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Difficult Dyads and Unsuccessful Treatments: A Comparison of Dropout, Poor, and Good Outcome Groups in Brief Psychotherapy

by

Lisa Wallner Samstag

A dissertation submitted to the Graduate Faculty in Psychology
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Abstract

Difficult Dyads and Unsuccessful Treatments: A Comparison of Dropout, Poor, and Good Outcome Groups in Brief Psychotherapy

by

Lisa Wallner Samstag

Advisor: Professor Paul L. Wachtel

The focus of this study was interpersonal processes of difficult patient-therapist dyads and early identification of treatment failures in 30-session psychotherapy protocols. Forty-eight dyads were equally divided into premature dropout (DO), poor outcome (PO), or good outcome (GO) conditions. Patients were treated as Beth Israel Medical Center and most met criteria for anxious-avoidant personality disorders. Groups were compared on: (1) the patient- and therapist-rated Working Alliance Inventory (WAI-12; Horvath & Greenberg, 1986; Tracey & Kokotovic, 1989); (2) the observer-rated Structural Analysis of Social Behavior (SASB; Benjamin, 1974; Benjamin, Giat, & Estroff, 1981); and (3) observer-rated Narrative Coherency from the Adult Attachment Interview (AAI; Main & Goldwyn, unpublished manuscript).

Results showed that subscores of each measure significantly differentiated outcome groups, and that the DO condition was not consistently found to have the most difficult therapeutic relationships, as hypothesized: while the DO group had the most problematic alliances compared to PO and GO groups, respectively, and the most incoherent narratives compared to the GO group, the PO condition demonstrated the highest level of hostile complementarity relative to the GO condition. PO patients also

reported fewer early attachment losses and traumas at intake compared to GO patients. Significant intercorrelations among measures found: 1) direct relationships among patient WAI-12 Bond and Total scores with Narrative Coherency; 2) indirect relationships among patient WAI-12 Goal, Task, and Total scores with SASB Negative Complementarity; 3) indirect relationships among all therapist WAI-12 scores with SASB Negative Complementarity; 4) indirect relationships between Narrative Coherency with both SASB Negative and Neutral Complementarity; and 5) a direct relationship between Narrative Coherency and SASB Positive Complementarity.

These findings suggest qualitative interpersonal differences among dyads in the three outcome groups and that patients and therapists do not consider similar aspects of the relationship to carry therapeutic importance. Narrative Coherency, adapted from the AAI and first used here in psychotherapy, points to a possible relationship between a patient's attachment system and their capacity to bond with a therapist. Overall, these results speak to the highly complex nature of the therapeutic relationship and have clinical implications for time-limited treatment of personality disordered patients at risk for treatment failure.

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Table of Contents

List of Tables

List of Tables (continued)

List of Figures

Chapter I. Introduction

The relationship between a patient and therapist has been conceptualized in a multitude of different ways since Freud first described the patient's positive transference as one of the important elements of a successful treatment (Breuer & Freud, 1885; Freud, 1912, 1913). In "The Dynamics of Transference" paper, Freud (1912) distinguished between three types of transference experiences, all based upon the displacement of feelings and fantasies from figures in the patient's past onto the analyst: (1) an erotic transference, which was defined as the patient's sexual feelings and fantasies about a love object from the past projected onto the analyst; (2) a positive, "unobjectionable" transference, or "the effective positive transference" by which the patient would consciously view the analyst as a trustworthy and supportive authority figure; and (3) a negative transference, which if predominant over the positive, rendered the patient incapable of following the "fundamental rule" to always free associate, and therefore "unanalyzable." While all forms of transference were eventually the object of the analyst's interpretations if they impeded the task of free association, both the erotic and negative transferences were understood to be most problematic in terms of the working relationship between analyst and analysand, and to the outcome of treatment. Freud stated that even the positive transference had "erotic sources...and psychoanalysis shows us that the people who in our real life are merely admired or respected may still be sexual objects for our unconscious" (1912, p. 105). However, he did not discuss the implications of objectionable transferences beyond stating that they impeded analysis.

The unobjectionable positive transference laid the groundwork for a "transference

neurosis" to form. This was defined as the patient's full experience of infantile conflicts in the presence of the analyst, and a "working through" of these conflicts essentially marked the end of a successful treatment. In other words, the point at which the illusory nature of the patient's relationship to the analysts was unearthed, the treatment was over. Components of the "real" relationship (e.g., the particular way the analyst behaved, dressed, etc) were not considered by Freud to be central to how the transference was manifested nor were they thought to effect how the work would progress *vis a vis* the "analytic pact" (1937, 1940).

Is the unobjectionable transference defined as the alliance? Friedman (1969) points out the paradox in conceiving of the transference (i.e., the unobjectionable positive transference) as both the major motivating force in the patient's collaboration with the therapist and the main source of resistance which, if the treatment is successful, will be removed. A similar argument is put forth by Horvath (1995), who states "whereas the good therapeutic alliance provided much of the initial thrust and security for the patient... the alliance itself was subject to interpretation" and "because the therapeutic alliance was based on projection, in the course of a successful analysis, it was fated ultimately to dissolve" (p. 8).

It was not until late in his writing that Freud hinted at the inclusion of rational, non-transference components in the formation of the analytic pact, separate from transferential components. For instance, in "Analysis Terminable and Interminable" he states: "the analytic situation consists in our allying ourselves with the ego of the person under treatment, in order to subdue portions of the id which are uncontrolled" (1937, p.

238). Here Freud was beginning to discuss the importance of the real, collaborative therapeutic relationship, recognizing that not all aspects of that relationship were due to displacement and projection, although this was certainly not central to his hypotheses regarding mechanisms of change. Ironically, the positive transference was emphasized by Freud in terms of a patient's suitability for analysis, yet its existence and characteristics were largely taken for granted, while the concepts of resistance and conflict were elemental in the evolution of psychoanalytic theory (Kazner, 1975).

Freud's followers both expanded and modified his conceptions of the unobjectionable positive transference and the analytic pact. About the time that Freud was including rational aspects related to the patient's ego in his conceptualization of the collaborative therapeutic relationship, others were writing about similar dynamic relationships. For instance, Sterba (1934) described the "ego alliance" and the importance of the patient's capacity for psychological mindedness, or the ability to move between an experiencing and an observing ego in order to engage in self-reflection. Here Sterba emphasized the distinction between the mature and rational, and the primitive and irrational aspects of the ego - the "therapeutic split" - explicitly stating that the former acted specifically as cooperative features of the relationship with the analyst. In a similar vein, Strachey (1934) described the "auxiliary superego ego" as the part of the patient with which the analyst forged a collaborative alliance.

Zetzel (1956) used the terms "therapeutic alliance" and "working alliance" interchangeably to describe the patient's attachment to the analyst as a reemergence of positive aspects of the patient's relationship with his or her mother through the process of

identification. In essence, the analyst must respond to the patient's "basic needs and anxieties" (1966, p. 100) before the patient will be able to withstand the work of analysis, namely interpretation of conflicts that arise in the transference neurosis. Zetzel stressed a distinction between the therapeutic alliance (i.e., nonneurotic) and transference neurosis (i.e., neurotic), stating that the rational, mature ego is the foundation of the alliance and that the "intuitive adaptive responses" (1966, p. 97) of the analyst in meeting the patient's basic needs and anxieties must take place very early in the treatment. She further clarified how either transference or alliance features would predominate and that this balance would shift back and forth over the course of treatment. It was with the nonneurotic components of the patient's ego that the therapist would form the collaboration, in order to help the patient examine his or her transference relationships from a more objective and rational position. Thus, similar to Freud's criteria of unobjectionable positive transference, Zetzel defined the establishment of a therapeutic alliance as a prerequisite to the analysis proper. Unlike Freud's initial conception of the analytic relationship, however, Zetzel's emphasized that the analyst could do something in the treatment to establish an environment of safety and trust, contributing with the patient to the establishment of the therapeutic relationship. The development of a therapeutic relationship was now conceptualized as having a direct impact on the process of treatment.

Another influential concept of the therapeutic alliance was outlined by Greenson (1965), who defined the "working alliance" as being crucial throughout an entire analysis, rather than being important only at the beginning of treatment. Like Zetzel, Greenson also

distinguished his concept of the working alliance from the transference neurosis, but he further elaborated upon the relationship between an analyst and patient by including the impact of the real or human features of the analyst as central elements (Gelso & Carter, 1985; Greenson & Wexler, 1969). Here, Greenson identified two interactive components of a working alliance and a successful analysis: (1) the consistent technical skill of the analyst in his or her use of interpretation and (2) insight regarding the patient's conflicts, within the context of an ongoing, positive, human, working relationship.

Building on Greenson's (1965, 1967) conception of the working alliance, Bordin (1979) presented a model of the therapeutic relationship which included three interrelated features he described as central to the development of any patient-therapist dyad, regardless of technique. This pantheoretical, dynamic formulation emphasized a negotiation between patient and therapist, including an explicit agreement between them with respect to the relevant therapeutic *tasks* (e.g., interventions such as free association or systematic desensitization which form the basis of the therapeutic work) and *goals* (e.g., the particular treatment outcomes desired), within the context of a positive, interpersonal *bond* (e.g., a relationship of mutual trust and respect).

This section has introduced one of the two general theoretical lines, this one which emerged out of Freud's pioneering conceptions of the patient-therapist relationship, namely, the contributions of ego psychological theorists such as Sterba, Strachey, Zetzel, and Greenson, who forecasted contemporary perspectives on the collaborative therapeutic alliance (e.g., Bordin). As Bromberg (1992) paraphrased an analytic joke, "it is no longer enough for the analyst to know absolutely nothing; it is now also important to be able to

express it. The day of the 'non-responsive analyst' is largely a memory; the day of the 'difficult patient' has arrived" (p. 498). He goes on to question what is meant by the term "difficult", replacing the notion of a "difficult patient" with "difficult process" and "difficult dyads." The Literature Review section will begin with the second theoretical line which stems from the interpersonal and object relational theories of Ferenczi, Balint, Sullivan, Klein, Kohut, and Bowlby, and the shifting role of the therapist in understanding therapeutic alliance/misalliance and psychological change (see Muran & Safran, 1998). This shift provides the basis for a growing body of research literature in psychotherapy and attachment domains.

Chapter II. Literature Review

The Shifting Role of the Therapist

The shift in focus from the limitations of the patient in developing a therapeutic alliance to include more of the contributions of the therapist or analyst was most evident in the literature on countertransference. Countertransference was initially defined by Freud as emotional reactions of the analyst to be "recognized" and "overcome" (1910, pp. 144-145), implying that feelings aroused in the analyst were an impediment to the treatment and should be eradicated. Racker (1957, 1968) attributed the general absence of writing on countertransference in the psychoanalytic literature until this time to the perpetuation of a myth in the field that defined analysis as a relationship between a "sick" patient and a "healthy" analyst. This was part of an overriding "resistance" where "countertransference [was] treated somewhat like a child of whom the parents are ashamed" (1968, p. 107).

Ferenczi, a contemporary of Freud's who also underwent a brief analysis with him, believed that the immediate, affective experience "felt in one's body" was the road to the achievement of "any real convictions" and that it was "the physician's love which cures the patient" (1912). These were radical views in light of the accepted technique of the day, with its focus on the transferential nature of the relationship between patient and analyst. Ferenczi considered Freud's treatment to be disproportionally focused on intellectual insight. In order to facilitate "basic character changes" in his patients through their experiential capacities, Ferenczi experimented with a number of "active" techniques to foster patient regression (see Grubrich-Simitis, 1986). These techniques included transference-countertransference enactments in the sessions; interventions which enabled

the patient to relax and reduce tension, followed by an increase in tension through frustration; and an intervention Ferenczi called "mutual analysis" which he defined as the direct disclosure of countertransference feelings to the patient. In marked contrast to Freud, Ferenczi was stating that admitting errors and analyzing countertransferences with the help of the patient was therapeutic. In a review of Ferenczi's writings, Aron & Harris (1993) note that while Freud's clinical practice shifted towards the treatment of training analysts, Ferenczi preferred to work with a more severely disturbed group of patients and, in fact, Ferenczi saw himself as working best with "peculiarly difficult cases" (1931). These authors describe Ferenczi's work as "largely concerned with the heart of the analytic situation, the relationship between patient and analyst" (Aron & Harris, 1993, p. 162).

Ferenczi's conceptions of the mutative ingredients of psychological change and the corresponding techniques he advocated were further developed by his pupils and analysands in what has been labeled the "Hungarian School" or "Hungarian Psychoanalytic Society". For instance, Michael Balint (1950) argued that Freud's metapsychology was overly restrictive in its emphasis on the physiological drives of the individual and therefore inadequate in explaining what occurred in the "Two-Body" analytic experience. The analyst was not conceived of here as a blank screen, situated to receive the analysand's projections and provide verbal communications in the form of interpretations, but rather as a person with whom the analysand was relating. Accordingly, free associations and interpretations, the primary currencies of classical psychoanalysis, were viewed as interpersonal acts such that the impact of the analytic, two-person *process* was technically

considered along with the *content* of the verbal material. Alexander & French (1946) similarly espoused the limits of analytic neutrality and described how a critical "corrective emotional experience" in analytic work involved exploration of how a patient's reactions to an analyst were not merely transference distortions but also included features unique to that particular moment in that particular relationship (see Wachtel, 1987).

A number of parallel forces contributed to the mounting theoretical shift from a primarily intrapsychic model towards an interpersonal perspective, initiated by Ferenczi, and a corresponding expansion of the classical definition of countertransference. These included the development of interpersonal and object relations theories, and particularly Klein's concept of projective identification (Klein, 1946; Bion, 1970), through the application of psychoanalysis to children and more severely disturbed adults who were previously considered unsuitable for psychoanalysis. These populations would naturally evoke more intense emotional reactions from the therapist, a phenomenon which had not been adequately addressed in psychoanalytic ego psychology. Countertransference is no longer considered by many as simply reactions to a patient's transference material but as all emotional reactions a therapist had to a patient. The "totalistic" view of countertransference (Kernberg, 1965) suggests that it should be conceived of as all of the reactions a patient has towards his or her therapist. This perspective, however, fundamentally changes the definition of transference from an exclusively one-person field. The incorporation of the impact of real experience and observable behavior into theories of human development - a dimension that *was* a part of psychology, but was even more fully developed in the interpersonal, self-psychological, and attachment perspectives -

allowed for a reconceptualization of therapeutic phenomena as "phenomena that go on between the observer and the observed in a situation created by the observer participating with the observed" (Sullivan, 1940; p. 12).

Sullivan's interpersonal theory, and the closely related theories developed either independently or as a direct elaboration of Sullivan's ideas (e.g., Karen Horney, Erich Fromm, Frieda Fromm-Reichmann, and Clara Thompson), represent another effort towards defining a two-person theory of psychoanalysis. This movement developed as a reaction to what was considered inadequate in classical drive theory regarding basic assumptions of human motivation; particularly the influence of society and culture in the formation of personality, which is what made this approach most distinct from the object relations schools and "a more truly psychodynamic point of view" (Greenberg & Mitchell, 1983; p. 85). Sullivan defined the self as operating in a motivational dialectic, balancing the need for interpersonal security and the need for authentic self-expression and satisfaction (1953). Here, the focus of emotional development was not on the individual psyche but the interactional field where "personifications" or "representations" developed from actual relationships with others. A sense of self formed within the context of the self-concepts of significant others. Mitchell (1988) summarizes Sullivan's theoretical perspective and states the following:

> A personality is not something one has, but something one does. Consistent patterns develop, but the patterning is not reflective of something "inside." Rather, the patterns reflect learned modes of dealing with situations and are therefore always in some sense responsive to and shaped by the situations themselves (p. 25).

According to Sullivan, interpersonal actions which are consistent with an

individual's sense of themselves are reinforced because they reduce anxiety and result in a feeling of security. In contrast, those experiences which disconfirm aspects of an individual's self-concept are threatening because they increase anxiety and are thereby avoided. Very early on, the infant begins to learn the "signs" from the environment which signal anxiety in the mother and to adjust his/her behavior in an attempt to elicit the nonanxious, responsive mother. Through the child's empathic connection to the mother, he/she in turn feels less anxious. With maturation, the avoidance of anxiety becomes a more complex pattern of "security operations" which serve to reinforce the "good-me" or anxiety-free parts of the self. The first experiences of anxiety and unsafety are so overwhelming to a helpless child that they are to be avoided at all cost. Areas of the personality which invoke anxiety are called "bad-me," or "not-me" in the case of very extreme states of anxiety. The extent to which past personifications distort present relationships will depend upon the degree to which anxiety and security operations dominate one's life. Stable self-concepts also form via the mechanism of "introjection". The theory of introjection assumes that individuals learn to treat themselves as they have been treated by significant people in their past (Sullivan, 1953). The introject is subject to restructuring over the entire course of life.

The implications of this perspective on thinking about the analytic relationship and the concept of transference/countertransference were to shift the primary focus from the assumption of distortion (i.e., the transference neurosis) to the ways in which the analytic experience was a co-construction or creation by patient and analyst. In his early work with male schizophrenics, Sullivan emphasized the interpersonal impact of language as a

manifestation of intrapsychic functioning, and how the symptoms of these "unanalyzable" patients conveyed important meaning about their subjective experiences:

> From its origin in concrete experience and a real interpersonal situation, each personification has itself had a developmental history which is in turn completely understandable in terms of the functional adequacy of the person in the series of interpersonal situations through which he has had to live. (Sullivan, 1964, p. 79)

He understood this disorder to be a profound disturbance in the individual's ability to cope with and relate to others, and that regarding treatment, "[f]ar more than any single action of the physician, it is his general attitude towards the patient that determines his value" (1962, p. 20). However, Sullivan did not fully formulate his critique of Freudian metapsychology (see Greenberg & Mitchell, 1983) nor, as Wachtel (1987) notes, did the interpersonalists go far enough in applying their basic assumptions to clinical practice and to the specific role of the analyst in facilitating change. Wachtel's (1987) integration of the Piagetian concepts of assimilation and accommodation in operationalizing transference phenomena is particularly useful in this context. As he states:

> Transference reactions, in Piaget's terms, may be seen simply as reflecting schemas which are characterized by a strong predominance of assimilation over accommodation. The experience with the analyst is assimilated to schemas shaped by earlier experiences, and there is very little accommodation to the actualities of the present situation which make it different from the former experience (1987, p. 31).

Like Sullivan, Kohut (1971, 1977, 1984) and others defined within the self psychology tradition, were also challenging the drive model and corresponding assumptions of classical psychoanalytic theory and technique. Self psychology is considered to be a type of object relations theory. Based on the conceptual distinction

made by Hartmann (1950) between the ego and the self. Kohut initially defined the self-structure as comprised of two poles or essential needs: idealizing and mirroring. His theory of psychopathology pointed to the impact of the parent's repeated failure in empathizing with the child's developmental requirements for mirroring and/or idealizing. This failure could be the result of a mismatch between the temperaments of the child and parent, as well as due to internal or external limitations in the parent's ability to respond appropriately (e.g., mental illness, difficult life circumstances). As a consequence of the parent's continued empathic failures, the child's development of self-esteem regulating structures was thought to be compromised. Feelings of shame and humiliation in response to repeated empathic failure and derision became central to the development of psychopathology. Optimal failures, however, defined as those breaks in empathy which were not overwhelming to the child, facilitated the creation of internal mental structures which would maintain and regulate self-esteem during future inevitable failures.

Kohut's most important contribution was his recognition of the potentially curative effect of the analyst's continued empathic responsiveness to the patient, through the development and interpretation of "selfobject transferences". In this type of transference, the patient used the analyst to satisfy unmet self-restorative or selfobject needs. The main types of selfobject transferences corresponded to the mirroring and idealizing aspects of the self, with the later addition of twinship transference. Recognition of the analyst's contribution to the selfobject transference emphasized the interactional or relational dimension of the analytic experience, and allowed for the incorporation of a broader range of facilatative interventions. The analyst had to be sufficiently available to the patient's

developmental "pull", which he defined as the "average empathic responsiveness" (Kohut, 1977) from the "human presence" of the analyst (Kohut, 1984).

One of the fundamental mechanisms of change, according to Kohut, came via the exploration of the inevitable "self-selfobject ruptures" between patient and analyst. These were considered to be inevitable because no analyst could always be perfectly empathic or available for self-object functions. The self-selfobject rupture is defined as a break in the therapeutic relationship, or empathic failure of the analyst, which is negatively related to the patient's sense of self. Through the analyst's understanding of, and focus on the patient's experience of that rupture, grows an increased capacity in the patient for self-regulation. The intrapsychic structures which serve to regulate self-esteem are formed though the process of "transmuting internalization" (Kohut, 1971). This is distinct from the process of identification (which is considered to be an internalization of the *whole* object), in that *parts* of the selfobject are internalized by the patient and reconfigured for their particular needs (Ornstein, 1983). As in the relationship between child and parent, the relationship between patient and analyst develops as a mutually interactive process: each individual is impacted upon and changed as a result of interaction with the other, which forces the relationship itself to change over time (Wolf, 1980).

In more contemporary self psychology parlance, the concept of intersubjectivity allows for an incorporation into treatment of both an emphasis on the patient's early failed attachment experiences with early, familiar objects and the growth potential from new interactive experiences with the therapist (Stolorow & Lachmann, 1980). Similar to Kohut, Stolorow, Brandchaft, & Atwood (1994) also identify breaks in the relationship

between a patient and therapist as critical moments in therapy which reflect important patient self-states or internal representations of self and other stemming from early attachment traumas. The San Francisco Psychotherapy Research Group (Weiss, Sampson, & the Mount Zion Psychotherapy Research Group, 1986; Weiss, 1993) has developed a therapeutic approach along this vein, which emphasizes a patient's motivation to master his or her problems by completing certain developmental tasks with the therapist. According to this theory, the patient is unconsciously motivated to challenge existing pathogenic beliefs by "testing" them in a enactment with the therapist. Here the lineage from Ferenczi's initial statements of the importance of enacting problems within the therapeutic relationship is clear.

The Contributions and Clinical Implications of Attachment Theory

In both Britain and North America, a great deal of attention was being directed to the explicit observation of children and their mothers, which would have an ultimate effect on psychotherapeutic practice and the role of the therapist in treatment. While the early analytic theories of Klein, Winnicott, Fairbairn, and Balint, in particular, assumed a relationship between the quality of the mother/infant relationship and later psychological development, people such as John Bowlby, Mary Ainsworth, Margaret Mahler, and Daniel Stern were finding empirical evidence for such links. Bowlby's (1969, 1973, 1980) "attachment" theory marked a radical departure from both drive and object-relations theories. Unlike Freud and Klein, Bowlby saw the psychological bond between a mother and child as a "primary motivational system" rather than as an instinct derived from feeding and elimination or infant sexuality. Attachment theory was an outgrowth of

Bowlby's criticisms of psychoanalysis' overemphasis on internal phenomena at the expense of external events (e.g., maternal deprivation) and on its lack of empirical evidence. He saw the more scientifically rigorous field of ethology and the work of neo-Darwinians such as Lorenz (1952) and Harlow (1958) as a potential base from which to advance his ideas. In many ways, he considered his thinking to be consistent with that of Ferenczi and Balint and was criticized by Klienians for:

> contaminating psychoanalysis with behaviourism...What started out as an attempt to find a sound biological underpinning for Object-Relations Theory became, in the face of the rejections of his ideas by his psychoanalytic colleagues, increasingly to look like a new psychological paradigm (Holmes, 1993, p. 66).

There are also similarities between attachment and interpersonal theories. For example, attachment theory, like interpersonal theory, is defined as a field theory comprised of interrelating cognitive, behavioral, and emotional elements mutually reciprocated between two individuals:

> Attachment behaviour, like other forms of instinctive behavior, is mediated by behavioural systems which early in development become goal-directed. Homeostatic systems of this type are so structured that, by means of feedback, continuous account is taken of any discrepancies there may be between initial instruction and current performance so that behaviour becomes modified accordingly (Bowlby, 1980, p. 39).

Whereas Sullivan did not consider the child's connections to others to be goal-directed until preadolescence (Mitchell, 1988), Bowlby identified "set-goals" and "proximity seeking" behaviour developing as early in the child as six months of age. If the mother is sufficiently emotionally responsive and available to the infant's bids for attachment, the

child will feel safe and secure and will be relaxed enough to explore the environment. The "internal working model" that develops in a secure individual is a mental representation of a loving, reliable care-giver, and a sense of self that is both worthy of that love and attention and efficacious in obtaining it from others. The internal model is used to anticipate and interact with the external world and is generalized to other relationships. An insecurely attached child, by contrast, has not experienced the mother as responsive and available and will develop an internal working model represented by a combination of love and dependency, and fear of rejection. The world is viewed by the insecure individual as an unsafe place and the self ineffective and unworthy of love and attention. The internal working model of an insecurely attached person is based on an effort to accommodate to, or cope with, the behavior of the care-giver, rather than being an accurate representation of the self and others. Bowlby describes two coping strategies or interpersonal defenses - avoidance and adherence - which lead to the development of avoidant and ambivalent attachments, respectively. These represent "multiple" internal working models of attachment (Bowlby, 1973).

These descriptions greatly overlap with Sullivan's theory of the development of personifications, introjects, and security operations, although Bowlby expanded the model of anxiety reduction and avoidance - so central to the organization of the self in the interpersonal perspective - by defining more elaborated and comprehensive patterns of relatedness . An attachment relationship is characterized as a specific kind of relationship which includes three defining elements (Weiss, 1982): (1) proximity seeking to a discriminated figure; (2) the secure base effect (Ainsworth, 1979; 1982); and (3)

separation protest. Bowlby saw attachment needs as important throughout the life cycle, as were Sullivan's security operations and Kohut's selfobject requirements necessary beyond childhood.

Bowlby subsequently identified the process of therapy as one which established a secure base through the reliability and responsiveness of the analyst, and his/her availability in being attuned to and working with a patient's negative emotions, particularly around issues of separation and loss:

> The therapeutic alliance appears as a secure base, an internal object as a working, or representational, model of an attachment figure, reconstruction as exploring memories of the past, resistance as deep reluctance to disobey past orders of parents not to tell or not to remember...The psychotherapist's job, like that of the orthopaedic surgeon's, is to provide the conditions in which self-healing can best take place (Bowlby, 1988).

When distressed, a patient will seek security through a therapist as an attachment figure. A patient's dependency on the therapist is considered in attachment theory to be appropriate and, therefore, an aspect of the real relationship between them rather than a neurotic or transferential one. The type of secure base that is established will be a product of the match between the particular patient and the particular therapist. However, the patient has likely had trouble establishing a secure base with others of the sort that serves to buffer the impact of stress (that is why he/she is coming to treatment), and the therapist must be attuned to how the patient's attachment patterns have prevented its development with others and also with him or her.

