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“Take a Sad Song and Make It Better”: What Makes an Interpretation Growth Facilitating for the Patient?

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Interpretations are considered to be an important active ingredient in psychodynamic treatment. Research shows mixed results regarding the empirical utility of interpretations, and continuing efforts are needed to investigate what makes interpretations helpful and effective. Our aim was to examine what allows an interpretation to facilitate growth, promoting the flourishing of the patient. We developed a coding system for evaluating the growth-facilitating elements of interpretation (GFI). The GFI is based on 3 scales: the optimal context for implementing the interpretation, the extent to which the interpretation includes positive regard and collaboration, and instills hope, and the immediate results of the interpretation. The GFI was used in a case study of a patient receiving supportive–expressive psychotherapy for depression. Analyses examined between-sessions and within-session processes. The integration of findings from the between-sessions and within-session analyses suggests that growth-facilitating techniques, manifest in growing positive regard, collaboration, and instilling hope, resulted in better outcomes, as reflected in the patient’s new associations, mood, and self-esteem, as well as in alliance, attachment to the therapist, and reduction of depressive symptoms. The present study demonstrates the benefits of integrating the psychodynamic perspective with that of positive psychology, for building interpretations that facilitate hope, growth, and flourishing. The GFI shows promise both for psychotherapy research and clinical practice and helps bridge the gap between the two.



Clinical Impact Statement

Question: This study explored the question: What allows a psychodynamic interpretation to facilitate growth for the patient? **Findings:** Analysis of a case study suggests that interpretations that were delivered with growth-facilitating techniques, manifest in growing positive regard, collaboration, and instilling hope, resulted in better immediate outcomes. **Meaning:** Clinicians are recommended to deliver interpretations in a manner that empowers patients and builds on their strengths in order to promote growth, relational maturity, and flourishing. **Next Steps:** Further studies are needed to explore these suggestions with larger data.

Keywords: psychodynamic treatment, supportive–expressive therapy, interpretation, therapeutic alliance, growth-facilitating interpretation

Although the psychodynamic and positive psychology literatures developed as distinct streams, psychotherapy practice has

much to gain from their integration (Chaves, Lopez-Gomez, Herivas, & Vazquez, 2019; Ruini, 2017; Seligman, Steen, Park, & Peterson, 2005). With regard to depression, both psychodynamic and positive psychology approaches have been shown to be effective in improving depressive symptoms (Gibbons et al., 2012; Layous, Chancellor, Lyubomirsky, Wang, & Doraiswamy, 2011; Leichsenring & Leibling, 2007; Sin & Lyubomirsky, 2009). Further exploration of the potential synergies between the two seems important to pursue, as major depressive disorder (MDD) is one of the leading causes of disability worldwide (Kessler et al., 2005), and only about half the patients suffering from MDD respond effectively to psychotherapy (Cuijpers et al., 2014). Contemporary positive psychology perceives mental health and depression as two opposite poles of a continuum, with mental disorders on one end, and positive mental health or flourishing on the opposite end, and

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the absence of symptoms without flourishing characteristics (termed *languishing*) in the middle (Keyes, 2005, 2007). According to this view, lack of symptoms is not the same as flourishing. Change in positive mental health predicts the prevalence and incidence of MDDs 10 years later (Keyes, Dhingra, & Simoes, 2010). Positive psychology interventions are based on systematic approaches aiming to overcome challenges by building on patients' strengths and assets (Rashid, 2009). Although positive psychology theory and interventions have become increasingly of interest in facilitating growth through adversity (Joseph & Linley, 2005), and alleviating depressive symptoms (Layous et al., 2011; Sin & Lyubomirsky, 2009), there has been rather little work on integrating positive psychology concepts and methods with those of psychodynamic psychotherapy. Some contemporary theories (Wachtel, 2011) stress the importance of delivering psychodynamic interventions in a manner that empowers patients and builds on their strengths. These theories highlight present or incipient adaptive tendencies to promote growth, relational maturity, and flourishing. The present study aims to further explore how interventions that facilitate and acknowledge the patient's growth and build on the patient's strengths can enhance psychodynamic work with patients suffering from depression. For this purpose, the supportive-expressive (SE) framework of short-term psychodynamic treatment is used.

SE therapy is a short-term psychodynamic treatment adapted to treat MDD, which was found to be effective for this population of patients (Gibbons et al., 2012; Leichsenring & Leibing, 2007). It is based on the implementation of both expressive (interpretive) and supportive techniques (Book, 1998; Luborsky & Crits-Christoph, 1998). This combination is expected to provide a facilitating, safe therapeutic environment for exploration and insight. It is generally agreed that the implementation of expressive techniques leads to symptom reduction as a result of patients gaining insight into their repetitive maladaptive interpersonal patterns (Gibbons, Crits-Christoph, Barber, & Schamberger, 2007; Jennissen, Huber, Ehrenthal, Schauenburg, & Dinger, 2018). In SE, insight is gained through the use of interpretations based on the core conflictual relationship themes (CCRT Book, 1998; Luborsky & Crits-Christoph, 1998). The CCRT is a formulation of the patients' most common wish in relationships (W), their expected responses from others to their wish (RO), and their reactions to these (unsatisfying) responses (RS). Often, the patients' main interpersonal wish is in conflict with their expected response from others, or in conflict with their own set of responses (RS). Therefore, their W is not actualized in their life, leading to symptomatic reactions (Book, 1998).

Theory and research on interpretations in psychodynamic psychotherapy have been highly controversial (Levy & Scala, 2012). Although much has been written about the recommended ways of building and delivering different types of interpretations in psychodynamic psychotherapy, and in SE in particular, empirical research has produced mixed and often confusing results regarding the contribution of interpretations to successful treatment. Some studies suggested that interpretations, especially transference interpretations, which focus on the patient's maladaptive patterns and their recurrence in the therapeutic relationship, can have a negative effect on treatment success, so that more transference interpretations are related to less successful treatment (Ogrodniczuk, Piper, Joyce, & McCa-

llum, 1999; Schut et al., 2005). Other studies found that interpretations may produce negative results for certain populations of patients, such as those with poor interpersonal functioning (Connolly et al., 1999). Empirical research sought to identify the conditions needed for interpretations to promote change, addressing questions about both the amount and the kind of interpretations suitable for given subpopulations of patients (McCarthy, Keefe, & Barber, 2016; Silberschatz, 2017).

