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A

Reflective Functioning and the Therapeutic Relationship: Understanding Change in Brief Relational Therapy

by

Elizabeth Bernbach

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

2001

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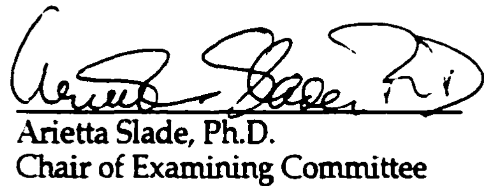

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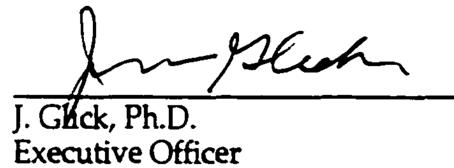

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Abstract

Reflective Functioning and the Therapeutic Relationship:

Understanding Change in Brief Relational Therapy

By

Elizabeth Bernbach

Advisor: Professor Arietta Slade, Ph.D.

The aim of this study was examine the relationship between change on self-report measures of symptoms and interpersonal problems and change on an observer-rated measure of reflective functioning over the course of a thirty-session Brief Relational Psychotherapy (Safran & Muran, 2000) treatment. Ten patient-therapist dyads were equally divided into good outcome and poor outcome groups. Patients were treated at Beth Israel Medical Center and met criteria for depressive or anxiety disorders. Case selection for good outcome or poor outcome groups was determined by change on the Reliable Change Index (Jacobson & Truax, 1991): a composite score derived from the Symptom Checklist 90-R (Derogatis, 1983) and the Inventory of Interpersonal Problems - 64 (Alden, Wiggins & Pincus, 1990). Groups were compared on the observer-rated Reflective Functioning Scale adapted from the 1998 Reflective-Functioning Manual, version 5 (Fonagy et al., 1998).

Results showed that Reflective Functioning (RF) scores did change significantly over the course of treatment. The curves of the changes for the two groups were different. The poor outcome group demonstrated very little change, either positively or negatively, from the beginning to the end of treatment. The good outcome group demonstrated an increase in RF during

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treatment. These findings suggest that RF is a way to measure change in a person's representations of the self and others over the course of psychotherapy.

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This dissertation is anchored in the relationships I developed with the many people at the Brief Psychotherapy Research Project at Beth Israel Medical Center and with my colleagues and professors at City College. In particular I want to thank Chris Muran, Ph.D. and Lisa Samstag, Ph.D. who hired me and took me under their wings with a warm supportive guidance. Chris has been a valued mentor whose integrity and sensitivity as a clinician and a researcher have been inspirational. Lisa is a dear friend and role model whose footsteps I am always eager and proud to walk in.

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Thank you to my family: my parents Paul and Therese, sister Sarah and brother Matthew, whose love and support has always allowed to follow my dreams.

Finally, to Nelson Hancock, my husband, my love, my editor. This is for you.

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Table of Contents

		Page
Chapter I.	Introduction....................................	1
Chapter II.	Literature Review..............................	5
Chapter III.	Method...	43
Chapter IV.	Results..	55
Chapter V.	Discussion..	65
Appendices	....	93
References	....	118

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List of Tables

		Page
Table 1.	Patient Demographic Variables	89
Table 2.	Patient Diagnostic Variables	90
Table 3.	Therapist Demographic Variables	91
Table 4.	Reliable Change Index Scores	91
Table 5.	Case Selection Criteria	92
Table 6.	Session Selection Criteria	92

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Chapter I. Introduction

Psychoanalytic theories of the self have closely paralleled the concomitant trends in philosophy and social theory in general. The early modernist theories in the 19th and early 20th centuries posited a contained, autonomous, discretely bounded self. Post-structural and feminist scholars have questioned this model and argued for models of the self based on the realities generated by intersubjective processes. These later theories have questioned the possibility of an autonomous self and replaced it with an inherently changing self with porous boundaries; a self that does not exist independent of its ever changing context. The post-structuralist notion of the self is a self in constant dynamic dialog with a context. A context includes a place in time and space, and it includes relationships with other selves.

We still ask, what is the self? This study will not be so bold as to attempt to define the idea of the self. Rather, it will present some elements believed to be components of the self, and it will hypothesize and explore how these elements might change over the course of psychotherapy. For the purposes of this study we will consider the realm of mental representations as a key element of the self. While one aspect of the self is the physical self, the bodily sentient self which is an essential aspect of one's context, it will not play a central role here. Instead, this study will focus on the premise that an essential feature of the self-as-mental-representations includes representations of others. There is no such thing a single solitary self. As D.W. Winnicott wrote, "there is no such thing as a baby" (Winnicott, 1958). By this

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he means that inherent in the concept of a baby is a mother. Inherent in the concept of the self is another.

In psychodynamic psychotherapy the patient's experience is explored and questioned in terms of representations by talking and thinking about the self with another person. What is it about this process that is potentially beneficial, healing, curative? What is it that changes through this meeting of two minds? Change during psychotherapy is clearly the result of a range of factors. This study proposes that one of these elements is the patient's mental representations of him or her self in relation to others. It is hypothesized that it is the unique property of psychotherapy, with its focus on exploring the patient's experiences and mental representations, that specifically fosters this change.

This study will draw on theory and research of two fields: mother-infant attachment research and psychotherapy research. Both have been producing evidence that suggests that it is the bi-directional exchange in interpersonal relationships that is crucial for development. Attachment researchers propose that the child develops a sense of self through seeing himself reflected in the mind of the mother. Thus it is the mother's capacity to accurately perceive and represent the experience of the child that fosters the same capacity in the child.

Psychotherapy researchers have found that for treatment to be successful, the patient and therapist must have a strong mutual therapeutic alliance or relationship. They have found that not only does the therapeutic relationship provide the structure in which the therapeutic action takes place, but that the dynamic process of developing and negotiating the relationship

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is in itself therapeutic. It is therapeutic in that it allows the patient to see the patterns of how they interact with others, what their expectations are of others, and how they represent themselves in relation to others. Simultaneously, it is the therapist's ability to accurately perceive, understand and represent the patient's experience and explore it with the patient that is crucial for change. This dialogic process is inherent in all relationships, but is particularly highlighted in the therapeutic relationship where the focus remains primarily on the patient's experience and where the relationship itself is often the subject of scrutiny.

Though the power of this interpersonal process may seem obvious on an intuitive level, it is nonetheless challenging to measure. Continuing the above parallel between the parent-infant relationship and the therapist-patient relationship, this study will take a construct that emerged from the research of the former and apply it to the latter. Fonagy, Target, Steele and Steele (1998) have developed a scale for measuring what they call reflective functioning (RF). "RF is the psychological capacity to perceive the self and others in terms of mental states (feelings, beliefs, intentions and desires). It also refers to the capacity to reason about one's own and other's behavior in terms of mental states, i.e. reflection" (Fonagy et al, 1998, p. 8). The RF scale provides a way to operationalize and measure an individual's capacity to represent him or herself in relation to others, thus capturing an aspect of the dialectic process of development.

The aim of this study is to measure the change in a patient's RF over the course of a thirty session psychotherapy treatment. It is hypothesized that the metacommunication and exploration of interpersonal process and

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mental states that is inherent in psychotherapy produces changes in the patient's representations of him or herself in relation to others. Measuring RF is one way to capture this aspect of the therapeutic communication and change in mental representations it occurs within the interpersonal process of the patient and therapist.

Up to now, RF has not been used before as a way to measure change in a patient's mental representations over the course of psychotherapy. By asking these questions, I hope to explore and further define one aspect of the process and effects of psychotherapy. If therapists have a better understanding of these processes, then perhaps we can focus on more specific mechanisms of change and continue to refine our psychotherapeutic techniques.

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Chapter II. Literature Review

This literature review will begin by tracing the history of the concept of the therapeutic alliance through the history of psychoanalytic theory. This will lead to a discussion of reflective function and its roots in attachment theory. Following the review of reflective function literature, I will describe the developmental and clinical theory of intersubjectivity, which defines very specifically the dialectical process of how the self develops through interactions with others. Finally, this review will cover the literature on therapeutic alliance ruptures. Alliance ruptures will be defined, and it will be argued that they constitute potentially rich moments in which to explore a patient's interpersonal representations. The disequilibrium that is created during an alliance rupture and the process of its resolution is thought to be a time when a patient's interpersonal representations are highlighted and thus ripe for exploration. It is the premise of this study that the process of exploration can be conceptualized and measured in terms of reflective functioning.

History of the Therapeutic Alliance: Refining the Understanding of the Therapeutic Relationship

A central concern during the past century of psychotherapy research has been to determine exactly what it is that changes during the course of therapy and to identify specific elements that contribute to that change. Not surprisingly, one focus in this research has been the relationship between the

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therapist and the patient. Beginning with Freud (Breuer & Freud 1885, Freud 1912, 1913) this relationship has been conceived of as being made up of several different but inter-related parts. In Freud's 1912 paper, "The Dynamics of Transference," he divided the therapeutic relationship into three parts, each based on the patient's transferring feelings and fantasies from his or her past onto the analyst: (1) the erotic transference, defined as the patient's sexual feelings and fantasies about a love object from the past projected onto the analyst; (2) the negative transference, which if too strong would prevent the patient from following the "fundamental rule" to always free associate, leaving the patient "unanalyzable;" and (3) the positive "unobjectionable" transference, or "the effective positive transference" by which the patient would consciously view the analyst as a trustworthy and supportive authority figure. He suggested that this aspect of the transference is conscious, whereas the erotic and negative transferences are unconscious. While the latter transferences were the most difficult to manage in terms of their potential to impede the treatment, the unobjectionable transference was considered "a vehicle of success in psychoanalysis" (Freud 1912, p.105). Because this transference provided the foundation upon which the treatment rested, it, unlike the other two forms of transference, was not to be analyzed.

This description of the "unobjectionable transference" is considered by many to be the basis of what is today called the therapeutic alliance. This concept has gone through many different permutations and has been re-worked considerably over the past century, but the basic idea remains the same: for the patient and therapist to be able to work together therapeutically, they must have established mutual trust, respect and an understanding that

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they are working toward the same goal. For Freud, the unobjectionable transference was necessary if the "transference neurosis" was to develop. The transference neurosis was defined as the patient's experience of the infantile conflicts in the presence of the analyst. It was then the "working through" of these conflicts that marked the end of a successful treatment. When the patient came to understand that the way he had perceived the analyst was based on relationships from his past, the treatment was considered complete. Freud did not address the impact of the "real relationship" (the particular way the analyst behaved or dressed) on the transference.

In "Analysis Terminable and Interminable" Freud began to talk about a rational, non-transferential aspect of the relationship when he stated that, "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.235). Though he did not think that these non-transference elements were central to psychological change, he did eventually begin to contemplate the importance of the real, collaborative relationship between the analyst and the patient.

Sandor Ferenczi (1932) expanded on Freud's notion of transference neurosis by emphasizing that the patient should not only recall his or her early experiences and conflicts, but should actually re-experience them in the present relationship with the therapist. These ideas were later to be taken up by Michael Balint (1968), D.W. Winnicott (1965) and Alexander and French (1946). By shifting the focus of the therapeutic relationship from the recovery of memories of the past, to the present experience of the patient in the here-

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and-now interaction with the therapist, Ferenczi brought the impact of the therapist's 'real' personality on the patient and the therapeutic relationship under greater scrutiny.

The school of ego psychology, led by Anna Freud (1936) and Hans Hartmann (1958) stressed the adaptation that the ego must make to the reality of its environment. This emphasis on the here and now was in part a reaction to Melanie Klein and her following, who believed that *everything* is transference and therefore the only useful therapeutic interventions were transference interpretations. The ego psychologist's response to this was to focus on aspects of the real relationship, which later would be called the therapeutic alliance. This shift broadened the role of the therapist and allowed for modification of the traditional analytic stance and technique such that interventions other than transference interpretations were valued and integrated into their model.

Simultaneously, Sterba (1934), following Freud's notion of the unobjectionable positive transference, described the "ego alliance." This stressed the importance of the patient's capacity for psychological mindedness, and the patient's ability to move between an experiencing and observing ego in order to engage in self reflection. With attention to the patient's metacognitive capacity, this theory anticipated the concept of reflective function (Fonagy, 1991), which will be outlined below. Sterba stressed the difference between the mature and rational aspects of the ego, which aid in the cooperative features of the relationship with the analyst, and the more primitive and irrational aspects of the ego that need to be analyzed. This focus on the observing ego as separate from other aspects of the psyche

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that are engaged in the transference was central to the later development of the theories of the therapeutic or working alliance. In the same year, and in a similar vein, Strachey (1934) presented his theory of the "auxiliary superego ego" as the part of the patient with which the analyst created an alliance.

Elizabeth Zetzel (1956, 1966) was the first to use the terms "therapeutic alliance" and "working alliance." These terms were used interchangeably to describe the patient's positive attachment to the analyst, which through the process of identification, was a reemergence of the patient's relationship with his or her mother. Like Freud and Sterba, Zetzel stressed the difference between the therapeutic alliance and the transference neurosis, 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 needs and anxieties of the patient must take place very early in the treatment. Zetzel's theory suggests that the relationship will cycle back and forth between these two places over the course of treatment, and that it is with the non-neurotic aspects of the patient's ego that the therapist forms a collaboration in order to help the patient examine his or her transference relationship from a more objective and rational position.

The focus on the *real* aspects of the therapeutic relationship as opposed to the transferential aspects allowed the thinking about development to focus on the *real* relationship with the patient's caretakers in childhood, as opposed to the fantasized aspects of the relationship. Zetzel proposed that if the patient's ability to develop trusting relationships was compromised (i.e. if the patient was not able to form a stable, trusting relationship with the analyst or with other people in their lives) this was the expression of a deficit in the

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patient's developmental experiences. The way to begin to repair this, she argued, was not through transference interpretations, but rather through providing the patient, through the real relationship with the therapist, with a supportive environment in which the patient could begin to develop a trust in another. Thus, the parallel between the maternal relationship and the therapeutic relationship was set up with a specific focus on the therapeutic alliance as providing this structure. This focus on the importance of the real mother-infant relationship, and its developmental impact was the precursor to the work of John Bowlby and later attachment theorists.