The difficulties patients face in the establishment of the secure base highlights Bowlby's unique conceptualization of defenses (see Hamilton, 1985). He considers a

secure attachment to be a "primary defense" and insecure attachments as "secondary defenses". Secondary defenses are the paradoxical interpersonal strategies or "dilemmas" (Ryle, 1990) that individuals developed in the service of maintaining close proximity to attachment figures which may be rejecting, unavailable, or intrusive. In both avoidant and ambivalent strategies, aspects of the self are compromised and inhibited in order that attachment remain the primary goal. To the extent that the therapist is able to provide a secure base and allow the patient to confront previously overwhelming feelings, a sense of security will be internalized as the attachment with the therapist is given up and the patient will be more likely to develop secure attachments with others. However, Bowlby does not explicitly discuss situations in which the therapist fails to establish a secure base.

One of the central tenants of attachment theory in older children and adults is the importance of narrative. Coherent narrative is the result of a secure individual's ability to represent and articulate their significant relationships. "Autobiographical" or "narrative competence" (Holmes, 1992) is the ability to hold on to or represent a sense of personal history in the mind. Developmentally, the ability to hold on to one's self germinates in an infant as a result of the mother's consistency and reliability in holding the infant. Additionally, if the mother is able to "take the baby's perspective" (Bretherton, 1991), understanding that the infant has a mind, then the child will learn that he or she has a mind as others have minds, which leads to the development of the capacity for self-reflection. Insecurely attachment individuals will evidence specific types of narrative: avoidant patients have a dismissing quality to their narratives while ambivalent patients have a preoccupied style (Holmes, 1992).

Coherency also contributes to a sense of security by connecting or re-connecting split-off parts of internal experience and sense of self. Language and narrative in therapy provide a way to make sense of a patient's story and to symbolically link inner and outer worlds (see Schafer, 1976; Spence, 1982). One of the tasks of therapy in establishing a secure base is the co-creation of a more coherent narrative. Therapist's interventions should, therefore, contribute to increased autobiographical competence for the patient which allows for the assimilation of new experience and ownership of their own narrative. Research by neo-Bowlbians such as Main, Fonagy, Dozier, and colleagues, has begun to explore links between narrative competence, security of attachment, and psychotherapy outcome and will be elaborated in the review of research literature below.

To summarize, the theoretical developments outlined above had an enormous impact on the role of the therapist in terms of understanding contributions to the therapeutic process and, subsequently, to the possible interventions which facilitated psychological change in their patients. The relational movements were, in part, reactions to the inadequacies of Freudian and Klienian "one-person" metapsychologies which emphasized intrapsychic functioning in explaining emotional development, psychopathology, and technical considerations, as well as to the dogmatic means by which it's tenants were enforced on the psychoanalytic community. The so-called "two-person" theories of people such as Sullivan, Kohut, Bowlby, Winnicott, and their colleagues, emphasized the significance of external and social realities. Developments broadly included the distinction between distorted and real aspects of the therapeutic relationship and how the inclusion of therapist contributions to the alliance influenced and expanded

the range of possible therapeutic interventions. The next section of this literature review covers theory which specifically addresses difficulties in the establishment of a working alliance.

Therapeutic Misalliance: The modern conceptualization of alliance developed from dynamic models with a focus on the description of patient characteristics and transferences necessary to form a positive therapeutic relationship. Although the early writing on therapeutic and working alliance included some references to disruptions or impasses (Fenichel, 1941; Greenacre, 1959; Greenson, 1965, 1967; Nunberg, 1926, 1955), the importance of explicitly working with negative transferences and the difficulties clinicians experienced in forming a therapeutic alliance were more fully elaborated upon by only a few theorists. Dickes (1975) argued that negative transference also plays a role in the development of the therapeutic alliance. He describes the importance of the therapist as someone upon whom a patient may vent anger and express sexual desire, without the fear of retribution.

Moving beyond the analytic explanations of patient unanalyzability or therapist countertransference issues, Carl Rogers (1954) provided one of the first published case studies of a treatment failure from the humanistic school: The case of Mr. Bebb. In a successful therapy within this school, the therapist established a therapeutic relationship through the provision of empathy, congruence, and unconditional positive regard (1951), which themselves would enable the client (his preferred term) to embark on his or her own process of psychological growth and healing. There is a rich literature of unsuccessful or failed psychotherapy case studies from a range of therapeutic orientations (see Stricker,

1995; Strupp, Schacht, Henry, & Binder, 1992).

As was noted earlier, Kohut (1971, 1977, 1984) emphasized that the repair of inevitable empathic failures by the analysts - called self-selfobject ruptures - through interpretation, were pivotal to therapeutic change. Specific ruptures would or would not develop depending upon the interaction between the particular patient-analyst dyad, with the analyst viewed as a full participant in the development of ruptures. He states that these empathic failures or ruptures could be "traumatizing" to the patient and therefore unanalyzable if the analyst contributes "too much" to the interaction, particularly in the early phases of treatment when the reliability of the therapeutic relationship is forming.

Langs was the first to use and explore the concept of "therapeutic misalliance" (1973) in the identification of aspects of technical problems in psychoanalysis. Therapeutic misalliance encompassed a number of previously studied areas (e.g., transference-countertransference, resistance, acting-out), but Langs also considered the term to extend beyond them. Langs (1975) states the importance of including therapeutic misalliance in an overall conception of the alliance:

> In particular, this concept is especially relevant to the adaptive and interactional aspects of the patient-therapist dyad, including the mutual influence of the patient and analyst upon each other, and the realistic and intrapsychic consequences of the relationship for both participants. While not all disturbances in the therapeutic alliance take the form of misalliances...it seems advisable to make a special study of these particular interactions since they are basic to many disturbances in the analytic situation and probably the single most common dimension to stalemated or failed analyses (p. 78).

Through case examples, Langs (1975) illustrates how certain patient-therapist dyads will

paradoxically seek to create misalliances as a method of "symptom relief". He conceives of the therapeutic misalliance as a collusion between patient and therapist to avoid those areas which are anxiety provoking for both members of the dyad, including feelings of closeness and intimacy, a denial of separateness through unconscious fantasies of omnipotence and inappropriate gratification, and circumvention of the potentially painful change process through repetition and justification of unsatisfying relationships. Such avoidances may reflect a major or a minor disruption in the alliance and therapeutic work, but they are always mutually reinforcing in that they result in a temporary feeling of relief or "cure" through shared defenses of the dyad.

The temporary relief afforded by a therapeutic misalliance is consistent with Winnicott's concept of the "false self"(1960). Winnicott describes a continuum of true and false self organizations which co-exist in a dialectical relationship. The false self develops as a defensive function to hide and protect the true self from exploitation and annihilation, which it does through compliance with the demands of parental wishes. The false self enables the true self to exist. From this perspective, "impasses in therapy are not seen as a function of resistance or a lack of cooperation, but rather as an enactment of the [patient's] experience of self as an object, which is central to the early failures in the development of the self" (Newirth, 1995; p.74). Newirth goes on to argue that the goal of treatment becomes the reintegration of those disowned parts of the patient's affectively alive, subjective self through the use of the therapist's own experience.

Bordin also emphasized that the repair and working through of strains or ruptures in the alliance was crucial to the process of change (1979, 1994). While analytically-

oriented clinicians had been writing about and working with transference, defense, and alliance phenomena for many years. Bordin's transtheoretical language enabled psychotherapy researchers to begin testing these concepts empirically. Research on the therapeutic alliance has consistently confirmed the centrality of the alliance construct and its predictive value in the overall outcome of therapy, as well as in the ongoing process of therapy. To date, one of the most robust findings remains the relationship between the patient's rating of the alliance early in therapy and overall treatment outcome. This has been validated in dozens of research studies across different types of therapies of varying treatment lengths. A review of the research literature on the assessment of difficult therapeutic relationships follows.

Assessing Difficult Relationships: A Review of the Research Literature

Gradually, focus has been shifting towards the systematic study of therapeutic misalliance and the dimensions which predict problematic patient-therapist relationships and poor overall outcome, as a means to more fully understanding mechanisms of the change process. The systematic assessment of difficult therapeutic relationships has been approached from a number of perspectives. For example, psychotherapy process studies have examined specific events within treatments where alliances were disrupted (e.g., alliance ruptures). They have, as well, compared more globally the quality of alliance and interpersonal behavior across differential outcome groups (e.g., good vs. poor treatment outcome, and premature termination) in determining which patient-therapist dyads constitute a suitable match. However, patients who prematurely terminated from treatment are surprisingly under represented as subjects in process-outcome studies, even

though they account for an average of about 47% (Wierzbicki & Pekarik, 1993) of the patient population in short-term therapy projects and can range as high as 67% (Sledge, Moras, Hartley, & Levine, 1990). Furthermore, attrition rates have been found to be comparatively higher in patients diagnosed with personality disorders (Persons, Burns, & Perloff, 1988). As Bordin (1979) has suggested, severe alliance ruptures could result in premature and unilateral termination by the patient. Therefore, it would be expected that premature dropout cases would be characterized by more extreme ruptures and generally more problematic alliances than cases defined as resulting in poor overall outcome who did nonetheless complete treatment. Dropout cases may provide an additional context within which to identify and study features of problematic therapeutic relationships. Paradoxically, it is the patients who have the greatest difficulty in establishing relationships with others and in taking responsibility for their lives who are most in need of therapy, but who seem to benefit the least from it (Luborsky, 1976). Hartley and Strupp (1983) conclude that the efficacy of any therapy (to which I would add, and any individual therap*ist*) is ultimately determined by the degree to which these "difficult" cases are helped (see also Strupp & Hadley, 1977; Strupp, Hadley, & Gomes-Schwartz, 1977). At a more practical level, the high rates of patient attrition from brief psychotherapy suggest that a substantial proportion of people seeking outpatient treatment are probably not receiving adequate care.

A new area of research is emerging which has begun to examine categories of adult attachment status and its relationship to clinical diagnosis and psychotherapy outcome. To date, studies have demonstrated a relationship between insecure adult

attachment status and poor outcome in psychotherapy (e.g., Fonagy, 1991; Fonagy, Leigh, Steele, Steele, Kennedy, Matton, Target, & Gerber, 1996). As Fonagy, Steele, Steele, Leigh, Kennedy, Mattoon, & Target (1995) predict, "[t]he AAI may be even more useful in identifying those who are likely to drop out early from treatment" (p. 226). In an earlier research project comparing intensive and nonintensive psychoanalytic treatment, Fonagy & Tallandini (1993) found that all patients who had prematurely terminated were catagorized as preoccupied based on the AAI. Methodologies developed within the attachment literature provide additional, transtheoretical research tools for the study of interpersonal relationships, which may be useful in identifying additional features of the patient-therapist dyad linked to outcome.

The findings of research examining various aspects of therapeutic misalliance and treatment failure in short-term psychotherapy fall generally into categories identifying patient characteristics, therapist interventions, and the interaction of these dimensions with respect to alliance development and overall treatment outcome. The following section of the literature review will cover five research domains which have directly addressed these general areas, each of which contribute to an understanding of the components of difficult therapeutic dyads and their impact on treatment outcome. Broadly defined, the five domains include: (1) premature termination, (2) alliance ruptures, (3) differential treatment outcome, (4) patient-therapist matching, and (5) narrative coherency as developed within the adult attachment literature.

Premature Termination: Failed treatments have been defined in the psychotherapy literature in a multitude of different ways and this lack of consensus has contributed to

conflicting and confusing research findings in the literature. In fact, the defining criteria are least reliable and valid for those patients who terminate therapy prematurely compared to other outcome conditions (e.g., high vs. low change). One reason why dropouts are often not included in psychotherapy process research studies may be due to the variability within this subsample and, hence, to inconsistencies in identifying who they are. Failed treatments have been defined in the psychotherapy literature in a multitude of different ways and this lack of consensus has likely contributed to conflicting and confusing research findings.

Frayn (1992) conceptualized two categories of psychotherapy dropouts. He found that 50% of patients who dropped out of therapy did so within the first month, while the rest of the premature terminators remained in therapy longer but failed to complete the full course of treatment. He observed that an early vs. late pattern of attrition was evident in the NIMH Collaborative Depression Project (Elkin, Shea, Watkins, Imber, Sotsky, Collins, Glass, Pilkonis, Leber, Docherty, Fiester, & Parloff, 1989) in which 44% of the premature terminators left therapy within the first month. Frayn believes that the "early terminators" drop out of therapy within the first month due to lack of motivation and the presence of a "negative transference" which develops "before a significant therapeutic alliance is available" (p.258). Later dropouts, he hypothesizes, are a more heterogeneous group who leave treatment due to a variety of conflictual and environmental reasons. These percentages of early dropouts are consistent with rates reported by Garfield & Bergin (1986) who noted that 50% of dropouts did so prior to the eighth session.

Wierzbicki & Pekarik (1993) conducted a meta-analysis on studies of premature

termination, summarizing studies from January, 1974 to June, 1990, and found that dropout rates differed significantly as a function of the distinct definition used by each of the authors. In general, the definitions fell into three conceptually distinct categories: (1) termination by failure to attend a scheduled session, (2) therapist judgement that the patient terminated before the work was complete, and (3) number of sessions attended. The different categories seem to reflect the fact that this is typically a heterogeneous sample. In other words, people drop out of therapy for a wide variety of reasons. Without a specific and valid definition of premature dropout, it is unclear as to who comprises a given sample of patient dropouts. For instance, a patient who fails to attend a scheduled session may have done so due to a random accident rather than because he or she was unhappy with the therapist. Similarly, a patient who accepts an unexpected job offer in another city early on in the treatment may have been completely satisfied with the therapy, but would be defined as a premature dropout due to the few number of sessions completed. Finally, while the therapist's judgement may be one of the most valid methods of defining patient premature termination, it is also the least reliable, as therapists use very different criteria for making such as assessment (Pekarik, 1983, 1985, 1991).

A second reason for the paucity of empirical studies including dropout samples may have to do with the difficulty in collecting data from these subjects. Patients who feel they are not receiving satisfactory treatment and are considering early termination may be less inclined to spend time completing self-report inventories for the benefit of the study. In support of this supposition, "missing data" was found to be a better predictor than a number of self-report indices in a pilot study which looked at the early identification of

treatment failures in brief psychotherapy (Samstag, Batchelder, Muran, Safran, Bernbach, & Winston, 1995). Lack of overall outcome data may be a factor in the emphasis on pre-treatment variables (e.g., demographic and descriptive data) in the literature on dropouts. In contrast, an "intention-to-treat" model (Gillings & Koch, 1991) applied to psychotherapy research assumes early attrition and incorporates more frequent assessments into the procedure so that regardless of where in the treatment protocol a patient withdraws, comparative data is available and the patient can be included in end point analyses. Measures collected after each session also allow for ongoing assessment of therapeutic process.

Research on premature patient dropout has included assessment of the predictive validity of both pretreatment and in-session predictors of outcome, with a majority of variables studied falling within the former category. In terms of pretreatment variables significantly associated with patient dropout, findings seem to most consistently demonstrate an inverse, albeit weak relationship between dropout and socioeconomic status (Baekeland & Lundwall, 1975; Garfield, 1986). Wierzbicki & Pekarik's meta-analysis (1993) confirmed this statistically. These authors also found that there was a significantly increased risk for dropout among minority patients and patients with low education status. While a few patient demographic variables have been reliably demonstrated to predict dropout, overall, their clinical utility is rather limited. These global indices do not tell us much about the mitigating factors influencing the relationship between patient and therapist, how each of them think about the relationship, and specifically what is going wrong between them. Moreover, they tell us little about what

the therapist might do to increase the likelihood that the patient will stay on course. As a number of researchers have now demonstrated empirically (e.g., Forman & Marmar, 1985; Henry, Schacht, & Strupp, 1986; Henry, Schacht, & Strupp, 1990; Safran, Muran & Samstag, 1994), the type of interpersonal dynamics and processes that develop in the relationship between a particular patient and therapist will depend on their unique interaction.

Studies examining the validity of in-session alliance or process variables within dropout samples represent a small body of literature to date, and those studies that have been conducted present mixed and inconclusive results. Some studies have found that patient ratings of a variety of alliance measures at pretreatment (Mohl, Martinez, Ticknor, Huang, & Cordell, 1991) or early in treatment (Beckham, 1992; Plotnikov, 1990; Tryon & Kane, 1990) significantly predict premature dropout, while others show no relationship between patient and therapist ratings of alliance after the first session and premature termination (Kokotovic & Tracey, 1990). In contrast to their previous findings, Tryon and Kane (1993) found that therapist ratings of alliance were predictive of termination type, while patient ratings were not. The results of these dropout studies are inconsistent with the general finding that patients' assessment of the alliance, as compared to therapists' and third-party observers', is the best predictor of overall outcome (Horvath & Symmonds, 1991). One of the possible reasons for the weak or contrasting findings in this literature may be the methods by which subjects were selected. As Wierzbicki and Pekarik (1993) have recommended, careful operationalization of criteria for defining premature termination is required.

Alliance Ruptures: A second body of theoretical and empirical work which has addressed the issue of problematic therapeutic relationships is the alliance rupture literature. A number of researchers have been focusing simultaneously on the elaboration of aspects of alliance strains or ruptures, approaching the phenomenon from a variety of empirical vantage points. Initial studies were completed by Lansford & Bordin (1983), Forman & Marmar (1985), and Lansford (1986), identifying poor alliance cases and describing the components of repair and related improvements. In general, these studies indicated that certain interventions made by therapists, such as addressing and linking patient defenses and problematic feelings towards the therapist, improved the quality of the alliance.

The work of Safran and his colleagues has involved detailed qualitative and quantitative analysis of interpersonal-experiential therapy sessions, describing distinct rupture types and the processes by which these breaches in the alliance are resolved with the therapist (Safran & Segal, 1990). A rupture is defined as an indication of strain or deterioration in the quality of the therapeutic relationship and it is considered to be a crucial moment in treatment where the patient's maladaptive "working model" or "interpersonal schema" can be explored, understood, and changed. These authors have identified patient "interpersonal markers" which lead to either "withdrawal ruptures", "confrontation ruptures", or admixtures of the two (Safran, Crocker, McMain, & Murray, 1990). The model of rupture and repair has evolved over the past decade and is described in three stages of "rational-empirical" validation research (Safran & Muran, 1996; Safran, Muran, & Samstag, 1994).

Safran and his colleagues have used a number of observer-rated measures of therapeutic process and content, as well as patient- and therapist-rated scales of alliance and interpersonal behavior, to track shifts in the sequence of patients and therapist behavior which lead to disconfirmation of patients' maladaptive interpersonal schemas. The models generally describe patients as initially responding in a defensive way (i.e., the rupture marker). This is directly followed by the therapist's focus on that moment through friendly and supportive inquiry, empathic reflection, or self-disclosure (e.g., "I am aware that you stopped talking after I made that interpretation. What just happened there?"), and then encouragement of the patient's exploration of their own experience, the fears which serve to block or interfere with the exploration of the rupture experience, including their assumptions about the response expected from the therapist. Finally, the therapist encourages expression of the underlying wish (e.g., "I need your help"). Therapists who responded to patient rupture markers with hostility or criticism did not evidence later components of the model. The links between patient and therapist behaviors were statistically confirmed using a number of patients and therapists, over different phases of short-term therapies (Safran & Muran, 1996).

Another approach was undertaken by Rhodes, Hill, Thompson, & Elliott (1994), who assessed subjects' retrospective reports of moments when they felt misunderstood by their therapist and how these events were either resolved or not. Unlike Safran et al. (1994, 1996) who systematically studied the components of rupture events and their repair *within* individual therapy sessions, Rhodes and colleagues included experiences of misunderstanding events and their development in a naturalistic design, which included

experiences occurring *across* a number of sessions following a misunderstanding event. In this way, the authors attempted to capture a more general, distinctive process which developed in the relationship between patient and therapist as the result of a significant disruption in the alliance.

Subjects (made up of psychologists and graduate students in clinical and counseling programs) completed the Retrospective Misunderstanding Event Questionnaire, where they were asked to describe the details of a misunderstanding event in their personal psychotherapy. Responses were categorized by raters into resolved and unresolved groups. The authors defined "resolution" as "client perception of a satisfactory outcome such that the client felt able to continue the work of therapy" (Rhodes, et al., 1994, p. 475). The event did not necessarily have to be discussed with the therapist and the evaluation was to be made independently of overall treatment outcome. In contrast, unresolved misunderstanding events were defined as "unsatisfactory outcomes to events such that [subjects] experienced a hindrance in their communication with their therapists" (p. 475). The authors conclude that the subject's assertion of negative feelings toward the therapist, and corresponding non-rigid, accepting reactions of the therapist were descriptive of resolved misunderstanding events; whereas unresolved events and generally poor therapeutic relationships were defined both by the therapist's seeming unawareness of the subject's negative feelings, and an inability of the therapist to accept and work with negative assertions when they were expressed.

The different methodologies employed in the studies summarized in this section either focused on therapist interventions or on the patient's working model or schema, and

they resulted in similar, although not identical resolution models, which provides some validation for the construct. However, the inconsistent definition and operationalization of alliance ruptures, similar to that of premature terminators, makes the comparison of these research findings difficult. In addition, studies in this area have not always directly related alliance ruptures and repair cycles to overall outcome.

Interpersonal Process and Treatment Outcome: Similar to the alliance rupture research, designs which contrast therapeutic process between "good" and "poor" overall treatment outcome cases allow for fine-grained analysis of patient and therapist contributions. As mentioned above, the methodological hurdles within the alliance rupture literature have been the operationalization of the construct and it's relationship to overall outcome. What are the specific features of therapeutic relationships related to patient degree of change or lack of change? Since different patient-therapist dyads play out subtly distinctive interpersonal dances, which also vary greatly in terms of intensity, their components have proven difficult to generalize and, therefore, to study in traditional, large sample research designs. Studies which have compared processes among cases with differential treatment outcome help to elucidate some of the features of more and less effective therapeutic interventions by including overall outcome as a variable.

The theory of interpersonal complementarity has been applied to psychotherapy research and provides a way to operationalize and assess the development of the manifest relationship between patient and therapist. As Keisler & Watkins (1989) state:

> Interpersonal complementarity addresses a component of the patient-therapist relationship, distinct from the therapeutic alliance, consisting of the degree of fit of the interpersonal transactions between patient

> and therapist. In contrast to the working alliance that conceptualizes the conscious and realistic relationship, interpersonal complementarity emphasizes the automatic and distorted relationship resulting primarily, but not exclusively, from the patient's rigid and extreme parataxic distortions (p. 183).

Sullivan's interpersonal theory (1953, 1954, 1962) has been elaborated into a number of empirically validated models used to assess interpersonal behavior on two orthogonal dimensions - affiliation (on the horizontal axis) and control (on the vertical axis) - which form an interpersonal circle or circumplex (see Figure 1). The ongoing negotiation between the amount of friendliness or hostility, and the amount of control or submission in the circumplex space, are assumed to be central elements in the interaction of individuals in relationships. Individuals reinforce each other's behavior and self-presentation in terms of both affiliation and control. Starting with Leary and his colleagues (Leary, 1957; Freedman, Leary, & Coffey, 1951), who introduced the notion of interpersonal complementarity, and Carson (1969) who extended Leary's work to included the organization of interpersonal behavior around four main quadrants of the interpersonal circle (friendly dominance, friendly submission, hostile dominance, and hostile submission) (see Figure 2), variations of the circumplex model have provided reliable means of assessing the interaction of behavior between patients and therapists.

A number of concepts derived from interpersonal theory are worthy of definition here (see Table 1 for a summary). In general, complementarity is defined as an interpersonal context in which two individuals engage in a back and forth cycle where each elicits or "pulls" for certain predictable behaviors from one another, which confirm

the individual's self-experience. Reciprocity and correspondence are two components of complementarity: *reciprocity* occurs on the control axis (dominance edicts submission, and submission elicits dominance) and *correspondence* occurs on the affiliation dimension (friendliness elicits friendliness and hostility edicts hostility). Combining the two axes, an example of a complementary transaction would include friendly-dominance followed by friendly submission. The case where an individual's response is complementary on one axis but not the other is called *acomplementarity* (e.g., friendly-dominance followed by friendly-dominance), and when not complementary of either axis, is called *anticomplementarity* (e.g., friendly-dominance followed by hostile-dominance).

Broadly defined, there are two opposite perspectives regarding the role of interpersonal complementarity and outcome in psychotherapy. One perspective suggests that disconfirming or noncomplementary therapist responses to that which is evoked by patients leads to positive, clinical change, while the second hypothesizes that therapists who behave in ways which reinforce and confirm the way patients have been responded to by others will effect good therapeutic outcome (Dietzel & Abeles, 1975). Orford (1986) reviewed 14 studies incorporating methodologies from four of the major interpersonal theories (Carson, 1969; Kiesler, 1983; Leary, 1957; Wiggins, 1982), but not including Benjamin (1974, 1979), for empirical evidence of the construct of interpersonal complementarity. He found that complementarity was supported for predictions of friendly-dominant and friendly-submissive behaviors only, and that the status of the respondents in relation to each other made a difference to the type of complementarity evidenced. The more "resources" or "responsibility" an individual has for producing a

friendly-dominant response (e.g., as in a therapist responding to a patient, or a parent to a child), the greater the likelihood that a friendly-dominant response will occur to *any* elicitation. For example, friendly-dominant behavior in response to hostile-dominance is anticomplementary (i.e., not complementary on either axis): a hostile-submissive act is predicted by the theory of complementarity. While anticomplementary behavior was found to be relatively infrequent, Orford's review included studies whose sample covered a range of subjects (e.g., families, children and patents, and patient and therapists) and it may be that there is a difference among the relatively higher status roles in the frequency of noncomplementary responses, for instance, between parents and therapists. Other common results not predicted by complementarity theory include evidence of hostile-dominant acts followed by more hostile-dominance, and hostile-submission met by friendly-dominance. Orford suggests that in addition to status differentials between respondents, research studies need to address the influence of setting or context. The difficult therapeutic dyad, such as in cases of premature patient termination, is one such context which has not be examined in terms of interpersonal complementarity.

Strupp and his colleagues at Vanderbilt University have been conducting psychotherapy process-outcome research over the past four decades, often focusing on the nature of the therapist's role in treatment, and emphasizing the distinctive processes of failure in psychotherapy using constructs such as therapeutic alliance and interpersonal complimentarity (Strupp, 1960; Strupp, 1993; Strupp & Binder, 1984). The Vanderbilt I Project compared the effectiveness of trained, professional clinicians to lay counselors (university professors recommended for their teaching abilities) with respect to

psychotherapy outcome in a sample of young, male university students in time limited therapy.