Another promising direction of research examines the *context* in which interpretations should be provided to have the greatest effect. Owen and Hilsenroth (2011) have found that psychodynamic techniques were most effective when the alliance between patient and therapist was strong. Ryum, Stiles, Svartberg, and McCullough (2010) found that greater emphasis on transference work provided in the context of a weaker alliance was less effective in reducing interpersonal problems. Supportive techniques are part of SE psychotherapy and may be a means to strengthen the alliance (Leibovich, Front, McCarthy, & Zilcha-Mano, 2019; Leibovich, Nof, Auerbach-Barber, & Zilcha-Mano, 2018), attenuate anxiety, and create a comfortable atmosphere of being understood and appreciated, thereby paving the way for further exploration (Book, 1998; Carsky, 2013; Wachtel, 2011). Consistent with the positive psychology framework, the supportive attitude creates an opportunity for experiencing a *positive* trusting relationship, a core component of the well-being experience (Keyes, 2005; Seligman, 2018), and for acceptance and positive regard, another core component of well-being experience (Farber, Suzuki, & Lynch, 2019). The SE framework suggests that interpretations that are provided together with a supportive platform are essential for the curative process of therapy (Book, 1998). This is in line with the conceptualization of the therapeutic relationship as an attachment relationship. When patients are able to form a secure attachment with the therapist, they are free to explore internal and external experiences from a secure base, knowing that in times of distress and hurt feelings they can turn to the therapist as a safe haven (Bowlby, 1988; Mikulincer, Shaver, & Berant, 2013). Such a secure attachment with the therapist can then serve as a corrective experience with the therapist (Sharpless & Barber, 2012), which paves the road for changing attachment schemas and working models to more benevolent ones (Mikulincer & Shaver, 2007). A change toward more secure attachment with the therapist provides an opportunity for positive and growth-enhancing functioning (Lopez, 2009).

Some contemporary psychodynamic and integrative theories (Wachtel, 2011) stress the importance of delivering interpretations in a manner that empowers patients by building on their strengths and highlighting the positive steps they already have taken toward making a change. Contemporary writing on growth and development in psychotherapy emphasizes the benefit of focusing on the patient's strengths and virtues for treatment success (Duckworth, Steen, & Seligman, 2005; Flückiger & Grosse Holtforth, 2008; Scheel, Davis, & Henderson, 2013). Focusing on the strengths and virtues of patients is one of the core elements in positive psychology interventions (Seligman et al., 2005; Wong, 2006) that may lead to the desired development of flourishing by enhancing resilience, altruism, self-awareness, and meaningful purpose in life (Sandage & Hill, 2001). Hope can be considered as one of the virtues of human development that can promote resilience

throughout the life span (Snyder, 2000). Hope contains clear goals and a possible pathway to achieve them (Ruini, 2017). It was found to be consistently and robustly associated with life satisfaction (Park, Peterson, & Seligman, 2004) and with health variables (Snyder & McCullough, 2000). According to Seligman's model of "learned optimism" (Seligman, 2006), the optimistic explanatory style consists of making attributions that are internal, stable, and global for positive events, and external, unstable, and specific for negative ones (Seligman, 2006). The benefits of an optimistic explanatory style have been shown to include good physical health and decreased depressive symptoms (Boehm & Kubzansky, 2012; Carver, Scheier, & Segerstrom, 2010). Hope is considered to be an important active ingredient of psychotherapy (Yalom, 2005), and to be related to better treatment outcome, including symptom reduction and improvement in quality of life in MDD (Vilhauer et al., 2013). Findings suggest that hope is important not only for patients but also for therapists (Coppock, Owen, Zagarskas, & Schmidt, 2010). Greater hope in therapists was found to be related to stronger alliance, whereas less hope was related to more alliance ruptures and greater distress (Bartholomew et al., 2019). Integrating a hopeful attitude and optimism about possible changes into interpretations may be a promising way to improve interpretations, although this approach has not yet received adequate empirical attention.

A well-delivered interpretation, attuned to the particular dynamics of the patients and attentive to their adaptive resources and not just their pathology, may result in the patients feeling contained and subjectively recognized by others, in better control of their problem, better able to understand their strengths as well as the maladaptive patterns they follow time after time. This approach can enhance the learned optimism experience (Seligman, 2006) and help in becoming more hopeful that they are able to make a change. On the contrary, an insensitive interpretation can make the patient feel damaged and demeaned (Wile, 1984), create a sense that someone else is the "expert" on the patient, and that the patient's own self-understanding is not important or valid. An interpretation can even be used as a "weapon" by the therapist in a rupture or disagreement, blaming patients and making them feel responsible for the problems that arise in therapy (Schut et al., 2005). The common focus (both in practice and research) on disorders, symptoms, and pathology may be both clinically counterproductive and theoretically reductive in the sense of leaving out other important criteria and potential targets of change. From the clinical, research, and theoretical vantage points, it is important to complement this focus with attention to matters of relatedness, growth, flourishing, and the sense of meaning in life.

Flourishing may be defined as living in accordance with an optimal range of human functioning (Fredrickson & Losada, 2005; Keyes, 2005, 2007; Yildirim & Belen, 2019). Huppert and So (2013) defined flourishing as the experience of mental well-being and effective functioning by mirroring the opposite of mental illnesses symptoms, consisting of 10 positive components: competence, emotional stability, engagement, meaning, optimism, positive emotions, positive relationships, resilience, self-esteem, and vitality. In the growing literature on positive psychology, two general perspectives of flourishing have been offered: the hedonic approach, which focuses on happiness, pleasure, and pain avoidance; and the eudemonic approach, which focuses on the quest for

meaning and self-realization (Ruini, 2017; Ryan & Deci, 2001). In this article, we consider both hedonic and eudemonic points of view, by examining whether the patient reacted to the interpretation with a flow of new associations that reflect vitality and cooperation (Ulberg, Amlo, Critchfield, Marble, & Høglend, 2014), a change to a more positive mood, or what appears to be a more positive sense of self-esteem. A nonflourishing reaction to an interpretation is one where the patient became more defensive, withdrawn, or critical, showing signs of a rupture (Safran & Muran, 2000).

Research about how exactly interpretations should be delivered and their immediate outcome in the session is not common yet. Such research is needed, however, to expand our understanding of what makes an interpretation a sensitive, attuned, and meaningful one (Høglend, 2014). Based on a small sample of patients with avoidant personality who received SE psychotherapy, Schut et al. (2005) showed that even a few disaffiliative patient-therapist transactions (e.g., the therapist belittling and blaming the patient), before, during, or after interpretations, were negatively associated with patient change. The present study explores the elements that may guide therapists in delivering CCRT interpretations from a vantage point that includes not merely accuracy in identifying maladaptive patterns but also concern with support, human relatedness, and attention to acknowledging and building upon the patients' strengths and facilitating their psychological growth. Particularly in this sense, it seeks to integrate traditional psychodynamic concepts and concerns with those derived from positive psychology. To enable investigation of the therapist's interpretations, and to identify the components that facilitate patient growth and flourishing, we developed the Growth-Facilitating Interpretation (GFI) coding system, which we implemented in the case study in the following text. Our aim was to identify active supportive, affirming, collaborative attitudes that *at the same time* address experiences that the patient finds uncomfortable.