The parallel between the maternal relationship and the therapeutic relationship is found in the work of a variety of other authors. For example, Wilfred Bion's (1970) concept of containment, D.W. Winnicott's concept of holding (1970), Greenacre (1968), and Loewald (1960). Each of these theories proposes that for therapeutic change to take place, the therapeutic relationship must provide something in addition to, and other than, insight gained through transference interpretations.

Ralph Greenson (1967, 1971) also divided up the therapeutic relationship into the transference and the real relationship. While emphasizing that the boundary between the two is artificial, he stressed that the real relationship is comprised of the undistorted perceptions that the patient and therapist have tor each other. These include liking, trust and respect, and these components allow the patient and therapist to consciously work together toward a common goal. Greenson felt that all of these elements come together to form the therapeutic working alliance. Within this

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model, Greenson stresses that rationality and objectivity are an integral, though previously often overlooked, aspect of therapy.

Edward Bordin (1979) refined the concept of therapeutic alliance by creating a model that overrides any allegiance to a psychological theory or psychotherapy technique. His model simply states that for any type of therapy to be effective there must be a strong therapeutic alliance. To operationalize the therapeutic alliance Bordin broke down the concept into several interrelated parts: the task, the goal and the bond.

In Bordin's model for a therapy to be successful the patient and therapist must agree on the goals of the treatment. These may be the resolution of neurotic conflicts for a more psychoanalytic treatment, or the reduction of the severity of a specific phobia for a more behaviorally oriented treatment. If goals are established, then the tasks by which those goals are to be obtained must be agreed upon. For example, in a psychoanalytic treatment, free association is one of the means through which conflicts are resolved. Conversely, a behavioral treatment to reduce the severity of a phobia may consist of flooding or desensitization techniques. Finally, there must be a strong bond between the patient and therapist. There must be a mutual atmosphere of respect and understanding of each other.

These three dimensions continually influence each other and are mediated by each other. Whether or not the patient is open to exploring new tasks or reevaluating the goals of treatment will depend on the strength of the bond. Simultaneously the experience of negotiating new parameters will impact the bond. Thus, while the overall quality of the alliance is a crucial mediating aspect of the success of treatment, the specific approaches involved

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will vary with each new dyad. Breaking down the alliance concept in this way allowed it, and therefore an aspect of the therapeutic relationship, to be measured and led to an abundance of psychotherapy research projects (Horvath, Gaston, & Luborsky, 1993; Horvath and Symonds, 1991; Orlinsky, Grawe, & Parks, 1994). These studies have been consistently confirming what Sterba, Zetzel and others intuited, which is that the therapeutic alliance is an integral and pivotal element in psychotherapeutic change. The current findings of these studies along with their connection to attachment theory and RF will be outlined further below.

History of Attachment Theory: Toward a Theory of Representations

Throughout the history of psychoanalysis, there have been many theories (Klein, Fairbairn, Winnicott, Balint) that place the antecedents of adult mental well being in the quality of the early parent-infant relationship. Though followers of psychoanalytic theory intuit that this is obviously the case, it was not until the past twenty five years, with the work of John Bowlby, Mary Ainsworth, Margaret Mahler, Daniel Stern, and others, that researchers have been able to find empirical evidence that begins to explain this central psychoanalytic tenet. John Bowlby's (1969, 1973, 1980) attachment theory was a departure from both Freudian drive theory and Kleinian object relations theory. Bowlby felt that these two theories placed too much emphasis on the internal world of the infant and neglected the events of the 'real' external relationship between the infant and the mother. Thus, attachment theory moved away from the centrality of fantasy around infant feeding, elimination and sex as the source of drives and conflicts which

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motivate the bond between mother and infant, and moved toward, what Bowlby called, the "primary motivational system," that is driven by a biologically based need for safety and proximity between the mother and infant.

Bowlby, though trained as an analyst, turned to the contemporary research of ethology and the neo-Darwinians such as Lorenz (1952) and Harlow (1958) for inspiration. Bowlby himself felt that his theory, with its belief that the infant is hard-wired to seek out relationships with his caretakers from birth, was in keeping with the object relations theorists of his time. However, his endorsement of an "attachment behavioral system" was harshly criticized by the psychoanalytic community, which immediately ostracized him. This theoretical schism is only now beginning to be repaired.

Bowlby described an "attachment behavioral system" whereby the mother and child are entwined in a biologically based, bi-directional relationship that serves the Darwinian function of keeping the mother and child within close proximity to each other for, among other things, physical safety. The child is endowed with "attachment behaviors" such as, crying, looking, reaching, which serve to alert and inform the mother about her child's needs, so she can return her child to a state of comfort. The goal of this system is to keep the child and mother physically close to each other, to ensure the child's safety, and to establish what Ainsworth (1978) later termed a "feeling of security" (Slade and Aber, 1992). This cyclical interaction between the mother and infant is constantly in play: the infant's distress or need activates the attachment system, this leads to an "attachment behavior" to signal the mother, the mother then responds and takes care of the infant,

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relieving its distress, and returning to it a feeling of security, allowing the baby to explore its surroundings, secure in the mother's availability. When the infant is frightened or needs comfort, the system is activated again.

Another central aspect of Bowlby's model of the attachment system is what he called an individual's "internal working model of attachment" (IWM) (Bowlby, 1982). Internal working models are developed in infancy and emerge out of real interactions with primary caregivers. They are dynamic models which capture the patterns of past interactional experience, and are subsequently used to predict future experiences. Thus, IWMs are prototypes of interpersonal relationships and, in psychoanalytic language, can be thought of as the mechanisms of transference (Slade and Aber, 1992). Thus, as infants become better able to predict their mother's style of availability, attunement and response, they begin to tailor their behavior in complementary ways. Infants also begin to tailor their own self-representation as more or less able to get what they need from their caregivers. These IWMs begin to develop very early in infancy and are thought to function outside of conscious awareness (Bretherton, 1985, 1987).

Mary Ainsworth and her colleagues (1978) developed a way to operationalize Bowlby's notions about the attachment system in the now famous "strange situation" procedure. This procedure intentionally stresses the child, thus producing the attachment behaviors, and provides an opportunity to witness the child's style of responding to the mother. Using the results of this experiment, along with data from at home visits with the same families, Ainsworth described two main categories of the child's behavior in relation to their attachment figures (in this case their mothers):

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secure and insecure. The secure children naturally displayed their distress, and turned to their mothers, confident that they would be soothed. The mother of a secure child is easily able to make him or her feel safe and calm again, so that he or she can return to play.

Though there are several different patterns of insecure attachment, they all have in common a compromise of the attachment system. Some insecure children don't express their neediness completely, others don't turn to their mothers for soothing and comforting. Some mothers of insecure children are unable to soothe them; others even exacerbate their infant's distress. In general, children learn how to get the most of what they need from their caregivers. Thus, if a parent is overwhelmed by a large amount of crying by the infant and then withdraws because of it, the child will likely limit his or her crying and learn how to act to get what he or she needs from its mother.

While Ainsworth was able to beautifully capture the behavioral manifestations of the attachment system, it wasn't until the work of Mary Main that the representational processes underlying attachment behaviors were further explored. Just as Ainsworth found that a child's behaviors revealed his expectations regarding maternal availability, Main (Main et al., 1985) wanted to see how the parents of secure and insecure children talked about their own childhoods. Main's research group hypothesized that the content of parents' life stories would differ depending on whether their children were rated as secure or insecure. Thus, Main and her colleagues developed the Adult Attachment Interview (AAI) (George, Kaplan, & Main 1985), which was administered to the mothers of children who had

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previously been evaluated in the strange situation. The AAI asked these mothers to reflect back on their own experiences of being parented, particularly on their own responses to situations that might have activated their attachment systems, such as: separations, losses, and rejections.

What they discovered was that it was the structure, not the content, of the parent's narratives that revealed something about their own early experiences of being parented. In examining these AAIs, Main and her colleagues discovered several patterns of representation. The different patterns of representation that the mothers displayed on the AAI correlated with the different types of secure and insecure behaviors that their children demonstrated during the strange situation experiment.

Mothers of children who were rated secure during the strange situation tended to be able to talk freely and coherently about their own childhoods. When these mothers described their relationships and experiences with attachment figures they were easily able to provide clear examples of a range of experiences and feelings. In these examples they told coherent stories that indicated prior thought about how their own and others' different feelings and perspectives influenced their experiences, behaviors and personalities. In general, these mothers neither idealized nor devalued these attachment relationships. Rather, they were able to appreciate the complexity and subtle nuances, both positive and negative, of their relationships.

In contrast, parents rated as insecure and dismissing often had difficulty remembering specific early experiences, and tended not to place much importance on early relationships. Their descriptions of these

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experiences and relationships tended to be brief, lacking insight and feelings. These mothers tended to idealize their relationships, a process that served to mask the difficult realities of these experiences and their painful reactions to them (Slade &Aber, 1992). Thus, their reporting of these relationships in a general and overly positive light was frequently at odds with apparent reality of their histories, and they often didn't have specific memories to back up the defensive way they remembered their relationships. Another category of mothers, classified as insecure and preoccupied, demonstrated a different but equally insecure way of remembering and presenting their pasts. These mothers seemed to be currently engaged in the struggles of dependency with their own parents. They reported their memories of their early relationships with a certain preoccupation suggesting that they were still actively trying to please them. Though they reported many more examples of early experiences with their parents than the dismissing group did, they reported these experiences in a very incoherent way. Their stories weren't organized, suggesting that they had not been coherently integrated into their personal narrative.

Thus, the AAIs revealed that it was not only what and how much the mothers remembered that determined their attachment status, but the coherency with which they told their stories and the overall organization and integration of their thoughts and feelings about these relationships. In other words, it is not the presence or absence of trauma or loss that determines one's security in adulthood, but one's ability to reflect on experience. The crucial determinants are how the memories of one's experiences are organized and understood by the individual; whether or not they have access

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to the memory itself, and if so, if they have insight into its impact on themselves and others and some perspective on why it occurred.

Main's finding that a mother's representations of her relationship with her own parents is correlated with the behavior her child, parallels Bowlby's concept of IWMs. Thus together, Main's study and Bowlby's IWMs suggest that underlying differences in styles of attachment behavior are different mental representations of the self in relation to attachment figures (Main et al., 1985). It also suggests that underlying the patterns of non-verbal behavior and language is the same structure of mind, presumably the seat of relationship representations (Main, 1985, p. 67; Slade and Aber, 1992 p.162; Slade, 2000). It was in the further interpretation of the texts of the AAIs that Main and her colleagues began to focus on the importance of narrative coherency and metacognitive monitoring (Main & Hesse, 1990; Main, 1991) as the verbal vehicle for representations.

Narrative Coherency on the AAI and Reflective Function

Narrative coherency is an area of increasing interest and research. One branch of this field of study has come out of Mary Main's work on the Adult Attachment Interview (1991, 1993). She and her colleagues have found that a coherent narrative reflects the secure individual's ability to accurately represent and articulate the stories around their significant attachment relationships. Autobiographical and narrative competence is the ability to hold on to and represent a sense of personal history. Developmentally, this ability is a result of the parent providing an affectively attuned, consistent and reliable environment for the infant. If the parent is able to "take the

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baby's perspective" (Bretherton, 1991), understanding that the baby has a mind, then the infant will learn that he or she has its own mind, which eventually leads to the capacity for self reflection and reflection about other's minds.

According to Main and her colleagues, coherency is defined as follows: (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 AAI 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) builds on Bowlby's notion of multiple working models of attachment. Bowlby's definition of multiple working models of attachment describes two "incompatible" mental representations of the same attachment figure existing concurrently (for example, an abusing parent who is thought of as both as a loving care-giver and an abusive attacking one), while Main's theory holds that multiple models contain "conflicting propositions." Main's propositions are comprised of two components, 1) a propositional attitude (believing, hoping, wanting, fearing, desiring) and 2) the content of the proposition (that my mother will recognize my needs when I approach her; that my father dislikes me, etc.) (Main, 1991, p, 133). To have "multiple

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models" of attachment related events, a scenario could either have propositions containing conflicting *contents*, such as,

> 'I believe that my mother is unfailingly loving and has always acted in my best interest/I believe that my mother is ridiculing and rejecting and does not consider my interest' (Main, 1991, p, 133).

Or a scenario could have propositions containing conflicting propositional *attitudes*, such as,

> 'I fear that father will leave this family/I hope that father will leave this family' (Main, 1991, p, 133).

This is important in that it identifies an area of cognitive functioning that mediates the development of secure attachment status, which will be expressed through language via narrative coherency. Main continues and states:

> 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 experience exist, either metacognitive knowledge has yet to develop or there have been failures of corrective metacognitive monitoring (p.134).

It is this emphasis on the importance of interpersonal representations as expressed through metacognitive monitoring and narrative coherency that Fonagy and his colleagues used as the theoretical basis for developing the construct of reflective functioning.

Reflective Functioning

Fonagy and Target (1995, 1996, 1998; Target &Fonagy, 1996) elaborated the concept of metacognitive monitoring, which they call "mentalization" and

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reflective functioning (RF). Fonagy and his colleagues have operationalized and developed a scale to measure aspects of metacognitive abilities in adults as a means to explain the generational transmission of security from mother to child (Fonagy et al., 1995).