The Vanderbilt II Project (reported in Strupp, 1993; Henry, Strupp, Butler, Schacht, & Binder, 1993; and Henry, Schacht, Strupp, Butler, & Binder, 1993) was designed to compare the impact of training on therapist effectiveness. In an initial phase of this project, Henry et al. (1986) identified a cohort of four therapists who treated both one patient defined as having good outcome (i.e., high-change) and one as having poor outcome (i.e., low-change). The first 15 minutes of the third therapy session were rated by third party observers using the Structural Analysis of Social Behavior (SASB; Benjamin, Giat, & Estroff, 1981). The good and poor outcome dyads were compared with respect to interpersonal process variables reflecting interrelationships of affiliation and interdependence on the SASB, which includes the concept of interpersonal complimentarity. Complementarity is defined here as reciprocity on the interdependence dimension of the model (e.g., control evoking submission) and correspondence on the affiliation dimension (e.g., friendliness evoking friendliness). Henry et al. (1986) expanded upon the traditional definition of complementarity by dividing scores into positive and negative complementarity. Overall, results demonstrated a significant relationship between disaffiliative interpersonal behaviors and outcome where therapists in the poor outcome dyads exerted more hostile interpersonal control and less friendly autonomy towards their patients, who themselves responded in complementary ways with a greater frequency of hostile separation and less friendly, autonomy-taking behavior. A pattern of more frequent complex communications (defined as a speech utterance conveying more

than one interpersonal message) was found in the poor outcome cases, although this finding was not statistically significant due to the small sample size. Here, Henry and colleagues directly demonstrate the important relationship of interpersonal process to change in psychotherapy and that "the same therapist, using similar techniques with similar patients, nonetheless might exhibit markedly different interpersonal behaviors in low-change cases as compared to high change cases" (Henry et al., 1986, p. 30). This clearly contradicts the "uniformity myth of therapists" (Keisler, 1966) which considers clinicians in psychotherapy research studies to be interchangeable entities.

In a second study by the same authors, Henry, Schacht, & Strupp (1990) explored the mechanism by which differences they found in interpersonal behaviors between patients and therapists effected overall outcome change. They hypothesized that internal personality structures or "introjects" would direct interpersonal behavior in a way that confirmed one's sense of self, which is a basic tenant of interpersonal theory (Sullivan, 1953). Therefore, hostile introjects, incorporating self-concepts which are critical, neglectful, or destructive, were assumed to mediate hostile and maladaptive patterns of interpersonal relationships, whereas affiliative introjects reflecting generally accepting, helping, and nurturing treatment of the self, would effect friendly interactions with others. Therapists rated their own self-concepts using the INTREX Introject Questionnaire (Benjamin, 1983) and two trained clinical psychologists rated the first 30 minutes of session three for SASB interpersonal process variables. Fourteen therapeutic dyads were divided into equal numbers of good and poor patient outcome cases. Comparing these two groups, the hypothesized link between quality of therapist self-concept and observed

interpersonal behavior was confirmed. The results showed that hostile therapist introjects (defined as ratings of self-concept) were significantly related to hostile interpersonal behavior and were characteristic of poor outcome dyads. The Henry et al. studies (1986, 1990) identify additional components of problematic alliances, as well as validate ratings of the early therapeutic relationship in predicting differential treatment outcome by defining the therapist's contributions to the relationship as a technique of therapy and potential mechanism of change.

To my knowledge, only two previously published studies of brief psychotherapy (Hartley & Strupp, 1983; Najavits & Strupp, 1994) have examined interpersonal process across the continuum of outcome possibilities: in other words, comparing dropout, poor outcome and good outcome cases within the same design. As part of the Vanderbilt I study, Hartley & Strupp (1983) examined therapeutic alliance in a sample of male college students in a 25-session protocol. The subjects were divided into high outcome, low outcome, and premature termination groups depending on their status at the end of treatment. High or low outcome was determined by a composite score including patient, therapist, and observer ratings of pre and post treatment assessment measures; premature termination was defined as the completion of no more than five therapy sessions. These authors were not able to statistically predict premature termination based on observer ratings of alliance. However, they noticed different patterns of alliance development among the three conditions. Specifically, the mean alliance scores for the dropout group increased in later sessions compared to the two completed treatment groups, which showed a decrease in mean ratings. The dropout patients were observed "to be slightly

less involved in the therapy" (Hartley & Strupp, 1983, p. 31) which may have served to increase their therapist's level of engagement in the process and accounted for the increase in the mean alliance rating for this condition. Hartley and Strupp note that the small sample of six dropout subjects may have accounted for the nonsignificant findings, as well as confounding "external" reasons why subjects terminated therapy prematurely

The second study (Najavits & Strupp, 1994) was part of the Vanderbilt II Project which examined therapist effectiveness before, during, and after psychodynamic training. Najavits & Strupp included patient "length of stay" in treatment as an outcome variable, in addition to a composite index of patient symptom change. This study looked at a much larger sample of outpatient psychotherapy subjects (N=80 patients and N=16 therapists) and found that 25% of the correlations between length of stay and in-session ratings of therapist behavior were significant, compared to only 6% of the correlations between outcome (i.e., the composite index) and therapist in-session behavior. The authors also found that therapists defined as "more effective" demonstrated more positive behaviors in session, such as warmth, understanding, and helping and showed less negative behaviors, such as belittling, ignoring, and attacking compared to the "less effective" group. Furthermore, more effective therapists had no patients terminate prematurely (defined here as dropping out prior to session 16), while a minimum of two of the five patients of the less effective therapists prematurely terminated. Thus, therapist in-session behavior was demonstrated to be a significant factor in predicting which patients prematurely dropped out of treatment. Overall, "significant results were almost entirely relationship oriented" (p. 114).

A preliminary study conducted by Samstag, Batchelder, Muran, Safran, & Winston (1998) also compared self-reported alliance and interpersonal behavior ratings of early session among dropouts, good and poor outcome cases. Using a more comprehensive definition of patient dropout, these authors found that both patients and therapist self-report ratings of the working alliance and interpersonal complementarity statistically distinguished the three outcome groups, but that different variables were significant for each rater. For instance, the lowest alliance scores were found in the dropout condition compared to the poor outcome and good outcome conditions, respectively, from both patient and therapist perspectives. Differences in perspective were demonstrated for measures of interpersonal complementarity, where therapist ratings of patient hostility and patient ratings of therapist friendliness predicted dropout.

The findings of this study are considered important for two reasons: first, they suggest a valid means of identifying a certain type of difficult patient-therapist dyad which can be distinguished from more successful therapeutic relationships; and second, they point to differences in the way patients and therapists conceptualize the therapeutic relationship and the mutative features of it. Early prediction of potential treatment failures in psychotherapy is critical in advancing understanding of potential mechanisms of change and improving therapeutic technique.

Patient-Therapist Matching: A domain of clinical and research literature which examines therapeutic relationships from yet another vantage point is known as patient-therapist matching. Here, parameters of interpersonal compatibility are identified in an effort to optimize the pairing of patients and therapists and improve delivery of mental

health services. An assumption held within this perspective is that features of both patients and therapists contribute to causality, although different therapeutic approaches emphasize patient and therapist characteristics to varying degrees (see Berzins, 1977). For example, the humanistic schools focus on personal qualities of the therapist (e.g., warmth and empathy) while placing less of an emphasis on patient characteristics. In contrast, analytically-oriented treatments consider the patient's level of "treatability" to be one of the key factors predicting successful outcome. Certain therapies, such as behavioral treatments for phobias, consider the role of the specific technique (e.g., flooding vs systematic desensitization), rather than the quality of the therapeutic relationship, to be key in the facilitation of treatment success. A number of the studies reviewed above, particularly the work of Safran et al. (1994, 1996) in the Alliance Rupture section, and research by Strupp and colleagues (Hartley & Strupp, 1983 ; Henry et al., 1986, 1990; Najavits & Strupp, 1994) in the Differential Treatment Outcome section, could also be defined as matching studies.

The notion of an ideal patient-therapist match is just that: an ideal, a theoretical construct. Writing from a psychoanalytic perspective, Kantrowitz (1992, 1993, 1995) describes the often very subtle ways in which both participants in the therapeutic dyad are shaped by their unique interaction, and suggests that the extent to which the patient is able to change is "dependent on the nature of the particular patient-analyst match and the extent to which the analyst is aware of and responsive to his or her impact on the patient" (1993, p. 894). She emphasizes the centrality of the analyst's character in the development of each therapeutic relationship and how addressing aspects of the analyst's

character can be an important mechanism of psychological change for the patient. The assumption here is that a unique therapeutic experience is *created* with every analyst-patient match. This extends the concept of therapeutic alliance in that it positions the therapist or analyst squarely in the center of the relational matrix: the role of the therapist is to be aware of shifts in patient reactions and experiences as resulting from the *interaction* with them. The analyst must be attuned to areas of "sameness" and "difference" with each patient. While that which may be facilitating for one patient may be problematic for another, in general, Kantrowitz defined a facilitating or "compensatory" match as one where a patient is able to identify with some aspect of the analyst's character, or have a deficit compensated for, or disconfirmed by, some quality in the analyst. A match is defined as impeding when the analyst demonstrates a "blind spot" which prevents a shared problem from being recognized and explored with the patient.

Certainly in many clinic settings, where there are patients presenting with heterogeneous demographic and diagnostic profiles and a limited number of therapists with scheduling constraints, therapists are often matched with patients with whom they have difficulty working. A number of studies described earlier have compared good and poor outcome cases from the same therapist, demonstrating that therapists respond differently depending on the particular patient (Forman & Marmar, 1985; Henry et al., 1986; Henry et al., 1990). Under what interpersonal conditions do therapists' skills wax and wane? Patients often resolve therapeutic impasses by terminating treatment: therapists, on the other hand, particularly when attempting to adhere to the manualized treatments used in many research settings, may become stuck in repeating particular

interventions rather than focusing on the interpersonal process which has developed as the result of ineffectiveness of the interventions. Hartley & Strupp (1983) describe a similar phenomenon where therapists of the less motivated and more defensive patients in their dropout group were observed to "compensate" for the patients' lack of involvement by increasing their involvement in the sessions just prior to the patient terminating treatment. "Mismatched" patient-therapist dyads are another way of conceptualizing difficult or unproductive therapeutic relationships.

The literature on patient-therapist matching is broadly defined within two areas of research which attempt to identify pairs or interactions of variables from patient-therapist dyads related to outcome in psychotherapy. This goes a step beyond comparing independent patient and therapist qualities that each member of the dyad brings into treatment. Symmetrical matching variables are those where both patient and therapist are assessed on the same measure or characteristic. In this way, the degree of similarity and difference can be ascertained. Variables which have been extensively researched include demographic characteristics (e.g., age, gender, ethnicity, and socio-economic status); attitudes, values, and beliefs; personality styles; prior experiences; and compatibility of goals. While the degree of similarity with respect to age (Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983), gender (Blase, 1979; Jones, Krupnick, & Kerig, 1987), ethnicity (Jones, 1978) and socio-economic status (Carkhuff & Pierce, 1967) have been found to contribute to positive patient perceptions of the therapeutic relationship, similarity with respect to gender and ethnic background seem most strongly associated with patient's experience of being understood and liked by their therapists (Beutler,

Clarkin, Crago, & Bergan, 1991). The patient's subjective experience of being understood may come, in part, from the ability to first identify with his or her therapist on visible features such as gender and ethnicity, which contributes to a positive working alliance. The focus of this research proposal is on the asymmetrical, interpersonal features of patient-therapist interactions.

Asymmetrical matching variables are those which are different for patients and therapists. Here the assumption is that certain characteristics or features are weighted differently, some relevant for patients and some relevant for therapists. Most of the research which has examined the interaction of asymmetrical variables includes studies of the efficacy of particular therapeutic techniques for particular patient populations or diagnostic categories (e.g., National Institute of Mental Health's collaborative study on treatment of depression (Elkin et al., 1989), which emphasized treatment technique as opposed to therapist effectiveness. However, two review papers of treatment outcome studies have found significant "therapist effects" to be greater than "treatment effects" (Luborsky, Crits-Christoph, McLellan, Woody, Piper, Liberman, Imber, & Pilkonis, 1986; Crits-Christoph, Baranackie, Kurcias, Beck, Carroll, Perry, Luborsky, McLellan, Woody, Thompson, Gallagher, & Zitrin, 1991). Other studies of asymmetrical variables include the effects of matching therapist and patient interpersonal and intrapsychic styles. Studies of patient-therapist matching on asymmetrical variables have provided the basis for a now well-established body of literature employing interpersonal or circumplex models.

A further development in the circumplex model came from Benjamin (1974, 1982, 1984) who designed a system comprised of three domains or surfaces (two interpersonal

and one intrapsychic) compared to the single domain of other models. Benjamin's structural analysis of social behavior (SASB) grew out of studies of family process and has been used extensively by psychotherapy researchers over the past two decades. The SASB has been described as "the most detailed, conceptually rigorous, and empirically validated of current models" (Henry et al., 1986, p. 27). The model will be further elaborated in the Method section below.

In addition to studies which have specifically outlined the unique roles patients and therapists play in the repairing of alliance ruptures or in the therapeutic relationship of good compared to poor outcome cases, a re-analysis of the Vanderbilt II study by Talley, Strupp, & Morey (1990) found an interaction effect regarding the match between patient and therapist ratings of self-concept or introject in terms of the affiliation dimension. Patients who rated themselves as more affiliative were found to have better overall outcome when their therapists' self-ratings matched theirs (i.e., were also affiliative), whereas therapist's degree of self-affiliation had little effect on outcome for patients with more hostile introjects. These authors make an assumption that high self-affiliation scores are an indication of "better self-adjustment", and that the better adjusted patients demonstrated greater gains when their therapists were also better adjusted. In contrast, the more poorly adjusted patients (with hostile introjects) were less influenced by the level of therapist self-adjustment. Talley et al. (1990) note that their interpretation of these findings is consistent with the results of the Vanderbilt I study reported by Strupp (1980a, 1980b, 1980c, 1980d). In Vanderbilt I, the less disturbed patients showed more improvement in therapy when they were treated by experienced clinicians compared to lay

counselors. This finding was reversed with the more disturbed patients, who made comparatively less progress regardless of the skill of the therapist. In other words, "when therapists were working with more disturbed patients, skilled therapeutic interventions failed to be executed or, despite being executed, were ineffective in bringing about significant change" (Talley, et al., 1990, p.186).

A second finding in the Talley et al (1990) study regarded the influence of patients' and therapists' interpersonal needs on the process of therapy. Anticomplementarity (defined here as interactions which disrupt one's self-concept) was measured by the distance between ratings on self-concept and/or ratings on dimension of self-behavior and other behavior. They hypothesized that the greater the distance between self-concept and analogous interpersonal behaviors, the poorer the patient's outcome. With anticomplementarity operationalized in this way, Talley et al, (1990) found that therapists and patient demonstrated opposite trends. In general, interpersonal theory proposes that the greater the degree of anticomplementarity or discrepancy between one's behavior and one's self-concept, the greater the possibility of that self-concept being disrupted. For patients in this study, it was found that the greater the discrepancy between their introject and therapist behavior ratings, the better the outcome: for therapists, the greater the discrepancy between their introject and patient behavior ratings, the poorer the patient outcome. The authors conclude that therapists seem to be less effective when their self-concepts are disrupted by incongruent patient behaviors, while for patients, disruption of self-concept by anticomplementary therapist behaviors is a therapeutic experience required for ultimate change (see Benjamin, 1992; Carson, 1969).

Alliance and narrative competency: The literature on narrative competency, specifically as developed in adult attachment theory, is an additional conceptual domain included in this study. Research in adult attachment is another area in which a methodology for studying interpersonal relationships has been validated and may prove useful in understanding dynamics within therapeutic relationships. There are two main reasons why aspects of attachment theory are relevant to a study of difficult dyads and failed treatments in short-term psychotherapy. First, a number of studies have been conducted which link insecure adult attachment categories to personality disorders and poor overall psychotherapy outcome (Dozier, 1990; Fonagy, 1991; Fonagy et al., 1996; Fonagy et al., 1995). Second, there is a relationship between the basic tenants of attachment theory, which stems from Bowlby's observations of children who had been separated from their parents (Bowlby, 1969, 1973, 1980), and what has been described as a consistent theme in psychotherapy of coping with loss (Wolff, 1971). Loss, endings, and separation have been described as playing a particularly important role in short-term therapies where the end of treatment is a focus of the work from the outset (Mann, 1973).

A specific aspect of adult attachment assessment which is considered to be a central component of insecure attachment status is incoherency rated either throughout the verbatim narrative of the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1996), or specifically during description of potentially traumatic experiences (Main, 1991; Main & Goldwyn, unpublished manuscript). Coherency is defined as: (1) adherence to Grice's (1975) four "maxims" of coherent discourse (i.e., manner, quality, quantity, and relevance); (2) the ability to monitor one's own cognitive functioning bearing in mind the

state of mind of the listener (e.g., thinking about thinking); and (3) overall plausibility of narrative (George, et al., 1996). The interview assesses the subject's current state of mind in terms of attachment, which "is classified as secure-autonomous when - whether life history appears favorable or unfavorable - the presentation and evaluation of experiences is internally consistent, and responses are clear, relevant, and reasonably succinct" (Main, 1996; p. 240). Incoherent narratives indicate loosely structured, multiple models of attachment relationships. Main (1991) also found that ten and eleven-year-old boys classified as insecurely attached had less coherent stories, had less access to early memories, and showed a reduced capacity to monitor their own thinking processes, defined as "metacognitive monitoring", compared to the securely attached boys.

Main (1991) expands upon Bowlby's conception of the multiple internal working model attachment. Whereas Bowlby's definition comprised two "incompatible" mental representations of an attachment figure existing concurrently (e.g., as in the case of an abusing parent who is thought of as both a care-giving figure and an attacking one), Main's hypothesis is that multiple models contain "conflicting propositions". She defines two components of propositions:

> a propositional attitude (believing, hoping, wanting, fearing, desiring) and a related content (that my attachment figure will respond positively to me when I approach her, that my attachment figure dislikes me, etc.). "Multiple models" of attachment-related events would then be described as conflicting propositions such as, e.g., 'I believe that my mother is unfailingly loving and has always acted in my best interest/I believe that mother is ridiculing and rejecting and does not consider my interests' (an example of conflicting *contents*), or, 'I fear that father will leave this family/I hope that father will leave this family (an example of conflicting propositional *attitudes*) (Main, 1991, p. 133).

This distinction is important in that it identifies an area of cognitive functioning that mediates the development of secure attachment status. Main (1991) goes on to state that:

> The consideration of multiple models of attachment leads directly to the topic of metacognition, since it is likely that where multiple contradictory models of the self or of experience exist, either metacognitive knowledge has yet to develop or there have been failures of corrective metacognitive monitoring (p. 134).

Fonagy's conceptualization of "self-reflective function" is yet a further elaboration of metacognitive capabilities. He and his colleagues have attempted to operationalize components of Main's (1991) metacognitive abilities in adults as a means to explain the generational transmission of security from mother to child (Fonagy et al., 1995). His research has also demonstrated relationships between deficits in self-reflective function, insecure attachment, and borderline psychopathology (Fonagy, 1989; Fonagy, 1991).

The creation of an autobiographical narrative between a patient and therapist, including both the patient's historical past and the history of the therapeutic relationship, has been defined as a central feature of most therapies (Spence, 1982; Schafer, 1976) and as Holmes proposes (1993a), discourse in psychotherapy may be evaluated by the criterion of coherency with "autobiographic competence" as a marker of secure attachment.

Summary

The theoretical and research literature reviewed in this proposal strongly supports the study of difficult therapeutic dyads in order to further understand the features of mismatched patients-therapist pairs and to more precisely predict those patients who will prematurely terminate therapy or go on to have poor overall outcome. Theorists drawn

from analytic, object-relational, interpersonal, and self-psychology schools have emphasized the clinical importance of therapists working with inevitable alliance ruptures to effect therapeutic change. A paradigmatic shift from a classical, one-person theory of change to a two-person, relational model repositions the clinician as a co-creator of a real relationship with the patient, which could have the effect of influencing the patient's self-concept and self-expression.

Psychotherapy research has demonstrated empirical evidence of the direct relationship between measures of therapeutic alliance and overall outcome, and for the kinds of interpersonal behaviors that contribute to the development of therapeutic relationships resulting in good or poor treatment outcomes. The operationalization of the therapeutic relationship, and particularly the difficulties that arise in its formation, include study of alliance ruptures, interpersonal components of patient-therapist matches, differential treatment outcome, and premature dropouts. The concept of narrative coherency, developed within the attachment literature, is introduced in this research proposal as an additional domain which may help to define an aspect of therapeutic misalliance in the developing relationship between patients and therapists. Difficult therapeutic relationships provide an important clinical phenomenon for the examination of the mechanisms of psychological change.

General Hypotheses

The purpose of the current study was to examine the predictive validity of a number of early, in-session indices of therapeutic alliance, interpersonal behavior, and narrative coherency in a sample comparing two distinct types of treatment failure

conditions, defined as Dropout (DO) and Poor Outcome (PO), and a Good Outcome condition, from patient, therapist, and observer perspectives. In general, the DO dyads were hypothesized to have more problematic therapeutic relationships than the PO, and GO dyads, respectively. Both significance levels and effect sizes are reported in the Results section. Effect sizes, defined as the strength of the results or effects, were included as a statistic due to the limits of the proposed study's sample size in providing the statistical power required to find significant results (Cohen, 1990; Paquin, 1983; Rosnow & Rosenthal, 1989). The specific hypotheses and research questions, grouped by the independent variables used in the study, are as follows:

A. Descriptive Variables

Even though the emphasis in this study was on the therapeutic dyad, comparisons of patient and therapist descriptive data were analyzed in order to rule out these variables as possible factors contributing to any differences found among outcome groups. It is hypothesized that for patients there will be no significant differences on variables such as diagnostic category, age, marital status, gender, race, education, and employment status. It is also hypothesized that for therapists there will be no significant differences on variables such as degree, age, and years of clinical experience.

Question: Is there a greater occurrence of significant early loss for patients in the two treatment failure groups (e.g., DO and PO)? Attachment theory predicts that unresolved early losses are reflected in the incoherent narrative around those traumatic experiences. However, it is not clear if perhaps all patients seeking time-limited psychotherapy might have a higher frequency of early loss compared to those interested in

open-ended treatment, for example, or compared to non-patients. These latter comparisons are obviously beyond the scope of this study.

B. Working Alliance Inventory

1) The DO cases will have considerably poorer therapeutic alliance scores compared to the PO and GO cases, as measured from both patient and therapist perspectives.

2) The PO cases will have considerably poorer therapeutic alliance scores than the GO cases, but because patients have been demonstrated to be more sensitive in their ratings of alliance, patient scores will better discriminate PO from GO groups compared to therapist ratings.

C. Narrative Coherency

1) The DO dyads will have a significantly lower narrative coherency rating overall, compared to the ratings of the PO and GO groups.

2) The PO dyads will have a significantly lower narrative coherency rating overall, compared to the ratings of the GO group.

3) Narrative Coherency scores will be (a) highly positively correlated with patient and therapist Cluster scores falling on the positive side of the circumplex, (b) highly negatively correlated with Cluster scores falling on the negative side of the model, (c) highly positively correlated with Positive Complementarity scores, (d) highly negatively correlated with Negative Complementarity scores, and (e) highly negatively correlated with Complex Communications scores as measured by the SASB.

4) Narrative Coherency scores will be positively correlated with both patient and

therapist ratings of therapeutic alliance.

Question: Is Narrative Coherency correlated with SASB Neutral Complementarity? The Neutral Complementarity score was developed for this study and it is not clear how it will relate to psychotherapy process and overall outcome, if at all.

D SASB

1) Patients and therapists in the DO group will show (a) considerably more hostile and (b) considerably less affiliative interpersonal behaviors (called Cluster scores), compared to patients and therapists in the PO and GO groups.

2) Patients and therapists in the PO group will show (a) considerably more hostile and (b) considerably less affiliative interpersonal behaviors, compared to patients and therapists in the GO group.

3) Patients will demonstrate considerably more Complex Communications in the DO group compared to the PO and GO groups.

4) Patients will demonstrate considerably more Complex Communications in the PO group compared to the GO group.

5) DO dyads will have (a) considerably higher scores of Negative Complementarity and (b) lower scores of Positive Complementarity compared to the PO and GO dyads.

6) PO dyads will have (a) considerably higher scores of Negative Complementarity and (b) lower scores of Positive Complementarity compared to the GO dyads.

Question: This study included neutral Cluster scores and Neutral Complementarity scores (i.e., interpersonal behaviors scored on the interdependence axis which are considered neutral with respect to either friendliness or hostility) as a variable. No clear

hypotheses are predicted with this variable. Instead, a research question is posed: are there differences among the three outcome groups with respect to neutral Cluster scores and Neutral Complementarity?

Chapter III. Method

Design

This study used data from a larger research project at Beth Israel Medical Center's Brief Psychotherapy Research Program in New York City. The program, which began in the early 1980's, serves as a center for process-outcome research in the treatment of individuals with long-standing character pathology, and for clinical training in a number of time-limited psychotherapies (McCullough & Winston, 1991). Cases used in the current research participated in the program between 1990 and 1995.

Patients were recruited for the Brief Psychotherapy Program primarily through advertisements in local newspapers, and by referrals made from mental health professionals and patients who have participated in previous studies. General inclusion and exclusion criteria for patients were as follows: (1) age between 18 and 60 years, (2) evidence of at least one close personal relationship (including previous therapy), (3) no evidence of mental retardation, organic brain syndrome, or psychosis, (4) no DSM-III-R (Diagnostic and Statistical Manual for the DSM, Revised, 1987) axis II diagnosis of paranoid, schizoid, schizotypal, narcissistic, or borderline personality disorder (although some exceptions were made regarding inclusion of these diagnoses when there was evidence that the patient was able to form a positive therapeutic alliance, presented with a circumscribed treatment issue, and it was thought the patient might benefit from a time-limited approach), (5) no DSM-III-R axis III medical diagnosis, (6) no evidence of current or recent substance abuse, (7) no history of destructive impulse control problems or active suicidal behavior, (8) no current or recent use of psychotropic medication such as

neuroleptics or lithium, and (9) no concurrent participation in other forms of psychotherapy. Patients provided informed consent to the research protocol (see Appendix A). The Structured Clinical Interview for DSM-III-R (SCID; Spitzer, Williams, & Gibbon, 1987) and the Structured Clinical Interview for DSM-III-R Personality Disorders (SCID-II; Spitzer, Williams, & Gibbon, 1987) were used in formulating diagnoses. Patients also completed self-report interpersonal and symptom measures (see Assessment Instruments section below).

Intake assessment interviews were conducted by clinical psychology graduate students who had undergone extensive training with the instruments. The training included study of the SCID manual and a series of corresponding videotaped interviews, as well as observation of a number of live interviews by skilled diagnosticians (both observing the expert interviewers and being observed by them). A recent reliability study of assessment interviewers on the Project, rating axis I and II diagnostic categories from videotaped interviews, is currently being completed.

Treatments

Patients accepted in the project were randomly assigned to one of five manual-based, 30-session, once-per-week therapies. The treatments included two types of dynamic (Pollack, Flegenheimer, & Winston, 1992; Laikin, Winston, & McCullough, 1992), a cognitive-behavioral (Turner & Muran, 1988), a supportive (Pinsker & Rosenthal, 1988), and a brief relational therapy (Safran & Segal, 1990; Safran & Muran, 1996). A brief description of the main distinguishing features of the different treatments follows, with the reader referred to the citations provided above for further information.