The GFI derives from a view that *both* the traditional emphasis on relieving symptoms and addressing disorder, *and* the positive psychology emphasis on growth, strengths, and flourishing are important. Unlike the approach that *contrasts* positive psychology criteria with the more common criteria that emphasize distress and maladaptation, the present study aims to *integrate* the two. We are interested in how the therapist can explore the patient's depressive experiences and other problematic behavioral and emotional tendencies in a way that pays attention *also* to the patient's current and potential strengths. The contribution of the present study is in exploring ways of addressing both pain and human potential, and in understanding how attention to the latter also serves more effectively the aim of addressing the former. In the present study, we examined a case of SE psychotherapy administered to a depressed patient both at the level of therapy sessions and of each interpretation that was given in these sessions. We focused in particular on the elements that enable an interpretation to promote the patient's flourishing and growth. Our focus was directed toward the change between sessions in therapist adherence and competence in delivering supportive and expressive techniques. We also investigated how various components of technique influence different measures of immediate outcome, both during the sessions and after them.

Method

Patient, Therapist, and Treatment

The patient was a woman in her twenties, seeking treatment for depression from which she has been suffering for several years. The therapist was a psychologist in her forties. The treatment was part of a pilot phase of a randomized controlled trial (RCT) comparing SE therapy with the supportive-only element of SE. The treatment in the focus of the present case study included both supportive and expressive elements. The expressive elements were based on identifying and working through the patient's CCRT to assist her in recognizing her internal representations and maladaptive relationship patterns, and working through them (Luborsky, 1995). The supportive elements were based on strengthening the alliance and the patient's self-esteem, while providing the patient with a corrective experience with the therapist and actualizing her unmet interpersonal wish (Leibovich et al., 2018). The active phase of treatment lasted 16 weeks, and therapy sessions were provided weekly (for additional details, see Zilcha-Mano, Dolev, Leibovich, & Barber, 2018).

Measures

Depressive symptom severity. Symptom severity was assessed at intake and before each session, using two measures. The first measure was the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1967), a 17-item clinically administered measure of the severity of depression. The procedure included 2 months of extensive training and achieving high reliability. Evaluators began by observing another evaluator at work, after which they administered the measures with a trained evaluator for several weeks, before performing the evaluation by themselves. Throughout the trial period, the reliability of the evaluators was evaluated on a weekly basis. Interjudge reliability was .93 and considered excellent (Fleiss, 1981). The second measure was the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), a 21-item self-reported inventory. Internal reliability for the present study was .91.

MDD diagnosis. MDD was diagnosed at intake, at Week 8, and at the end of the therapy, using the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998), a 154-item structured interview, used to assess 17 common Axis I disorders. It was used to confirm the MDD diagnosis, assess comorbid conditions, and identify conditions that merited exclusion from the study. The evaluators went through similar training as in the HRSD.

Working alliance. The alliance was assessed after each session, using the Working Alliance Inventory (12-item version; Horvath & Greenberg, 1989), as reported by the patient. Internal reliability in the present study was .90.

Attachment to the therapist. Attachment to the therapist was assessed after each session, using the Experiences in Close Relationships—Relationship Structures Questionnaire (ECR-RS; Fraley, Heffernan, Vicary, & Brumbaugh, 2011), a nine-item self-report questionnaire for assessing attachment orientations in relationships. Internal reliability in the present study was .80 for the Anxiety Scale, and .82 for the Avoidance Scale.

Interpersonal problems. Interpersonal problems were assessed before each session by the Inventory of Interpersonal

Problems—Circumplex (IIP-C; Alden, Wiggins, & Pincus, 1990; Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988), a 32-item self-reported inventory, assessing behaviors that are related to interpersonal problems. Internal reliability in the present study was .90. For the present study, we used assessment taken at intake and at the last session.

Quality of life. Quality of life was assessed at intake and every fourth session with the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q; Endicott, Nee, Harrison, & Blumenthal, 1993). Quality of life ratings, as measured by the Q-LES-Q, are sensitive to treatment-related change, even in the short term (Gladis, Gosch, Dishuk, & Crits-Christoph, 1999), and were found to be related to positive outcome in populations of patients with MDD (Zilcha-Mano et al., 2016). Internal reliability for the present study was .86. For the present study, we used assessment taken at intake and at the last session.

Therapist adherence and competence. The degree to which the therapist adhered to using supportive or expressive techniques, or both, and the degree of competence in these techniques were assessed using the Penn Adherence—Competence Scale (PACS; Barber & Crits-Christoph, 1996). In this study, we focused on two of the three subscales of the PACS: the Supportive and the Expressive. The coders were supervised by an international expert on the use of the PACS, with vast experience in the use of PACS in RCTs of SE treatment. PACS coding was performed by two graduate students in clinical psychology who were blind to the treatment conditions. The research team met for supervision sessions weekly. Each session was coded by two coders, and their coding was averaged. Intercoder reliability for adherence and competence were excellent (Fleiss, 1981): Expressive—Adherence scale = 0.88, Supportive—Adherence scale = 0.90, Expressive—Competence scale = 0.81, and Supportive—Competence scale = 0.89.

Growth-facilitating interpretation. The GFI coding system was developed for the present study. The aim of GFI was to code for elements that are expected to affect the extent to which a given interpretation has the potential to facilitate growth and development, the context of the interpretation, and its immediate outcome. The GFI is based on the literature on psychodynamic techniques that facilitate growth (Leibovich & Zilcha-Mano, 2017; Leichsenring & Schauenburg, 2014; Safran & Muran, 2000; Wachtel, 2011), as well as on the positive psychology vantage point of growth-facilitating techniques (Bartholomew et al., 2019; Duckworth et al., 2005; Farber et al., 2019). The coding system was developed as follows: Initially, based on theoretical and clinical knowledge, the most important factors contributing to a growth-facilitating interpretation were chosen. Next, the items were reviewed, divided into three parts (before, during, and after the interpretation), and confirmed by the authors. The resulting GFI coding system codes the therapist's behavior and patterns of interaction with the patient that facilitate growth—before, during, and after each interpretation in a given therapeutic session. In addition to quantitative scores, the GFI also includes verbal comments to enable content analysis.