The reflective function refers to mentalization and metacognition and depends on the development of a self who thinks and feels. RF implies the ability to understand another's state of mind _as_ a state of mind. It entails the ability to understand mental states as essentially propositional and intentional, i.e. entailing beliefs and wishes. RF refers to the capacity to think about and understand one's self and others in terms of mental states (feelings, beliefs, intentions, and desires). It also refers to the capacity to reason about one's own and others' behavior in terms of underlying mental states (Fonagy et al., 1998). Thus, RF is an important component of being able to take someone else's perspective, and to take his or her feelings or ability to understand something into consideration. This then helps people to anticipate and predict their own and others' reactions and expectations, and places interpersonal interactions in a more meaningful and predictable structure. Fonagy and Target describe RF as a representational aspect of the core of one's self-structure (Target and Fonagy, 1996).

Reflective functioning is a basic intrapsychic and interpersonal achievement. This developmental capacity to reflect on feelings and thoughts is built up through an intersubjective process primarily between the infant and caregiver, but also between the child and other adults and siblings. Though the young child does not consciously think in terms of mental states, this capacity begins to develop very early. The emergence and full

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development of RF depends on the caregiver's capacity to more-or-less accurately perceive the intentionality and mental states of the infant. "Unconsciously and pervasively the caregiver ascribes a mental state to the child with her behavior, this is gradually internalized by the child, and lays the foundations of a core sense of mental selfhood" (Target & Fonagy, 1996, p.461). In their empathy with the child, the caregivers think about the child's needs and behaviors, and thus demonstrate to the child that they think of him or her as an intentional being whose behavior is driven by thoughts, feelings, beliefs and desires, and in so doing they give meaning to the child's actions. This facilitates a sense of mental agency or an intentional stance in the child, who through the process of thinking about the thoughts of others, begins - like the caregiver - to think about mental experiences. If the child can look to the caregiver and find an accurate representation of its own experience reflected back in a safe and consistent way, the child will have the opportunity to experience a range of emotions, experiences and intentions. Experiencing such a range leads a child to begin to develop a theory of mind. Thus, the child will learn to rely on the use of mental states as an adaptive and efficient mode of functioning. However, if the child does not find its mind accurately reflected in the caretaker's mind, but rather finds that other mind to be filled with malevolent or insensitive representations that are contradictory to its own experience, then the child will resist exploration of mental states out of fear.

Experiences of trauma or neglect in the absence of a benign, consistent, thoughtful other create scenarios in which it is adaptive for the child not to develop the capacity for RF. It is less disturbing to remain concrete and

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isolated than to contemplate the hostile, thoughtless, barren or cruel minds of one's objects. Thus, not developing the mentalizing capacity enables the child to circumvent pain and the devastating experience of not being considered by those they depend on. In these cases the inhibition that was developed out of adaptive necessity, will remain the prevailing mode of relating even when the child, or later adult, is no longer in the proximity of the traumatic environment and the original unloving, thoughtless others.

Narrative Coherency, Reflective Function and Clinical Applications

Recently, 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. Studies are beginning to reveal a relationship between insecure adult attachment status and poor outcome in psychotherapy (Fonagy, 1991; Fonagy, Leigh, Steele, Steele, Kennedy, Matton, Target, & Gerber, 1996). Research has also demonstrated relationships between deficits in RF, insecure attachment status and borderline psychopathology (Fonagy, 1989; Fonagy, 1991; Fonagy, 2000). Fonagy and his colleagues suggest that one's attachment status, as determined by the AAI, may be useful in identifying patients who are at risk for prematurely dropping out of treatment. In an earlier study, Fonagy and Tallandini (1993) found that the patients who ended their treatments prematurely were categorized as preoccupied on the AAI. In the future, research within the attachment domain may produce methodologies that provide additional, transtheoretical research tools for the study of interpersonal relationships, (Samstag, 1998).

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Samstag (1998) found a significant correlation between scores of narrative coherency (as defined and measured by Main's above mentioned criteria) during psychotherapy sessions and overall psychotherapy outcome. In her sample of adult patients in short term psychotherapy, those with good outcome had the highest narrative coherency, those patients with poor outcome had moderate narrative coherency and those who dropped out of treatment had the lowest narrative coherency. Samstag also found that narrative coherency was significantly correlated with the patient rating of the bond component of the overall rating of the therapeutic alliance, and the patient rating of the overall alliance itself. She interprets this finding to suggest that:

> "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." (p. 96)

Psychoanalytic theorists outside of attachment theory (Schafer, 1976; Spence, 1982) have also been looking at the way patients express themselves in psychotherapy as a measure of internal organization. Like Main and Fonagy, Schafer and Spence believe that through language and narrative a patient can make sense of their histories and link their inner and outer worlds. This increased coherency in turn contributes to a sense of security by connecting split-off parts of internal experiences and aspects of the self. Thus, one goal of therapy is to help the patient to create a more coherent narrative. Therapist's interventions should, therefore, contribute to increased autobiographical competence for the patient. This allows the patient to

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assimilate new experiences more easily and to further understand their own narrative. Current research by attachment theorists, such as Fonagy and Dozier (Dozier 1988; 1990), has begun to explore links between narrative competence, security of attachment and psychotherapy outcome.

Intersubjectivity

The developmental and clinical theory of intersubjectivity is relevant to the concept of reflective function because it emphasizes the dynamic relationship of interdependent mental representations and its role in healthy development. Intersubjective theory describes how the relationship between two people, infant and mother, or patient and therapist, is the essential ingredient in the process of developing representations of the self in relation to others. Jessica Benjamin's concept of "mutual recognition" and Lewis Aron's concept of "self-reflexivity" provide useful contexts in which to think about the development of reflective function.

Two different branches of contemporary psychoanalytic theorists have adopted the name intersubjectivity. One branch led by Robert Stolorow (Stolorow & Atwood, 1992; Orange Atwood, & Stolorow, 1997), uses the term intersubjectivity to describe the psychological field that is created any time two individuals, namely therapist and patient, are in each other's presence. The emphasis in their work is on the mutual regulation created in the context of this intersubjective field.

The other branch of intersubjectivity, which is most relevant to this project, includes the work of Jessica Benjamin and Lewis Aron. One main tenet of Benjamin and Aron's work on intersubjectivity, is the idea that

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intersubjectivity is a mental state and a developmental achievement that occurs in relation to another individual.

In the 1970's and 80's the school of feminist psychoanalytic criticism (Benjamin 1988, 1992; Dinnerstein, 1976; Chodorow, 1978) redefined certain aspects of classical psychoanalytic theory and broadened its perspective. They created new ways of looking at the internal world of the relationship between the conscious and unconscious and the dynamics of conflicts to include a less distorted view of motherhood, and the feminist perspective. Jessica Benjamin has brought this revision of the role of the mother in psychoanalytic theory from that of being an object of the infant who exists to fulfill the infant's needs, to one of being a subject.

Benjamin describes the child's experiencing the mother as a separate other, with a subjectivity and internal world of her own, who has her own needs and desires that are independent of her child, as a developmental necessity and milestone. The child's disappointing realization that the mother's desires, though often inclusive of the child, occasionally do not include the child at all, is a major step in developing a healthy independence and sense of self. By realizing that the mother has her own separate internal world, the child simultaneously learns, that he or she does as well. Benjamin believes that this capacity to recognize the other as a separate self is an important aspect of intersubjective relatedness. She believes that this capacity is its own separate course of development.

This theory of intersubjective relatedness as its own course of development is a departure from traditional psychoanalytic theory of development (Mahler et al., 1975). Traditionally, the developmental

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accomplishment of the child's perception of the mother is the development of "object constancy," or the child's realization that the mother is a separate person. Benjamin and the intersubjective theorists view the developmental goal as the child coming to recognize the mother as a separate *subject*. This is a more complex, but richer and more finely nuanced way of understanding the process of the development of the self. It brings intersubjective recognition into development as a necessary condition for the development of an autonomous self.

Benjamin captures the relationship of this new trajectory of developmental theory and its relationship to the traditional theory in her statement, "where objects were, subjects must be" (1990, p. 34). She adopts this subject-subject relationship, and the term intersubjectivity, from the work of Jurgen Habermas (1971). For Benjamin, intersubjectivity "refers to that zone of experience or theory in which the other is not merely an object of the ego's need/drive or cognition/perception, but as a separate and equivalent center of self" (1992, p.45).

This idea that it is only through the recognition of others that an individual can develop a whole separate sense of self also has roots in the works of the philosopher George Hegel (1807) and the psychoanalyst D.W. Winnicott (1958). Benjamin proposes that in human interaction there is a constant oscillation between relating to others as objects and relating to others as subjects. She uses the terms intrapsychic and intersubjective respectively to discuss these two realms. Winnicott (1951, 1958) beautifully described this oscillation by focusing on the space between these two positions in his terms transitional space and transitional objects. He writes that the relationship

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between internal world and external world exists in this realm of representations. The capacity to be alone reflects the ability to carry the other within us through transitional objects, transitional space and representations. For Winnicott, aloneness is also a developmental achievement that develops out of the realization that the mother has her own self that is independent of the child. Therefore, the capacity to be alone, requires the emotional maturity to accept that the other's needs and priorities are not always going to be the same and the self's and thus, "implies a tolerance of ambivalence" (1958 p. 31). Winnicott goes on to say that, "Maturity and the capacity to be alone implies that the individual has had the chance through good-enough mothering to build up a belief in a benign environment." (1958, p. 32). Like ego-psychologists and attachment theorists this implies that the capacity to be alone is developed through real, as opposed to fantasized, experiences. The child's trust in a "benign environment" can be interpreted as analogous to attachment theory's concept of the child experiencing the mother as a secure base. Thus, the child is free to explore its physical environment and its internal environment, in other words to be alone, when it feels secure and safe in its relationship with its caregivers. Again in Winnicott's words, "It is only when alone (that is to say in the presence of someone) that the infant can discover his own personal life," (1958, p.34). It can be inferred that when he says "in the presence of someone," he means either physically or, more importantly, representationally.

For Benjamin, the recognition of the other is inconsistently maintained. She sees intersubjectivity as a dialectic process where subjects recognize each other as separate centers of subjective experience, but also continually negate

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each other as separate subjects (Benjamin, 1992). One exception to this process is the way it unfolds in therapy. Because the therapeutic relationship is focused on understanding the patient's experience, the therapist shouldn't be negating it. Maybe this is one way that the therapeutic relationship is different from others. If one benefit resulting from the uniquely tipped balance of the therapeutic relationship is the patient's enhanced ability to recognize the self in relation to other, then it seems that it is likely that therapeutic change occurs somewhere in this vicinity.

Daniel Stern (1985), like Benjamin, conceives of intersubjectivity as a developmental achievement. Stern conceives of intersubjectivity as "the capacity to recognize another person as a separate center of subjective experience with whom subjective states can be shared." An aspect of this theory is the developmental recognition of subjective mental states in the other as well as the self. Stern (1983) writes that at around the seventh month there is: "a momentous discovery, namely, that he or she can share with another a state of mind such as intention. In other words, the infant develops a theory of interfaceable minds" (p.89). Thus, Stern is suggesting that the infant naturally intuits that the other has an internal mental state that is accessible to the infant at that moment. The state of sharing and connection of two internal worlds becomes "not only possible, but a goal to be sought" (p. 89).

Here another point of difference between the intersubjective and traditional psychoanalytic theories emerges. The intersubjective perspective as presented by Benjamin, Stern and others proposes the development of the self occurs in a bi-directional fashion, producing a self that is mutually related

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to and recognized by others in a dialectic continuum. While the classical psychoanalytic and ego-psychological theorists emphasize an ultimate goal of individual autonomy.

Thus, in psychotherapy and all relationships, the intersubjective schools shift the focus to the transitional space between people. This interpersonal arena of representations that was described so elegantly by Winnicott, becomes the fertile ground for exploring change. As will be outlined in more detail later, this focus on the interpersonal, intersubjective, relational space in between two people, is the focus of the Brief Relational Therapy that has been developed by Muran and Safran, which will be outlined in Chapter III.

Intersubjectivity and the Therapeutic Relationship

If we understand intersubjectivity as the developmental achievement of mutual recognition, how then does this inform our understanding of what takes place during the course of psychotherapy and of the relationship between the patient and therapist? Lewis Aron (1999) writes about the difference between a relationship being mutual versus a relationship being equal. He proposes that the therapeutic relationship is one of mutual recognition in Benjamin's terms, while it is not equal, in that the therapist and the patient have different prescribed roles. The therapist's role is to focus on and try to understand the experience of the patient, while the patient's role is to try to understand the self in relation to others, including the therapist.

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Lewis Aron's model for the therapeutic relationship "assumes mutual, even if unequal, participation of patient and analyst from beginning to end" (Aron, 1999, p.8). Aron describes a representational structure that he calls "self-reflexivity," which allows for the patient's oscillation between participating in something to observing the self and others participating in something. Aron intentionally differentiates his term self-reflexivity from the term self-reflection, which he understands to mean thinking about oneself from outside. Aron defines self-reflexivity as a "dialectical process of experiencing oneself as a subject as well as reflecting on oneself as an object. It is not only intellectual observational function, but an experiential and affective function as well" (Aron, 1999, p.11).

Aron places the beginnings of this self-reflexive structure in the process of the Oedipus complex. During this phase the child goes from having exclusive relationships with mother and father (child as a participant) to realizing that mother and father have a relationship which excludes the child (child as observer). This oscillation between self as participant and self as observer is only attained after Piaget's stage of concrete operations has been achieved and two different perspectives can be held in mind simultaneously (Fischer, 1980; Flavel, 1963, 1983). Aron states that it is this "oscillating function is clinically important because the oscillating function becomes the basis on which a person can participate in analysis" (1999, p.9). The antecedents of this oscillation can be found in the previously mentioned theories of Sterba and Zetzel.