In general, all treatments include a high level of therapist activity.

Brief Adaptive Psychotherapy: The first dynamic therapy (Brief Adaptive Psychotherapy; BAP; Pollack et al., 1992) is based on a psychoanalytic, ego/interpersonal model of character pathology in which character, conflict, and defense are understood as patterns of adaptive or maladaptive behaviors and beliefs. Through clarification, confrontation, and interpretation, distortions in interpersonal maladaptive patterns become increasingly accessible to the patient's ego for reality-testing. Interpersonal material is drawn from patients' past, current, and therapeutic relationships, with a focus placed on the emergence of maladaptive patterns in the transference. The goal of treatment is the integration of wishes, beliefs, needs, and impulses into more adaptive patterns such that the patient receives greater satisfaction from interpersonal relationships.

Short-Term Dynamic Psychotherapy: The second dynamic therapy (Short-term Dynamic Psychotherapy; STDP; Laikin et al., 1992) is defined as a psychoanalytic, drive/conflict model in which the patient's defensive warding off of guilt and grief are thought to produce psychiatric symptoms, including anxiety and interpersonal problems. The therapist in this model actively and repeatedly confronts patient defenses whenever they are evident until conflicted thoughts and feelings emerge and their toxicity reduces. Understanding links between impulses/feelings to anxiety and the patient's defensive structure, as well as deep, affective experiencing in the session are considered to be the main mechanisms of change in this model.

Cognitive-Behavioral Therapy: The Cognitive-Behavioral Therapy (CBT; Turner & Muran, 1988) is derived from an understanding of psychopathology as the development

of cognitive generalizations or self-schemas which guide the processing of intrapersonal and interpersonal information, and which have become maladaptive for an individual in his/her current environment. In treatment, the goal is to provide new learning experiences through a functional analysis of specific problems and strategies to facilitate change (e.g., role-plays, self-monitoring, exposure, and home work assignments). Through processes of accommodation and assimilation, the patient's schemas are thought to develop into more adaptive structures.

Supportive Psychotherapy: A goal of Supportive Psychotherapy (SUP; Pinsker & Rosenthal, 1988) is the reduction of a patient's anxiety using techniques which enhance coping mechanisms, bolster defenses, and build self-esteem. These techniques include clarification, suggestion and education, praise, and exploration of the influence of childhood interpersonal patterns on present adult functioning. Anxiety-inducing interventions such as confrontation of defenses used in STDP or interpretation of the transference used in both STDP and BAP, are avoided in this approach.

Brief Relational Therapy: Brief Relational Therapy (BRT; Safran & Segal, 1990; Safran & Muran, 1996) is defined as a set of therapeutic principals and techniques used to negotiate the therapeutic relationship, and is specifically designed to work with impasses or ruptures in the alliance. This is an integrative model, based on features of psychoanalytic, cognitive, and experiential approaches which has been described as consistent with relational perspectives in contemporary psychoanalysis. In the treatment, phenomenological exploration of moment-to-moment interactions between patient and therapist and deteriorations in their relatedness, serves to disconfirm dysfunctional

interpersonal schemas and provide corrective emotional experiences.

Due to the small number of cases available within each treatment, therapy type was not considered as an independent variable in the proposed study. A comparison of a previous data set (Samstag et al., 1995) found no significant differences among the five types of treatment on patient or therapist self-reported alliance scores. This provided some rationale for collapsing cases across treatment conditions in the current research proposal. While fidelity ratings will not be systematically collected on this current sample, findings from a previous study demonstrated adequate adherence to the respective treatment manuals (Santangelo, Safran, Muran & Winston, 1994). All evaluation and therapy sessions were videotaped as part of the Project's procedure for clinical supervision and research purposes.

Participants

Subjects in the current study were 48 patient-therapist dyads accepted for a 30-session protocol of psychotherapy. The 48 dyads included 48 patients treated by 38 therapists. The 48 patients had a mean age of 38.96 years (SD = 7.75). They were just over half female (56%) and the majority were not currently married (71%). Sixty-five percent had completed a college or graduate level degree, most were White (85%), and most reported being presently employed (81%). There was no significant differences among the three outcome groups on any of these patient demographic variables (see Table 2). Primary axis I diagnoses included depression (63%), anxiety (25%), and V-codes (13%); primary axis II diagnoses included mostly Cluster C or Personality Disorder Not Otherwise Specified (PD NOS) with Cluster C features (79%), two patients with Cluster

B (4%), and eight with no axis II diagnosis (17%). The frequencies of diagnostic categories within each outcome groups are presented in Table 3, and comparisons indicated no statistical distinction among them. The number of patients randomly assigned to each of the five treatment conditions were as follows: STDP = 23%; BAP = 25%; SUP = 10%; CBT = 21%; and BRT = 21%). There was no significant difference among outcome groups in terms of treatment type (see Table 4).

Information regarding history of early, severe attachment traumas or losses was collected from the patient intake assessment material and included as a descriptive variable in this study. "Early" was defined as occurring before the age of 12 years, and "severe" was defined as (1) death of a parent or caregiver, (2) physical or sexual abuse by a parent or caregiver, or (3) unwilling ejection from the home (e.g., being sent to an orphanage). These categories have been identified as severe by a number of attachment researchers (e.g., Adam, Sheldon-Keller, & West, 1995; Main, 1991; Main & Goldwyn, unpublished manuscript; West & Sheldon-Keller, 1994). Overall, 13 patients (27%) in the sample reported occurrence of severe early attachment trauma or loss (see Table 5). Using a Fisher exact test, a significant difference in the number of patients reporting such experiences was found among the three outcome groups: in the GO group, N=5/16; in the PO group N=1/16; and in the DO group, N=7/15 (the information was missing for one subject in this group) ($\chi^2 = 6.63$, df = 2, $p < .05$.) The significant effect was carried by the relatively fewer number of patients in the PO condition reporting experiences of early severe attachment trauma and loss. In addition, two of the five patients in the GO group and 3 of the seven in the DO group reported multiple losses of this kind.

The 38 therapists had a mean age of 38.54 (SD = 8.86) years, with a mean of 7.65 (SD = 9.34) years clinical experience. Sixty-one percent were female and all were White. They were 37% Ph.D./Psy.D.'s, 34% M.D.'s, and 29% M.A./M.S.W.'s. As with the patient sample, there were no significant differences on any of the therapist descriptive variables among outcome groups (see Table 6).

Overall Outcome Assessment

In addition to providing demographic information and family and treatment histories, patients completed overall outcome assessments at pre- and post-treatment. These paper-and-pencil, self-report scales included the Symptom Checklist-90, Revised (SCL-90-R; Derogatis, 1983; see Appendix B) and the 64-item, circumplex version of the Inventory of Interpersonal Problems (IIP-64; Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988; Alden, Wiggins, & Pincus, 1990; see Appendix C). Both instruments are commonly used in the assessment of overall outcome in psychotherapy research.

The SCL-90-R is a 90-item scale which assesses severity of common symptoms reported by adult psychiatric and medical patients. Normative studies have been conducted on clinical and non-clinical populations (Derogatis, 1983). Patients are asked to rate the extent to which symptoms have been experienced over the past week and they include questions about feeling annoyed or irritated, feeling tense, and any trouble sleeping or remembering things. Items are rated on a five point scale, ranging from "not at all" (zero) to "extremely" (5). The overall mean score, or Global Severity Index, is considered to be the most sensitive of the three global indices computed from the SCL-90-R (the stability coefficient was .90) and will be used as a measure of general psychopathology in

this study (e.g., Beutler & Crago, 1983)[1]. The author of the scale reports acceptable psychometric statistics for the nine primary symptom dimensions (somatization, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism), including test-retest reliability coefficients ranging from .78 - .90, and internal consistency coefficients ranging from .80 - .90.

Discriminant, concurrent, and convergent validation have been tested and established by a large number of studies reported in the original manual which correlated the SCL-90-R with similar, validated multidimensional measures of psychopathology (e.g., the Minnesota Multiphasic Personality Inventory and the Social Adjustment Scale - Self Report). Construct validity was assessed in a study which intercorrelated and factor analyzed the SCL-90-R's of a sample of 1,002 psychiatric outpatients. When compared to the hypothesized nine-dimension structure, the rotated factor loadings from this analysis "matched quite well" (p. 25; Derogatis, 1983). The SCL-90-R has also been demonstrated to be sensitive to change over a wide range of psychological and medical disorders (e.g., depression, anxiety, sexual dysfunction, stress syndromes, drug and alcohol abuse, cancer, and eating disorders) with both adult and adolescent subjects in psychotherapy and pharmacological research projects.

The IIP-64 (Alden, Wiggins, & Pincus, 1990) is a revised version of the original

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[1] While norms are provided in the manual to convert mean scores to standardized *t* scores, increasingly researchers are using the mean scores as an index of overall symptomatology. The original normative studies have become outdated and the use of raw mean scores affords the opportunity for comparison with other scales using similar scaling (e.g., Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988).

127-item scale developed by Horowitz, Rosenberg, Baer, Ureno, & Villasenor (1988). It assesses the severity of distress which develops in interpersonal situations and, like the SCL-90-R, it is an instrument commonly used in psychotherapy outcome research. This version maps onto the dimensions of the circumplex model. Patients are asked to rate items which begin with the stem "It is hard for me to" or "These are things I do too much," on a five-point scale ranging from 0 ("not at all") to 4 ("extremely"). The scaling was explicitly modeled after the SCL-90-R. Examples of typical items are "it's hard for me to join in on groups" and "I fight with other people too much." High internal consistency and test-retest reliability coefficients are reported by the authors of the IIP-64.

The overall mean scores of these two measures, taken at time one (i.e., intake assessment) and time two (i.e., termination assessment), was used in the computation of reliable change (RC) scores to classify individual cases as either good or poor outcome[2] (Jacobson & Truax, 1991). The RC index[3] is a statistical procedure used for evaluating the degree to which patients demonstrate clinically significant change (i.e., not occurring by chance) from pre- to post-treatment assessment. It is a method of assessing outcome

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[2] Patients who dropped out of the project prematurely were dissatisfied and typically unwilling to complete the post-treatment, self-report assessment. RC scores were, therefore, only computed on patients who completed the 30-session protocol and turned in their assessment packages.

[3] $RC = \frac{X_2 - X_1}{S_{DIFF}}$

The standard error of difference (S_{DIFF}) is computed from the standard error of measurement (S_E). The S_E is derived from a sample of 188 comparable patients who had participated in other research studies on the Project and who would not be included in the proposed study.

which incorporates the predictive power of large sample data with ideographic precision. Jacobson and Truax (1991) identify two types of reliable clinical change based on a statistical differentiation between "recovery" (i.e., RC > 1.96) and "improvement" (i.e., change in the expected direction but RC < 1.96). In order to increase power, cases defined as either recovered or improved in this study will be classified as good outcome. However, a more rigorous definition of improvement will be used here, where an RC score of $\geq .5$ (e.g., half a standard deviation) but < 1.96 is required. Therefore, cases in the proposed study will be classified as GO if RC $\geq .5$, and as PO if RC < .5.

Post-session Questionnaire

Both patients and therapists independently completed a Post-session Questionnaire (PSQ after each therapy session. The PSQ included the short form of the Working Alliance Inventory (WAI-12; Tracey & Kokotovic, 1989) and three items addressing perceived tension in the session between therapist and patient (see Appendix D). Three previous studies with similar subject samples found that this scale was one of the most predictive of ultimate treatment outcome (Winston, Muran, Safran, Samstag, & Twining, 1992; Samstag et al., 1995; Samstag et al., 1998).

The WAI-12 was derived from the original 36-item scale created by Horvath & Greenberg (1986). This instrument assesses three factors or dimensions of the therapeutic alliance: the affective Bond between the therapist and patient and how that mediates agreement with respect to the Tasks and Goals of treatment. Items such as "I think my therapist likes me" (Bond), "My therapist and I agree about important changes" (Goal), and "Therapy gives me a new way of looking at things" (Task) are rated on a 7-point,

Likert-type scale, from 1 ("not at all") to 7 ("always"). The authors of the original scale used an intraclass correlation to test internal consistency, reporting a reliability estimate of .93 for the overall measure (Horvath & Greenberg, 1986). Support for the validity of this instrument was established in two ways: one, by agreement of two groups of experienced raters, who came from a range of theoretical and clinical backgrounds, on items which best reflected the three subscales (percent agreement values ranged from 85.3 to 94.8); and two, by the use of a multi trait-multi method model of analysis to examine convergent and discriminant validity indices. Horvath & Symonds (1991) conducted a meta-analysis of 24 studies examining validity of the alliance constructs in predicting overall psychotherapy outcome. They found an average effect size of $r = .26$, defining this as a very conservative estimate of the strength of the relationship between alliance and outcome due to the inclusion of non-significant result in the analysis.

The 12-item short form used in the study proposed here was empirically derived from a factor analysis (Tracey & Kokotovic, 1989). These researchers administered the 36-item version to a sample of patients and therapists, across a diverse range of clinical orientations, after the first therapy session. Four items per subscale were selected based on the highest factor loadings. The three factor scores and total score of both the long and short versions have been consistently found to be highly intercorrelated (Alder, 1988; Bachelor, 1991; Horvath & Greenberg, 1986, 1989; Safran & Wallner, 1991).

Case Selection

Selection of the 48 patient-therapist dyads used in this study was based on two general decision rules (see Table 7 for a summary of study selection criteria). First,

patient outcome status was assessed and cases were selected if they met criteria for one of three outcome conditions: (1) premature dropout (DO; N=16), (2) completed treatment with poor overall outcome (PO; N=16), and (3) completed treatment with good overall outcome (GO; N=16)). Inclusion criteria for each outcome group were defined as follows. For the DO condition, patients must have completed a minimum of four sessions and have terminated within the first third of the treatment (i.e., by session 10). It is thought that patients who drop out either earlier or later in the process might comprise a qualitatively different sample of subjects (Frayn, 1992). Both patients and therapists must have indicated on at least one PSQ that the therapeutic relationship was problematic, thus preventing dyads from being selected who prematurely terminated due to interfering life events (e.g., a new job), or due to the patient feeling better after just a few sessions. GO and PO groups were defined as patient-therapist dyads who complete all 30 sessions of the treatment protocol and turned in their assessments at intake and termination. RC scores (Jacobson & Truax, 1991), defined earlier in the Overall Outcome Assessment section, were then computed with pre- to post-treatment patient symptom measures and used to distinguish good (i.e., high positive change) from poor outcome (i.e., low positive change or negative change) cases. These criteria for identifying more homogeneous samples of outcome conditions were used by the author in previous studies and found useful in statistically discriminating DO from GO groups on a number of alliance and interpersonal measures (Samstag et al., 1995; Samstag et al., 1998).

The second general criterion regarding selection of dyads for the study concerned therapists. Therapists were recruited from the Department of Psychiatry at Beth Israel

Medical Center. They represented a range of clinical disciplines, including M.D., Ph.D., and Master's level backgrounds. Clinicians participating in the Research Project met weekly for didactic group training seminars and clinical supervision, and often treated more than one patient in the Project. To guard against the possibility of a therapist effect determining patient outcome (e.g., a particular clinician having a high number of DO cases), dyads first meeting criteria for one of the three outcome conditions were included in the study if the therapist had not previously treated a patient falling within that same outcome category. In other words, within each outcome condition, there were 16 different therapists; if a therapist treated more than one patient within an outcome condition, the clinician's first case was systematically selected for the study. The therapist to patient ratio in this study was 1:1.26, as some therapists treated multiple patients, each of whom met criteria for a *different* outcome condition.

Observer Process Ratings

Observer ratings of therapeutic process and narrative were made using two scales: (a) the Structural Analysis of Social Behavior (SASB; Benjamin, 1974; Benjamin et al., 1981) and (b) Narrative Coherency ratings, adapted from Main & Goldwyn (unpublished manuscript).

The SASB is a circumplex model of interpersonal behavior which plots social discourse around two general orthogonal axes of affiliation and control. The horizontal affiliation axis spans from hostile to friendly and the vertical control axis from controlling to submissive. SASB measures the dynamics of interpersonal relations as they are reflected in the structure of language. The SASB model is unique with respect to other

circumplex models (Carson, 1969; Kiesler, 1983; Leary, 1957 ; Wiggins, 1982) in that it incorporates three different perspectives, or foci, of interpersonal behavior: Surface 1 is the focus of interpersonal behaviors on another person (focus on other); surface 2 is the reaction of the self to the behavior of another (focus on self), and surface 3 is the reaction of the self to the self (introject). Surfaces 1 and 2 are interpersonal in nature, whereas Surface 3 is considered to be primarily introjective and an index of therapeutic content. Only surfaces 1 and 2 will be used as they are considered to be most relevant to a study emphasizing interpersonal process (see Figure 2).

With the interpersonal model expanded in this way, the control dimension changes its meaning depending on the surface. Benjamin redefines this dimension as the interdependence axis. For instance, on surface 1, the top portion of the control axis (which is neutral with respect to affiliation) translates into "Freeing and Forgetting" the other (autonomy granting), and the bottom portion (also neutral with respect to affiliation) into "Watching and Managing" the other (dominating or controlling). In contrast, on surface 2, the same points are identified as the self "Asserting and Separating" (autonomy taking) and "Deferring and Submitting" (complying or accepting) in response to a behavior of the other. The anchors of the affiliation dimension remain constant across surfaces such that all behaviors falling on the right of each surface are friendly, whereas all those falling on the left side are hostile.

Surface 1 and 2 are divided into four quadrants, eight clusters, and 36 interpersonal behaviors which represent unique interactions of affiliation and

interdependence (see Table 8 for a description of each Cluster score on the two surfaces)[4]. The 36 behaviors (called the full scale model) may be collapsed into cluster and quadrant versions. The cluster and quadrant versions of the model were psychometrically validated (Benjamin, Foster, Roberto, & Estroff, 1986), and research seems to support the eight category, cluster version as the best suited and most widely used for observer based coding (e.g., Coady, 1991; Henry et al., 1986; Henry et al., 1990; Safran et al., 1994, Safran & Muran, 1996).

The SASB variables used in the current research study included the following mean weighted frequencies: (a) patient and therapist Cluster codes, (b) Positive, negative, and Neutral Complementarity, and (c) Complex Communications (i.e., frequency of utterances receiving two or more simultaneous scores). Neutral complementarity was defined as reciprocity on the interdependence dimension and correspondence on the affiliation dimension where neither friendliness nor hostility is detected. Research to date has typically collapsed SASB cluster scores into combinations of four quadrants: friendly, hostile, dominant, and submissive. Raters in previous studies forced codes which fell at the top (e.g., 1-1 and 2-1) or bottom (e.g., 1-5 and 2-5) of the SASB model onto either the hostile or friendly side of the circumplex. Rather than collapsing Cluster codes in this research study, affectively neutral codes were maintained as scored in the sessions.

Inclusion of the neutral category had implications for computation of SASB

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[4]Benjamin has refined and developed her model over the past three decades, and slightly different terminology has been used in defining the clusters. Depending on the date of publication, one version identifies a 1-1 code, for example, as "emancipate" and another as "freeing and forgetting.".

complementarity. Complementarity scores were computed in two sequences per case: (1) patient utterance followed by therapist response (Patient-to-Therapist), and (2) therapist utterance followed by patient response (Therapist-to-Patient). In previous studies where clusters are collapsed into quadrants (friendly-dominant, friendly-submissive, hostile-dominant, hostile-submissive), each speech interaction or "exchange unit" (e.g., the last patient thought unit of a speech turn followed by the first thought unit of the next therapist speech turn) is assigned a value of 3, 2, or 1, according to the degree of complementarity between speakers' utterances. For example, "3" represents both reciprocity on the interdependence dimension *and* correspondence on the affiliation dimension (i.e., the highest degree of complementarity, called a complementary transaction); "2" represents reciprocity on the interdependence dimension *or* correspondence on the affiliation dimension (i.e., a moderate degree of complementarity, called an acomplementary transaction); and "0" represents neither reciprocity on the interdependence dimension *nor* correspondence on the affiliation dimension (i.e., no complementarity, called an anticomplementary transaction). This method was first used by Carson (1969) and Dietzal & Abeles (1975), and later augmented by Henry et. al (1986) who added positive and negative valences to distinguish degrees of friendly vs. hostile complementarity.

Complementarity scoring in this study was changed in the following three ways. First, interdependence and affiliation dimensions were scored separately. Each exchange unit was assigned a value of 3, 2, or 1 depending on the degree of reciprocity on the interdependence dimension, and a second value indicating the degree of correspondence on the affiliation dimension (see Table 9). Second, the affiliation score included positive,

negative or no valence, reflecting correspondence on the friendly, hostile, or neutral areas of the model. Following Henry et al. (1986), any exchange including a hostile cluster code received a negative valence (e.g., if either patient or therapist received a cluster score from the hostile half of the circle, the entire exchange unit and resulting complementarity score was categorized as hostile); a neutral code matched with a friendly code was scored with a positive valence; and two matched neutral codes were scored as an affectively neutral exchange (no valence). Third, the sum of affiliation and interdependence complementarity scores were analyzed both separately and combined. In this way, complementarity scoring incorporated the neutral cluster codes of the SASB model. While the literature to date has found the affiliation dimension to be more predictive of psychotherapy outcome, this may in part be an artifact of the scoring procedures employed.

The Narrative Coherency scale was used to measure the overall degree of coherency or verbal fluency of the patient-therapist dyad in each 15-minute segment of therapy. This scale ranges from 0 ("highly incoherent") to 2 ("highly coherent") and is an abbreviated version of the measure developed by Main her colleagues (Main, 1991; Main & Goldwyn, unpublished manuscript). In the proposed study, highly incoherent segments of patient-therapist narrative were defined as having a high frequency of false starts and incomplete thoughts, interruptions (e.g., patient and/or therapist interjections), word-finding difficulty, use of generalities rather than specific names or terms (e.g., the pronoun "you" in place of "I"), and over-elaborations (e.g., more detail than is necessary such that the main point is lost or the topic is eventually changed). Such segments are difficult for the reader to follow and do not clearly communicate the speakers' ideas. In contrast,

highly coherent segments flow smoothly, the reader easily comprehends what the patient and therapist are communicating, speakers are articulate and succinct, and there is a sense of collaboration between them (see Appendix D for further description of the scale points). Preliminary research is presently being conducted with a similarly abbreviated coherency scale by Malcolm West and his colleagues who are rating projective stories told by mothers about pictures of separation experiences (West, personal communication February, 17, 1997).

Coding

Four third-party observers were trained to acceptable reliability standards on instruments measuring interpersonal process (SASB) and narrative (Narrative Coherency) in psychotherapy sessions (see above for description of these measures). These individuals were selected as having the highest reliability ratings from a larger pool of possible raters who were being trained on a variety of psychotherapy research instruments used in the Research Project. All four raters were graduate students currently enrolled in clinical psychology programs. Their mean age was 32 years (range 28-41). Once raters met a minimum reliability criterion on each of the two measures, they were combined into two teams of two raters each. All scoring was done by consensus, using the same two teams for all ratings; half the data were scored by each rating team (i.e., 24 cases), equally divided among outcome groups (i.e., eight cases in each of the good, poor, and dropout groups). Raters were blind to treatment outcome and study hypotheses. Coding of the two observer-rated scales was conducted using both video tapes and session transcripts. Recalibration meetings were conducted every four to six weeks during coding of study

data in order to guard against rater drift.

Training for the SASB was conducted by the author and J. Christopher Muran, Ph.D., director of the Research Program, as per the SASB manual. William Henry, Ph.D., who has done extensive research with the SASB models, acted as a consultant and attended one of the recalibration sessions. Raters participated in approximately 60 hours of weekly seminars, practice coding, and readings. The length of training was more extensive than that outlined by the authors of the SASB manual due to the large number of coders participating in the Research Program and the focus on "difficult" therapeutic dyads, which tended to promote a great deal of discussion and disagreement among raters. Training for coding of Narrative Coherency was conducted by the author. The same four raters who coded SASB data participated in approximately 15 additional hours of training seminars, practice coding, and readings related to adult attachment and the Narrative Coherency measure.

Data Preparation

Patient-therapist dyads were selected and categorized into three outcome groups, as described in the Subjects section above. Alliance data collected from patients and therapists were collapsed across sessions 3 - 8 for the completed treatment groups (i.e., GO and PO), and across a maximum of six sessions working backwards from the last session attended for the DO group (e.g., if the patient terminated after the seventh session, alliance scores are collapsed across sessions three through seven; if session 10 is the last, then alliance scores were collapsed across sessions five through 10). This window of six early sessions was developed to be a general index of the therapeutic alliance. It was

defined this way for three main reasons: (a) the mean number of sessions in a previous study of dropouts was eight (providing a rationale for selecting sessions three through eight in the completed treatment groups), (b) sessions just prior to the dropout session were preferable in terms of observing therapeutic process which might best predict premature termination behavior (which justifies shifting the window slightly depending upon when the patient ended treatment), and (c) ratings from the first two sessions were omitted as the patient typically required this time to become familiar with the instrument and uninhibited about evaluating their therapist. Mean WAI-12 Total scores thus represented a measure of the quality of the therapeutic relationship from both patient and therapist perspectives, within the first third of treatment. A mean of ratings over this window of the therapy was found in another study to statistically discriminate outcome groups (Samstag et al., 1995). Alliance ratings are generally collected within the first third of treatment and have been found to be predictive of overall outcome (e.g., Horvath & Symonds, 1991), although ratings taken at the first session have been found to be less predictive than ratings taken a little later, such as at the third session (Marziali, 1984). The alliance index in this study was included to serve as validation of the outcome group selection procedure and to examine the relationships among alliance and observed based indices.

Three segments from the beginning fifteen minutes of sessions, randomly selected from within the first third of treatment, were transcribed and prepared for observer coding. Therapeutic process has not been found to differ significantly as a function of the segment rated (i.e., early, middle, or late in the hour) (Gomez-Schwartz, 1978). It was further

surmised that the first fifteen minute segment had an advantage over middle and late segments in terms of raters having context to help them understand the process they are observing. Transcript preparation of the fifteen minute segments included subdividing patient and therapist speech turns into more discrete "thought units," as outlined in the SASB manual. The sessions selected for observer coding were not yoked to those from which WAI-12 scores were collected because of limitations in the number of videotaped sessions available and because the instruments were scored on different quantities of therapy session (i.e., the WAI-12 was rated on entire sessions while the SASB and Narrative Coherency were scored on the first 15 minutes). Each rating team scored the three segments of a dyad in sequence, in order to provide a context for making rating judgements across treatment.

IV. Results

Rater Reliability

Training of the raters began with the SASB and the structuring of the interrater reliability assessment was based on initial findings from this training. Therefore, reliability results will be presented first from the SASB and second from the Narrative Coherency scale.