A potential interpretation was defined as a new statement that the therapist makes about the patient or the therapeutic relationship, which expands the original themes articulated by the patient to broader patterns, conflicts, and themes, rather than merely reflecting back the patient's words or ideas. The interpretation was specified to end when the therapist ends convey-

ing her new idea to the patient. If the patient interrupts and says something while the therapist conveys the new idea, and it is clear that the therapist is continuing her line of thought, the interpretation is still going on. Similarly, if a new idea connects to the previous one without a pause, it is assumed to be the same interpretation. The preinterpretation period was considered to be the 3 min before the start of the interpretation (or starting at the end of the last interpretation, whichever was longer). The postinterpretation period was considered to be the 3 min after the interpretation ended (as long as no other interpretation started). If the effect of the interpretation seemed longer than 3 min, the longer segment was considered. These 3-min intervals were chosen based on the authors' clinical experience, and their utility was further examined during the coding process. The GFI contains three scales, and the second scale is divided into two subscales (based on content). The scales and the items they consist of are shown in Figure 1.

The coding was performed by two coders, both clinical psychologists, one an intern, the other a licensed supervisor with 22 years of clinical experience in psychodynamic psychotherapy. To assess the interrater reliability of the two coders, the intraclass correlation coefficient (ICC) was calculated using the SPSS statistical package, Version 22, using a mean-rating ($k = 2$), absolute-agreement, two-way random-effects model. The reliability was calculated based on the average score of all the questions in the GFI. The resulting ICC was in the good range, $ICC(2, 2) = .72$ (Fleiss, 1981), indicating that coders had a good degree of agreement and suggesting that the GFI items were rated similarly by the coders. The agreement on whether a given intervention by the therapist was an interpretation was .92, meaning that 92% of the therapist's interventions that were coded by one of the coders as an interpretation were also coded by the other coder as an interpretation.

Procedure

The study was conducted with the approval of the relevant ethics committee. The patient and therapist signed informed-consent forms, agreed to be videotaped during the sessions, and agreed to the use of the measures collected for the research. To protect the confidentiality of the patient and therapist in the clinical vignettes, we disguised the background details. The patient answered an ad published at the university and through the social networks, offering short-term therapy for depression. After a pre-screening call for an initial assessment of exclusion criteria, the participant underwent two intake meetings to further assess inclusion and exclusion criteria and to complete the measures before treatment. She met the criteria for MDD according to the MINI, and she met the other inclusion criteria. The patient completed the HRSD and BDI at the intake and before each session, the Working Alliance Inventory and ECR-RS after each session throughout the study, and the IIP-C and Q-LES-Q at intake and at the last session.

The case was chosen because it was a pilot, rather than one for which a blind comparison of treatments was deployed. Therefore, we are permitted to expose the type of treatment. Moreover, we were interested in a pilot case that showed development in the adherence and competence coding of techniques. We chose three sessions for GFI coding (Sessions 4, 6, and 8), which are the ones coded for adherence and competence in the general trial. These sessions enable us to capture the changes occurring during the first half of the

Pre-interpretation (prologue)	
1.	How <i>supportive</i> is the prologue? High (6-7) means that the therapist actively supports the patient's strengths, defenses, and self-esteem. Low (1) means the therapist is highly critical of the patient.
2.	Does the prologue <i>lead</i> into the intervention and connect with it? Did the therapist prepare the ground for the intervention by bringing up the issue that is the topic of the intervention, or somehow connect it with the patient's concern (7), or did the therapist merely deliver the interpretation (1)?
3.	Is the switch to the intervention <i>smooth</i> and natural (7), or does it come as a surprise (1)?
Interpretation	
<i>Positive regard and collaboration</i>	
4.	Is the content <i>non-critical</i> ? (7) or critical (1)?
5.	Does it <i>combine supportive</i> and expressive elements (7), or does it contain only interpretations, without any supportive elements? (1) In what way?
6.	Is it <i>non-blaming</i> ? (7) In what way? And if it is blaming (1), in what way?
7.	Is it <i>tentative</i> ? (7) In what way? Or is it "I, the therapist, am telling you the truth" (1), and if so, in what way?
8.	Does it <i>invite collaboration</i> (7), or does it invite the patient to agree (1)? In what way?
9.	Does the intervention <i>attribute the insight to the patient</i> (7), or is the therapist telling the patient something the patient doesn't know (1)?
<i>Instilling hope</i>	
10.	Does it suggest a <i>vicious circle</i> (7), or is it about a linear process (1)? In what way?
11.	Does it refer to a <i>fixed</i> trait of the patient or a fixed problematic phenomenon (1), or does it point to variability in this trait or phenomenon (7)? In what way?
12.	Does the intervention explicitly or implicitly refer to what the patient <i>can do to change the pattern</i> (7), or only to what the patient is doing now (1)?
13.	Is there acknowledgement that the patient is <i>beginning to move</i> in the direction suggested (7), or is the intervention only about what the patient is doing wrong (1)?
Post-interpretation	
14.	Are there <i>new associations</i> or a flow of associations (7), or is the patient silent, repetitive, and defensive? (1) In what way?
15.	Are there any indications of patient's <i>mood, confidence, self-esteem</i> , or anything about whether the patient shows an inclination to move in new directions, or see things differently (7)? In what way?
16.	Does the <i>alliance</i> seem to be stronger (7), the same? (3-4), or weaker (1)?
17.	Are there signs of a <i>rupture</i> or no such signs? If yes, how strong are they? (1=strong rupture; 7=no rupture). Of which type? Confrontational or withdrawal? Describe the rupture.
18.	Was there a corrective emotional experience? If yes, in what way? Describe.

Figure 1. Growth-Facilitating Interpretation (GFI) Scales Coding System.

treatment. In the current case, each interpretation in the three sessions chosen was coded using the GFI to provide as full an understanding of the therapeutic process in these sessions as possible.

Results

Patient

Dana (all details are obscured) was a 21-year-old student at the university. She was detached from her family, which was Ortho-

dox religious and did not approve of her choice of a rather secular way of life. Dana turned to our lab to receive short-term therapy for depression. She felt lonely, not sure what to do with her life, disappointed in herself for not being a good student she thought she should be, and deliberating about leaving the university and finding a job. She had just broken up with her boyfriend, Ben, which also contributed to her low mood. Dana received a diagnosis of MDD on the MINI interview and was found eligible to start therapy. At the intake session, she achieved an HRSD score of 14 and a BDI score of 20, which are consistent with her MDD diagnosis. Her IIP-C measures indicated a high level of distress (IIP-C total = 23). Her expected alliance with her therapist was 4.17. Her quality of life rating (Q-LES-Q) was 3.13.