Aron stresses that the development of intersubjectivity comes in large part from the oedipal child's identification of "self-as-subject with the self-as -

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object and the other-as-subject as other-as-object. Thus, the child begins to achieve Benjamin's developmental goal of seeing the parent as both a separate other and as a separate subject. Due to the dialectical properties of intersubjectivity, the child also begins to see him or herself from the parent's perspective as both an object and a separate subject. The child's identification with the parents' subjectivity includes an identification with the parent's subjective representation of the child as both a subject and an object. Thus, the child's identification with the parent produces what Benjamin's theory refers to as both intersubjective and intrapsychic complementarity (Aron, 1999).

Thomas Ogden (1986, 1989, 1994) uses the terms symbol and the symbolized to describe the orientation of the self in relation to the self. He writes: "for symbol to stand independently of the symbolized, there must be a subject engaged in the process of interpreting his perceptions.... The achievement of the capacity to distinguish symbol and symbolized is the achievement of subjectivity," (1986, pp.224-225). Like Winnicott, who locates the subject as existing in the transitional space between the mother and child, self and other, Ogden also focuses on the dialectical nature of analytic intersubjectivity. He calls this space, "The analytic third. It is neither subject, nor object, but jointly created, intersubjectively, by the analytic pair." He writes that it is the individual's subjectivity concurrent with the intersubjectivity of the dyad that are constantly engaged in a symbiotic relationship that "create, negate and preserve the other" (1994, p.64). It is this continuous dialectic process that creates the intersubjective analytic third.

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In another related theory, Sheldon Bach (1985) distinguishes between "subjective awareness" and "objective self-awareness." The former concept refers to an individual's being totally immersed in one's own thoughts and actions with the awareness of oneself as the agent or the subject of one's thoughts and actions. The latter concept is a qualitatively different state of consciousness reflecting the ability to take oneself as an object of one's thoughts and actions. Bach writes,

> "Thus, one might say the child is confronted with the double or complementary task of establishing a sense of self as a center for action and thought, and of viewing the self in the context of other selves as a thing among other things. What is required is both a subjectification and an objectification, two different perspectives on the same self" (Bach, 1985, p.53).

Auerbach and Blatt (Auerbach, 1993; Auerbach and Blatt, 1996) have drawn on Bach's and other's work and have developed their own concept of reflexive self-awareness or self-reflexivity, which is the capacity to move easily between subjective and objective perspectives on the self.

We see repeated in these theories the process of oscillation. With each change of position a new vantage point from which to view the self in relation to another is created, and visa versa. These theories describe this dialectic process as occurring initially in the development of the infant and continuing throughout the life of the individual. This process is also repeated in the analytic relationship, which due to its specific focus on the patient, serves to highlight and further define the patient's various vantage points of the self in relation to others. Aron's relational-perspectivist approach of psychotherapy "views the patient-analyst relationship as continually being

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established and reestablished through ongoing mutual influence in which both patient and analyst systematically affect, and are affected by, each other." (Aron, 1999, p.17).

Main at al.'s theory of metacognitive monitoring (1985) and Fonagy et al.'s theory of mentalization and reflective functioning (Fonagy and Target 1995, 1996, 1998; Target and Fonagy, 1996) are theoretically congruent with the above mentioned concepts of intersubjectivity. At the foundation of the concepts of metacognitive monitoring and RF is the assumption that self-development is necessarily an interpersonal process built on interaction with the minds of others (Target and Fonagy, 1996). The concept of RF both captures the dialectic processes mentioned above and provides a way to measure them.

Ruptures of the Therapeutic Alliance and their Resolution

This section will bring together the research on therapeutic alliance ruptures, their resolution, and how this interpersonal process can be understood as providing a fertile context for reflective functioning. Alliance rupture resolutions are presented by many researchers as critical junctures in psychotherapy where the potential for progress is enhanced. By looking at those moments in terms of underlying mental states and representations of self and other we may get a more specific idea of what it is that is enhanced through this process and how reflective functioning may play a role.

As described above, there has been repeated empirical evidence validating the construct of the therapeutic alliance and establishing it as a

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critical element in the quality of psychotherapy treatment both for its predictive value in the overall outcome of therapy, as well as during the ongoing process of therapy. Inherent in the idea that a strong alliance is required for a successful treatment are the questions about what happens when there is a breach or rupture of the alliance. The current research in this area has begun to demonstrate that not only is a strong alliance necessary for good outcome in psychotherapy, but that an alliance is strong when it is able to provide a stable enough foundation to withstand the inevitable ruptures that it will be faced with. A rupture in the therapeutic alliance is defined as a negative shift in the quality of the relationship between the patient and therapist. Ruptures vary in severity and duration. Some may go unnoticed by the therapist and some may result in treatment termination (Safran, 1990; Safran & Segal, 1990; Safran & Muran, 1996). Since negative process and ruptures or strains in the alliance are inevitable, the critical difference between a rupture being used productively versus it resulting in premature termination is the way the therapist manages it (Bordin, 1994; Horvath, 1995; Henry & Strupp, 1994; Foreman & Marmar, 1985; Rhodes, Hill, Thompson, & Elliott, 1994; Binder & Strupp, 1997; Safran and Muran, 1996).

The question then is, what is it about the resolution of a rupture that is potentially so rich? What happens in that space that may feel so uncomfortable and be so difficult to manage between the therapist and the patient that is so productive? This section will begin to further define the connections between the therapeutic opportunities presented during a rupture and the increased potential for metacognitive awareness and reflective functioning.

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Though this section will focus on more contemporary research and theories of alliance ruptures, they have their roots in the work of Heinz Kohut, who wrote extensively about these difficult strains in treatment that he referred to as empathic failures. Kohut (1971, 1977, 1984) believed that empathic failures by therapists were inevitable. The therapist at some point will misunderstand the patient in a way that is perceived as a blow, a failure, as the patient not being known or understood by the therapist. Kohut called these failures self-object-ruptures and felt that their interpretation was critical for therapeutic change. Each patient-therapist dyad produces its own ruptures created by contributions from both parties. The elements leading up to the empathic failure and its subsequent handling were considered pivotal for the treatment. On one hand, the exploration of the rupture could provide the richest material, with the greatest potential for understanding the patient's interpersonal process. On the other hand, if the therapist's contribution was too great, or if the perceived empathic failure was too devastating, it could lead to the end of the treatment. The latter was a particular danger if it occurred too early in the treatment.

Bordin (1979, 1994) also felt that empathic failures, or alliance ruptures, were inevitable and that their working through was potentially very productive for effecting new understanding and change. Bordin's method of measuring the alliance (as mentioned above) allowed research on the impact of good or poor alliances on the therapeutic outcome. His transtheoretical language has opened the door to the study of the alliance as part of the therapeutic process, independent of specific techniques and modalities. Like Kohut before him and ample research after him, Bordin found that the quality

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of the therapeutic alliance is the most robust predictor of treatment success, particularly the alliance in the early phase of treatment. Bordin also stresses that repeated severe alliance ruptures might result in the patient prematurely terminating the treatment.

Lansford & Bordin, (1983), Forman & Marmar (1985), and Lansford (1986) conducted some of the initial studies in alliance rupture. After identifying poor alliance cases they began to focus in on the components and process of repair. These studies began to indicate that there were certain therapist interventions, such as addressing the ruptures and making connections between the patient's defenses and difficult feelings toward the therapist, that tended to improve the quality of the alliance. Weiss and Sampson and the Mount Zion Psychotherapy Research Group (1987) have conducted similar research, suggesting that focusing on the pathogenic beliefs of the patient, how they are enacted with the therapist and the process of exploring and disconfirming them is a pivotal mechanism of change in therapy.

Over the past fifteen years Jeremy Safran and his colleagues have been studying the alliance rupture and repair cycle in depth. Much of this research has been carried out with J.Christopher Muran at the Beth Israel Psychotherapy Research Project (Safran, Crocker, McMain & Murry, 1990; Safran, 1993a; 1993b; Safran, Muran, & Samstag, 1994; Safran & Muran, 1994, 1995, 1996; Muran, Gorman, Safran, Twining, Samstag & Winston; Muran, Segal, Samstag, & Crawford, 1994; Safran & Wallner, 1991). These studies have been looking both qualitatively and quantitatively at the alliance rupture and repair process that is a component of every psychotherapy

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treatment. Though they have looked at the rupture-resolution process in several modalities, their main focus has been on interpersonal-experiential therapy sessions (now referred to as Brief Relational Psychotherapy (Safran & Muran, 2000), which will be discussed later). They have identified and categorized different types of ruptures and different paths of resolution (Safran & Segal, 1990, Safran & Muran, 1996, Safran & Muran, 2000).

The Beth Israel Psychotherapy Research Project (PRP) defines a rupture as an impairment or deterioration in the quality of the therapeutic relationship, which may vary in intensity, duration and frequency (Safran & Segal, 1990, Safran & Muran, 1996). A rupture may occur when two people perceive the same incident differently. The patient brings his or her own meaning to the rupture which is a product of "core cognitive structures" or "schemas", as Safran & Muran refer to them. These schemas are analogous to the IWMs of attachment theory. They are mental representations of the way people perceive themselves in relation to others. Like IWMs, these generalized expectations are based on past experiences (Safran, 1990a; Safran et al., 1990). Also like IWMs these schemas develop out of real experiences and were adaptive at the time of their development. Later, when these schemas are elicited in different contexts they may well be maladaptive and no longer serve the same protective function they were originally developed for. The patient's expectations lead him or her to act in a way that elicits the very interpersonal consequences that were feared, thus confirming their dysfunctional expectations (Luborsky, 1984; Safran, 1984a, 1984b; Safran & Segal, 1990; Strupp & Binder, 1984; Wachtel, 1977). This cycle gets repeated again and again until it is also repeated in the relationship with the therapist.

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The therapist then responds in a way that is different from others and refrains from participating in the patient's cognitive interpersonal cycle. Thus in treatment the therapist highlights the patient's dysfunctional beliefs by challenging them.

Conversely, when the therapist fails to adequately understand the patient's dysfunctional belief about interpersonal interactions, and the therapist's actions and reactions to the patient inadvertently confirm the patient's maladaptive interpersonal schema, an alliance rupture is likely to occur. Assuming that the therapist becomes aware of this, the dyad is then presented with an opportunity to explore the dysfunctional processes that produced the rupture and allows them both to gain greater and more refined understanding of the patient's problematic schemas (Safran & Segal, 1990; Safran & Muran, 1996; Safran & Muran, 2000).

What exactly does this process of exploration do? One possibility is that it creates the cognitive space for increased reflective functioning. During a rupture, the treatment is presented with a difficult, but rich moment in which the patient's maladaptive interpersonal expectations are front and center and thus easier to examine and understand. It is in this moment that the potential for increasing the patient's capacity for RF is ripe. Exploring a rupture involves unpacking what the patient had expected from the interaction, what the patient perceived actually took place, how he or she reacted to this disappointment. In other words, it means thinking about the interaction in terms of mental states, and thus increases the possibility for enhancing the patient's RF. Safran writes:

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> Resolving alliance ruptures involves a process of therapeutic metacommunication, i.e. talking about what is currently transpiring in the therapeutic relationship. Therapeutic metacommunication is of course a central intervention in any interpersonal approach to therapy and is not restricted for use in the context of an alliance rupture. It is precisely in the context of an alliance rupture, however, that metacommunication becomes most critical. (Safran et al., 1990, p. 159)

This process of metacommunication is precisely the context in which the potential for reflective functioning is at its greatest. The interpersonal nature of a rupture leads to exploration of the underlying mental states of both parties in the interpersonal interaction. The patient and therapist's representations of themselves and each other during the rupture become the focus of the exploration. It means thinking about the self as a subject and the other as a subject. This process of thinking about two selves in relation to each other is elegantly elucidated by the intersubjective theories of Benjamin and Aron. We can understand the emphasis on metacommunication during the exploration of a rupture as enhancing the process of "mutual recognition." Like Benjamin's child realizing that the mother has needs and a subjective self of her own, the patient during a rupture realizes that the therapist sees things differently than the patient does and has a subjectivity of his or her own. If the therapeutic alliance is strong enough, the patient can further elaborate their representations of themselves in relation to the therapist and others; if not, the rupture will continue and the gulf between the patient and therapist will remain.

Kohut, Bordin, Safran & Muran all emphasize that how the therapist responds in the face of a rupture is crucial. It can either be productive or lead

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to further ruptures. Again this can be looked at in terms of RF by asking whether the therapist is encouraging and enhancing exploration of the underlying mental states of both the patient and the therapist during the rupture. Safran writes that looking at the contributions of both the therapist and patient to the rupture requires "self-reflection" (p. 45, 1993). Again, by thinking of this "self-reflection" in terms of RF we are provided with a methodology for more specifically qualifying and quantifying this intuitively simple, yet relatively un-operationalized and thus un-measured concept. In this context, measuring the patient's capacity for reflective functioning is a way to operationalize one aspect of the therapeutic communication and change as it occurs within the interpersonal process between the patient and therapist.

Statement of the Problem

The purpose of this study is to examine the relationship between RF and psychotherapy outcome. If, as outlined above, we think of RF as measuring an individual's capacity to think about him or herself and others in terms of mental states, and we think of RF as a developmental capacity that is dynamic and subject to change over time, then what would we expect to happen over the course of a thirty session psychotherapy treatment? This study seeks to examine the hypothesis that the process of negotiating ruptures in the therapeutic alliance often enhances the patient's capacity for reflective function, and furthermore, that change through psychotherapy typically involves an increased capacity for reflective functioning.

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To explore this question, change of patients' RF in two different groups will be measured: 1) those who met criteria for good therapeutic outcome, and 2) those who met criteria for poor therapeutic outcome (see the Overall Outcome Assessment section of Chapter III: Method for outcome criteria).

Hypotheses

It is hypothesized that:

1) Good outcome cases (RCI > 1.96; see Chapter III: Method) will be characterized by either higher initial RF or significant increase in RF across time.

2) Poor outcome cases (RCI<1.96; see Chapter III: Method) will be characterized by lower initial RF and no significant change in RF across time.