Interrater reliability on the SASB was tested in three phases: training/precoding, and two reliability checks on study data. In the training/precoding phase, individual coders were compared to ratings made by trained SASB coders on a 15-minute segment of one session which was not included in the study data. The mean weighted kappa estimate (Cohen, 1968) for the four raters selected for this current study from the larger Research Program pool was .85 (range: .78-.98). For the first reliability check of study data, interrater reliability was tested among *individual* raters. Individual coders independently rated 10-minute segments from three different cases, one from each outcome group. Mean weighted kappas were .54, .59, and .88, for GO, PO, and DO groups, respectively. These estimates were considered inadequate and a decision was made to have raters work in pairs, resolving disagreements with consensual validation. The second interrater reliability check on study data was conducted between rating teams. Two teams, of the same two raters each, coded 10-minute segments from six cases (two from each of the three outcome groups). The mean weighted kappa estimate was .75 (range: .51-.88). The one case which did not meet an acceptable level (.51) was recoded by one rating team and the resulting mean weighted kappa was .80 (range: .71-.88).

For Narrative Coherency, interrater reliability estimates were calculated in three phases, similar to the SASB data, but using an intraclass correlation coefficient (ICC; 3, k) (Shrout & Fleiss, 1979) estimate. In the training/precoding phase, 15-minute segments from five cases not included in the test data were rated by the four individual coders and compared to scores made by the author and confirmed by Arietta Slade, Ph.D. This yielded a mean ICC of .93 (range: .91-.94). The first reliability check of individual raters coding study data included the same three cases used in the SASB reliability check, except the entire 15 minute segment was used. The ICC (3, k) was .86, which was considered acceptable. However, since SASB coding was done in pairs, it made practical sense that raters also follow the same format for Narrative Coherency rating. The second reliability check on study data was similarly conducted on the two rating teams. Narrative Coherency ratings for these same six cases used in SASB ratings (again, using the full 15-minute segment for Narrative Coherency coding) yielded an ICC (3, k) of .84. While the six cases used for the team reliability check represented only one-eighth of the data, it is consistent with the literature using this type of very labor-intensive coding.

Analysis of Independent Variables

Therapeutic alliance. Mean WAI-12 scores were computed across a window of up to six sessions, as described in the Method section, above. Means (M) and standard deviations (SD) for the Total and Factor scores of the WAI-12, from both patient and therapist perspectives, are presented in Table 10. Two 3 x 4 (Outcome Group x WAI-12 score) MANOVAS, one for patient ratings and one for therapist ratings, were computed. As expected, there was a significant between-subjects effect from the patient perspective

with the GO group ratings statistically greater than the DO group scores (F (6,88) = 3.27, $p < .01$). Univariate F-tests revealed that all three factor scores were also significantly different among groups in the expected direction, namely, the DO group having the lowest alliance ratings, the GO group having the highest, and the PO group with scores in between. Post-hoc Tukey Honestly Significant Difference (HSD) tests indicated that for patient Bond, Task, and Total scores, the DO group had significantly lower ratings than both the PO and GO groups, but there was no difference between the latter two groups; for the Goal factor, the DO group score was significantly lower than that of the PO group but not of the GO group ($p < .05$).

Thus, patients in the DO group perceived that they and their therapists agreed less on the tasks of therapy and that there was a weaker relational bond between them than did patients in the PO and GO groups, respectively. Also, patients in the DO group perceived that they and their therapists agreed less on the goals of treatment compared to the PO patients, but not compared to the GO group. In other words, patients in the PO group indicated the highest degree of agreement on therapy goals. Patients' ratings of alliance were not significantly different in the two outcome conditions that completed the treatment protocol (i.e., PO and GO groups).

Differences among outcome groups failed to reach significance on the multivariate level from the therapist perspective. Univariate F-tests were conducted regardless, due to the exploratory nature of the current research. Post hoc tests revealed a pattern of differences similar to the patient ratings: for Bond, Task, and Total scores, the DO group had significantly lower ratings than both the PO and GO groups, but there was no

difference between these latter two; therapist Goal ratings in the DO group were only significantly different from GO group scores ($p < .05$).

Effect sizes were computed as correlation coefficients (Cohen, 1988) in order to compare their relationship to statistical significance. For patient ratings, effect sizes ranged from moderate to large (.40 - .53); for therapist ratings, effect sizes were all within the moderate range (.37 - .44) (see Cohen, 1992, for a definition of effect size categories). These results are consistent with, and even higher than effect sizes reported in previous studies (e.g., an average effect size of .33 is reported in a meta-analysis by Horvath & Symonds, 1991).

Results of WAI-12 comparisons also indicate that while patients' ratings of the therapeutic alliance were more robust in discriminating outcome groups than therapists' ratings, therapists perceived the relationship with their patients in a similar way. More specifically, therapists in the DO group perceived that they and their patients agreed less on the tasks of therapy and had a weaker relational bond with them compared to therapists in the PO and GO groups, respectively. Whereas patients' ratings of agreement on the goals of treatment were statistically lower in the DO compared to the PO group, therapists' ratings of the Goal factor did not differentiate among any outcome groups. For dyads who completed the treatment protocol (i.e., PO and GO groups), therapists ratings of the alliance were not statistically different. This was consistent with patients' ratings.

It is notable here that a number of the items in the therapist's version of the WAI-12 are worded such that the therapist is assessing his/her perception of the *patient's* view of aspects of the relationship. For example, "my patient was confident in my ability to

help him/her" (a Bond item). This is one step removed from a direct assessment of the therapist's perception of the same component (e.g., "I was confident in my ability to help my patient") and puts the emphasis on the patient's capacity for developing the therapeutic relationship. The difference in focus of these two versions of the WAI-12 may have contributed to the more predictive power of the patient alliance ratings. This point will be further elaborated in the next chapter.

Narrative Coherency. Narrative Coherency scores were averaged across the three therapy segments, resulting in a mean score for each dyad. The means and standard deviations (in parentheses) for each outcome group were as follows: GO = 1.46 (0.64); PO = 1.04 (0.56); and DO = 0.97 (0.51). Using a one-way ANOVA, Narrative Coherency was found to significantly discriminate outcome conditions with scores falling in the expected direction (F (2,45) = 3.41, $p < .05$). A post-hoc Tukey HSD test found that Narrative Coherency ratings for the GO group were significantly higher than those for the DO group ($p < .05$). While the mean scores for the PO group fell between the other two groups, these ratings were not significantly different from them. The effect size (r = .36) fell within the moderate range.

The Narrative Coherency scores fell in a similar pattern to the patient and therapist WAI-12 scores. In other words, the DO dyads were rated as having the least coherent narratives in the first 15 minutes of sessions, as rated by observers, and the GO dyads as having the most coherent. Recall that the DO groups had the poorest alliances and the GO had the strongest, as indicated from both patient and therapist perspectives. Comparatively, the predictive power of the Narrative Coherency measure in discriminating

outcome groups was slightly less than that of WAI-12. The implications of different rating perspectives (e.g., patient, therapist, and observer) of these two scales is addressed later in the Discussion section.

SASB. The SASB data were divided into three separate sets of frequency analyses comparing outcome groups. First, interpersonal communications measured by the 16 Cluster codes were compared for patients and therapists independently (i.e., one comparison for patient behaviors and one for therapist behaviors). Second, Complex Communications (defined as more than one Cluster code rated for a single speech unit) produced by patients and therapists were analyzed (i.e., similarly, one comparison for patient data and one for therapist data). Third, comparisons were conducted with Positive, Negative, and Neutral Complementarity scores, which measured the interaction of patient and therapist interpersonal communications (i.e., one comparison examined patient utterances followed by therapist responses and the other examined therapist utterances followed by patient responses). In this way, SASB measured both the frequency and quality of interpersonal behaviors rated for patients and therapists as *individuals* and as *dyads*.

SASB: 1) Cluster Scores. Prior to analyzing the Cluster scores, all observed frequencies were weighted by the grand mean of number of thought units for patients and therapists respectively. In the case of Complex Communications, each code was included as one occurrence of that Cluster. The grand mean of thought units, summed across three therapy segments, was 236.42 for patients and 403.38 for therapists. To compute the weights for each subject, the observed total sum of thought units was compared to the

grand mean for all cases: if the subject's number of thought units was *greater* than the grand mean, the subject's sum was divided by the grand mean; however, if the subject's number of thought units was *less* than the grand mean, the grand mean was divided by the subject's sum (Bill Henry, personal communication, March 23, 1998). For example, the sum of thought units for the therapist in dyad 1 was 411, which is greater than the grand mean of 403.38 for all therapists. Thus, the weight score for this therapist is 411/403 = 1.02. Observed frequency Cluster scores were then multiplied by each subject's weight score, thereby accounting for the difference in proportions of speech production among different session segments and different patient-therapist dyads. The resulting weighted Cluster score means and standard deviations are reported in Tables 11 (therapist focus on other), 12 (patient focus on other), 13 (therapist focus on self), and 14 (patient focus on self).

Two 3 X 2 X 8 (Outcome Group X Focus X Cluster) MANOVAs were conducted, one for patient communications and one for therapist communications. Square root transformations of the weighted Cluster frequencies were used as the dependent variables in each analysis, due to the positively skewed nature of these data and unequal variances among Outcome Groups (Emerson & Stoto, 1983). As expected, there was a significant main effect for Focus for both patient (F (1, 45) = 398.02, $p < .001$) and therapist (F (1,45) = 369.58, $p < .001$) communications. These results indicate that patients spent more time focusing on themselves, while therapists spent more time focusing on patients. There were also expected significant main effects for Cluster for both patient (F (7,315) = 92.24, $p < .001$) and therapist (F (7, 315) = 241.86, $p < .001$)

communications, as well as significant Focus X Cluster interactions for both patients (F (7, 315) = 104.02, p < .001) and therapists (F (7, 315) = 196.15, p <.001). In other words, speakers did not equally utilize the eight different Cluster categories of the SASB model. However, the was no significant between groups effect, indicating no statistically significant difference among outcome groups on Cluster scores with each surface. This means that patients and therapists were rated by observers as each behaving consistently among the DO, PO, and GO groups.

As with previous analyses, univariate F-tests were computed even though multivariate tests for the between-subjects factor were not significant. There were no significant differences among groups on any of the surface 1 or 2 Cluster ratings and effect sizes fell within the low to moderate ranges (.00 - 31). The findings reported thus far are consistent with results from previous studies of psychotherapy process using the SASB and provide a degree of validation for the method used here. While there were no Clusters that statistically differentiated the groups, a number of informal comparisons demonstrated that mean scores of hostile Clusters fell in expected directions. For example, patients did more belittling/blaming of therapists in the PO and DO groups, and therapists similarly engaged in more of the same behavior with patients in these groups; also patients and therapist were each found to show a greater frequency of sulking/appeasing behaviors in PO and DO groups, as well as walling off/avoiding behaviors. An informal comparison of positive Cluster scores revealed that patients and therapists in the PO and DO groups engaged in a greater degree of affirming/understanding behaviors compared to the GO group. Furthermore, therapists

were shown to engage in helping/protecting interpersonal acts most with PO patients, next with GO patients, and comparatively least with DO patients.

Thus, while both patients and therapists in the DO and PO groups demonstrated greater degrees of individual hostile interpersonal behaviors, as was hypothesized, these differences were not statistically significant.

SASB: 2) Complex Communications. Complex Communication scores were tallied for both patients and therapists. Means and standard deviations are presented in Table 15. Two one-way ANOVAS were conducted and even though the means fell in the expected direction (i.e., with PO and DO groups both demonstrating almost twice the frequencies of Complex Communications compared to the GO group), no significant differences among groups were found. The resulting effect sizes for patient and therapist analyses was r = .28 and .28, respectively.

To summarize the SASB results thus far, comparisons of those variables which assessed individual patient and therapist communications did not find any differences among DO, PO and GO outcome groups.

SASB: 3) Complementarity Scores. Before Complementarity scores could be analyzed, patient and therapist exchange units were identified (Method section, above). All speech units which were scored with a code from the unexpected surface (e.g., a therapist utterance coded as surface 2 or a patient utterance coded as surface 1) were deleted from complementarity analyses. This procedure followed Henry's method (Bill Henry, personal communication, March 23, 1998).

Next, Complementarity scores were weighted in a similar procedure to that

described above for Cluster scores. The mean number of exchange units, summed across the three session segments for both Patient-to-Therapist and Therapist-to-Patient sequences was 182.00. An initial comparison of the nine possible Complementarity scores (i.e., positive, neutral, and negative scores computed separately for affiliation, interdependence, and combined dimensions) indicated no differences between affiliation and interdependence dimensions. Therefore, in order to reduce the family-wise error rate, only positive, neutral, and negative total Complementarity scores were used in further analyses. Means and standard deviations of these weighted Complementarity frequencies are reported in Table 16.

Two 3 x 3 (Outcome Group x Complementarity Score) ANOVAS were conducted, one for each exchange sequence. These data did not violate assumptions of normality to the extent that Clusters scores did thus transformations were not required. There was no significant overall difference among the three outcome groups on this variable. However, univariate *F*-test revealed that negative Complementarity scores were significantly higher for the PO group compared to the GO group with the DO group scores falling in between. This finding was consistent for both exchange sequences: Patient-to-Therapist (F (2, 45) = 3.21, $p < .05$) and Therapist-to-Patient (F (2, 45) = 3.13, $p < .05$). Effect sizes computed with Complementarity data were consistent with the other analyses, falling within the low to moderate ranges for both Patient-to-Therapist (.09 - .35) and Therapist-to-Patient (.17 - .35) sequences.

Overall, the SASB results showed that Negative Complementarity was the only variable to predict outcome, with patient-therapist dyads in the PO group evidencing the

greatest degree of complementary hostile interpersonal behavior. The other two dyadic variables - Positive and Neutral Complementarity - did not differentiate outcome groups, nor did any of the variables which assessed individual patient and therapist communications. In sum, a dyadic or relationship SASB index of hostile interpersonal communication was more relevant to overall outcome than friendliness or affectively neutral complementary behavior, and more relevant than SASB variables measuring individual patient and therapist utterances.

Correlational analyses of WAI-12, Narrative Coherency, and SASB. Those process variables which were found to significantly discriminate outcome groups were compared in three separate correlational analyses using Pearson *r*'s. These analyses were conducted in the hopes of advancing the understanding of specific components of the therapeutic alliance and how it is operationalized in terms of interpersonal and attachment behaviors. Correlational analyses also provided validation of the Narrative Coherency index.

First, the four WAI-12 scores from both patient and therapist perspectives, and observer-ratings of Narrative Coherency were intercorrelated (see Table 17). As expected, the factor and total scores within each perspective were highly positively intercorrelated (i.e., patient: $r = .65$ - $.94$, $p < .001$; and therapist: $r = .75$ - $.97$, $p < .001$). Correlations between patient and therapist scores were somewhat less in magnitude, but none the less, highly significant ($r = .32$ - $.60$, $p < .05$ - $.001$). Correlations of Narrative Coherency with patient and therapist alliance scores revealed significant positive estimates for patient Bond ($r = .29$, $p < .05$) and patient Total ($r = .27$, $p < .05$) ratings. None of

the therapist alliance scores were correlated with Narrative Coherency scores. In other words, only the patient's assessment of the therapeutic alliance was directly related to observer ratings of Narrative Coherency, and from the patient's perspective, not all components of the alliance were equally relevant in terms of the structure of the narrative produced (i.e., agreement about Tasks and Goals of therapy was not related to Narrative Coherency from the patient's perspective).

Next, alliance scores were correlated with SASB Complementarity scores (see Table 18). Results indicated that certain WAI-12 subscores were significantly inversely related with only Negative Complementarity for both Patient-to-Therapist and Therapist-to-Patient exchanges (r = -.28 to -.33 and r = -.28 to -.34 for patient ratings, respectively; and r = -.34 to -.49 for therapist ratings in both exchanges). Put another way, the greater the degree of Negative Complementarity between patient and therapist as rated by outside observers, the poorer the therapeutic alliance as reported from both patients and therapists. One difference in the correlational results between patient and therapist ratings was found with Bond scores. While correlations between Complementarity and therapist Bond were highly negatively correlated in both exchange sequences and resulted in the same estimate (r = - .49, p < .001), Negative Complementarity and patient Bond were not significantly correlated in either exchange sequence (r = -.25, and - .27).

These findings are interesting when one considers the differences in estimates between patients' and therapists' ratings with Narrative Coherency found in the first correlational analysis (e.g., patient Bond and Total scores were the only WAI-12 variables which was significantly related to Narrative Coherency). The interpretation of such

comparisons and how patients and therapists differentially conceive of the relational or Bond component of the alliance will be elaborated later in the Discussion section.

Finally, Narrative Coherency and the three Complementarity scores were intercorrelated (see Table 19). Narrative Coherency was found to be significantly directly related to Positive Complementarity in Patient-to-Therapist and Therapist-to-Patient exchange sequences (r = .44, p < .01; and r = .44, p < .001, respectively), and significantly inversely related to Neutral (r = -.29, p < .05, and r = -.28, p < .05, respectively) and Negative (r = -.35, p < .05, and r = -.33, p < .05, respectively) Complementarity scores. These results provide additional support for the validity of the Narrative Coherence measure. In addition, there were no significant correlations among the three Complementarity scores, providing evidence for the construct validity of these indices. Interestingly, Neutral Complementarity was more highly related to Negative (r = .20 - .21) than Positive (r = -.01 - .00) Complementarity. This suggests that the concept of affiliative neutrality as defined in the SASB manual may more likely be perceived in psychotherapy process as being hostile when rated by outside observers.

Overall, the intercorrelations among the WAI-12, Narrative Coherency, and SASB scales reflected some interesting relationships among the subscores which are summarized in four main significant findings: (1) patient Bond and Total WAI-12 scores were positively correlated with observer ratings of Narrative Coherency; (2) Goal, Task, and Total WAI-12 scores from both patient and therapist perspectives were negatively correlated with observer-rated SASB Negative Complementarity; (3) the therapist Bond factor of the WAI-12 was also negatively correlated with observer-rated SASB Negative

Complementarity; and (4) Narrative Coherency was directly related to SASB Positive Complementarity and indirectly related to Negative and Neutral SASB Complementarity scores (both observer-rated). The resulting *r*-values generally fell within the moderate range, indicating that while the values were statistically significant, the relationships among the different scales' subscores were not all that strong.

Chapter V. Discussion

The primary focus of the study was to compare features of the developing therapeutic relationship in early sessions of time-limited (e.g., 30-sessions) psychotherapy treatment protocols by examining the differences among 48 patient-therapist dyads that met criteria for three groups: good outcome, poor outcome, and premature dropout. The treatments included psychodynamic, cognitive-behavioral, interpersonal-experiential, and supportive orientations. Most of the patients had personality disorders with comorbid diagnoses of anxiety and depression, and were considered to be similar to a private practice population. Therapists were M.D.'s, Ph.D.'s and Master's-level clinicians with an average of approximately seven and a half years of experience with the model. Patients and therapists independently rated the therapeutic alliance after each session using the WAI-12 (Horvath & Greenberg, 1986; Tracey & Kokotovic, 1989), a measure based on Bordin's (1979) conceptualization of the alliance. Mean WAI-12 total and factor scores (i.e., bond, goal, and task) were computed from as many as six sessions within the first third of treatment. External observers used video tape and session transcripts to measure interpersonal process with SASB (Benjamin, 1974; Benjamin et al., 1981), and to measure the quality of communication patterns between patients and therapists with an abbreviated version of the Narrative Coherency scale used in the AAI (George et al., 1996; Main & Goldwyn, unpublished manuscript). Three sessions from each case were randomly selected from the first third of treatment, with the first 15 minutes coded by observers on these two scales. An additional focus of the study included the interrelationship of all three scales, with the aim of further operationalizing development of the therapeutic

alliance.

Therapeutic alliance and Narrative Coherency: Common factors. Concerning the alliance, there was a significant difference found with the overall patient-rated WAI-12 scores, where the GO group demonstrated statistically higher scores than the DO group. Considering the Bond, Goal, Task, and Total scores separately, both patient and therapist ratings of the alliance revealed a general pattern of DO cases scoring the therapeutic relationship as more problematic compared to both the PO and GO cases. There was no significant difference between the PO and GO groups, which were the two outcome conditions which completed the 30-session treatment protocol. For most of the WAI-12 subscores, the means fell in the direction of the GO having the strongest alliance ratings from both patients' and therapists' perspectives, the DO group having the most problematic alliances, and the PO groups having scores that fell in between. The exception to this was found with ratings on the agreement of goals of therapy, where patients in the PO condition rated that aspect as more problematic compared to the DO group only, and where therapists' ratings distinguished only the DO from GO groups. It seemed that the Goal factor was the least powerful in predicting outcome in this sample and that overall, patient ratings were more predictive than therapist ratings of alliance.

The finding that both patient and therapist ratings of the alliance predicted overall outcome – regardless of therapy orientation - was an expected result which has been well-established in the literature. The fact that overall WAI-12 ratings did not differentiate the PO group from the other two was inconsistent with findings from a previous study where patient ratings of the WAI-12 were found to differentiate GO from DO, and DO from PO

groups (Samstag et al., 1998). One reason for this discrepancy is the smaller sample size in the current study. Even though the WAI-12 means fell in the expected direction, and moderate to large effect sizes were found in each comparison, the power was not great enough to statistically differentiate all three groups from each other. The significant univariate differences between the DO from both the GO and PO groups is consistent with findings from the previous study and suggests trends in a similar direction that would likely be confirmed with a larger sample size.

A second reason for the lack of statistical significance between the completed treatment conditions may have to do with the difference between GO and PO cases in terms of the RC cut-off criterion. There were a number of subjects who fell at the limits of the RC cut-off criterion, such that GO and PO cases were distinguished by a few one hundredths of a point. The problem in creating categorical groups from a continuous variable is such that there will always be cases which fall at the limits and potentially obscure differences between groups. The research on treatment failures at Beth Israel Medical Center are the only studies known to this author in which a significant relationship between RC outcome categories and alliance has been demonstrated, representing a first attempt at identifying patterns among these variables. A proposed alternative method would be to collect self-report termination data from DO cases and conduct regression analyses using RC as an independent variable. This would avoid the problems created by outcome criteria cutoff scores, as well as increasing statistical power of the sample.

Questions remain regarding the lack of significance between the GO and PO

groups, especially when comparing these results to other psychotherapy process studies which have found such differences. One reason may have to do with the rigorous and consistent definition of treatment termination at session 30 (with a range of no more than a few sessions in either direction) by the Brief Psychotherapy Research Program. Many other studies of this kind use much a broader range of treatment lengths in their methodologies and may, as a result, be capturing greater outcome variability in their "completed treatment" samples. For example, the Vanderbilt studies typically report treatment protocols as being "a maximum of 25 sessions" (e.g., Henry et al., 1990; p. 769) but do not report the range. Sachs (1983), using the Vanderbilt sample, indicated that the mean number of sessions in her study was 18 out of a possible 25, but she also omitted the range. Does this mean that data collected on an average of two-thirds of the way through the treatment protocol are compared to data collected at session 25 in these studies? Patients who prematurely terminate in the middle portion of treatment or agree with their therapists to end halfway through the protocol may represent distinct outcome groups, subsumed in studies less consistent in their conceptualization of termination.

Results of the comparison of Narrative Coherency ratings among outcome groups were similar to the WAI-12, where GO had the highest scores, DO had the lowest, and PO scores fell in between. There was a statistical difference overall, with post-hoc comparisons indicating that the distinction lay between the two extreme scores (i.e., between GO and DO). The reason that Narrative Coherency failed to distinguish the PO group from the others, even though the means fell in the expected direction, may also be due to a small sample size and lack of power. A moderate effect sizes was found, also

similar to the WAI-12 data.

What is Narrative Coherency measuring in this study? The scores paralleled those of the WAI-12, both in direction and magnitude of effect. Correlational analyses indicated that Narrative Coherency may be, in part, an observer measure of aspects of the therapeutic alliance. For instance, Narrative Coherency was significantly correlated with patient ratings of Total and Bond WAI-12 scores; it did not correlate at all with therapist ratings of the alliance. This suggests that the measure is more specifically tapping into a feature of the affective bonding capacity of the dyad, and specifically as the patient experiences it. As Bordin (1994) defined it, "bonding of the persons in a therapeutic alliance grows out of their experience of association in a shared activity" and it "is likely to be expressed and felt in terms of liking, trusting, respect for each other, and a sense of common commitment and shared understanding in the activity" (p. 16). The results of this study suggest that it is the patient's perception of the quality of this bonding which is reflected in their ability to make their needs known in a clear, succinct, and specific way to the therapist. Put another way, those patients who can communicate their distress in a coherent fashion are more likely to have their needs met by the therapist, which will result in a stronger emotional bond between them. It was also found here that Narrative Coherency was not linked to the therapist's experience of the relational bond or the dyad's agreement about tasks and goals of treatment. *Bonding* is different from *attachment* in that the term *attachment* implies that the object is a source of security. Thus, patients develop attachments to therapists whom they view "as better able to cope with the world" (Bowlby, 1988, p. 26); the patient relies on the therapist as a source of security while

therapists do not rely on their patients in the same way (Farber, Lippert, & Nevas, 1995).

As Bowlby (1969) outlined, internal working models of attachment are dynamic mental representations of self and others in relationships which enable the individual to make meaning of interpersonal exchanges and, ideally, to respond flexibly and adaptively to the environment by mentally experimenting with different behavioral strategies. Individuals who have experienced early maternal unavailability and deprivation are unable to continually revise their internal working models of attachment because of the defensive exclusion of information which stimulates unbearable feelings of anxiety, anger, and/or guilt (Bowlby, 1980). As Slade (in press) succinctly summarized,

> ...Bowlby suggested that different patterns of attachment reflected differences in the degree of *access* an individual has to certain kinds of thoughts, feelings and memories. Certain types of insecure models permit only limited access to attachment related thoughts, feelings and memories, whereas others provide exaggerated or distorted access to attachment relevant information... in essence, the structure and functioning of the child's mind is determined by the types of feelings that are recognized and allowed expression within the (mother-child) dyad.

In this way, an individual engages in rigid and distorting interpersonal behaviors, including verbal communication, which serve a self-protective function but may lead to psychopathology. Later research expanded upon Bowlby's views to include the impact of ongoing miscommunication between and a child and caregiver on the development of internal working models, which is similar to Sullivan's description of security operations in adults (see Bretherton, 1995).

The results of the present study, which randomly sampled segments of psychotherapy narrative and did not focus exclusively on description of early attachment experiences, suggests that Narrative Coherency may possibly be considered as a measure

of a speaker's defensiveness or intrapsychic conflict with respect to *any* type of emotionally unresolved experience, not only attachment experiences. A critical next step in the application of Narrative Coherency as a process measure in psychotherapy research would be to conduct a content analysis of those areas of incoherency in transcripts in order to determine what speaker's are discussing when they become incoherent.

Another crucial aspect of Bowlby's theory of the development of attachment patterns and internal working models, which was first confirmed by Ainsworth's empirical studies (1979; Ainsworth et al., 1978), includes the quality of the adult caregiver's response to the infant. During the first year of life, the infant forms secure, insecure, or disorganized patterns of attachment based on the degree of attunement and consistency of maternal responses to their needs (see reviews in Silverman, 1991, 1992, 1998; Slade, in press). The interactive cycle between a mother and infant is initiated by the infant's bids for comforting and soothing when stressed, the pace of which is set by the child's particular temperament.