Therapist

Suzie (all details are obscured), a licensed psychologist, was in her mid-40s, married with children. She had 6 years of clinical experience in psychodynamic psychotherapy. She received comprehensive training in SE therapy, a manualized psychodynamic treatment (Luborsky, 1984), as part of the pilot phase of the RCT. The training included guided reading, followed by an individual training workshop in supportive and expressive techniques. During the pilot phase and after the start of the research, she received weekly group supervision from two supervisors, as well as weekly individual supervision from one of the supervisors. Individual and group supervisions made extensive use of videotaped sessions for feedback.

The Process and Outcome of Treatment

The therapy started with Suzie getting to know Dana, first as a person, then learning about her history and the current issues that brought her to seek treatment. An important issue that came up in Dana's history was her detachment from her parents, who for many years seemed not to show interest in her nor to value her choices. Dana's choice to become secular disconnected her from the community she grew up in, and her new values and meaning in life were not yet clear to her. Dana was emotionally distant from her siblings as well, two of whom she considered her best friends, and from her friends. She did not like to share her thoughts and feelings and did not want them to feel sorry for her. In the fourth session, Suzie introduced the CCRT conceptualization, and from then onward the two concentrated on deepening their understanding of Dana's CCRT, as proposed in the SE protocol. Dana was specifically concerned about her relationship with Ben, her former boyfriend, with whom she was again considering being in a relationship. This relationship was a main concern in the first half of therapy, because Dana was frequently hurt by Ben, who did not consider her as his girlfriend, and she often became detached from him. The conflict about wanting to be close but being afraid of getting hurt if she were to show her true feelings was a central issue in the therapy, discussed both at the level of her relationships outside the therapy room and with Suzie. Suzie also helped Dana work through a crisis she had while in therapy, when she dropped out of school and for a while had nowhere to live, and no job or money.

When the treatment ended, Dana's HRSD changed from 14 before treatment to 6 at the end of treatment, which is below the

cutoff for a clinical sample (cutoff for HRSD = 11.75; Jacobson & Truax, 1991; Rehm & O'Hara, 1985). It is considered as almost meeting the criteria for reliable clinical change, as the difference between her two HRSD scores is almost 8.35 points (Grundy, Lambert, & Grundy, 1996). Her BDI changed from 22 before treatment to 2 at the end of treatment, which is also below the cutoff for a clinical sample (cutoff for BDI = 17.10; Beck, Steer, Ball, & Ranieri, 1996; Jacobson & Truax, 1991; Whisman, Perez, & Ramel, 2000). Her reliable clinical change index for the BDI score was statistically significant, as the difference between her two BDI scores is larger than 7 (Whisman et al., 2000). Additionally, Dana no longer met the criteria for depression, as determined by the MINI interview. Her level of interpersonal problems was also lower (IIP-C = 14), and her quality of life ratings improved to 3.44 when the treatment ended.

Case Formulation

Suzie introduced the CCRT in the fourth session, consistent with the protocol. According to the CCRT formulation, Dana's wish was to have the feeling that she is wanted, that others show genuine interest in her (W), but she felt that people often ignored her needs or were critical of her (RO). Therefore, she avoided relationships and emotional talk (RS), which made her wish even more difficult to be fulfilled. As a result, she was lonely and depressed.

Adherence, Competence, and Outcome of the Chosen Sessions

Table 1 shows the mean scores of adherence and competence rating of supportive and expressive techniques (based on PACS) at each of the three sessions we examined. The change in the patient's rating of her depression, alliance, and attachment to the therapist (the difference between the score before and after the session) is shown in Table 2.

GFI Coding

A total of 19 interpretations were identified in the three sessions (six in Session 4, five in Session 6, and eight in Session 8). Table 3 shows the scores of the three items of the Preinterpretation scale. The Interpretation scale was divided into two subscales: Positive Regard and Collaboration, and Instilling Hope. Because the two items (4, 6) showed high correlation ($r = .6$) and held similar meaning, we computed their mean score to obtain a five-item (rather than a six-item) score. Table 4 shows the scores of the five items of The Positive Regard and Collaboration subscale. The

Table 1
Mean Scores of Adherence and Competence in the Delivery of Supportive and Expressive Techniques

Session	Supportive techniques		Expressive techniques	
	Adherence	Competence	Adherence	Competence
Session 4	2.3	2.2	3.0	2.4
Session 6	3.8	3.8	3.4	3.6
Session 8	5.6	5.7	3.4	4.1

Table 2
Difference in Patient Rating Before and After the Session

Session	HRSD	ECR-RS (Attachment) avoidance	ECR-RS (Attachment) anxiety	WAI (Alliance)
Session 4	-2.00	-0.67	0	0.59
Session 6	-4.00	-0.66	0	0
Session 8	0	0.17	0	0.75

Note. HRSD = Hamilton Rating Scale for Depression (Hamilton, 1967); ECR-RS = Experiences in Close Relationships-Relationship Structures Scale, answered concerning the therapist as an attachment figure (Fraley et al., 2011); WAI = Working Alliance Inventory (Horvath & Greenberg, 1989). Difference rating = score after the meeting - score before the meeting.

correlations of the different items in this subscale are presented in Appendix Table A1. Table 5 shows the change in the four items of the Instilling Hope subscale. The correlations of the different items in this subscale are presented in Appendix Table A2. Four items were coded for the segment following the interpretation. They can be considered as the immediate outcome of each interpretation. Table 6 shows the changes in the four items of the Postinterpretation scale.

Clinical Vignettes That Demonstrate the Coding of the Interpretations

An interpretation that received a low score. This was the last intervention offered by the therapist in Session 4. The session received lower scores on competence in supportive and expressive technique, and a lower score in adherence to supportive techniques than during the other sessions. This example received lower techniques and postinterpretation scores on the GFI. During the beginning phase of therapy, as at the intake sessions, Dana was pessimistic about her future, her mood was low, and she described difficulties in coping with her everyday duties. She seemed lonely and unable to share her feelings and thoughts with her siblings or friends. Earlier in this session, Suzie introduced the CCRT conceptualization. Dana appeared rather passive and quiet during most of the session. She talked about feeling disappointed that a job interview she was waiting for was canceled. She spent most of the preceding week alone in her apartment, feeling sick and weak, and deliberating what to do next. Before the interpretation, Dana said in response to a question by Suzie that she was distressed and that she experienced various feelings and thoughts, but would not share them.