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Chapter III. Method

Design

This study was conducted at the Brief Psychotherapy Research Project at Beth Israel Medical Center in New York City. Since the 1980's, the Brief Psychotherapy Research Project has been examining the therapeutic relationship during the treatment of adults with long-standing character pathology. It has also served as a clinical training forum for a number of different time-limited psychotherapies (McCullough & Winston, 1991). Subjects used in the current study were patients in the research project between 1990 and 1998.

Patients come to the Brief Psychotherapy Research Project primarily through advertisements in the New York Times and the Village Voice, and also via referrals made from mental health professionals and former patients who have participated in the project. The criteria for participating in the study are as follows: (1) participants must be between 18 and 65 years old, (2) participants must report having at least one close personal relationship, (3) there must be no evidence of mental retardation, organic brain syndrome, or psychosis, (4) patients must not have met criteria for a Diagnostic and Statistical Manual III-R or IV (DSM III-R or DSM IV) diagnosis of paranoid, schizoid, schizotypal, narcissistic, or borderline personality disorder, (5) no DSM III-R or IV 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

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medication such as neuroleptics or lithium, and (9) no concurrent participation in other forms of psychotherapy. Upon agreeing to participate in the research project, each patient signed an informed consent to the research protocol (see Appendix A). The Structured Clinical Interview for DSM III-R and IV (SCID; Spitzer, Williams, & Gibbon, 1987, 1994) and the Structured Clinical Interview for DSM III-R and IV Personality Disorders (SCID-II; Spitzer, Williams, & Gibbon, 1987, 1994) were used to formulate diagnoses. Patients also completed self-report interpersonal and symptom measures (see Assessment Instruments section below).

The SCID and SCID-II were administered as part of the intake process by clinical psychology graduate students who had undergone extensive training with the instruments. The training included study of the SCID manual and watching the corresponding SCID videotaped interviews, as well as observation of a number of live interviews by skilled diagnosticians. The graduate students were also observed and supervised by skilled diagnosticians. A reliability study of assessment interviewers (rating axis I and axis II diagnostic categories from video taped interviews) at the Brief Psychotherapy Research Project, is currently being completed.

Treatment

Patients accepted into the project were randomly assigned to one of five manual-based, 30-session, once per week therapies: a cognitive-behavioral treatment (Turner & Muran, 1988) , two types of dynamic treatment (Pollack, Fleigenheimer & Winston, 1992; Laikin, Winston & McCullough, 1992), a supportive treatment (Pinsker & Rosenthal, 1988) and a

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relational treatment (Safran & Segal, 1990; Safran & Muran, 1996; Safran & Muran, 2000). All of the patients included in this study were randomly assigned to the brief relational psychotherapy (Safran & Segal, 1990; Safran & Muran, 1996; Safran & Muran, 2000). Brief Relational Therapy (BRT) is defined as a set of therapeutic principles 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 psychodynamic, cognitive, and experiential approaches that 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 (Safran & Muran, 2000; Samstag, 1998).

Participants

Subjects in this study were ten patient-therapist dyads who completed the thirty-session protocol of BRT psychotherapy. Five of the cases demonstrated good outcome and five cases demonstrated poor outcome (the method for determining treatment outcome will be defined below under Overall Outcome Assessment). The ten dyads included ten patients treated by four therapists. The patients had a mean age of 38.7 (range 25 - 55) (see Table 1). Seven of the patients were female. Four were married, two divorced or separated and four single and never married. All ten patients were White. Six patients had completed college or a graduate level degree; four had taken

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some college courses. Nine reported being employed. Primary axis 1 diagnosis included dysthymia (5), depression (2), social phobia (1), simple phobia (1) and generalized anxiety disorder (1). Primary axis II diagnoses included avoidant personality (3), personality disorder not otherwise specified with cluster C features (5), histrionic (1), no diagnosis (1) (see Table 2).

Information regarding early traumas or severe losses of attachment figures was collected during the patient intake assessment process. 'Early' is defined as occurring before twelve years of age. 'Severe' is defined as (1) the 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 previously been defined as severe by attachment researchers (e.g., Adam, Sheldon-Keller, & West, 1995; Main, 1991; Main & Goldwyn, unpublished manuscript; West & Sheldon-Keller, 1994). Overall, of the ten patients in this study, three of them reported having experienced severe early attachment trauma or loss.

The therapists were all recruited from the Department of Psychiatry at Beth Israel Medical Center (see Table 3). Three of them had Masters degrees in clinical psychology and one had a Ph.D. in clinical psychology. The four therapists had a mean age of 32.1 (range = 27 to 43), with a mean of 3.8 years of clinical experience. Three of them were female, and all were White. The therapists participated in didactic seminars and weekly group supervision for BRT.

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Overall Outcome Assessment

Patients were asked to complete overall outcome assessments at pre-, mid- and post- treatment. These paper-and-pencil, self-report scales included 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 B) and the Symptom Checklist-90 Revised (SCL-90-R; Derogatis, 1983; see Appendix C). Both measures are frequently used in the assessment of overall outcome in psychotherapy research.

The IIP-64 (Alden, Wiggins, & Pincus, 1990) is a revised version of the original 127-item scale developed by Horowitz, Rosenberg, Baer, Ureno, & Villasenor (1988). The authors report high internal consistency and test-retest reliability coefficients. The IIP-64 assesses the severity and type of distress that develops in interpersonal situations. 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 designed in the same format as the SCL-90-R. Examples of typical items are "it's hard for me to understand another person's point of view" and "I argue with people too much."

The SCL-90-R is a 90-item scale that assesses severity of common symptoms reported by adult psychiatric and medical patients, and like the IIP-64, it is commonly used in psychotherapy outcome research. Normative studies have been conducted on clinical and non-clinical patients (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

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annoyed or irritated, feeling tense, or having trouble sleeping or remembering things. Items are rated on a five-point scale ranging from 0 ("not at all") to 5 ("extremely"). 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). Derogatis reports acceptable psychometric statistics for nine primary dimensions (somatization, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychosis), including test-retest reliability coefficients ranging from .78 to .90, and internal consistency coefficients ranging from .80 to .90.

The original manual for the SCL-90 reports that discriminant, concurrent, and convergent validation have been tested and established in a large number of studies. Taken together, these studies correlate 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). Both psychotherapy and pharmacological research projects have shown the SCL-90-R 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).

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Outcome was determined by calculating the reliable change (RC) scores between time one (intake) and time two (termination) on the SCL-90-R and the IIP-64 (Jacobson & Truax, 1991). The RC index is a statistical calculation used to evaluate the degree to which patients demonstrate clinically significant change from pre- to post-treatment. 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., RC < 1.96). Cases in this study will be considered to have good outcome if the RC index is greater than 1.96, and will be considered to have poor outcome if the RC index is smaller than 1.96 (see Table 4).

Post Session Questionnaires

After each psychotherapy session, both the patient and the therapist filled out a Post Session Questionnaire (PSQ). The PSQ includes, among other scales, three questions inquiring about perceived tension between the patient and the therapist during the (see Appendix D). The patient and therapist versions of the PSQ are parallel. The patient and therapist filled out the PSQ independently of each other and they remained blind throughout the treatment to how the other completed his or her PSQ's. The questions inquiring about tension in the therapeutic relationship ask the patient and therapist first to decide if there was such tension in the session. They are then asked when during the session the tension occurred (in the beginning and/or middle and/or end). Finally they are asked to rate the severity of the tension on a five point Likert-type scale from 1 ("low") to 5 ("high"). Tension reported

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on these questions is one indication that there has been a shift in the quality of the therapeutic relationship and that an alliance rupture has occurred.

Case Selection

The ten patient-therapist dyads selected for this study were chosen based on several criteria (see Table 4). First, they all had to have completed thirty psychotherapy sessions in the BRT treatment modality, and completed all of the outcome assessments at intake and termination. In an attempt to control for therapist variability (e.g. a therapist effect determining outcome) an equal number of good and poor outcome cases were chosen for each therapist. Thus, one of the therapists had two good and two poor outcome cases; and three therapists had one good and one poor outcome case. In total, five good outcome cases and five poor outcome cases were chosen. As described in the Overall Outcome Assessment section above, outcome was calculated using the RC index from pre- and post-treatment patient symptom measures. Good outcome is defined as an RC index that is greater than 1.96, and poor outcome as less than 1.96 (see Table 4).

Session Selection

Specific psychotherapy sessions were selected to be scored for reflective function based on several criteria (see Table 5). Sessions one and two were not considered eligible in order to give the patient and therapist some time to adjust to each other and the PSQ's. The thirty sessions were divided equally into thirds. All of the sessions selected for this study contain ruptures in the therapeutic alliance, as measured by the PSQ. One session was

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chosen from each third based on either the patient or the therapist rating of "degree of tension in the therapeutic relationship" on the PSQ (rated 1 "low" through 5 "high", on a Likert-type scale). This reporting of tension in the therapeutic relationship is an indication of a rupture in the alliance. The session with the highest rating of tension from each third of treatment was chosen. If the highest rating was given to more than one session, then one of these was chosen randomly. Selected sessions were also at least five sessions apart from each other. Thus, if two sessions with high ratings of tension from two different thirds of treatment were less than five sessions away from each other, then one of them would be eliminated. For example: if session 9 was chosen from the first third of treatment, and both sessions 11 and 15 were given the highest rating of tension in the second third, then session 15 would be chosen because it is more than five sessions away from session 9.

Observer Rating of Reflective Functioning

The ten point RF scale was originally developed at the London Parent-Child Project for the purpose of coding Adult Attachment Interviews (AAIs) (Fonagy, Steele and Steele, 1991a). The AAIs of Fonagy's sample of 100 mothers and 100 fathers were coded by four and three judges respectively. The mean correlation coefficient among the judges of the mothers' RF scores was .67 (range = .59 - .83). The mean correlation coefficient between the judges of the father's RF scores was .83 (range = .79 - .89). Thus, they were able to establish inter-rater reliability. Correlations between the AAI and RF scores yielded six factors, the strongest coefficient alpha (.90 for mothers, and .92 for fathers) was for coherence in internal working models of attachment.

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Other factors (e.g., guilt, pressure to achieve) were not relevant to this study and therefore are not included here. This reported strength of the relationship between RF and the coherence in internal working models of attachment further supports the hypothesis that measuring of RF would be a way to measure change of mental representations of self and other over the course of a psychotherapy treatment. In addition, they found that RF scores were "consistently the strongest contributors to judges' assessments of attachment security, and accounted for more than half the variance in the secure/insecure distinction" (Fonagy, et al., 1998, p. 15). Several subsequent studies, The Cassel Hospital Study (Fonagy et al., 1996) and The Prison Health Care Study (Levinson and Fonagy, in press) have also validated the construct of RF.

To the author's knowledge no manual exists for coding RF of either the patient or the therapist during psychotherapy sessions. Therefore, for this study, the Fonagy et al. RF manual (version 5) (Fonagy, Target, Steele, & Steele, 1998) was adapted for this new application. The patient's capacity for reflective functioning was measured from videotapes and transcripts of psychotherapy sessions (see Appendix E for further description of the scale points). The patient's RF was measured during one entire fifty-minute psychotherapy session from each third of the treatment (see previous section for session selection criteria). Each session was given overall codes for the lowest instance of RF, the mode of RF, and the highest instance, or peak of RF.

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Scoring Reflective Functioning

Four RF scores were given to each session: low, mode, peak and mean. The low RF score is the lowest level of RF that the patient expresses. This score will be given to the lowest example of RF from the patient when the patient is presented with the opportunity to think reflectively about something. The low score is a measure of instances when the patient disavows RF or rejects the opportunity for RF, either passively or actively (for example, utterances that would receive an RF score of 1 or -1). For many patients there may not be a striking instance of disavowal or rejection of RF, but when this does occur it is important that is captured.

The mode score characterizes the average RF level of the transcript. It should represent the most general or frequently occurring level of RF for that transcript.

The peak score is the highest level of RF that the patient reaches during that session, even if it is only reached once. There is no length requirement for the peak score, and it may occur at any time during the session. Some transcripts will have no clear peak. In these cases the mode and peak ratings will be the same. Other transcripts may have a wide range between the mode and peak scores. If the transcripts seems to be divided equally between two scores, then the higher of the two scores will be the peak. If more than half the transcript is given a higher code, then the mode and peak will be the same.

The mean RF score is the mean of the low, mode and peak scores for each session.

For scoring of RF, each therapy session will be divided into thirds. The rationale for this is to provide shorter and more manageable chunks of

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sessions to code, while trying to preserve the narrative and thematic flow of a psychotherapy session. Each third will be scored separately and given separate low, mode and peak scores. These scores will then be used to create the overall RF scores for the session. The lowest of the three low scores will become the overall low score. The modes will be averaged together to produce the overall mode. The highest peak score of the three will become the overall peak score for the session.

Coding

The third party raters for RF were six graduate students in Masters or Ph.D. level clinical psychology programs (see Table IV). The raters were blind to treatment outcome and study hypotheses. RF was coded using both video tapes and verbatim transcripts of the fifty minute psychotherapy sessions. The raters met with the principal investigator for eight months prior to coding the data for this study. Training involved a combination of lectures, readings, practice codings of videotaped psychotherapy sessions, and discussions directed towards calibration. The raters passed an initial inter-rater reliability test before coding sessions designated for this study (interclass correlation coefficient (ICC 2,k) = .94). After training, they continued to meet every other week while coding study data to guard against rater drift. Twenty percent of the sessions (1/5 or 6/30) coded for this study were rated by all six raters in order to evaluate inter-rater reliability. The ICC's (2,k) for these six sessions had a mean of .83 and a range of .74 - .95.

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Chapter IV. Results

In this study, ten patients' capacity for reflective functioning (RF) was measured at three points, once in each third, of a thirty session Brief Relational Therapy (BRT) treatment, as described in chapter III: Method.