This central component of attachment theory has direct implications for the study of patient-therapist dyads. In other words, what does a therapist do in order to be a secure base for his or her patient and reduce their level of distress? Therapists in the GO group were communicating something different from the therapists in the PO and DO groups which resulted in their patients feeling understood, experiencing stronger alliances and ultimately feeling less subjective distress at the end of treatment. I will address this important issue later in the section on interpersonal behaviors measured by the SASB.

To return to the relationship between Narrative Coherency and WAI-12 found in

this study, it may be that the patient's ability to coherently communicate their distress to the therapist is also indirectly suggestive of a "transferential" component of the therapeutic alliance. While some authors contend that a measure such as the WAI-12 assesses more conscious aspects of the therapeutic collaboration (see Gelso & Carter, 1985), these data indicate that the bonding capacity of a patient may also be influenced by early attachment experiences, or transference. Transference is a complex clinical concept developed within psychoanalytic theory and was defined initially by Freud as a mode of "displacement" of unconscious thoughts, feelings, wishes, fantasies, and object-relationships onto the person of the analyst (Breuer & Freud, 1895; Freud 1912). Interestingly, Freud first considered the relationship to one's father as being the primary relationship "prototype" (see Laplanche & Pontalis, 1973). To reiterate one of Bowlby's central tenants of attachment theory here, the child develops a repertoire of behaviors which he/she has learned will elicit comforting responses from the mother and excludes behaviors that do not. The links between these early relational experiences, mental representations, and the quality of adult attachment patterns has now been established empirically by Main and her colleagues (Main, 1991; Main & Goldwyn, unpublished manuscript; Main, Kaplan, & Cassidy, 1985). In this assessment, the subject's capacity to coherently articulate past relational experiences with care givers to an interviewer was predictive of their degree of current attachment security.

It is not eminently clear from Main's work the extent to which narrative coherency in the AAI contributes to overall adult attachment security status. Is coherent, cooperative discourse equivalent to adult security? There are a number of areas which are

considered in the scoring of the AAI. For instance, inferred relationships between the speaker and his or her parent, defined as "role-reversal," "loving vs. unloving," "pressure to achieve," and "rejection," are rated on a nine-point Likert-type scale. A second category is defined as the speaker's overall present state of mind with respect to attachment, which includes ratings of coherency of narrative, anger, idealization, lack of memory, lack of resolution of mourning, fear of loss, and passivity (the reader is referred to the AAI manual for a more detailed description of the rating scales; Goldwyn et al., 1996). There is a great deal of overlap, especially among the latter category items, and it would be interesting to conduct an analysis of the independent contributions of each scale to the overall categorical attachment classification rating. If the rating of the degree of coherency in the AAI narrative is, in fact, primarily how the label of adult security is determined, one cannot then argue that coherency predicts adult security (Jeremy Safran, personal communication, July 27, 1998). The statistical link with a third, objective criterion, such as a speaker's self-report rating of adult attachment classification (e.g., Griffin & Bartholomew, 1994), would establish the necessary independence of these constructs.

This raises an interesting point with respect to coherency and self-report ratings of adult attachment status. If the degree of cooperativeness and coherency in terms of "how the story is told" is such an important component in determining adult attachment, what are paper-and-pencil questionnaire versions, which do not include the same assessment of a speaker's narrative, actually measuring?

The present study did not include an independent assessment of patient or therapist

attachment status and, therefore, to conclude that Narrative Coherency is assessing degree of attachment security is merely as assumption. These results suggest that a patient's capacity to coherently construct a narrative within the context of a psychotherapy session is empirically linked to the development of the therapeutic alliance, and whether coherency is a reflection of adult attachment status and related early attachment experiences or a more fundamental intrapsychic process, remains to be determined. Regardless of the current state of the empirical literature, incorporating an attachment *perspective* into the understanding and use of the alliance in psychotherapy certainly alters the original conception of transference from a projected, distorted process into something real which can be brought into the consulting room and utilized in an empathic way. Dozier and her colleagues (Dozier, 1990; Dozier, Cue, & Barnett, 1994) have studied the impact of different adult attachment systems on the process of psychotherapy and development of the therapeutic relationship. I found the descriptions of the interpersonal dynamics of Dismissing and Preoccupied patients described in these papers to be extremely vivid and considered them more clinically useful than Freud's erotic, positive, and negative transference categories. As Fonagy and Tallandini (1993) found in their study, all of the patients who terminated prematurely from psychotherapy were classified on the AAI as preoccupied. I am now curious about the different attachment classifications of patients and therapists in this sample.

A word of caution at this juncture. While it was interpreted earlier in this section that Narrative Coherency may be an observer measure of an aspect of the therapeutic alliance, the significant WAI-12 - Narrative Coherency correlations fell within the

moderate effect size range. Thus, while Narrative Coherency was empirically found to be related to the patient's subjective experience of the relational bond with the therapist, as well as to the overall quality of the alliance, it is a modest relationship at best. This finding seems to indicate that the WAI-12 and Narrative Coherency scales are not exactly assessing the same underlying phenomena. The difference in rating perspectives may be a reason for the moderate-level strength of the relationship here (i.e., observers rating language structure are a few steps removed from the direct assessment of the mental representations of patients and therapists). However, there have been conflicting results found in studies comparing the three rating perspectives. Tichnor & Hill (1989), for example, created an observer measure of the WAI-12 and found nonsignificant correlations with patient (r = -.18) and therapist (r = .03) versions of the scale, and between patient and therapist versions (r = .09). In other words, the relationship among observer-rated Narrative Coherency and patient-rated WAI-12 scores in this study was greater than that found among observer and patient ratings of the same scale in the Tichnor & Hill (1989) paper. The latter results lie in marked contrast to the highly significant relationships among all subscores of patient with therapist ratings of the WAI-12 found here and may be an artifact of the small sample sized (N = 8) used by Tichnor & Hill (1989). In another study, Rozmarin, Muran., Gorman, Nagy, Safran, & Winston (1998) correlated patient and therapist WAI-12 ratings and found that the higher these correlations, the stronger the relationship with overall treatment outcome. Clearly, more research needs to be conducted assessing the relationships among patient, therapist, and observer perspectives of clinical phenomena such as the alliance in order to tease apart

these issues.

Similar to observer ratings, a therapist rating their impressions of what a patient is thinking and feeling about the therapeutic relationship is also removed from what is in the mind of the patient. Recall that a replicated finding in alliance research is that of patient ratings of the therapeutic relationship as the best predictor of treatment outcome (Horvath & Symonds, 1991). It was mentioned in the Results section that certain WAI-12 items on the therapist version of the scale were in fact measuring the therapist's impression of the patient's conception of the alliance. This may be an artifact of the theoretical context from which Bordin developed the WAI, with remnants of an emphasis on a "one-person" psychology (Chris Muran, personal communication, July 28, 1998). While these items include aspects of the therapist's perspective on the relationships, moving towards a "two-person" psychology, they also reflect an allegiance to a primary focus on the patient's experience. It would be most interesting to have therapists more directly assess their own impression of the relationship between them and their patient. For example, to what extent is the therapist confident in his or her own ability to help the patient, rather than the therapist's impression of the patient's confidence in his or her ability; and does the therapist like/appreciate his or her patient, rather than the current wording of the scale which taps the therapist's impression of the patient's experience of being liked/appreciated by the therapist. This type of alliance measure may be more strongly linked to treatment outcome than the current conception of therapist's view of the relationship.

Overall, these findings suggest that Narrative Coherency may be measuring one of the mechanisms by which aspects of a positive therapeutic alliance are established between

a patient and therapist. However, correlational data do not tell us anything about causality and it is obviously not possible to determine from this study if Narrative Coherency influences the development of the alliance or if it is the other way around. Perhaps a third variable, such as the degree of resolution of early attachments loss and trauma, influences the development of both of them.

The difference among outcome groups with respect to self-reported history of early, severe losses and traumas regarding attachment figures was a puzzling finding, particularly in light of the lack of dichotomy between PO and GO groups on alliance and Narrative Coherency scores. Significantly fewer patients in the PO group (i.e., one of 16 or 6.25%) reported evidence of at least one loss or trauma involving a parent or guardian in the assessment interview. Comparatively more patients in DO group (i.e., almost half) reported such experiences and the GO group patients fell in between (i.e., approximately one third). It was notable that in the GO and DO groups, a number of patients reported multiple loss/trauma experiences. Do fewer patients classified as PO actually experience less early, severe attachment loss and trauma? Perhaps patients in the PO have more difficulty accessing painful early memories and hence, selectively/defensively excluded such experiences from consciousness. This interpretation of the data is consistent with Bowlby's description of defenses as misattributions due to attempts at making sense of the world consistent with the way in which one has experienced it.

Further evidence supporting a possible defensive stance of PO subjects in this study comes from a clinical example provided by one patient treated by this author. This PO patient called the author after her participation in the study was completed and

requested long-term treatment with her. About a year into the second therapy, she recalled that her mother gave birth to a still born daughter when the patient was about two years of age, and that her mother remained very depressed throughout her life as a result. Themes of loss subsequently dominated the treatment. The feelings which surfaced for the woman in this context were painful ones and it became clearer why the event of the still born sibling had not been reported in the initial assessment. While this is merely anecdotal evidence, it may be suggestive of the kind of selective inattention, or defensive exclusion of painful information by patients who do not ultimately make much in the way of improvement in time-limited psychotherapy. This patient clearly required more time in treatment in order for a secure base to be established with the therapist, which eventually enabled her to venture into very painful areas of her life.

Unlike the structured AAI, which measures coherency in the subject's narrative regarding specific early, severe attachment losses and traumas, this study examined randomly selected segments of narrative from psychotherapy sessions. While portions of the sessions chosen might serendipitously have included a similar focus on such attachment experiences, the general context of the psychotherapeutic setting, which typically focuses on interpersonal relationships, was thought to activate the attachment systems of patients (and therapists) in a way which might be similar to the AAI. Is Narrative Coherency measuring a fundamental relational phenomenon, or common factor in psychotherapy, seemingly related to the therapeutic alliance, which is not dependent upon a particular therapeutic technique? The triggering of anxiety or traumatic responses within the context of the relationship with the therapist would then be reflected in the

quality of narrative created in the patient's efforts to communicate and connect with, or disengage from them (i.e., evidence of the internal working model or attachment system). As stated earlier, Mann (1973) and Wolff (1971) identified issues of loss, endings, and separation as consistent and central themes in short-term psychotherapies.

Interpersonal behavior: Common and unique factors. Results of comparisons using the SASB were mixed in this study. Overall, significant main effects were found with mean weighted cluster frequencies, indicating that patients focused more on themselves and therapists focused more on their patients. Also, for the sample as a whole, the eight cluster scores were not equally utilized. These results are consistent with other research using observer ratings of SASB, and provide some validation for the method (Coady, 1991; Henry et al., 1986).

While hypotheses predicting that outcome groups would be significantly different in terms of frequency of interpersonal behavior were not supported, scores for certain variables did fall in expected directions. For example, patients in the GO group were rated as having lower hostile surface 2 scores (e.g., sulking/appeasing [2-6] and walling off/avoiding [2-8]) compared to the two treatment failure groups. Similarly, therapists in the GO group had lower hostile surface 1 scores (e.g., belittling/blaming [1-6] and ignoring/neglecting [1-8]) compared to the treatment failure groups. On the friendly half of the SASB, patients in the DO group were rated as doing less disclosing/expressing (2-2) compared to the other groups, as was anticipated. Means which reflected patterns inconsistent with the literature included therapist affirming/understanding (1-2) and helping/protecting (1-4) behaviors. In these clusters, the highest scores were found in the

PO group. This suggests that therapists were exhibiting a greater frequency of friendly behaviors, possibly in an effort to engage the patients. Here, SASB data suggest a possibly qualitative difference between PO and DO cases and point to further complications in the interpretation of interrelationships among the measures used in this study. Do therapists who evidence a greater frequency of affiliative behaviors *cause* poor treatment alliances and outcomes or is therapist behavior the *result of* treatment process? Again, the nature of correlational analyses do not allow for such inferences to be made.

Finally, comparisons of Complex Communications found higher mean frequencies in PO and DO groups, respectively, compared to the GO group, for both patients and therapists. While the direction of these scores fell in the expected direction, differences among groups were not statistically significant. In sum, patients and therapists in the GO groups evidenced less hostile behaviors and less mixed messages compared to the two treatment failure groups; and the PO group had relatively higher means in the friendly clusters compared to both the GO and DO groups, for both patients and therapists. As stated above, none of the between group comparisons were statistically significant and all of these interpretations of the findings must be taken with extreme caution until additional research can be completed.

One reason why the SASB cluster frequency results did not come out as hypothesized may be the inclusion of patient-therapist dyads from five different therapy orientations. The standard deviations of these data were consistently very large and obscured any potential between groups differences in mean scores. Such variability with differential outcome groups is consistent with other SASB research studies (Bill Henry,

personal communication, May 8, 1998). However, only low to moderate effect sizes were found in the current study. It is possible that patient and therapist interpersonal behaviors related to good vs. poor outcome or premature termination cases differ with respect to treatment orientation (note that previous studies which have used observer ratings of SASB included subjects from one type of treatment). For example, in the dynamic treatments, a therapist who is adhering to the treatment manuals would likely be exhibiting a high frequency of watching/managing and interpretive behaviors. Compare this to a supportive therapist who would be attempting to reduce the patient's anxiety by possibly behaving in a more affirming/understanding way (see Zetzel, 1956). In this way, SASB Cluster scores may represent a unique factor in psychotherapy (i.e., are more directly related to specific therapist interventions) which interact with therapeutic alliance in determining psychotherapy outcome (Gaston, 1990). Any potential differences between outcome groups in this study may have, therefore, been obscured by combining treatment orientations. The current sample is too small to conduct analyses between treatment groups.

Does the alliance between a patient and therapist exist as a catalyst that allows a psychically mutative intervention such as insight to take effect? Or is alliance, defined as an emotional attachment or empathic bond between a patient and therapist, linked developmentally to a patient's psychological structure and thus itself an agent of change? The answer likely lies somewhere in the middle of these two perspectives. Gaston (1990) proposed a hierarchical regression model in which outcome, therapist interventions, in-session symptom change, and alliance are controlled. This, she explains, would provide a

stronger test of the hypothesis that alliance itself is a therapeutic agent compared to models which more globally connect alliance with overall outcome. In this way, the independent contributions of these factors, as well as their interactions, could be examined. Gaston outlines the idea of how alliance may differentially interact with therapeutic interventions and could be operationalized as "the better the alliance, the more effective the exploratory interventions; while the poorer the alliance, the more effective the supportive interventions" (p. 151).

A second reason for the lack of statistically significant findings with Cluster scores in this study may also have been due the nature of the sample studied. Most of the patients in the current research met criteria for a DSM-III-R axis II diagnosis and may have represented a more chronic and clinically disturbed population compared to the higher functioning patients used as subjects in the Henry et al. (1986) and Coady (1991) studies. Such a population would be expected to exhibit more rigid and extreme interpersonal behaviors, which may account for the high standard deviations of the SASB cluster data.

The results of analyses of SASB Complementarity scores supported the hypothesis that Negative Complementarity would distinguish outcome groups. This variable may represent a common psychotherapy process factor similar to alliance and Narrative Coherency. The significant result with Negative Complementarity was found in both Patient-to-Therapist and Therapist-to-Patient exchange sequences. However, an unexpected finding was that the mean in the PO group was significantly higher than that of the GO group, with the DO mean falling between these two (i.e., the DO group did not

evidence the highest degree of Negative Complementarity, as hypothesized). Thus, overall, the PO and DO groups were found to be qualitatively different from each other and not simply quantitatively different, as had been the general hypothesis. Taking into consideration the higher WAI-12 scores of the PO group compared to the DO group, it may mean that the PO dyads had a just strong enough alliance to engage in some form of a relationship, albeit a complementary hostile or negative one. Comparatively, the DO dyads could not engage in any type of sustaining relationship and they terminated prematurely. Neither Neutral nor Positive Complementarity scores differentiated the three outcome groups, as was hypothesized. The inclusion of Neutral Complementarity was unique to this study, and while this variable did not yield any significant results, the finding that Negative Complementarity did still discriminate groups suggests an even more robust effect.

Interrelationship of WAI-12, Narrative Coherency and SASB. Correlational analyses showed that Negative Complementarity was significantly negatively related to patient Goal, Task, and Total WAI-12 scores, and to all therapist WAI-12 scores, with therapist Bond demonstrating the strongest inverse relationship. In general, while patients and therapists produced more friendly interpersonal behaviors compared to hostile ones overall, Negative Complementarity appeared to have greater "therapeutic valence" (Kiesler & Watkins, 1989). What these authors mean by therapeutic valence is that the occurrence of negative or hostile behaviors is more influential or salient with respect to overall treatment outcome than positive or friendly behaviors (i.e., a high level of hostile communication predicts treatment failure, even in the context of friendly communication

patterns).

To return to the question of what the therapist does to promote "corrective emotional experiences" in treatment and good overall outcome, it may be more accurate to reframe the question and ask what the therapist does to avoid treatment failure. The results of this study indicated, for example, that a high degree of complementary hostile communications between the patient and therapist predicted poor overall outcome. The interrelationship of SASB Complementarity and WAI-12 Bond scores is interesting in light of the significant correlation between patient Bond ratings and Narrative Coherency. It might be concluded here that patients and therapists were attending to different aspects of the developing relationship, particularly with respect to affective components, and that the common factors of alliance, attachment, and interpersonal complementarity differentially influence the change process from patient and therapist perspectives. For therapists, negative interpersonal complementarity behavior seemed to carry the therapeutic valence in terms of bonding, while for patients, it was the experience of feeling understood.

In general, those variables proporting to more directly measure the therapeutic relationship dyad (i.e., WAI-12, Narrative Coherency, SASB Complementarity) predicted outcome across a range to treatment types, whereas scores of individual patient and therapist behaviors (i.e., SASB Cluster and Complex Communication scores) did not. To review, the dyad measures assessed different aspects of the quality of the therapeutic relationship while the SASB Cluster and Complex Communication scores assessed interpersonal communications of patients and therapists separately.

Finally, Narrative Coherency was significantly directly correlated with Positive Complementarity and significantly inversely correlated with Neutral and Negative Complementarity. These results were as expected and provide further validation for the Narrative Coherency measure used in this study. The significant inverse relationship with Neutral Complementarity suggests that this category may be perceived clinically as negatively impacting upon the developing therapeutic alliance.

Limitations and future research. There were a number of limitations of this study which are important to outline here. In terms of generalizability of the findings, this patient population was a largely White, middle class group, approximately half men and half women, presenting to a 30-session treatment facility conducting research on psychotherapy process and outcome. Patients paid a fee for therapy and agreed to have all sessions video-taped. Most of the patients met criteria for a DSM-III-R personality disorder diagnosis and had longstanding interpersonal difficulties. The therapists were similarly White, middle class, half men and half women, and most had either an M.D. or Ph.D. degree. This population may represent a more chronic and clinically disturbed population compared to the many process-outcome studies conducted on college student samples attending free counseling centers (e.g., such as with the Vanderbilt studies). Also, the therapists in this study may represent a more clinically skilled group of clinicians.

The data were collected from an archival sample and selection of study cases was limited to data available from the patient-therapist dyads who had previously participated in the Brief Psychotherapy Program at Beth Israel Medical Center. One problem was that outcome assessment data (e.g., patient and therapist ratings at the end of treatment) were

not collected on cases which had prematurely terminated, and the current study design was significantly influenced by this procedure. The definition of three distinct outcome groups was a way to work around the lack of pre- to post-therapy symptom change scores in the DO condition. However, statistical power was reduced as a result. As was mentioned above, the cut-off points for RC scores introduced divisions between patients who were not very different in terms of outcome and may have contributed to the lack of significant distinctions on independent variables between GO and PO groups. An alternative research design would be to put resources into collecting termination data from patient-therapist dyads who dropped out of therapy, perhaps by offering financial incentive, and using RC scores as a continuous outcome measure. In this way, multiple regression analyses could be utilized on the entire sample. An additional benefit of a regression analysis design is that the unique contributions of alliance, Narrative Coherency and interpersonal behavior (e.g., SASB Negative Complementarity) could be assessed.

A second problem was that there were not enough subjects in the Beth Israel sample to either compare the potential effects of treatment type across outcome groups, or to restrict the cases selected to any one particular treatment. A comparison of treatment groups may have helped to explain the insignificant results of SASB cluster score analyses. Alternatively, the variability in SASB cluster scores may have been reduced by limiting the sample to one type of treatment. Also, it would be interesting to test for a possible interaction of WAI-12 and Narrative Coherency with intervention type. While the collapsing of different treatment orientations was not an issue for relating common factor variables such as alliance and coherency to outcome, variables such as interpersonal

behavior, which may be unique to therapeutic orientation, were not found to distinguish outcome groups in this kind of design. The work of Goldfried and his colleagues, for example, has demonstrated a difference in alliance ratings in cognitive-behavioral compared to dynamic-interpersonal therapies (Goldfried, Castonguay, Hayes, Drozd, & Shapiro, 1998). Any further conclusions regarding interactions of alliance and interpersonal behavior between treatments awaits future research. The inclusion of patient, therapist, and observer perspectives in this study was a strength of the current design, which could be incorporated to an even greater degree in subsequent process-outcome studies. For example, the RC scores utilized only patient ratings of overall outcome. It is recommended that therapist and observer ratings be included in the computation of pre- to post-treatment change in the future, in order to provide a more comprehensive assessment index.

Another limitation was the cross-sectional nature of the design. A number of previous studies have examined the development of the alliance over time, and suggest that in good overall outcome cases, the alliance increases over the course of treatment (Klee, Abeles, & Muller, 1990; Luborsky, et al., 1983; Marziali, 1984). The results are not so conclusive with the addition of poor outcome and dropout samples, however, and clearly more longitudinal research needs to be conducted with these populations in order to elucidate how components of the therapeutic relationship function as agents of change. As mentioned above, different types of treatment interventions may have different relationships with alliance development and ultimate outcome.

While Narrative Coherency looks like it may be a promising variable with respect

to furthering understanding of the therapeutic alliance and how it functions as a mechanism of psychological change, the next step will have to be the linking of in-session coherency data with AAI information. This interview includes detailed inquiry of early childhood attachment experiences as well as the degree of resolution of any losses and/or traumas. Degree of resolution is a critical component in attachment research on early maternal deprivation, in that it is not simply the experience of traumatic early attachment experiences which predicts insecure adult attachment status but how adequately the subject has worked through them. While the implications of this kind of work stimulate ideas about possible transference phenomena, in this research, the relationship between early attachment experiences and their impact on the development of a therapeutic relationship is an indirect one. Narrative Coherency ratings could also be used to identify therapeutically relevant portions of sessions for micro-analytic study, a method suggested by Greenberg (1986).

Studies conducted by Safran and colleagues (Hill & Safran, 1994) have examined patients' "cognitive schemas" of relationships with mother, father, and significant others, and have measured changes in these relationship schemas over the course of therapy using the Interpersonal Schema Questionnaire. Recent work at Beth Israel is now incorporating patient schemas of relationships with therapists and how they are related to patient change in treatment. Such research is an example of the kind of empirical link needed between intrapsychic functioning at the level of mental representation and interpersonal behavior and affect regulation within the context of a developing therapeutic relationship.

Another area for future research is that of therapist attachment status and it's

potential impact on therapeutic process. Diamond and her colleagues have been developing an adaptation of the AAI where therapists are interviewed about their patients (Diana Diamond, personal communication, June, 1997). For instance a therapist is asked to provide five adjectives about a patient and to then elaborate on those descriptives. The interview is then rated in a similar way to the AAI, assessing degree of coherency of the narrative, among other things. Researchers at Beth Israel have been using therapist versions of the ISQ to begin assessing therapist's internal working models of attachment and how they might be linked to the quality of therapy they provide.

Summary and conclusions. This study found the WAI-12, Narrative Coherency, and SASB Negative Complementarity to predict overall outcome in a sample of character disordered patients and their therapists, participating in a 30-treatment protocol. Cases were selected based on inclusion criteria for one of three outcome groups: good outcome or one of two treatment failure conditions (i.e., poor outcome and dropout). The sample was collapsed across five different types of treatments. On the WAI-12 overall, the DO group was found to have significantly lower scores (i.e., indicative of less positive therapeutic relationships) than the GO group, although univariate and post-hoc comparisons found that patient and therapist ratings also distinguished DO from PO group scores on all but the Goal factor. Narrative Coherency ratings were highest for the GO group (e.g., indicating most coherent narratives), moderate for the PO group, and lowest for the DO group, with a statistical difference between GO and DO groups. The PO group demonstrated significantly higher scores on SASB Negative Complementarity compared to the GO group, with DO scores falling in between. The SASB Cluster scores

did not differentiate outcome groups.

Correlations among the three measures found: (1) significant direct relationships between patient WAI-12 Bond and Total scores, and Narrative Coherency; (2) significant indirect relationships between patient WAI-12 Goal, Task, and Total scores, and SASB Negative Complementarity; (3) significant indirect relationships between all therapist WAI-12 scores and SASB Negative Complementarity; (4) a significant positive correlation between Narrative Coherency and SASB positive Complementarity; and (5) significant negative correlations between Narrative Coherency and both SASB negative and Neutral Complementarity. These findings suggest that patients and therapists consider different aspects of the therapeutic relationship to carry therapeutic weight or valence, particularly in terms of the affective components of the relationship. Narrative Coherency, which was adapted from the AAI and developed specifically for this study, points to a possible relationship between aspects of a patient's attachment system and their capacity to bond with a therapist. A next step will be to examine different attachment styles and the resolution of early attachment losses and traumas on the development of Narrative Coherency and therapeutic alliance.

Overall, the results were interpreted in terms of common *vs.* unique factors in the process of psychotherapy and relationship to overall outcome. The indices measuring the relationship between patient and therapist, such as WAI-12, Narrative Coherency, and SASB Complementarity were thought to reflect relational variables common to all types of treatment orientations, while SASB Cluster scores, which measured interpersonal behaviors of patients and therapists individually, may have been linked more specifically to

to therapy orientation. It was not possible in this project to include treatment orientation as a dependent variable. Future process-outcome research clearly needs to examine the interaction of alliance and interpersonal behavior.

In conclusion, the comparison of two types of treatment failure conditions yielded interesting findings in terms of quantitative differences between them and suggested that patients who prematurely terminate a time-limited therapy do not necessarily develop a quantitatively more problematic or hostile therapeutic relationships than patients who complete the treatment protocol with poor overall outcome. While the DO group had the most problematic therapeutic alliances and the most incoherent psychotherapy narratives, the PO group demonstrated the highest levels of hostile complementary behaviour and reported significantly fewer experiences of early attachment loss and trauma. These findings speak to the highly complex nature of the therapeutic relationship and have clinical implications for the treatment of personality disordered patients, particularly those who have a hard time bonding with their therapist. One of the goals of psychotherapy process-outcome research is, of course, to guide clinicians in the delivery of more efficacious treatments. The current study may help to shed a little more light on the operationalization of the therapeutic relationship and its relationship to psychological change.