Suzie: *There's a part inside you trying to warn you: "Don't share your feelings." You say you do have the option to experience various feelings inside, but you will not share them. It contradicts your wish. In order for you to feel comfortable, for other people to see you and to appreciate you, you need to let go of this thing inside . . . it's part of the maladaptive pattern, I think. . . .*

Dana: *Hmmm . . . [silence]*

Suzie: *I think it's very meaningful to understand this. You're looking at your past, your past experience. We are influenced by things that happened, makes us adopt patterns. . . .*

Dana: *Hmmm . . .*

Suzie: *How does this conversation strike you?*

Dana: *[silence] It's hard for me to express what I feel. . . .*

Suzie: *It's OK. . . .*

Dana: *It's interesting . . . I usually do not think of things from this perspective, about relationships I mean. . . . It is difficult for me to express how it makes me feel [laughs uncomfortably].*

The first interpretation subscale, Positive Regard and Collaboration, is coded relatively low (4) in this example. Suzie presented the "truth." She was somewhat critical and censuring, not highly supportive or tentative and only at the end invited Dana to respond, but not to participate in constructing the interpretation. The second interpretation subscale, Instilling Hope, scored even lower (2) in this example. Suzie suggested that Dana was capable of experiencing different feelings but did not indicate that there was any variance in her capability to share them in different situations. Rather she used labels such as "maladaptive patterns" and "your wish." The interpretation did not talk about a vicious cycle that may be changed, and there was no hint that Dana was already doing something useful to change the pattern (such as coming to therapy). This interpretation was about Dana's defensive RS, which made her wish difficult to fulfill. This may generally be true and accurate, but the way in which it was presented, which scores low regarding GFI techniques, was not very helpful to Dana. Suzie wanted to challenge the way Dana perceived her problems, to make her understand the pattern of her behavior and the price she was paying for it, but Dana appeared to be closed to this interpretation and became more defensive. The score on the immediate postinterpretation (or interpretation outcome) items was also low

Table 3
Scores of Items of the Preinterpretation Scale

Session	Preinterpretation items		
	How <i>supportive</i> was this part?	Does it lead to the interpretation?	Was the switch to the interpretation <i>smooth</i> ?
Session 4	4.67	5.50	5.33
Session 6	4.40	6.00	5.80
Session 8	5.63	6.13	6.38

Table 4
Scores of Items of the Positive Regard and
Collaboration Subscale

Session	Positive regard and Collaboration items				Attributes insight to the patient
	Accepting	Supportive	Inviting	Tentative	
Session 4	4.09	2.67	3.00	2.00	2.17
Session 6	5.10	5.20	5.80	3.20	2.80
Session 8	6.63	6.25	4.00	3.13	4.25

(4.4). Dana was silent, restrained, and defensive, languishing if not even more depressed. There was no apparent positive change in her mood, self-esteem, or cognitions. The alliance did not seem strong at that point of the session, and the silences indicated a rupture of the withdrawal type.

We can think of this short exchange between Suzie and Dana as reenacting Dana's CCRT. Dana wished for positive regard and genuine interest by Suzie (W), but she probably felt criticized (RO). As a result, she became emotionally restrained and distant (RS), which made it even more difficult for her to have her wish fulfilled. This was an enactment of the CCRT, which was replayed as part of the therapeutic relationship, without enough insight or space for change.

An interpretation that received a high score. This interpretation was the first one in Session 8, when the scores of adherence and competence, as well as the alliance, were considerably higher. We offer this short vignette to demonstrate the competent use of growth-facilitating interpretation techniques, and show how the postinterpretation coding was higher too. Dana started the session by talking about her interactions with Ben during the preceding week. Suzie listened and asked clarification questions such as "could you elaborate on what exactly happened?" Before the interpretation, Dana said she was offended and hurt by Ben, who was dismissive and hostile on the telephone. Dana then said that she explained to Ben what hurt her and how she needed him to behave with her.

Suzie: *That's great! It's really moving to hear this! This kind of disclosure to Ben is something new, right?*

Dana: *Right.*

Suzie: *I hear that something has changed here. You understood that he had wanted to talk, and you initiated it, something you would not do before, and you didn't only initiate, but you interpreted the situation be-*

tween the two of you in a different way than usual. This time you didn't feel that what Ben exhibited was your fault, and this new understanding enabled you not to withdraw and disconnect. On the contrary, you chose to actually talk to him about what bothered you, and he responded to all this! In his own way. . . .

Dana: *Exactly, and it went on. At our next talk he was showing signs of withdrawing again . . . He's the one usually withdrawing or closing up. . . .*

Suzie: *And how did you react to that?*

This interpretation does not contain the (unfulfilled) Wish, the expected (negative) Response from the Other, and the (dysfunctional) Response of the Self. It does provide a hint, however, of the patient's dysfunctional CCRT (which the therapist and patient discussed at length in the preceding sessions) and highlights the positive way in which this CCRT is changing: The RO is different, because Dana is no longer perceiving Ben's behavior as a rejection. The RS is also markedly different, because Dana is not withdrawing, but talking about what is bothering her. All this gives an opportunity for Suzie to work through the CCRT in what we termed here *a growth-facilitating way*, highlighting the positive actions that Dana took to change her CCRT pattern and celebrate the emerging changes.

In this example, the scores were high on all of our scales. The Preinterpretation score was high (6.3) because the interpretation was closely connected with Dana's concerns, and Suzie listened carefully, showing interest, affirmation, and support. The score on the first interpretation scale, Positive Regard and Collaboration, was high (5.7) because Suzie took seriously the manner in which Dana interpreted the situation, and she was not critical, but rather inviting. She was also supportive, in the sense that she admired Dana for her new abilities and strengths, showing positive regard and genuine enthusiasm. The score on the second interpretation scale, Instilling Hope, was also high (6.25) because Suzie spoke about the change Dana was making. Suzie was looking for this change, and stopped Dana as soon as she identified it, so that she could make the interpretation that stressed and "celebrated" the change. This change produced a circular and mutually determined situation, in which Dana's behavior affected Ben and vice versa. Dana's problematic trait of withdrawal (RS) was not permanent, but rather open to change. After the interpretation, Dana became talkative and spoke in a lively voice, although the topic made her uneasy. The alliance seemed strong and no rupture was manifest. The

Table 5
Scores of Items of the Instilling Hope Subscale

Session number	Instilling hope items			
	Vicious circle	Variability in trait	What the patient can do to change	Acknowledgment that the patient is beginning to move in the right direction
Session 4	2.17	2.67	2.17	2.17
Session 6	3.40	3.80	4.20	2.80
Session 8	3.75	6.37	5.88	6.38

Table 6
Scores of Items of the Postinterpretation Scale

Session	Postinterpretation items			
	New/flow of associations	Change in mood, confidence, self-esteem, perceptions	Stronger alliance	No rupture
Session 4	4.67	4.33	4.33	3.67
Session 6	4.80	4.60	4.60	4.00
Session 8	6.50	5.37	6.25	6.13

Postinterpretation score was also high (6.8), showing immediate elevation in flourishing characteristics such as being more open and optimistic, proud, seeming more self-confident and trusting of the therapist.