Reduction of the data

For each of the three data points four RF measurements were calculated: 1) the mode RF score for that session; 2) the mean RF score for that session 3) the highest or peak RF score reached in that session and 4) the lowest RF score reached in that session. The means and standard deviations for these RF scores for each data point are presented in table 6.

Table 6: Means (M) and Standard Deviations (SD)

Reflective Functioning	Mode	Mean	Peak	Low
	M (SD)	M (SD)	M (SD)	M (SD)
1st Treatment Third: (sessions 1-10)				
Good outcome	**4.93** (.60)	**4.78** (.85)	**7.40** (1.14)	**2.00** (1.00)
Poor outcome	**4.20** (2.33)	**4.20** (1.96)	**6.60** (2.30)	**1.80** (1.48)
All cases	**4.56** (1.65)	**4.49** (1.46)	**7.00** (1.76)	**1.90** (1.20)
2nd Treatment Third (sessions 11-20)				
Good outcome	**5.27** (.44)	**4.95** (.63)	**7.40** (.55)	**2.20** (1.30)
Poor outcome	**4.60** (1.53)	**4.20** (1.47)	**6.60** (1.52)	**1.40** (1.52)
All cases	**4.93** (1.12)	**4.56** (1.14)	**7.00** (1.15)	**1.80** (1.40)
3rd Treatment Third (sessions 21-30)				
Good outcome	**3.57** (1.20)	**3.59** (.96)	**6.40** (1.14)	**.80** (1.10)
Poor outcome	**4.23** (1.20)	**3.85** (1.27)	**6.40** (1.52)	**1.00** (1.58)
All cases	**3.99** (1.18)	**3.72** (1.07)	**6.40** (1.26)	**.90** (1.29)

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Changes in RF over the course of treatment

The first analysis was aimed at evaluating whether change in RF occurred across groups over time. Four repeated measures, mixed between/within ANOVAs (with RF as the dependent variable; and time and outcome group as the independent variables) were calculated, one each for : RF low, RF mode, RF mean and RF peak (see tables 7, 8 and 9 below). In these mixed, two factor ANOVAs the first factor represents the outcome group and is the between-subjects factor. The second factor represents the repeated measurement and is the within-subject factor. Due to the small sample size and because they are more readily interpretable, the F values were converted to correlation coefficients (effect sizes) [1], which reflect the magnitude of the effect of alpha and the degrees of freedom.

Table 7: Main effect for time

Reflective Functioning	Mode	Mean	Peak	Low
Within Subjects ANOVA				
Effect size	.85	.72	.52	.53
Observed power	.88	.48	.20	.21
Alpha level	.01***	.08**	.33	.31

* = p < .10
** = p < .05
*** = p < .01

When the whole sample is looked at together and RF is measured by the mode (the mode characterizes the most general or frequently occurring

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level of RF for that session), there is a significant main effect for change in RF over the course of the treatment (see table 7 above). The strength of the effect size: .85, is significant at p=. 01. When RF is measured by the mean over the course of treatment there is a large but not significant effect size (.72; p = .08). This finding for the mean and mode are presumably capturing the same effect, as these numbers are very similar (see table 6). The effect sizes for the RF peak and RF low were also large at: .52 (p = .33) and .53 (p = .31) respectively, but they do not reach significance. Thus, when all of the subjects are looked at together, the RF mode changes significantly over time.

Interestingly, the direction of the change of the RF mode over time was different from that hypothesized. It was hypothesized that RF would steadily increase over the course of treatment for those subjects who reported good outcome. However, the findings show that the RF mode and RF mean increased at the middle third (sessions 11-20) and then decreased in the last third (sessions 21-30) of treatment (See chart 1 and chart 2).

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[1] correlation coefficient (effect size) = square root of (1- Wilke's Lambda)

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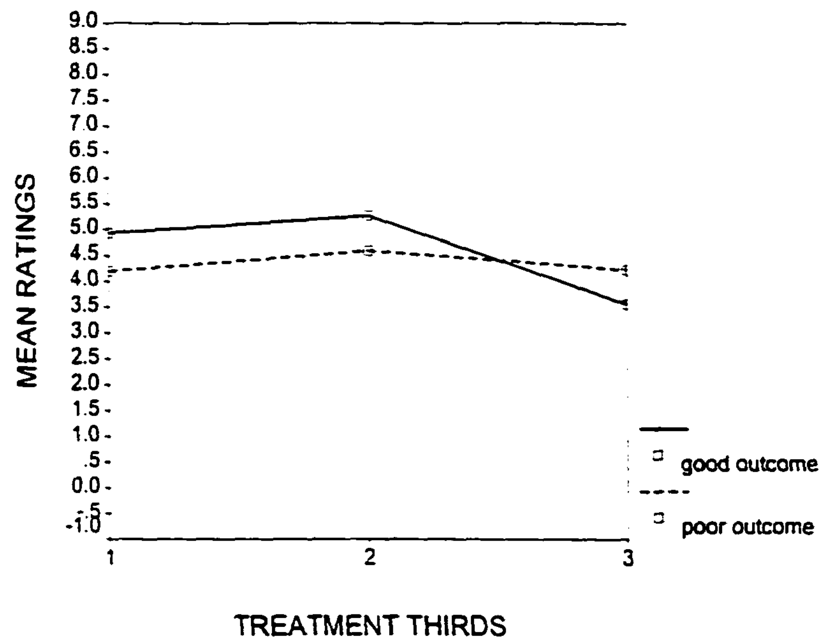

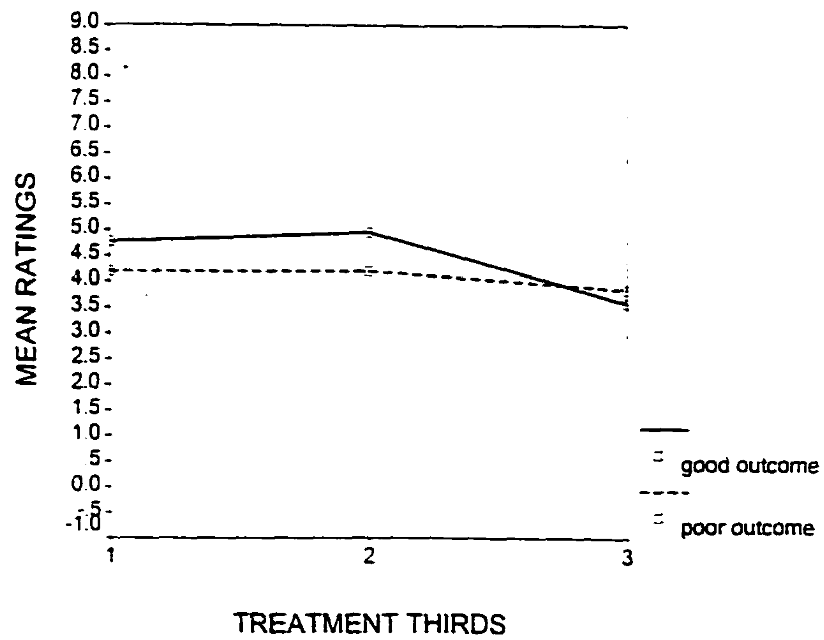

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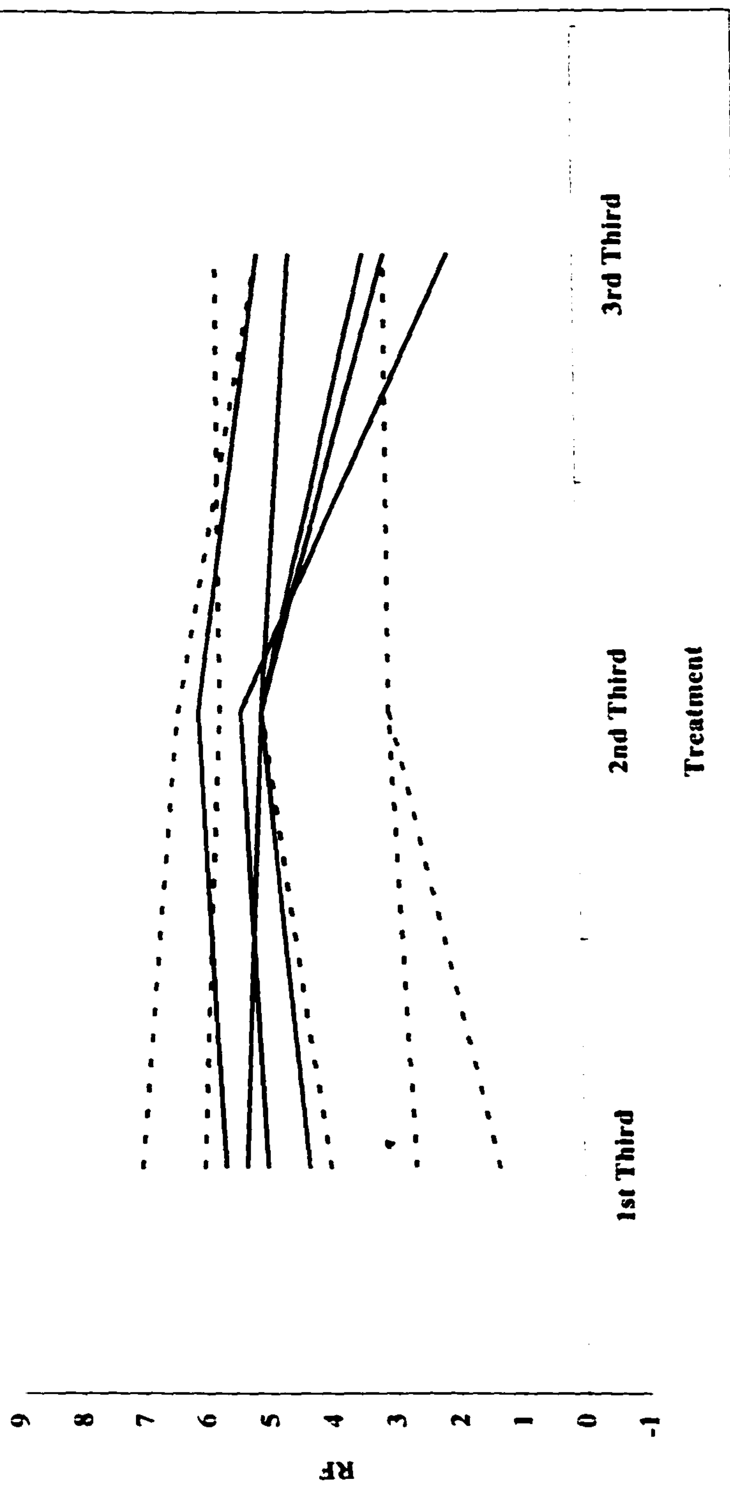

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Relationship between outcome group and capacity for RF

The next analysis was conducted to test the hypothesis that there would be a difference in the degree of change in RF for the different outcome groups. It was hypothesized that the good outcome group would reveal an increase in RF over the thirty sessions, while the poor outcome group would show no increase. To assess for a main effect for outcome group (see table 8 below) the ten patient-therapist dyads were categorized into either the good outcome group (n=5) or the poor outcome group (n=5) according to their Reliable Change Index (RCI). The RCI is calculated by comparing the change from intake (pre-treatment) to termination (session 30) on two self-report measures of symptomatology: the Symptom Checklist-90R (see appendix C) and the Inventory of Interpersonal Problems-64 (see appendix B). The RCI of the good outcome group was equal to or higher that 1.96; while the RCI for the poor outcome group was lower than 1.96 (see page 45, and table 4). As seen in table 8 below, none of the main effects for group was significant. Thus, there was no significant relationship between outcome group and magnitude of RF. This suggests that good outcome subjects did not necessarily have higher RF than poor outcome subjects (see chart 3), and that there was no relationship between degree of RF capacity and outcome group. Some subjects who reported poor outcome were rated as having higher RF than some subjects who reported good outcome (see chart 3).

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Table 8: Main effect for group

Reflective Functioning	Mode	Mean	Peak	Low
Within Subjects ANOVA				
Effect size	.11	.18	.23	.15
Observed power	.06	.07	.09	.07
Alpha level	.76	.63	.51	.68

Relationship between outcome group and quality of change in RF over time

This analysis was conducted to examine whether there was any difference in the way RF changed over time (increases versus decreases) between the good outcome group and the poor outcome group. The results of this ANOVA analysis for an interaction effect between outcome group and time is presented below in table 9. While the effect sizes for these analyses were moderate to large, none reached significance. As in the first analysis (table 7), the mode RF score seems to be the most robust way to see change in RF. Here there is a large, but not significant effect size for RF mode (effect size of .66; $p= .13$). This trend supports the hypothesis that the curves of the two groups are different (see chart 1). The good outcome group seems to carry the effect found in the within subjects analyses. Thus, when separated into good outcome and poor outcome groups it appears that the RF of the good outcome group increases during the middle third (sessions 11-20) and then decreases during the last third (sessions 21-30) of treatment in a quadratic curve; while the RF of the poor outcome group has a smaller increase during the middle third (sessions 11-20) and a smaller decrease during the last third

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(sessions 21-30), suggesting a linear curve, or smaller amplitude of change over time in either direction (see charts 1 and 3).

Table 9: Interaction effect between time and group

Reflective Functioning	Mode	Mean	Peak	Low
Between Subjects ANOVA (Time x Outcome Group)				
Effect size	.66	.53	.38	.46
Observed power	.37	.21	.11	.16
Alpha level	.13	.31	.59	.44

It wasn't possible to assess for a significant difference in RF between the good outcome and poor outcome groups at each of the three points in time because the variability of the good outcome group (mean = 4.93; standard deviation = .596) was much smaller than the variability of the poor outcome group (mean = 4.20; standard deviation = 2.33). This can be seen just by looking at chart 3, which shows that some of the poor outcome group subjects began with higher RF than any of the good outcome subjects, and some began with lower RF than any of the good outcome subjects.