Table 1

Summary of interpersonal complementarity terminology

Term	Description
Complementarity	An interpersonal context in which two individuals engage in a back and forth cycle where each elicits or "pulls" for certain predictable behaviors from one another, which confirm the individual's self-experience
Reciprocity	Complementarity on the control axis (dominance elicts submission, and submission elicts dominance)
Correspondence	Complementarity on the affiliation dimension (friendliness elicits friendliness and hostility elicits hostility)
Acomplementarity	When a response is complementary on one axis but not the other (e.g., friendly-dominance followed by friendly-dominance)
Anticomplementarity	When a response is not complementary on either axis (e.g., friendly-dominance followed by hostile-dominance)

Table 2

Comparison of patient demographic variables among GO, PO, and DO groups using one-way ANOVA or chi-square tests

Demographic Variables	GO	PO	DO	df	*F*-value or χ^2
Mean Age (SD)	38.00 (7.92)	40.56 (7.58)	38.31 (7.76)	2,45	0.54
Gender					
Female	9	7	11		
Male	7	9	5	2	2.01
Marital Status					
Single/Never Married	7	9	12		
Married	7	4	2		
Divorced/Separated/Widowed	2	3	1	4	4.04
Currently Employed					
Yes	13	15	11		
No	3	1	5	2	3.16

Table 2 (continued)

Comparison of patient demographic variables among GO, PO, and DO groups using one-way ANOVA or chi-square tests

Demographic Variables	GO	PO	DO	df	*F*-value or χ^2
Education Level					
High School Diploma	4	5	8		
College Degree	8	6	4		
Graduate/Professional Degree	4	5	4	4	2.97
Race					
White	12	14	15		
Minority[1]	4	2	1	2	2.14

[1] Minority status included Asian-American and Hispanic groups

Note. Fisher exact test was used when cell sizes < 5; GO = Good Outcome, PO = Poor Outcome, DO = Dropout

Table 3

Comparison of patient diagnostic variables among GO, PO, and DO groups using Fisher exact tests

Diagnostic Variables	GO	PO	DO	df	FI
DSMIIIR: Axis I					
Depression	8	10	12		
Anxiety	6	4	2		
V-codes	2	2	2	4	2.95
DSMIIIR: Axis II					
Cluster C	8	6	5		
Cluster B	0	1	1		
NOS	6	7	6		
None	2	2	4	6	3.08

Note. GO = Good Outcome; PO = Poor Outcome; DO = Dropout; FI = Fisher exact test

Table 4

Comparison of the frequency of patients in GO, PO, and DO groups randomly assigned to each of the five treatment types using a Fisher exact test

Treatment Group	GO	PO	DO	df	FI
STDP	7	1	3		
BAP	2	5	5		
SUP	2	2	1		
CBT	3	4	3		
BRT	2	4	4	8	7.94

Note FI = Fisher exact test, GO = Good Outcome, PO = Poor Outcome, DO = Dropout

Table 5

Analysis of the frequency of patients reporting severe childhood attachment loss and trauma compared among GO, PO, and DO groups using a Fisher exact test

Severe Early Attachment

Loss/Trauma	GO	PO	DO[1]	df	FI
Yes	5	1	7		
No	11	15	8	2	6.63*

[1]. Information on losses was missing for one patient in the DO group

Note. GO = Good Outcome, PO = Poor Outcome, DO = Dropout FI = Fisher exact test

* $p<.05$.

Table 6

Comparison of therapist demographic variables among GO, PO, and DO groups using one-way ANOVA or chi-square tests

Demographic Variables	GO	PO	DO	df	*F*-value or χ^2
Mean Age (SD)	39.06 (10.88)	38.25 (7.65)	38.31 (8.06)	2,45	0.04
Years Clinical Experience (SD)	9.00 (9.76)	8.13 (8.85)	5.81 (9.40)	2,45	0.50
Gender					
Female	8	9	9		
Male	8	7	7	2	0.17
Degree					
Ph.D./Psy.D.	4	7	4		
M.D.	8	4	7		
M.A./M.S.W.	4	5	5	4	2.74

Note. Fisher exact test was used when cell sizes <5. GO = Good Outcome, PO = Poor Outcome, DO = Dropout

Table 7

Summary of dyad selection criteria

	Outcome Groups	
GO	PO	DO
Criterion I: Patient-therapist dyad completed 30-session protocol Patient completed pre- and post-treatment assessment batteries RC index ≥ 0.5	Patient-therapist dyad completed 30-session protocol Patient completed pre- and post-treatment assessment batteries RC index < 0.5	Patient terminated treatment between sessions four and 10 Patient completed pre-treatment assessment battery Problematic therapeutic relationship noted on at least one PSQ by patient and therapist
Criterion II: In the event of therapists with multiple patients, a therapist's first case within any outcome group was selected		

Note. GO = Good Outcome, PO = Poor Outcome, DO = Dropout

Table 8

Description of SASB Cluster labels for surface 1 (focus on other) and surface 2 (focus on self) codes

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Surface 1

1 **Emancipate:** 1. Without much worry, S leaves O free to do and be whatever O wants. 2. Without much concern, S gives O the freedom to do things on his/her own.

2 **Affirm:** 1. S lets O speak freely, and warmly tries to understand even if they disagree. 2. S likes O and tried to see his/her point of view even if they disagree.

3 **Active Love:** 1. S happily, gently, very lovingly approaches O, and warmly invites O to be as close as he/she would like. 2. With much love and caring, S tenderly approaches is O seems to want it.

4 **Protect:** 1. With much kindness, S teaches, protects, and takes care of O. 2. In a very loving way, S helps, guides, shows O how to do things.

5 **Control:** 1. To keep things in good order, S takes charge of everything and makes O follow his/her rules. 2. To make sure things turn out right, S tells O exactly what to do and how to do it.

6 **Blame:** 1. S puts O down, blames him/her, punishes him/her. 2. S tells O his/her ways are wrong and he/she deserves to be punished.

7 **Attack:** 1. Without worry about the effect on O, S wildly, hatefully, destructively attacks him/her. 2. Without caring what happens to O, S murderously attacks in the worst possible way.

8 **Ignore:** 1. Without giving it a second thought, S uncaringly ignores, neglects, abandons O. 2. Without giving it a thought, S carelessly forgets O, leaves him/her out of important things.

Table 8 (continued)

Description of SASB Cluster labels for surface 1 (focus on other) and surface 2 (focus on self) codes

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Surface 2

1 **Separate:** 1. S knows his/her own mind and "does his/her own thing" separately from O. 2. S has a clear sense of what he/she thinks, and chooses his/her own ways separately from O.

2. **Disclose:** 1. S clearly and comfortably expresses his/her own thoughts and feelings to O. 2. S peacefully and plainly states his/her own thoughts and feelings to O.

3. **Reactive Love:** 1. S relaxes, freely plays, and enjoys being with O as often as possible. 2. S is joyful and comfortable, altogether delighted to be with O.

4. **Trust:** 1. S learns from O, relies upon O, accepts what he/she offers. 2. S trustingly depends on O, willingly takes in what O offers.

5. **Submit:** 1. S thinks, does, becomes whatever O wants. 2. S defers to O and conforms to O's wishes.

6. **Sulk:** 1. With much sulking and fuming, S scurries to do what O wants. 2. S bitterly, resentfully gives in, and hurries to do what O wants.

7. **Recoil:** 1. With much fear and hate, S tries to hide or get away from O. 2. Filled with disgust and fear, S tries to disappear, to break lose from O.

8. **Wall Off:** 1. S walls him/herself off from O and doesn't react much. 2. S is closed off from O and mostly stays alone in his/her world.

Note. SASB = Structural Analysis of Social Behavior; S = Self; O = Other (Benjamin, 1988).

Table 9

SASB Complementarity scoring matrices for affiliation and interdependence dimensions

Affiliation:

Octants	Friendly (2, 3, 4)	Neutral (1, 5)	Hostile (6, 7, 8)
Friendly (2, 3, 4)	3+	2+	1-
Neutral (1, 5)	2+	3	2-
Hostile (6, 7, 8)	1-	2-	3-

Interdependence:

Octants	Top (1, 2, 8)	Middle (3, 7)	Bottom (4, 5, 6)
Top (1, 2, 8)	3	2	1
Middle (3, 7)	2	3	2
Bottom (4, 5, 6)	1	2	3

Table 10

Comparison of WAI-12 (patient and therapist rated) scores among GO, PO, and DO groups using MANOVA

		GO		PO		DO		Univariate	Effect Size
Rating Scale		M	SD	M	SD	M	SD	*F*-value	(*r*)
Patient:	Bond	5.38	0.92	5.24	0.89	4.19	0.81	8.78***	.53
	Goal	5.07	0.91	5.20	0.90	4.36	0.77	4.36*	.40
	Task	5.20	0.80	5.03	0.99	4.00	0.85	8.62***	.53
	Total	5.22	0.80	5.15	0.84	4.19	0.69	8.72***	.53
Therapist:	Bond	4.88	0.58	4.81	0.90	4.06	0.91	5.04**	.44
	Goal	4.86	0.63	4.83	0.88	4.14	1.02	3.58*	.37
	Task	4.74	0.59	4.76	0.92	3.93	1.06	4.67**	.41
	Total	4.83	0.56	4.80	0.81	4.04	0.95	5.14**	.43

Note. WAI-12=Working Alliance Inventory - 12; GO = Good Outcome, PO = Poor Outcome, DO = Dropout, $df = 2, 45$.
*** $p<.001$; ** $p<.01$; * $p<.05$

Table 11

Comparison of SASB Cluster mean weighted frequencies for therapist focus on other (surface 1) codes among GO, PO, and DO groups using MANOVA

	GO		PO		DO		Univariate	Effect Size
Focus on other	M	SD	M	SD	M	SD	*F*-value	(*r*)
1. Freeing/forgetting	2.19	8.78	0.51	1.55	0.17	0.67	0.71	.17
2. Affirming/understanding	112.59	58.85	182.08	122.01	124.22	102.36	2.31	.31
3. Nurturing/comforting	0.00	0.00	0.00	0.00	0.00	0.00	0.00	.00
4. Helping/protecting	129.08	56.61	161.80	83.65	121.65	58.42	1.61	.26
5. Watching/monitoring	48.78	89.04	35.57	37.33	31.50	44.17	0.35	.12
6. Belittling/blaming	3.49	9.00	7.54	10.63	7.23	12.11	0.72	.18
7. Attacking/rejecting	0.00	0.00	0.00	0.00	0.00	0.00	0.00	.00
8. Ignoring/neglecting	2.54	4.30	4.59	11.76	4.59	5.91	0.35	.12

Note. SASB = Structural Analysis of Social Behavior, GO = Good Outcome, PO = Poor Outcome; DO = Dropout; $df = 2,45$

Table 12

Comparison of SASB Cluster mean weighted frequencies for patient focus on other (surface 1) codes among GO, PO, and DO groups using MANOVA

	GO		PO		DO		Univariate	Effect Size
Focus on other	M	SD	M	SD	M	SD	*F*-value	(*r*)
1. Freeing/forgetting	0.00	0.00	0.00	0.00	0.00	0.00	0.00	.00
2. Affirming/understanding	0.98	1.66	2.61	5.54	1.80	2.98	0.75	.18
3. Nurturing/comforting	0.00	0.00	0.00	0.00	0.00	0.00	0.00	.00
4. Helping/protecting	0.46	1.20	0.76	0.85	1.74	3.67	1.40	.24
5. Watching/monitoring	0.97	1.93	0.81	1.45	1.75	3.67	0.63	.17
6. Belittling/blaming	2.64	6.17	6.84	14.21	6.06	14.59	0.53	.15
7. Attacking/rejecting	0.00	0.00	0.00	0.00	0.00	0.00	0.00	.00
8. Ignoring/neglecting	0.00	0.00	0.00	0.00	0.06	0.26	1.00	.21

Note. SASB = Structural Analysis of Social Behavior, GO = Good Outcome, PO = Poor Outcome, DO = Dropout, *df* = 2,45.

Table 13

A comparison of SASB Cluster mean weighted frequencies for therapist focus on self (surface 2) codes among GO, PO, and DO groups using MANOVA

	GO		PO		DO		Univariate	Effect Size
Focus on self	M	SD	M	SD	M	SD	*F*-value	(*r*)
1. Asserting/separating	0.52	1.04	0.25	0.69	1.41	3.11	1.57	.26
2. Disclosing/expressing	3.22	4.00	2.27	3.30	1.52	3.55	0.88	.19
3. Approaching/enjoying	0.00	0.00	0.00	0.00	0.00	0.00	0.00	.00
4. Trusting/relying	0.34	1.06	0.52	0.84	0.85	2.00	0.56	.16
5. Deferring/submitting	0.08	0.30	0.70	1.27	0.17	0.67	2.54	.32
6. Sulking/appeasing	0.15	0.60	4.03	9.41	1.18	2.88	1.99	.29
7. Protesting/recoiling	0.00	0.00	0.00	0.00	0.00	0.00	0.00	.00
8. Walling off/avoiding	0.00	0.00	0.11	0.42	0.26	0.59	1.60	.26

Note. SASB = Structural Analysis of Social Behavior, GO = Good Outcome, PO = Poor Outcome, DO = Dropout, *df* = 2,45.

Table 14

A comparison of SASB Cluster mean weighted frequencies for patient focus on self (surface 2) codes among GO, PO, and DO groups using MANOVA

	GO		PO		DO		Univariate	Effect Size
Focus on self	M	SD	M	SD	M	SD	*F*-value	(*r*)
1. Asserting/separating	94.42	130.57	50.28	56.84	121.93	125.94	1.73	.27
2. Disclosing/expressing	261.56	195.52	262.07	152.65	175.91	131.33	1.50	.25
3. Approaching/enjoying	0.33	0.34	0.00	0.00	0.00	0.00	0.00	.00
4. Trusting/relying	81.96	46.25	80.66	23.40	73.53	33.39	0.26	.11
5. Deferring/submitting	15.95	22.16	15.51	24.36	14.36	18.16	0.02	.03
6. Sulking/appeasing	8.23	14.10	33.34	46.26	22.19	29.77	2.36	.31
7. Protesting/recoiling	0.00	0.00	0.00	0.00	0.00	0.00	0.00	.00
8. Walling off/avoiding	44.52	41.49	66.72	60.95	73.79	105.93	0.67	.17

Note. SASB = Structural Analysis of Social Behavior, GO = Good Outcome, PO = Poor Outcome, DO = Dropout, $df = 2,45$

Table 15

Comparison of patient and therapist Complex Communication scores among GO, PO, and DO groups using one-way ANOVA

	GO		PO		DO		Univariate	Effect Size
Speaker	M	SD	M	SD	M	SD	*F*-value	(*r*)
Patient	18.77	26.36	32.88	36.95	34.99	36.83	2.08	.29
Therapist	1.89	2.90	5.40	13.79	6.89	8.23	1.89	.28

Note. GO = Good Outcome; PO = Poor Outcome, DO = Dropout, $df = 2, 45$

Table 16

Comparison of SASB Complementarity mean weighted frequencies for Patient-to-Therapist and Therapist-to-Patient sequences among outcome GO, PO, and DO groups using MANOVA

Complementarity	GO		PO		DO		Univariate	Effect Size
Category	M	SD	M	SD	M	SD	*F*-value	(*r*)
Patient-to-Therapist								
Positive	695.00	261.03	747.75	339.63	619.38	393.06	0.59	.16
Neutral	48.50	68.69	35.19	73.50	36.81	63.79	0.18	.09
Negative	64.81	57.22	167.81	167.63	108.81	92.41	3.21*	.35
Therapist-to-Patient								
Positive	743.75	256.71	781.88	352.00	647.50	377.29	0.69	.17
Neutral	66.44	90.91	41.50	77.28	42.13	70.49	0.51	.15
Negative	67.38	61.67	171.00	168.66	115.38	94.97	3.13*	.35

Note. SASB = Structural Analysis of Social Behavior, GO = Good Outcome, PO = Poor Outcome, DO = Dropout, $df = 2,45$ $^{*}p < .05$

Table 17

Intercorrelation of NC (observer rated) and WAI-12 (patient and therapist rated) scores using Pearson r analyses

			Patient				Therapist			
		NC	Bond	Goal	Task	Total	Bond	Goal	Task	Total
	NC	-								
Patient	Bond	.29•	-							
WAI-12	Goal	.19	.65•••	-						
	Task	.23	.75•••	.82•••	-					
	Total	.27•	.88•••	.90•••	.94•••	.				
Therapist	Bond	.15	.41••	.54•••	.53•••	.54•••	-			
WAI-12	Goal	.09	.32•	.40••	.49•••	.44••	.75•••	-		
	Task	.12	.48•••	.54•••	.60•••	.59•••	.81•••	.90•••	-	
	Total	.12	.43••	52•••	.57•••	.56•••	.90•••	94•••	.97•••	-

Note. NC = Narrative Coherency, WAI-12 = Working Alliance Inventory - 12, all correlations were one-tailed
*p <.05, **p <.01,***p < 001

Table 18

Intercorrelation of SASB Complementarity scores and WAI-12 scores using Pearson r analyses

		Patient WAI-12				Therapist WAI-12			
		Bond	Goal	Task	Total	Bond	Goal	Task	Total
Complementarity:	Positive	.20	.13	07	.14	.01	- 10	-.08	-.07
P -> T	Neutral	-.19	.02	.08	-.03	.05	.21	.15	.14
	Negative	-.25	-.33*	-.28*	-.32*	-.49***	-.35*	-.34*	-.41**
T -> P	Positive	.17	.16	.07	.14	-.01	-.16	-.11	-.11
	Neutral	-.13	.07	.11	.02	.09	.21	.16	.16
	Negative	-.27	-.34*	-.28	-.32*	-.49***	-.34*	-.34*	-.41**

Note. SASB = Structural Analysis of Social Behavior, WAI-12 = Working Alliance Inventory - 12, P-to-T = Patient-to-Therapist, T-to-P = Therapist-to-Patient; all correlations were two-tailed.
*p <.05; **p < 01;***p <.001.

Table 19

Intercorrelation of NC and SASB Complementarity scores using Pearson r analyses

			Complementarity:					
			P-to-T			T-to- P		
		NC	Positive	Neutral	Negative	Positive	Neutral	Negative
	NC	-						
Complementarity:	Positive	.44**	-					
P-to-T	Neutral	-.29*	.00	-				
	Negative	-.35*	.05	.21	-			
T-to- P	Positive	.44***	.98***	.01	.08	-		
	Neutral	-.28*	-.01	.97***	.20	-.01	-	
	Negative	-.33*	.06	.20	.99***	.09	19	-

Note. NC = Narrative Coherency; SASB = Structural Analysis of Social Behavior P-to-T = Patient-to-Therapist, T-to-P = Therapist-to-Patient; all correlations were two-tailed.
*p <.05; **p <.01,***p < 001.

Figure 1

The interpersonal circumplex

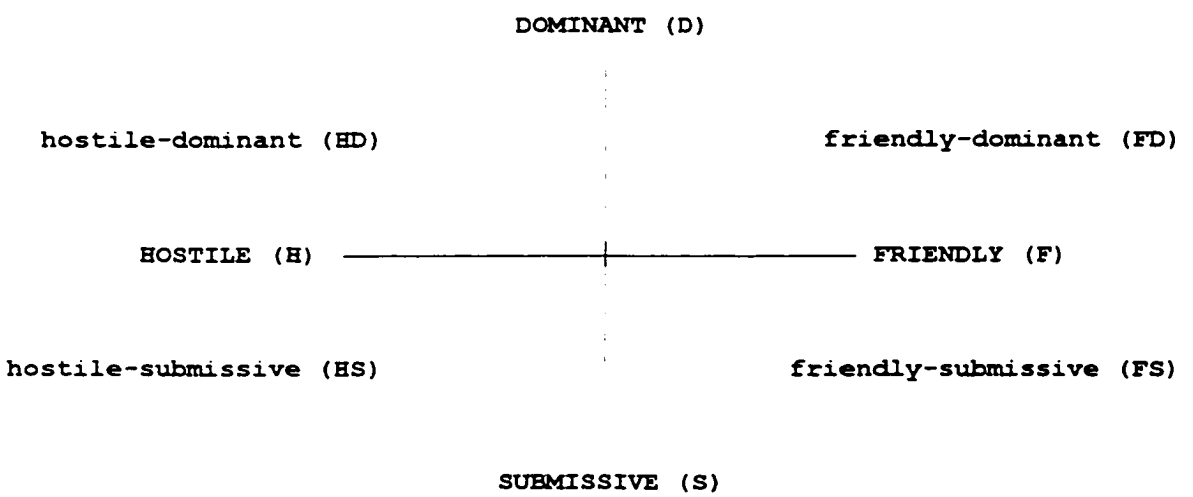
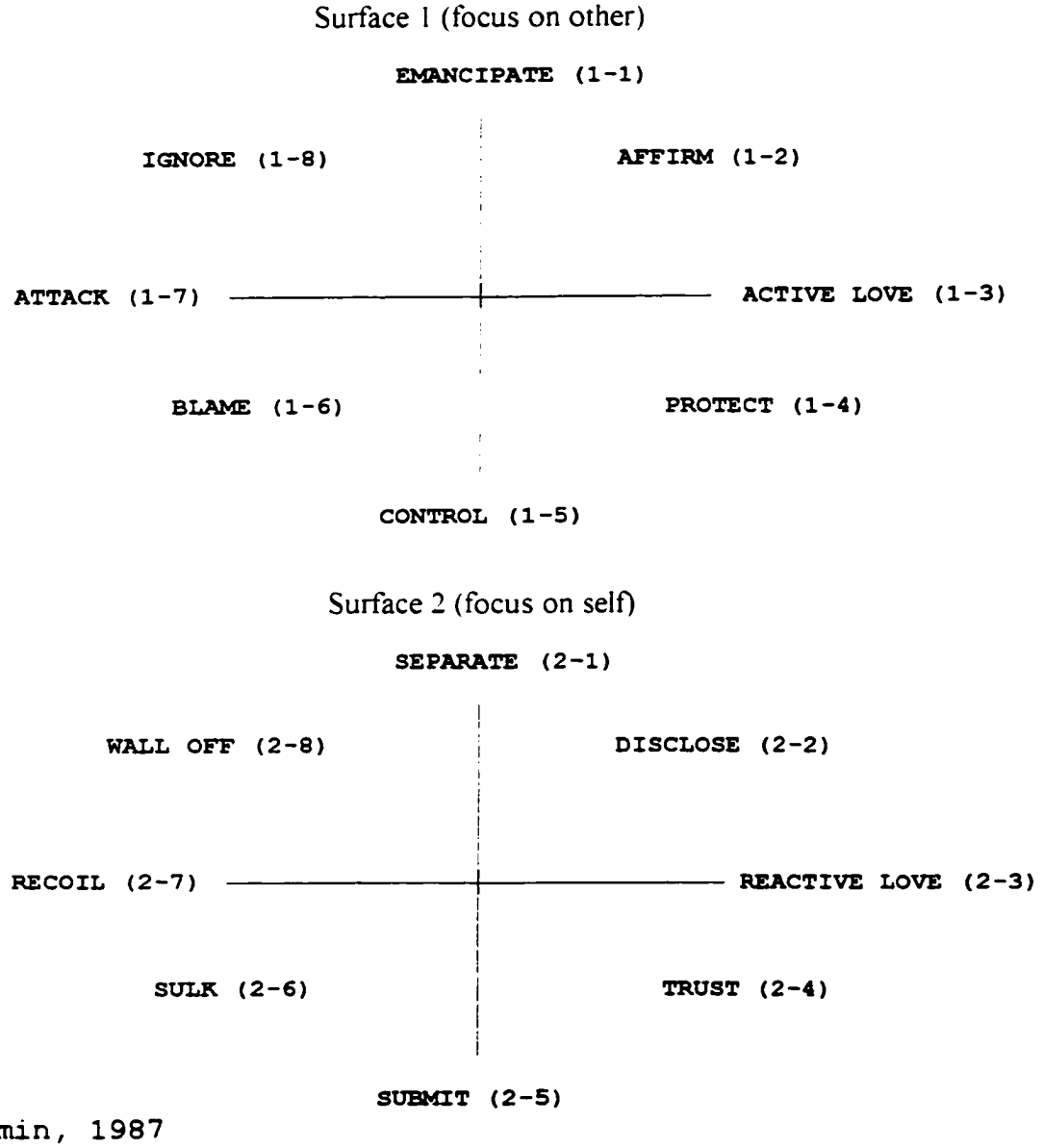


Figure 2

The SASB simplified cluster model



Benjamin, 1987

Appendix A: Patient Consent Form

Beth Israel Medical Center

Consent for Participation in Scientific Investigations

Title of project: Brief Psychotherapy Research Program

Name of Investigator: J. Christopher Muran, Ph.D.

Purpose and nature of program:

You are invited to participate in a study involving five forms of short-term and time-limited psychotherapy: (1) supportive psychotherapy, (2) short-term dynamic psychotherapy, (3) cognitive-behavioral therapy, (4) brief adaptive psychotherapy, and (5) brief relational therapy. We are attempting to learn more about different aspects of short-term psychotherapy so that you and others like you can receive the benefit of the best available treatment.

Treatment conditions:

If you decide to participate you will be randomly assigned to one of the five forms of short-term psychotherapy. All five forms of psychotherapy incorporate (a) high levels of therapist activity, (b) an approach focused on specific targeted problem areas, and (c) a treatment protocol of 30 sessions. The five psychotherapies, which have all proven to be significantly effective, differ primarily in some of the specific techniques employed; no one treatment approach has proven superiority over the others.

If you decide to participate in this study you will be asked to do the following:

1. Not to participate in other psychotherapy or take psychoactive medication while receiving treatment in this program.
2. Be available for 30 sessions.

3. Take two evaluation interviews and complete a package of questionnaires to evaluate how you are doing in treatment:
   a. Before beginning treatment
   b. Midway during treatment
   c. At termination of treatment
   d. Six months after treatment is completed.
4. Complete a post-session questionnaire after each session.
5. Agree to have evaluation and treatment sessions videotaped.
6. Consent to have information obtained from videotaped recordings of sessions used for scientific purposes, such as research study, professional publication, educational presentations in transcribed, audio taped, or videotaped format by program staff.

Possible risks:

We know of no inherent risks associated with these treatments. Each types of treatment may cause some emotional discomfort at times, but this is generally considered a natural part of the therapeutic process.