An interpretation dealing with a rupture that received a high score. This was the fifth interpretation at Session 8. In this vignette, we demonstrate a competent use of growth-facilitating interpretation techniques in dealing with a rupture, which is one of the challenging situations in therapy. A few minutes before the interpretation was offered, Dana shared with Suzie that she decided to drop out of the university. Suzie was surprised and asked a few more questions about it. Dana then talked about how Ben was very supportive and caring when she told him about her decision to leave university, and how special it was for her. Suzie reflected on how important and good it must have felt, fulfilling her wish of being understood in a nonjudgmental manner, being recognized and appreciated. A long silence followed, then Dana confronted Suzie:

Dana: *What I was thinking now . . . I felt that in that part where I talked about leaving the university, I really exposed myself. Usually, I talk about things from a side, more intellectually. Quitting the university . . . hmmm . . . my feelings are strong about it. I didn't push them aside, and I can feel them fully boiling inside me. I saw your reaction. It was different from usual. I was shocked, and went straight back to talk about my relationship with Ben, which is more comfortable for me.*

Suzie: *Wow . . . first of all, it's very meaningful for me that you said it . . . very important . . . let's check it. . . .*

Dana: *Yeah . . . About what you said . . . I think you're right. I think this exposing my feelings is a very important step for me, and can be helpful also in my relationship with Ben. . . .*

Suzie: *That's good . . . And what are you feeling now?*

Dana: *My first reaction was maybe even a little hurt. I bring up a subject that is important to me, and the reaction is different from I expected. If this is not about relationships, not about the subject of the therapy, then maybe. . . .*

Suzie: *Maybe you felt it was not legitimate on my side . . . and you went back to. . . .*

Dana: *Yes, I went back to the safer subject.*

Suzie: *It really moves me that you share this with me, and the distinction you make is very important. . . .*

Dana: *Yes, as a first reaction I felt hurt . . . I exposed something. . . . [silence]*

Suzie: *I'm very happy that you shared it . . . my reaction was probably . . . I cannot take back my reaction, but you recognized something in my reaction that was probably there. . . . And mostly, it's very moving that you shared what happened to you, you recognized it and shared, it's very important because it's very new and important for you. . . . How do you feel about it?*

Dana: *[silence] I was now thinking how different relationships are similar. . . .*

The conversation went on, with Suzie emphasizing how important it was for her that Dana recognized what happened and shared her feelings, after which they together went on to look at the similarities to Dana's relationship with Ben. Finally, they reflected back on how it felt for Dana to share difficult feelings with Suzie, and to actually talk about them, unlike what happened in earlier sessions, and what can be learned about Dana's patterns from this experience.

This conversation is instructive because although there is a rupture, the interpretation scored high both on the Positive Regard and Collaboration, as the interpretation was built in collaboration and included positive regard (5.7), and on the Instilling Hope scales (6). On the Postinterpretation scale, the score was moderate (4.75) because Dana brought up new associations, was active, and seemed more self-confident, and the alliance appeared to have strengthened. The rupture, which lowered the postinterpretation score, was slowly resolved before the end of the session. This demonstration showed Suzie's admiring, fortifying stance, which stressed Dana's new strengths and abilities. When she dealt with the rupture, Suzie first validated it, assuming responsibility for it, and asked about Dana's feelings and understanding. It was Dana who connected it with her other relationship, leading the talk toward deeper transference interpretations. A corrective emotional experience was evident. Suzie handled Dana's criticism in a way that was different from what Dana had expected (RO). This elicited a response from Dana that was different from the usual one (RS). She seemed to be relieved, more open emotionally, and intellectually curious about her relationship pattern. The way Dana brought up her negative feelings with Suzie shows an important change in her attachment pattern to Suzie. She is more trusting and confident, using the relationship as a safe haven for exploration of difficult interactions both outside and in the room. As a conse-

quence to this successful interaction, she seemed to flourish, expressed more positive emotions, was more open to deepening her thinking, and more optimistic about her strengths and abilities.

Discussion

In this case study, we investigated what allows an interpretation to facilitate growth, promoting the flourishing of the patient. Session analysis revealed that the therapist consistently gave a large number of interpretations and that there was a gradual growth in her competence in delivering the interpretations and in using supportive techniques. These developments manifested in improvement in the patient's symptoms, development of a more secure attachment with the therapist, and better therapeutic alliance, which probably enabled a safe haven for investigation and growth. At the end of the therapy, the patient showed improvement in both depression symptoms and quality of life. We also sought to investigate in depth what growing competence in delivering techniques means for the quality of the interpretations. To this end, we developed the GFI coding system, which codes each interpretation: the interaction before the interpretation, during its delivery, and after it, focusing on what we consider to be its growth-facilitating factors.

Findings based on the microanalysis of the interpretations in the present case study using the GFI suggest that in the course of treatment, the therapist became better at delivering a growth-facilitating interpretation. Examination of the periods before each interpretation shows that the therapist became gradually better at providing a good context for the interpretation, which manifested in her being more supportive before delivering interpretations. Supportive attitude is considered to be essential in SE as a basis for interpretation (Book, 1998). It is also consistent with the positive psychology notion of the importance of acceptance, positive regard, and the emphasis on the patient's strengths (Farber et al., 2019; Wong, 2006). Another component of providing a good context was working harder to connect the interpretation with whatever went on before it. This may have supplied greater motivation for the patient to become involved in the interpretation, because the interpretation was not imposed or forced upon her from the outside, but rather was an integral part of their conversation.

Next, we examined what the therapist was doing while delivering the interpretations. We found that she became better at encouraging collaboration with the patient and showing positive regard, being supportive, accepting, and attributing the insight to the patient herself, rather than delivering it from outside (Farber et al., 2019; Wachtel, 2011). The therapist was generally more inviting of the patient to collaborate in latter sessions, but she was less so in Session 8 than in Session 6. This may have been due to the patient being more confrontational in Session 8. The therapist also improved in instilling hope while delivering the interpretation. She promoted the patient's understanding of her patterns as a vicious circle, an understanding that may have helped the patient feel more in control of these patterns. The therapist also related to the patient's patterns as more variable rather than stable, which means she stressed a hopeful attitude according to which change is possible. Finally, she was clearer about what the patient can do to change her patterns, and about how the patient was already moving in the right direction to achieve this change. All these character-

istics of the therapist's behavior while delivering each interpretation were improved and enhanced as the therapy proceeded. Thus, they can be considered as promoting the patient's strengths together with interpreting her problematic and hurtful patterns. This also shows that these qualities of therapeutic participation in the work can be *learned*, that with supervision and attention to these dimensions of interpretation, therapists can get better at them.