RF used to predict outcome when RCI is used as continuous measure of change

Since using outcome as a categorical variable (with the RCI of 1.96 as the cutoff between good outcome and poor outcome) did not yield significant distinction between the RF of the good outcome and poor outcome groups, it was decided to use the RCI as a continuous variable to measure of change

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over time. A Pearson *r* correlation coefficient was computed to assess whether RF predicted treatment outcome, as measured by the RCI, when the whole sample is looked at together. The magnitude of RF, again as measured by the mode, in the initial (sessions 1-10) and middle thirds (sessions 11-20) of treatment modestly predicts treatment outcome (see table 10 below). Thus, when the whole sample is looked at together and RCI is used as a continuous variable, RF during the first ten sessions of treatment (Pearson r = .34) and during the middle ten sessions of treatment (Pearson r = .40) tends to predict how each subject will rate themselves on the SCL-90R and the IIP-64 (RCI) after they have completed the thirty session treatment. However, RF measured during the last ten sessions (Pearson r = .16) of treatment does not predict how subjects will rate themselves on the SCL-90R and the IIP-64 at the end of treatment. Though it is not so surprising that the beginning and middle of treatment predict where the treatment is going, it is surprising that the last third of treatment does not continue this trend.

Table 10

Correlational Analyses (RF by RCI Composite)

	RF Mode	
	Pearson r	**Alpha**
1st third	.34	.34
2nd third	.40	.25
3rd third	.16	.66

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Summary

Overall, there does seem to be a significant difference between the course of changes in RF (as examined in sessions where ruptures occurred) over thirty sessions of Brief Relational Psychotherapy between those patients who reported good outcome on self-report measures and those who reported poor outcome. This different course of change can be modestly predicted from the first and second thirds of treatment by looking at the RF mode. The surprising finding is the quadratic curve of the RF mode of the good outcome cases, which falls during the last third of treatment to below the RF level of the first third. This is the quite different from the steady increase of RF over time that was hypothesized for the good outcome group. The RF mode for the poor outcome cases stays relatively flat, which is more in keeping with what was hypothesized. Several different interpretations for these findings will be proposed in Chapter V.

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Chapter V. Discussion

The aim of this study was to explore the relationship between reflective functioning (RF) and therapeutic outcome (good or poor) in Brief Relational Therapy (BRT). It was hypothesized that those subjects who reported improvements in their symptoms (as measured by the SCL-90-R) and in their interpersonal interactions and problems (as measured by the IIP-64) would also demonstrate an increase in their RF (as measured by third party observers). A second hypothesis was that those subjects who reported poor outcome would show either lower RF than the good outcome group or demonstrate no increase in RF over the course of treatment.

The findings regarding the first hypothesis revealed that RF did change during therapy, but in unexpected ways. As was hypothesized, those subjects who were considered to have good outcome according to self-report measures, showed an initial increase in RF. However, this was unexpectedly followed by a decrease in RF during the final third of treatment. Central to this discussion will be an effort to account for this unanticipated finding.

The findings regarding the second hypothesis were more consistent with what was expected. Though some poor outcome cases demonstrated higher RF at the beginning of treatment than some of the good outcome cases, the RF scores of poor outcome cases showed very little movement over time regardless of where they began.

While the first hypothesis was not supported by certain aspects of the findings, the general orientation of the study was affirmed. That is, good and poor outcome cases did exhibit different patterns of change in RF over the

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course of treatment. The shapes of the curves representing the changes in RF for good (quadratic curve) and poor (linear curve) outcome cases were significantly different, but they did not differ exactly as the hypotheses predicted they would.

The drop in RF during the last third of treatment, in some cases to below the level of RF from the first third of treatment, is at first glance contrary to the theoretical models that generated the hypotheses. Based on contemporary relational and intersubjective theory reiterated below, we would expect RF to steadily increase over the course of treatment for good outcome patients. However, it must be remembered that RF was measured during sessions where high interpersonal tension was reported. Thus we must explore the relationship between RF and ruptures over the course of good versus poor outcome treatments. We can interpret these findings as evidence that ruptures in each third of treatment are qualitatively different and thus experienced differently depending on whether or not they occur in the context of a good outcome or a poor outcome case.

The study's methodology was premised on the assumption that ruptures, regardless of where they appear in the treatment, would provide fruitful moments to measure RF. What the methodology did not incorporate, and a phenomenon that appears to have exerted considerable impact, is the effect of impending termination on RF during a rupture. That is, ruptures in the final third of treatment are further complicated by the imminent end of the relationship, with the result being a decrease in RF during that rupture. Furthermore, this decrease in RF corresponds in suggestive ways with outcome, as measured by self-report questionnaires. In particular, patients

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who reported good outcome exhibited the most extreme drops in RF during ruptures in the final third of treatment. Meanwhile, patients who reported poor outcome exhibited less overall change in RF in either direction. This pattern suggests that strong change in RF, whether positive or negative, is indicative of good overall treatment outcome. Conversely, static RF throughout treatment, regardless of the starting point, is indicative of poor overall outcomes.

As will be outlined below, the dip in RF during a rupture occurring in the last third of good outcome treatments is actually not at odds with the theories that generated the original hypothesis. In the following pages the literature will be revisited and the impact of the methodology explored in the context of the findings.

Relational and Intersubjective Theories of Development and Psychotherapeutic Change

Relational and intersubjective theories of development maintain that humans are driven from birth to seek relationships with others, and that one of the central struggles of human life is an interpersonal one, pitting the development of a sense of autonomy against the establishment and maintenance of intimate relationships with others (Greenberg & Mitchell, 1983; Holmes, 1996; Benjamin 1988; Safran & Muran 2000). These theorists argue that since the quality of one's early relationships is seen as developmentally crucial, it is similarly the quality of the therapeutic relationship that is seen as fundamentally therapeutic. Relational theory and technique both assume that developmental failures can be repaired or

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partially overcome through interpersonal experiences within the therapeutic relationship. Relational theorists maintain that the process of negotiation between autonomy and connectedness, as it is played out between the therapist and the patient, is the vehicle of change. Thus, relational theorists view the therapeutic situation as inherently dyadic. This is in contrast to more classical psychoanalytic theories that suggest that the acquisition of knowledge through the therapist's interpretations is critically therapeutic (Brenner, 1976). For relational theorists, it is the mutual participation of the patient and therapist in a new real relationship that is potentially mutative. For example, Levenson (1972) argues that, "By the analyst becoming aware of his reactions and his participation in the patient's system, he engages the patient in elucidating this mutual participation in the perpetuation of the patient's difficulties. This engagement is effected through the analyst's attempt to understand, with the patient, what happened to the two of them" (cited in, Greenberg & Mitchell, 1983, p. 392). Thus, it is through the exploration of dialogic interplay that the patient's experience of him or herself in relationship with the therapist is enhanced and leads to therapeutic change.

Theories of intersubjectivity also depict development as an essentially dyadic process. For example, Benjamin (1988, 1998) argues that psychological development occurs through perceiving the self and other in dialogic relationship to one another. This model suggests that the interpersonal relationship itself, whether it is between mother and child (as in attachment theory), or therapist and patient (as in BRT), is the vehicle of development. In Benjamin's work, mutual recognition, the process of seeing the other as both

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an object and a separate subject, is a developmental milestone for a child and remains a central process in all subsequent relationships. In her view, mutual recognition is not static, but is instead a process of fluid oscillation between these two very different stances of seeing the other as an object and as a separate subject. In psychotherapy, it is posited that the vehicle of change is the process of both the therapist and patient navigating the therapeutic relationship between these two positions, seeing the relationship itself as well as the other from oscillating perspectives.

In this study, it was hypothesized that RF measures would capture the increased awareness of the patient's participation in this dyadic process. Increased self-awareness in that context and greater attunement to one's own and the other's mental states were expected to lead to heightened RF. It was also hypothesized that this increased awareness would be most easily detectable during the processing of a rupture in the therapeutic relationship.

Brief Relational Therapy and Reflective Functioning

Safran and Muran's BRT model of psychotherapy is based on these relational and intersubjective theories. In their model, therapy is seen as a process of intersubjective negotiation and thus the relationship between patient and therapist is regarded as the vehicle of therapeutic change. For example, the following is a list of some of the core tenets of BRT: BRT assumes a two person psychology; focuses on the here-and-now of the therapeutic relationship; stresses the ongoing collaboration between the patient and the therapist to explore both parties' contributions to their interactions; emphasizes in-depth exploration of the nuances of the patient's

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experiences in the context of unfolding therapeutic enactments; intensively uses therapeutic metacommunication and countertransference disclosure; emphasizes the subjectivity of the therapist's perceptions; assumes that the relational meaning of interventions is critical (Safran and Muran, 2000, p.258).

Safran and Muran argue that, "By working collaboratively with the patient to discover how both are contributing to the current interaction, the therapist is able to provide the patient with a new constructive interpersonal experience that challenges the patient's existing relational schemas" (Safran & Muran, 2000, p. 44). Their model is based on the theory that newly acquired awareness of immediate experience or actions, rather than retrospective reflection about them is critical for change. This new in-the-moment experiencing and awareness gives rise to change in representations of the self and other through the therapeutic relationship. In BRT the main focus is on the interpersonal process as opposed to the content of the sessions. There is an explicit effort to emphasize the importance of developing the patient's capacity to observe his or her own internal processes and actions in relationships with other people, including the therapist. It was assumed in this study that, 1) the patient's process of becoming aware of his or her own impact on the therapist and *vice versa*, and 2) the exploration of those experiences in the moment, would be captured as increases in a good outcome patients' capacity for RF.

As outlined by Peter Fonagy and his colleagues, RF is a capacity that offers numerous theoretical similarities to Safran and Muran's model of BRT. The congruencies described below lie at the heart of this project's hypotheses. Fonagy posits that RF is a psychological process that underlies the capacity to

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mentalize (to perceive and understand oneself and others in terms of mental states, i.e. feelings, beliefs, intentions and desires), and the ability to reason about one's own and others' behavior in terms of mental states. Fonagy also defines RF as involving both a self-reflective and an interpersonal component and as closely related to the representation of the self. He also believes that RF develops and expresses itself through interpersonal interactions (Fonagy et al., 1998, p. 5).

In light of the tenets outlined above, there is an elegant congruence between RF and the nature of what BRT is trying to address in its intersubjective relational stance. This theoretical congruence was the foundation underlying the hypothesis that in the context of BRT, and its commitment to focus on the mental states of the patient and therapist, the RF measure would be particularly sensitive to therapeutic change. Thus, it was hypothesized in this study that the subjects who made gains through the here-and-now, process oriented, dyadic focus of BRT would also reveal increases on measures of RF.

Attachment Theory, RF and Psychotherapy

The construct of RF emerged from the attachment research on the ways adults described their early childhood experiences with their parents on the AAI. Main and her colleagues found that the way subjects spoke about these experiences was more telling about their mental state regarding attachment than was the content of their stories (Main, 1991). Two of the most important constructs that initially emerged from this research were narrative coherency and metacognitive monitoring, both of which laid the

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groundwork for the theory of RF. Slade (1999) writes about the usefulness of these constructs for understanding clinical process in individual psychotherapy. For example, Slade explains that metacognitive monitoring, narrative coherency and RF are, "particularly relevant to understanding both the action of therapy and the dynamics of the therapeutic relationship." (1999, p. 581). She refers to RF as the crucial element that allows an individual to make sense of his or her own and other's psychological experience:

> The attention to narrative process in Main and Fonagy's work operationalizes what has always been intrinsic to good clinical listening: listening for changes in voice, for contradictions, for lapses, irrelevancies, and breakdowns in meaning, and for the subtle ongoing disruptions and fluctuations in the structure and organization of discourse...It tells the therapist what can be felt, what can be spoken, what can be known, and what cannot be contained...In essence this way of hearing language and understanding the organization of thought implies the experiences of seeking comfort and care constitute nodal, organizing events in the development of mind. (Slade, 1999, p. 582)

Here Slade emphasizes that an integral part of the therapeutic process is not only the content of what is communicated between the patient and therapist but the *way* it is communicated. She argues that language process is loaded with meaning about how the patient represents him or herself in relation to others. This idea that narrative coherency, metacognitive monitoring and RF are important tools for understanding clinical process is compatible with the relational and intersubjective theories of Safran and Muran's BRT model. The similarity in the theoretical underpinnings of the RF measure and the BRT model justifies why they have been paired in this research project. This compatibility presents further support for the assumption that a successful treatment would lead to a more flexible, more integrated sense of self in

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relation to the other, and that this would then be reflected in measures of a patient's RF.

Mental representations as a measure of therapeutic change

Just as this study used RF as a measure of therapeutic change, other empirical studies have also hypothesized a similar relationship between positive therapeutic outcome and changes in mental representations of the self and important others. For example, Blatt et al. (1991) hypothesized and found evidence supporting the idea that positive change in clinical outcome would be reflected in changes in the quality of the representations of significant others on the Object Relations Inventory (ORI). Blatt's study was an attempt to test empirically the quality of object relations as a measure of therapeutic change. In their study, object representations were broadly defined as, "Conscious and unconscious mental structures or schemata – including cognitive, affective and experiential components of interpersonal interactions encountered in reality" (Blatt et al. 1991, p. 273). They found that the extent of articulation of object representations did change and was significantly correlated with independent assessments of clinical outcome. As they hypothesized, object representations became increasingly more differentiated and cognitively more complex as individuals progressed in treatment. They concluded that object representation is a useful measure for assessing the degree of therapeutic progress.

In their study of the psychotherapeutic treatment of adolescents with severe psychopathology, Ford and Blatt (1994) found that the degree to which patients were able to imagine others as more human, more elaborated, and

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well-articulated, later demonstrated more appropriate interpersonal behavior. If we believe, as Fonagy does, that RF reflects an aspect of the mental representations of self and other, we would expect to find similar post-therapy changes in RF to what Blatt and his colleagues (Blatt et al.; 1991; Ford and Blatt, 1994) found in these studies.

