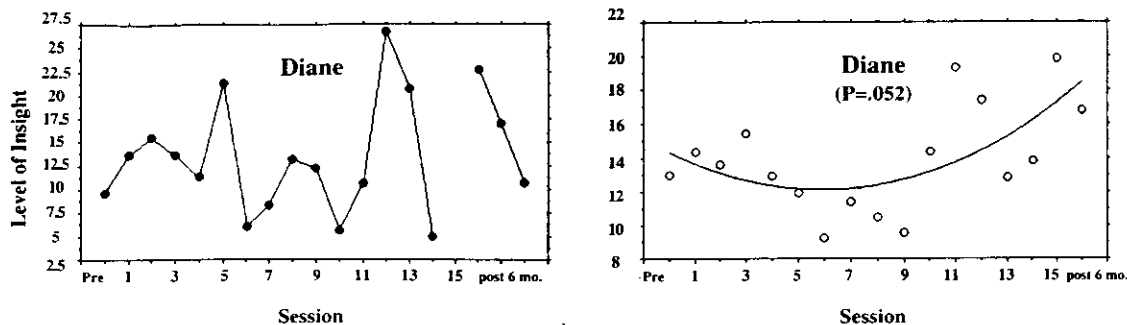


Figure 2.

may unconsciously map out a plan in order to use their time effectively. It is plausible, given our theoretical point of view about unconscious capacities, that patients may demonstrate insight at the beginning of therapy, in order to orient the therapist as to how he or she may help them. However, as the therapy proceeds, patients appear to lose insight as a part of testing the therapist. This apparent loss of insight is a condition for testing. A patient cannot carry out certain kinds of tests of his pathogenic beliefs in relation to the therapist and at the same time reveal much insight. Consider, for example, patients who test by putting themselves down in the hope the therapist will refute their self put-downs. Their testing would be ineffectual if, while putting themselves down they were to acknowledge, for example, that they were trying to determine whether or not the therapist would worry about them, or agree with or refute their self put-downs.

At first patients test relatively mildly because they can't be sure the therapist will pass their tests; in this phase they may continue to exhibit some insight. As the therapist passes these tests, patients may then test more and more vigorously and, in this period, they may in some sessions appear to lose all insight. When patients get closer to termination, their testing may subside in preparation for leaving therapy, and they may once again demonstrate pro-plan insight. Then in the follow-up sessions the patient does not test the independent evaluator and so displays higher insight than in the last session.

For example, Rachel, in her first session with her therapist, implied that she wanted to get a job, have fun, and separate herself from her dying husband. After implying this to the therapist, she began to test him by saying that she didn't really want a job, she just wanted to be taken care of, she was a fraud and not deserving of a job, and other similar false statements about herself. As the therapist passed these tests by encouraging Rachel in her search for a job, independence, and a satisfying life, Rachel tested more vigorously until in the middle of therapy she appeared to have lost all insight. Toward the end of therapy she began to acknowledge her abilities and her desire to find work. And by termination she had found two interesting jobs and was again expressing insight.

It is possible that in some cases the patient's drop in insight results from compliance with anti-plan interpretations. A check on this was possible because the planfulness of the interpretations was determined in a previous study (Norville, 1989). Ra-

chel and Robert consistently received pro-plan interpretations and Irene received moderately pro-plan interpretations. Hilde, however, received a relatively high proportion of anti-plan interpretations. Her drop in insight may therefore reflect compliance with anti-plan interpretations. Hilde's drop in insight was more persistent than the others'. However, like the other patients, she also showed a great increase of insight in the posttherapy session. This may have been due to the excellent rapport that she and the independent evaluator had developed in the initial intake interview; the posttherapy interview was conducted by the same evaluator.

There may be other explanations for these unexpected findings. It is possible that something in the therapy process causes patients to stop thinking or speaking insightfully. Or it is possible that patients begin to make more progressive statements of self-understanding toward the end of therapy, because they wish to leave the therapist feeling good about the work that they did together. However, this hypothesis is not consistent with the increase in insight found in the posttherapy interview with the independent evaluator. It is possible that insight goes up at the end of therapy because patients need to assure themselves that their work in therapy was positive and useful, and this would be consistent with the increased levels of insight in the posttherapy sessions. Also, this increase in the posttherapy session is consistent with the hypothesis that there is little or no testing with the independent evaluator, whom the patient has no reason to test. Another possible explanation for the drop in insight in the middle of the therapy may be that this results from the patient's resistance.

The parabolic pattern of insight found in this study may also reflect in part an artifact created by the standard protocol of questions being asked by the independent evaluator in the initial intake, the post- and the follow-up session. With more direct questions it is possible that patients will produce more insight statements. However, an examination of the data deleting the intake, post- and follow-up sessions shows that two of the four cases continue to be significantly fit by a parabolic curve and the other two cases were fit significantly by linear regressions with a negative slope. We suggest that this drop in insight is explained by testing. We would like to emphasize our finding that in four out of the five cases the patients' insight dropped to zero in the middle part of therapy and in the fifth case it dropped almost to zero.

The results of this study may explain why investigators who looked only at sessions in the middle of therapy found less insight than expected. In a study conducted by Luborsky et al. (1988) that examined insight in session 3 and session 5, it was found that of four categories of insight or self-understanding as defined by that group, none showed significant increases. In fact, two of four categories of insight showed a decrease from session three to five, one of which was statistically significant.

The development of insight as quantified in this present study suggests that, even in successful therapies, a patient's insightfulness may not change in a dramatic manner from the beginning to the end of the therapy. While several cases demonstrated improved behavioral functioning, these improvements—if related to insight at all—may be better understood by considering the quality, conviction, or content of insights. For example, Rachel started treatment with a relatively high level of insight. She did not appear to develop greater insight by the posttherapy interview according to this measure, although she had a successful therapy outcome. However, informal examination of the transcripts shows that the conviction and assurance with which Rachel made her insight statements had strengthened by the end of the treatment, and that her insight statements showed that she had modified some of her pathogenic beliefs. It is hypothesized that these changes in the conviction and content of Rachel's insights, as well as the behavioral improvement noted by the end of the therapy, was the direct result of the therapist passing her tests, which occurred throughout therapy including during the middle phases when Rachel appeared to have lost insight.

The results of these studies of the pattern of insight are tentative for a number of reasons. Only a small number of cases were studied. And one of these cases terminated treatment prematurely so that the completed quadratic curve was based on interpolation across four sessions. Our investigations were pilot studies, and were approached in the spirit of "investigative play". According to Barlow, Hayes & Nelson (1984):

Time-series research should be a dynamic interactive enterprise in which the design is always tentative, always ready to change as significant questions arise in the process. There should be an attitude of investigative play . . . Just as good clinicians often examine their case notes and assessment materials between client visits, the examination of client data allows discrimination of interesting patterns or leads which need to be followed. By adopting such an intellectual stance,

unexpected or even undesirable data patterns can often be clues on how best to treat this client and how to interpret particular behavioral phenomena. (pp. 178-179)

In order to generalize to the brief psychotherapy process as a whole, more cases need to be studied and methods further refined and standardized. However, despite the limitations of these studies, the results suggest that it would be fruitful to pursue the study of insight with more psychotherapy cases, including cases of differing lengths, and outcomes. This research also suggests it would be of use further to investigate different aspects of insight, including qualitative dimensions such as conviction, specific content, and strength. Further study of the changes in patient life activities that occur during the therapy process, and the relationship between activity change and insight may be useful. Finally, an examination of the process of testing occurring in the course of the cases already studied may provide confirmation of our tentative explanation of these findings.

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