Confidentiality:

Information that is obtained in connection with this study that can be identified with you, including evaluation materials and video taped recordings, will be held in the strictest confidence and would be voluntarily disclosed only with your explicit permission. We will share such information only with other members of our research and treatment team at Beth Israel. The only exception is the post-session questionnaire, which will not

be available to your therapist and which will be identified solely by your id number that will be provided at the onset. This exception is made because some of the material in this questionnaire pertains to your relationship with your therapist. While it is possible that at some point in the future selected excerpts from your sessions will be either presented or published for scientific purposes, adequate precautions will be taken to maintain complete confidentiality, according to the customary professional ethics of Beth Israel Medical Center.

Possible benefits:

All treatment groups off possible benefits to you because they follow principles that have been tested and proved effective for some time. We are attempting to study what aspects of the different treatments contribute to or detract from their efficacy, particularly in terms of specific types of people and specific types of problems. Thus, your participation may be beneficial to you and others in the future.

Withdrawal:

You may withdraw or cancel your participation at any time and you are under no obligation to participate. If you choose not to participate or withdraw at a later date, you will not jeopardize your future care by doing so. In this event you will be provided with standard Beth Israel care on the usual basis.

Questions:

If you have any questions, you may contact J. Christopher Muran, Ph.D., Program Director at 420-3819. If you have any unsatisfied complaints you may contact Navah Harlow, Patient Representative at 420-3818. You may request a copy of this consent

form at any time. You may also request feedback regarding aspects of the study upon your termination of the treatment.

Patient Name: _____ Patient Signature: _____

Investigator: _____

Appendix B: SCL-90-R

SCL-90-R

INSTRUCTIONS:

Below is a list of problems people sometimes have. Please read each one carefully, and circle the number to the right that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Circle only one number for each problem and do not skip any items. If you change your mind, erase your first mark carefully. Read the example below before beginning, and if you have any questions please ask about them.

EXAMPLE

HOW MUCH WERE YOU DISTRESSED BY:

		not at all	a little bit	moder-ately	quite a bit	extre-mely
1	Body aches	0	1	2	3	4

HOW MUCH WERE YOU DISTRESSED BY:

		not at all	a little bit	moder-ately	quite a bit	extre-mely
1	Headaches	0	1	2	3	4
2	Nervousness or shakiness inside	0	1	2	3	4
3	Repeated unpleasant thoughts that won't leave your mind	0	1	2	3	4
4	Faintness or dizziness	0	1	2	3	4
5	Loss of sexual interest or pleasure	0	1	2	3	4
6	Feeling critical of others	0	1	2	3	4
7	The idea that someone else can control your thoughts	0	1	2	3	4
8	Feeling others are to blame for most of your troubles	0	1	2	3	4
9	Trouble remembering things	0	1	2	3	4
10	Worried about sloppiness or carelessness	0	1	2	3	4
11	Feeling easily annoyed or irritated	0	1	2	3	4
12	Pains in heart or chest	0	1	2	3	4
13	Feeling afraid in open spaces or in the streets	0	1	2	3	4
14	Feeling low in energy or slowed down	0	1	2	3	4
15	Thoughts of ending your life	0	1	2	3	4
16	Hearing voices that other people can't hear	0	1	2	3	4

HOW MUCH WERE YOU DISTRESSED BY:

	not at all	a little bit	moder-ately	quite a bit	extre-mely
17 Trembling	0	1	2	3	4
18 Feeling that most people cannot be trusted	0	1	2	3	4
19 Poor appetite	0	1	2	3	4
20 Crying easily	0	1	2	3	4
21 Feeling shy or uneasy with the opposite sex	0	1	2	3	4
22 Feelings of being trapped or caught	0	1	2	3	4
23 Suddenly scared for no reason	0	1	2	3	4
24 Temper outbursts that you could not control	0	1	2	3	4
25 Feeling afraid to go out of your house alone	0	1	2	3	4
26 Blaming yourself for things	0	1	2	3	4
27 Pains in lower back	0	1	2	3	4
28 Feeling blocked in getting things done	0	1	2	3	4
29 Feeling lonely	0	1	2	3	4
30 Feeling blue	0	1	2	3	4
31 Worrying too much about things	0	1	2	3	4
32 Feeling no interest in things	0	1	2	3	4
33 Feeling fearful	0	1	2	3	4
34 Your feelings being easily hurt	0	1	2	3	4
35 Other people being aware of your private thoughts	0	1	2	3	4
36 Feeling others do not understand you or are unsympathetic	0	1	2	3	4
37 Feeling that people are unfriendly or dislike you	0	1	2	3	4
38 Having to do things very slowly to ensure correctness	0	1	2	3	4
39 Heart pounding or racing	0	1	2	3	4
40 Nausea or upset stomach	0	1	2	3	4

HOW MUCH WERE YOU DISTRESSED BY:

		not at all	a little bit	moder-ately	quite a bit	extre-mely
41	Feeling inferior to others	0	1	2	3	4
42	Soreness of your muscles	0	1	2	3	4
43	Feeling that you are watched or talked about by others	0	1	2	3	4
44	Trouble falling asleep	0	1	2	3	4
45	Having to check and double-check what you do	0	1	2	3	4
46	Difficulty making decisions	0	1	2	3	4
47	Feeling afraid to travel on buses, subways, or trains	0	1	2	3	4
48	Trouble getting your breath	0	1	2	3	4
49	Hot or cold spells	0	1	2	3	4
50	Having to avoid certain things, places, or activities because they frighten you	0	1	2	3	4
51	Your mind going blank	0	1	2	3	4
52	Numbness or tingling in parts of your body	0	1	2	3	4
53	A lump in your throat	0	1	2	3	4
54	Feeling hopeless about the future	0	1	2	3	4
55	Trouble concentrating	0	1	2	3	4
56	Feeling weak in parts of your body	0	1	2	3	4
57	Feeling tense or keyed up	0	1	2	3	4
58	Heavy feelings in your arms or legs	0	1	2	3	4
59	Thoughts of death or dying	0	1	2	3	4
60	Overeating	0	1	2	3	4
61	Feeling uneasy when people are watching or talking about you	0	1	2	3	4
62	Having thoughts that are not your own	0	1	2	3	4
63	Having urges to beat, injure, or harm someone	0	1	2	3	4

HOW MUCH WERE YOU DISTRESSED BY:

	not at all	a little bit	moder-ately	quite a bit	extre-mely
64. Awakening in the early morning	0	1	2	3	4
65 Having to repeat the same actions such as touching, counting, or washing	0	1	2	3	4
66 Sleep that is restless or disturbed	0	1	2	3	4
67 Having urges to break or smash things	0	1	2	3	4
68 Having ideas or beliefs that others do not share	0	1	2	3	4
69 Feeling very self conscious with others	0	1	2	3	4
70 Feeling uneasy in crowds, such as shopping or at a movie	0	1	2	3	4
71 Feeling everything is an effort	0	1	2	3	4
72 Spells of terror or panic	0	1	2	3	4
73 Feeling uncomfortable about eating or drinking in public	0	1	2	3	4
74 Getting into frequent arguments	0	1	2	3	4
75 Feeling nervous when you are left alone	0	1	2	3	4
76 Others not giving you proper credit for your achievements	0	1	2	3	4
77 Feeling lonely even when you are with people	0	1	2	3	4
78. Feeling so restless you couldn't sit still	0	1	2	3	4
79 Feelings of worthlessness	0	1	2	3	4
80 The feeling that something bad is going to happen to you	0	1	2	3	4
81 Shouting or throwing things	0	1	2	3	4
82. Feeling afraid you will faint in public	0	1	2	3	4
83 Feeling that people will take advantage of you if you let them	0	1	2	3	4
84 Having thoughts about sex that bother you a lot	0	1	2	3	4
85 The idea that you should be punished for your sins	0	1	2	3	4
86. Thoughts and images of a frightening nature	0	1	2	3	4

HOW MUCH WERE YOU DISTRESSED BY:

	not at all	a little bit	moder-ately	quite a bit	extre-mely
87. The idea that something serious is wrong with your body	0	1	2	3	4
88. Never feeling close to another person	0	1	2	3	4
89. Feelings of guilt	0	1	2	3	4
90. The idea that something is wrong with your mind	0	1	2	3	4

Appendix C: IIP-64

Inventory of Interpersonal Problems

Here is a list of problems that people report in relating to other people. Please read the list below, and for each item, consider whether that problem is a problem for you with respect to people in your life. Then select the number that describes how distressing that problem is and circle that number.

EXAMPLE

How much have you been distressed by this problem?

It is hard for me to:	Not at all		Moder-ately		Extremely
0. get along with my relatives.	0	1	2	3	4

Part I. The following are things you find hard to do with other people.

It is hard for me to:	Not at all		Moder-ately		Extremely
1. trust other people.	0	1	2	3	4
2. say "no" to other people.	0	1	2	3	4
3. join in on groups.	0	1	2	3	4
4. keep things private from other people.	0	1	2	3	4
5. let other people know what I want.	0	1	2	3	4
6. tell a person to stop bothering me.	0	1	2	3	4
7. introduce myself to new people.	0	1	2	3	4
8. confront people with problems that come up.	0	1	2	3	4
9. be assertive with another person.	0	1	2	3	4
10. let other people know when I am angry.	0	1	2	3	4
11. make a long-term commitment to another person.	0	1	2	3	4
12. be another person's boss.	0	1	2	3	4
13. be aggressive with other people when the situation calls for it.	0	1	2	3	4

14. socialize with other people.	0	1	2	3	4
15. show affection to people.	0	1	2	3	4
16. get along with people.	0	1	2	3	4
17. understand another person's point of view.	0	1	2	3	4
18. express my feelings to other people directly.	0	1	2	3	4
19. be firm when I need to be.	0	1	2	3	4
20. experience a feeling of love for another person.	0	1	2	3	4
21. set limits on other people.	0	1	2	3	4
22. be supportive of another person's goals in life.	0	1	2	3	4
23. feel close to other people.	0	1	2	3	4
24. really care about other people's problems.	0	1	2	3	4
25. argue with another person.	0	1	2	3	4
26. spend time alone.	0	1	2	3	4
27. give a gift to another person.	0	1	2	3	4
28. let myself feel angry at somebody I like.	0	1	2	3	4
29. put someone else's needs before my own.	0	1	2	3	4
30. stay out of other people's business.	0	1	2	3	4
31. take instructions from people who have authority over me.	0	1	2	3	4
32. feel good about another person's happiness.	0	1	2	3	4
33. ask other people to get together socially with me.	0	1	2	3	4
34. feel angry at other people.	0	1	2	3	4
35. open up and tell my feelings to another person.	0	1	2	3	4

36. forgive another person after I've been angry.	0	1	2	3	4
37. attend to my own welfare when somebody else is needy.	0	1	2	3	4
38. be assertive without worrying about hurting the other person's feelings.	0	1	2	3	4
39. be self-confident when I am with other people.	0	1	2	3	4

Part II. The following are things that you do too much.

40. I fight with other people too much.	0	1	2	3	4
41. I feel too responsible for solving other people's problems.	0	1	2	3	4
42. I am too easily persuaded by other people	0	1	2	3	4
43. I open up to people too much.	0	1	2	3	4
44. I am too independent.	0	1	2	3	4
45. I am too aggressive toward other people.	0	1	2	3	4
46. I try to please other people too much.	0	1	2	3	4
47. I clown around too much.	0	1	2	3	4
48. I want to be noticed too much.	0	1	2	3	4
49. I trust other people too much.	0	1	2	3	4
50. I try to control other people too much.	0	1	2	3	4
51. I put other people's needs before my own too much.	0	1	2	3	4
52. I try to change other people too much.	0	1	2	3	4
53. I am too gullible.	0	1	2	3	4
54. I am overly generous to other people.	0	1	2	3	4
55. I am too afraid of other people.	0	1	2	3	4
56. I am too suspicious of other people.	0	1	2	3	4

57. I manipulate other people too much to get what I want.	0	1	2	3	4
58. I tell personal things to other people too much.	0	1	2	3	4
59. I argue with other people too much.	0	1	2	3	4
60. I keep other people at a distance too much.	0	1	2	3	4
61. I let other people take advantage of me too much.	0	1	2	3	4
62. I feel embarrassed in front of other people too much.	0	1	2	3	4
63. I am affected by another person's misery too much.	0	1	2	3	4
64. I want to get revenge against people too much.	0	1	2	3	4

Appendix D: Post-Session Questionnaire

Therapist and Patient Versions

PSQ: THERAPIST VERSION

PART A

1. Did you experiences any problem or tension in your relationship with your patient during the session? Yes No

2. Please rate the highest degree of tension you felt during the session as a result of this problem. 1 2 3 4 5
   Low Medium High

3. To what extent was this problem addressed in this session?
   1 2 3 4 5
   Low Medium High

4. Please describe the problem briefly:

PART B
Working Alliance Inventory-12

The following items reflect your working relationship with your patient based on your most recent session. Please rate each item by circling the appropriate number in terms of how you felt about this session.

1 My patient and I agreed about the things I need to do in therapy to help improve his/her situation

1 2 3 4 5 6 7
Never Sometimes Always

2 My patient believed that what we are doing in therapy gave him/her new ways of at looking at his/her problem

1 2 3 4 5 6 7
Never Sometimes Always

3 My patient believed that I like him/her

1 2 3 4 5 6 7
Never Sometimes Always

4 My patient believed that I did not understand what he/she is trying to accomplish in therapy.

1 2 3 4 5 6 7
Never Sometimes Always

5. My patient was confident in my ability to help him/her.

1	2	3	4	5	6	7
Never			Sometimes			Always

6. My patient and I worked towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never			Sometimes			Always

7. My patient felt appreciated by me.

1	2	3	4	5	6	7
Never			Sometimes			Always

8. We agreed on what is important for him/her to work on.

1	2	3	4	5	6	7
Never			Sometimes			Always

9. My patient and I seemed to trust one another.

1	2	3	4	5	6	7
Never			Sometimes			Always

10. My patient and I seemed to have different ideas on what his/her problems are.

1	2	3	4	5	6	7
Never			Sometimes			Always

11. We have established a good understanding of the kind of changes that would be good for him/her.

1	2	3	4	5	6	7
Never			Sometimes			Always

12. My patient believed the way we were working with his/her problem was correct.

1	2	3	4	5	6	7
Never			Sometimes			Always

PSQ: PATIENT VERSION

PART A

1. Did you experiences any problem or tension in your relationship with your therapist during the session? Yes No

2. Please rate the highest degree of tension you felt during the session as a result of this problem. 1 2 3 4 5
   Low Medium High

3. To what extent was this problem addressed in this session?
   1 2 3 4 5
   Low Medium High

4. Please describe the problem briefly:

PART B: Working Alliance Inventory-12

The following items reflect your working relationship with your therapist based on your most recent session. Please rate each item by circling the appropriate number in terms of how you felt about this session.

1 My therapist and I agreed about the things I need to do in therapy to help improve my situation.

1 2 3 4 5 6 7
Never Sometimes Always

2 What we are doing in therapy gave me new ways of looking at my problem

1 2 3 4 5 6 7
Never Sometimes Always

3 I believed that my therapist likes me.

1 2 3 4 5 6 7
Never Sometimes Always

4. My therapist did not understand what I am trying to accomplish in therapy.

1 2 3 4 5 6 7
Never Sometimes Always

5 I was confident in my therapist's ability to help me

1	2	3	4	5	6	7
Never			Sometimes			Always

6 My therapist and I worked towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never			Sometimes			Always

7 I felt that my therapist appreciates me.

1	2	3	4	5	6	7
Never			Sometimes			Always

8 We agreed on what is important for me to work on

1	2	3	4	5	6	7
Never			Sometimes			Always

9 My therapist and I seemed to trust one another

1	2	3	4	5	6	7
Never			Sometimes			Always

10 My therapist and I seemed to have different ideas on what my problems are.

1	2	3	4	5	6	7
Never			Sometimes			Always

11 We had a good understanding of the kind of changes that would be good for me.

1	2	3	4	5	6	7
Never			Sometimes			Always

12 I believed the way we were working with my problem was correct.

1	2	3	4	5	6	7
Never			Sometimes			Always

Appendix E: Narrative Coherency Coding Manual

Narrative Coherency Scale:
Manual for rating psychotherapy sessions

Ratings of the degree of coherence of patient-therapist dyads are made on a 3-point, Likert-type scale, ranging from 0 ("incoherent") to 2 ("coherent"). Narrative coherency is assessed in 15-minute portions of psychotherapy transcripts according to violation of four maxims of coherent narrative (see Table 20). While this is not a scale measuring defensiveness or specific attachment status *per se*, different defensive processes may be identified within the operationalized criteria. Highly resistant or defended patients present with an overly rigid interpersonal style and may demonstrate certain features of incoherency. For example:

Secure: Individuals classified as secure are able to describe both pleasant and painful aspects of their lives in a coherent manner that neither minimizes nor maximizes the emotional qualities and consequences of past relationship experiences. There is a sense of sincerity or truth to their narratives.

Preoccupied: The narratives of these individuals are incoherent, and they appear still angry as if they were entangled in their past experiences with attachment figures. In addition to anger, the narrative may indicate a passive stance regarding ill-defined experiences of relationships, or a preoccupation with past traumatic events. These patients seem to be needy, demanding, and have heightened affective expression within the context of attachment needs.

Dismissing: this group is characterized by incoherence because of the lack of detail; they have few memories and a highly restricted range of emotions to attachment

experiences. These patients deny their need for help and seem resistant to treatment. Other patients with this type of attachment system may become disorganized when talking about emotional issues.

Coding decisions

Running ratings: As you read through the transcript of a session, make mental notes about the general feel of the session and where the rating shifts. Note in the margin of the transcript where a maxim has been violated and into which of the four categories the violation falls.

Also note if a statement is a example of metacognitive monitoring. A maxim may be violated but if the patient is able to reflect upon his or her language or the process of his or her communication, this is considered to be a quality of coherent narrative. Metacognitive monitoring is further expanded by the notion of "self-reflective functioning"; in the transcripts, look for examples of the following as signs of the ability to self-reflect or consider the "mentalization" of self and others as indications of coherency; in other words, internal experiences (emotions and cognitions) become the subject of discourse in ways described above (this is true for both patent and therapist):

Mention of mental states of self or other (e.g., "at the time I was aware of feeling angry", rather than "I was angry"; "I assumed she must have been angry even though she didn't show it")

Characteristics and limitations of mental states (e.g., "it took me a long time to realize that I was never going to have the kind of relationship with my mother that I was wishing for"; "I think I mistake depression in my father for rejection")

Complexity and diversity of mental states (e.g., "other people might say my mother was attentive but my experience was that she wanted to be in control"; "when she was outside of her family she could be very generous but with us it was a different story")

Linking mental states to behaviors/motivations (e.g. "he was angry but I think he must have been worried about his job")

Scoring Levels:

0 = Most of the segment is incoherent or is more incoherent than coherent. An incoherent passage is one in which the patient responds in a way that you, the reader, think her/she feels misunderstood by the therapist. A "0" score does not necessarily have to be completely lacking coherency but overall, the segment will contain more violations of the four maxims and less examples of metacognitive monitoring than a 1 or 2 rating. As the reader, you will have difficulty making sense of what the patient and therapist are talking about. There will be little or no sense of cooperation between the individuals and, as a result, the discourse will not flow smoothly. There may be a high number of uncodable statements as per the SASB, as well as Complex Communications. The patient and therapist may frequently interrupt each other, fill in each other's words, and/or not let the other get a word in edgewise. The patient and therapist may use jargon, have difficulty fleshing out ideas (e.g., "I don't know"), and may use a great deal of generalizations (e.g., "one does"). Often in segments rated "0", the therapist is confrontational and seems to be pushing his or her technique upon the patient rather than sitting with the patient in an empathic way.

1 = Approximately half of the segment is coherent and half is incoherent. For example, the patient may seem incoherent at first, fumbling with his or her words as he/she tries to communicate with the therapist, and as the reader you will be uncertain about what the patient is trying to articulate. However, with the help of the therapist structuring the session or asking specific questions, the discourse becomes more coherent over the segment. The therapist may ask things like "what do you mean by that" or "say more, I'm not sure I understand fully" which helps the patient to be more focused and coherent. As the reader, you become clearer here about the topics being discussed. Another example of a half coherent-half incoherent narrative includes one speaker being coherent and the other being incoherent. It is often (although not always) the case in psychotherapy that the patient is less clear in their statements and produces more maxim violations than the therapist. The patient typically speaks more than the therapist and thus has more opportunities to violate maxims. In contrast, sometimes therapists who are learning a particular technique are less confident about their interventions and may be repetitive, overly verbose, unclear, or inconsistent in their communication.

2 = The segment is mostly coherent or more coherent than incoherent. A "2" score does not have to be perfectly coherent. In other words, there may be a small number of maxim violations with statements which fall into the category of metacognitive monitoring. An example of this is when there has been a rupture or tension in the therapeutic relationship. The dyad may have stumbled through a difficult or awkward few moments which may have been reflected in incoherent dialogue. This interpersonal

process is then commented upon by either patient or therapist (e.g., therapist commenting to the patient "I noticed your voice was quavering just now...", or a patient withdrawing with silence or responses such as "I don't know"). The patient may make metacognitive monitoring statements after a maxim violation such as "I think I am getting off of the topic here." The focus of the segment then turns to this interaction, which is discussed in a more coherent way and may lead to other associations also discussed cooperatively and coherently. As the reader, you are quite clear about what the patient and therapist are talking about. The speakers will typically complete their thoughts, the patient will expand on the therapist's statements and vice versa. There will be a sense that the participants are working off of each other in a back and forth fashion.

Table 20

Descriptions of Grice's (1975) four categories of his Cooperation principle as operationalized for use in coding psychotherapy sessions

Maxim	Violations
Quality	Speaker produces contradictory statements or presents material which is inconsistent with behavior and has an implausible nature: e.g., patient presents idealized picture of mother when historical evidence suggests she was not so wonderful; e.g., therapist reflects a patient's experience and then the patient retracts or denies it
Quantity	Speaker is either overly verbose, producing excessively lengthy passages, or is withholding and blunt, refusing to flesh out responses. e.g., patient or therapist does not let the other "get a word in edgewise"; e.g., speaker responds frequently with "I don't know" or "I can't remember".
Relations	Speaker responds to a statement with irrelevant material which serves to shift the topic and inhibit exploration: e.g., therapist asks patient to describe something about the therapeutic interaction and the patient responds with an example from another relationship.

Table 20 (continued)

Descriptions of Grice's (1975) four categories of his Cooperation principle as operationalized for use in coding psychotherapy sessions

Maxim	Violations
Manner	There is no sense of collaboration between the patient and therapist, or of working with each other in a back and forth fashion. The reader has difficulty making sense of the narrative. e.g., patient and therapist frequently interrupt each other; e.g., speaker uses jargon and vague or nonspecific terms (use of "you" rather than "I"); e.g., frequent false starts and incomplete thoughts (uncodable SASB statements)

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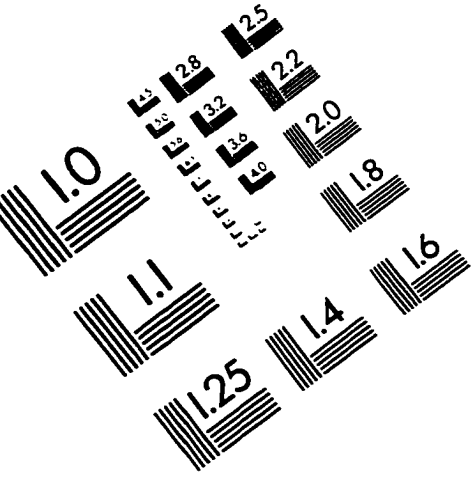
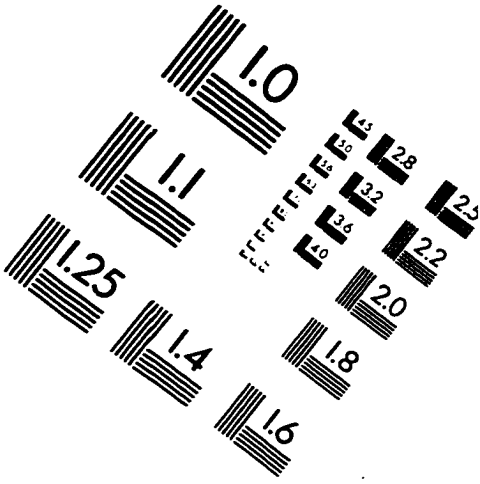
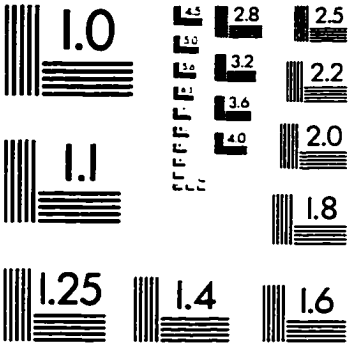
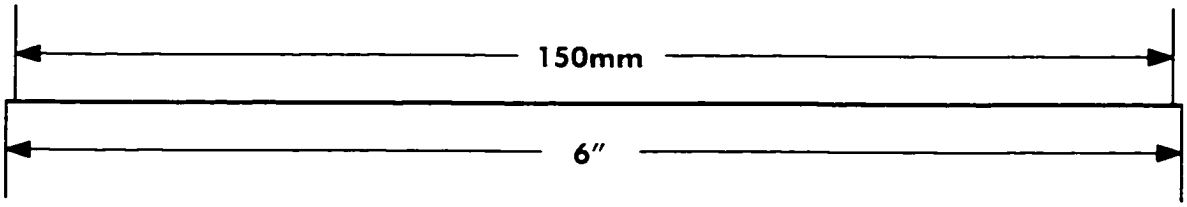
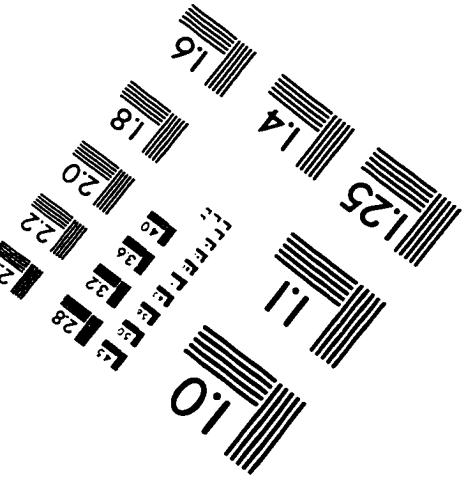
IMAGE EVALUATION TEST TARGET (QA-3)

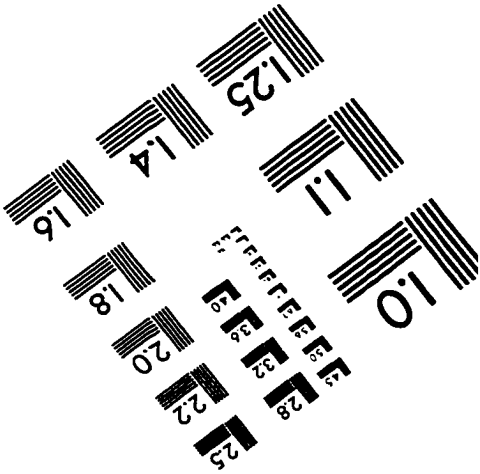












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