The therapist's improved competence in delivering the interpretations seemed to be meaningful and to promote the patient's emotional responsiveness immediately after each interpretation was delivered. When we examined the period after each interpretation, we found an improvement in the patient's ability to engage in the therapeutic process, to show greater openness, positive feelings, associative behavior, and confidence. These behaviors can reflect growing, flourishing, or positive mental health of the patient (Keyes, 2005, 2007), both from a hedonic point of view, being more open, talkative, and positive, and from a eudemonic point of view, of being more engaged, associative, and confident (Ruini, 2017; Ryan & Deci, 2001). This was also evident in what appeared to be a better alliance as the therapy proceeded. It was especially revealing that the periods following the interpretations were coded as showing fewer ruptures as the therapy proceeded, although the patient seemed more confident and less afraid of confrontations with the therapist when she disagreed or felt misunderstood. The findings indicate that the ruptures were fewer because they were resolved as the therapist's growth-facilitating techniques improved, and the patient was more confident and emotionally open. They also indicate that improvement in the competent use of these techniques promoted change in the patient by creating a new corrective emotional experience, which was reflected in the change in the patient's CCRT, and a move toward more secure attachment patterns. When the therapist was looking for the patient's strengths, both as a collaborative partner in meaning-making and as a competent promoter of change (instilling hope), she was acting differently from what the patient expected from significant others (RO). This enabled the patient to react differently from her usual maladaptive patterns (RS). In this way, the therapist "passed the patient's unconscious tests" (Silberschatz, 2012).

Interpretations are considered to be an important active ingredient in psychodynamic psychotherapy, and the element that differentiates it from other therapies. SE psychotherapy for depression that combines supportive and interpretive techniques was found to be useful (Gibbons et al., 2012; Leichsenring & Leibing, 2007; McCarthy et al., 2016). Yet, some research has suggested that interpretations may be harmful or not useful (Connolly et al., 1999; Ogrodniczuk et al., 1999; Schut et al., 2005), and this has encouraged research into the factors that make interpretations helpful. The context of the interpretation was found to be an important factor. Specifically, the therapeutic alliance was found to be a helpful context for interpretations (Owen & Hilsenroth, 2011; Ryum et al., 2010), and disaffiliative transactions were found to be harmful when they occurred before and while delivering interpretations (Schut et al., 2005). The present study continues these lines of research and considers the elements that are present when psychodynamic interpretations are delivered in a growth-facilitating manner, to contribute to the emerging understanding of how psychodynamic interpretations can be delivered competently. The findings demonstrate one approach to integrating

positive psychology conceptualizations and terms into psychodynamic frameworks to facilitate growth. We showed how more competent delivery of psychodynamic techniques can be characterized by a more collaborative, hopeful, and empowering attitude (Bartholomew et al., 2019; Coppock et al., 2010; Vilhauer et al., 2013) on the part of the therapist, stressing the patient's strengths (Duckworth et al., 2005; Flückiger & Grosse Holtforth, 2008; Scheel et al., 2013), and offering acceptance and positive regard (Farber et al., 2019). These characteristics are consistent with the literature on positive psychology techniques for promoting well-being, specifically for helping with depressive symptoms (Layous et al., 2011; Sin & Lyubomirsky, 2009). The positive psychology literature suggests that difficult times, such as depressive episodes, can be an opportunity for growth (Joseph & Linley, 2005). In our study, both the patient and the therapist showed growth in the course of the therapy, becoming more confident and open, and more competent in their ability to relate to each other and converse meaningfully and emotionally.

Further research is needed to understand the extent to which these growth-facilitating techniques moderate the effect of interpretations on outcome. Another instructive question raised by the mutual and synchronized development of therapist and patient concerns the conditions that make possible such quick development of the therapist. One likely contributor is the supervisory process, which includes watching videos, in the course of group and individual supervision. The conclusions of the study are provisional, however, for several reasons. First, the fact that it is a case study raises questions about the generalizability of our findings beyond a specific dyad. Second, the GFI coding system developed in this study for coding the growth-facilitating elements of the therapist's techniques in delivering interpretations is new and needs to be further evaluated and refined. It is reasonable to assume that a different instrument used to understand the given patient-therapist dyad would have produced other findings to complement the current ones. Future studies should continue testing its psychometric properties and validate it on larger data sets. Moreover, in future work, implementing the GFI coding for all sessions, as opposed to only three sessions, would provide greater detail in the antecedents and outcomes of interpretations, and would make it possible to examine in more detail changes in the interpretations as they occur over time. Validating the outcome items of the GFI against formal coding of rupture resolution (Eubanks, Muran, & Safran, 2018), would also add to the validity of the GFI scale.

Further exploration of these issues, along with the utilization of larger samples, is likely to shed further light on what makes interpretations useful in psychodynamic psychotherapy. It is also likely to further our understanding of the subtleties of technique that enable therapists to promote growth and flourishing of patients, and how these techniques should be taught in effective supervision. Interpretations in psychodynamic therapy have often highlighted the patient's defensiveness, unacceptable wishes and feelings, and maladaptive patterns. Integrating the psychodynamic perspective with that of positive psychology, the present study aimed to explore the effect of interpretations that pay attention to the patient's strengths, positive movement, and collaboration, and that are directed toward facilitating hope, growth, and flourishing.

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(Appendix follows)

Appendix
Intercorrelations of the Subscales Items

Table A1
Intercorrelations of the Positive Regard and Collaboration Subscale Items

Item	1	2	3	4	5	6
1. Not critical	—	.70**	.60**	.46*	.27	.49*
2. Combines supportive elements	.70**	—	.59**	.42	.34	.63**
3. Not blaming	.60**	.59**	—	.46	.30	.56*
4. Tentative	.46*	.42	.46	—	.68**	.25
5. Invites collaboration	.27	.34	.30	.68**	—	.24
6. Attributes insight to the patient	.49*	.63**	.56*	.25	.24	—

Note. $n = 19$.

* Correlation is significant at the 0.05 level (two tailed). ** Correlation is significant at the 0.01 level (two tailed).

Table A2
Intercorrelations of the Instilling Hope Subscale Items

Items	1	2	3	4
1. Vicious circle	1	.06	.15	.12
2. Variability in trait	.06	1	.79**	.86**
3. What the patient can do to change	.16	.79**	1	.68**
4. Acknowledgment of change	.12	.86**	.68**	1

Note. $n = 19$.

** Correlation is significant at the 0.01 level (two tailed).

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