Review of the methodology

The findings of this study are at first glance discrepant with the broadly held theoretical positions presented above. While one would expect RF to steadily increase over the course of a successful treatment, this study instead found that especially in cases with good outcome, RF initially increased, but eventually decreased. These findings can be accounted for theoretically and they can also be examined in light of the methodology used in this study. I maintain that these findings are best accounted for by explanations based on methodology. It is not the conclusion of this study that the findings undermine the use of RF as a measure of therapeutic change. Rather, it appears that the results can be better explained in light of specific methodological choices. In this section I will discuss some central elements of the methodology that I believe contributed to the counter-intuitive aspects of these findings.

When examining the findings of this, or any, study it is important to simultaneously consider the methodological structure inherent in the findings along side the theoretical interpretation of them. Broadly speaking, the most problematic methodological decisions in this study, which will be expanded on below, were as follows: choosing to look only at rupture sessions, failing

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to examine RF during the whole course of a rupture-resolution process, and assuming self-report and RF measures would tap into the same psychological processes in a parallel way. Each of these will be examined in the following sections.

First, I want to offer two caveats. First, given the small sample size (ten patient-therapist dyads) any interpretation of this data is provisional and its generalization is limited. A methodological choice was made here to forego a larger number of subjects in favor of the labor-intensive process of transcribing and coding entire fifty-minute psychotherapy sessions. The downside of using a small number of subjects is being left with little statistical power and also limited external validity, and generalizability of findings.

Second, it must be reiterated that RF was measured by raters who were all Master's level graduate students who had varying degrees of clinical experience (see table 3a). Though the raters were reliably trained to code RF, they likely lacked the clinical sophistication and experience to detect all of the complicated and subtle nuances of the interpersonal process during a rupture, and to understand how those nuances might impact RF.

Therapeutic Ruptures

While it was originally thought that the process of addressing a rupture in BRT would be an optimal time to measure RF, it appears from this study that there are other additional elements that complicate the relationship between a rupture, RF and psychotherapy outcome. In the literature review, it was hypothesized that a rupture between patient and therapist would be an interpersonal process that would leave the patient ripe for change in terms of

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RF. However, in trying to measure this phenomenon, the question of the timing of the moments chosen to measure RF became critical. In this context, it is crucial to determine the point in the rupture event at which the measurement of RF took place. By picking the one session with the highest reported tension in each third, and not measuring RF in the sessions on either side of it, we are limited to what is captured in that single session. By measuring only one session, the study makes the assumption that either the whole rupture event took place during that session, or that there would be enough evidence of change in RF captured in that one session to measure. In practice, it is impossible to predict specifically when the rupture-resolution process will begin or how long it will take. It is quite possible that the resolution process had just begun in the sessions chosen for measurement here, and was only mid-stream during the measurement of RF.

Because this study measured RF only in the sessions where there was a reported peak of tension, this method could easily have missed potentially critical information on either side of the rupture event. For example, in one of the good outcome cases, the patient became very angry and walked out in the middle of the session that was chosen as the third session for this patient-therapist dyad. This session was chosen because of the high degree of tension that was reported by the therapist, but obviously there was no opportunity for the therapist and patient to process the rupture in this session. In this case, it would have been the following sessions in which this rupture was surely processed, and therefore any changes in RF would be more likely revealed there.

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At this stage, it is impossible to know where change in RF would be evident in the course of a rupture event, or if there is a predictable pattern of this interaction across cases. These would be interesting and important areas to explore in further studies. It would be useful to look at sessions before, during and after a rupture is reported. The rupture process may take any number of sessions as of course there is no rule that dictates the length of a rupture. Perhaps the hypothesized increase in RF as a result of the intersubjective oscillation of viewing interaction from both the self's (patient/ therapist) and the other's (patient/ therapist) perspective could be seen more clearly in the sessions following a rupture. There is currently a methodology being developed both to identify when in a session ruptures occur, and to look at the course of the rupture-resolution process (Samstag, Safran & Muran, 2000; Muran & Safran, 2000). In future studies, this new methodology together with measurement of shifts in RF should provide a productive way to micro-analyze the intersubjective process during and after the course of a rupture and its resolution.

Another methodological choice made here was to look only at rupture sessions. By looking only at rupture sessions this study certainly missed other rich moments of change. It is problematic to assume that productively resolved rupture events are the only means of change. The process of working through a rupture may be only one component of many change events or processes (such as feeling listened to by another or creating a more coherent narrative of one's experiences) that occur over the course of treatment. Thus, by choosing to measure RF only at those moments of tension, we might have missed a primary vehicle of change. In fact, a patient's

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capacity for RF may be impaired during high-tension moments with the therapist. Taking this into account, it would make sense in future studies to measure RF during non-rupture sessions as well as rupture sessions and to compare the findings between the two.

Another way to address the question of when to measure RF is to not measure RF during the treatment at all. Rather, a semi-structured interview that explored interpersonal representations, such as the AAI, could be administered pre- and post-treatment and RF could be measured from these interviews. This would be a slightly different measure of the patient's RF since it would be measured outside of the direct context of the therapeutic process of a session. While this method may be preferable for some research questions, it lacks the added information about the interpersonal process of the treatment, which in this study has yielded some very interesting questions. A research team at New York Presbyterian Hospital-Cornell University Medical College is currently looking at changes in RF as measured from an AAI administered before and after a one-year treatment with borderline patients (Diamond et al. 1999a; Diamond et al, 1999b). Though they have only begun to code and interpret their data, their preliminary analyses suggest that RF does measure intrapsychic changes in interpersonal representations over the course of treatment.

Both the team at New York Presbyterian Hospital-Cornell University Medical College and the Beth Israel Brief Psychotherapy Research Project have started to administer adaptations of the AAI that have been developed to look at the patient - therapist relationship as an attachment relationship. The PET (Patient Experience of the Therapist) and the TEP (Therapist

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Experience of the Patient) (Diamond et al. 1999a; Diamond et al, 1999b), are administered after the psychotherapy treatment and contain questions that are parallel to the AAI. RF can be scored from these interviews and would capture the patient/therapist's overall RF for that relationship. This would be different from measuring RF from the content of the sessions as was done in this study, but it would provide another way to capture RF in the context of a therapeutic relationship.

Self-report measures vs. observer rated measures

There are also important methodological questions regarding the measurement of good outcome versus poor outcome, as well as the measurement of RF. Self-report measures were used here to determine outcome (SCL-90R and IIP-64) and to capture specific and thus limited domains of functioning. In future studies, a more diverse battery of assessments and/or interviews could be used to create a more comprehensive analysis of change and definition outcome.

The discrepancy revealed here between the self-report measures used to determine good or poor outcome and the observer-rated measure of RF raises interesting questions about what outcomes are being measured. One possible explanation for the surprising findings is that observer-rated measure of RF is tapping into something different from what the self-report measures are tapping into. One way to understand this discrepancy is as the expression of a disparity between unconscious and conscious processes. The paper and pencil self-report questionnaires ask subjects to report on their conscious experience of themselves. Meanwhile, RF is being measured by

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third party raters from the manner in which patients understand their experiences. There is a body of literature emerging from the attachment theory research and the psychotherapy process research that addresses and stresses the differences between self-report questionnaires and observer rated measures of semi-structured interviews (Bartholomew & Shaver, 1998; Dozier & Tyrrell, 1998; Crowell & Treboux, 1995).

For example, Bartholomew and Shaver, and Dozier and Tyrrell each suggest that self-report measures of attachment and observer-rated measures of attachment measure different things:

> Self-report measures focus on consciously, potentially inaccurate summaries by a person of his or her own experiences and behaviors. The AAI focuses primarily on the way a person talks about childhood attachment experiences, with major distinctions having to do with what might be called defensive style (e.g. denial, repression, compulsive self-reliance, and dismissal of attachment needs, on one hand, versus vigilance, sensitization, enmeshment in relationships, and preoccupation with attachment needs, on the other). These differences in communication and behavior and defensive style are not necessarily noticed or acknowledged by the people who exhibit them. (Bartholomew & Shaver, 1998, p. 30)

This suggests that the SCL-90R and IIP-64 scores reflect the patients' consciously held experiences of themselves. According to this line of thinking, the way the subjects reports on their experiences is necessarily, but not consciously, influenced by their own defensive styles.

Similarly, Dozier and Tyrrell (1998) and Hazan and Shaver (1987) make the distinction between Internal Working Models of attachment (IWMs) and attachment *style*. Attachment style is assumed to be accessible to consciousness and therefore able to be captured by self-report measures:

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> Assessments of IWMs are made through discourse analysis as subjects talk about thoughts and feelings regarding attachment figures. Attachment style is assessed through a subject's self-report of relationships with currently important figures in their lives. Additionally, IWMs are assessed in relation to earlier attachment figures whereas attachment styles are assessed in relation to current significant others. One might expect that there would be a strong relationship between the two but this expectation has not been supported by the empirical literature. However conceptually similar, the two seem to measure something different. Two differences that are key to our examination of therapy relationships involve the assessment of unconscious versus conscious process. (Dozier and Tyrrell, 1998, p. 225)

It must be reiterated that measuring RF is not the same as measuring attachment status from the AAI or directly and specifically measuring IWMs. However, measuring RF follows a similar process of trying to capture a construct that is revealed indirectly by the *way* a subject talks about themselves and their relationships, and by examining processes that the speaker is not necessarily consciously aware of. These different ways of understanding a person's functioning require different modes of operationalization and interpretation. It appears that in this study, the self-report measures tapped into a conscious perception of self, while the observer-rated measurement of RF captured a more unconscious way of processing (experiencing, understanding and predicting) interpersonal experiences.

As Fonagy and his colleagues explain below, RF is an aspect of an IWM and as such is affected by and affects unconscious processes such as defenses. Similarly, they also make this parallel distinction between measuring RF and measuring other experiences using self-report questionnaires, and between unconscious and conscious processes:

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> It is important not to conflate RF with introspection. A weakness of introspection is to define mental states in terms of consciousness or self report. RF is the capacity to make sense of, and thus regulate behavior. RF is an automatic procedure, *unconsciously* invoked in interpreting human action. We see it as an over learned skill, which may be systematically misleading in a way much more difficult to detect and correct than mistakes in conscious attributions would be. RF lends a shape and coherence to self-organization which is *entirely outside awareness,* in contrast to introspection which has a clear impact on experience of oneself. Procedural knowledge of minds in general, rather than declarative self-knowledge, is the defining feature. (Fonagy et al., 1998, p. 10) (italics added)

This adds further support to the idea that the self-report measures, which were used to determine therapeutic outcome, were accessing the patient's conscious experiences of themselves, while the observer-rated RF measures were capturing processes outside of conscious awareness. Thus, we would not expect them to necessarily show parallel patterns of change.

In light of these distinctions it is critical to note that in this study there were differences between the directions of the changes in patients' self-report measures and the observer-rated measurement of their RF. While the findings reported here seem to be consistent with the above mentioned theories, in future studies it may make sense to measure both the conscious (self-report) and unconscious (observer-rated) processes at many more points during the treatment. By measuring more points during the treatment, the relationship between the two can be tracked in both rupture and non-rupture moments. The discrepancy here between self-report and observer-rated measures may also be another artifact of the methodology. Just because self-report questionnaires and observer-rated RF may be measuring different things doesn't mean that those two things, conscious and unconscious processes, are

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unrelated. Perhaps if RF was measured in the sessions following a rupture, when RF might be higher, RF and self-report measures might be more concordant.

Given the above definition of RF by Fonagy and others, how do we interpret the specific *directions* of the discrepant measures? For the good outcome patients, in the final third of treatment, there is an observed decrease of RF (presumably an unconscious process) and an increase of positive functioning on the self-report questionnaires (presumably a conscious process). Following the above argument, it is possible that BRT has concurrent but different effects on the conscious and the unconscious realms of functioning. One way to address this is to think about a patient's engagement in his or her treatment.

According to Gomes-Schwartz (1978), two of the primary psychological qualities influencing treatment outcome are the severity of the patient's pathology and the patient's capacity to become involved in a therapeutic relationship. Similarly Lambert and Asay (1984) concluded that the most important variables to consider in evaluating a patient's capacity to gain from psychotherapy are those variables that directly assess the patient's capacity to participate in the therapeutic relationship. This is also consistent with the psychotherapy research findings that the therapeutic alliance is the most robust predictor of treatment outcome (Horvath & Greenberg, 1986; Martin, Garske & Davis, 2000).

I propose that one way to interpret the findings of this study is that those subjects who reported positive change on the self-report measures were engaged in their treatments and that by being engaged in the process of

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therapy their internal, unconscious worlds were "stirred up." By stirred up I mean that their previous ways of understanding their experiences were being questioned and reevaluated, and they consciously felt that the treatment was having an effect on them. The conscious feelings of, "hey, this is having an effect on me" were captured in the positive changes that the good outcome group reported on their self-report questionnaires. Unconsciously, their previous ways of interpreting their experiences were in the process of being undone and possibly made temporarily less efficient and more incoherent as a part of the therapeutic process. Their old ways of understanding interpersonal interactions were no longer as effective for providing an immediate method to interpret their own and others' experiences. In other words, the good outcome patients were engaged in their treatments; they were in the process of changing their internal working models or their internal representations of themselves and others. However, a new, more effective, and more flexible way of understanding had not yet been fully integrated into their unconscious. It is possible that the flux of this reorganization was captured in the decrease of the good outcome patients' capacity for RF in the moments of reported tension. This would also explain the relative stasis of the RF of the poor outcome group. Presumably, these people did not experience the, "hey, this is working" conscious experience of treatment as seen in the lack of significant change on their self-report measures. This suggests that they were not as engaged in the treatment as the good outcome group. Thus, not surprisingly, their unconscious RF processes were not as affected by the treatment and they revealed less change in RF, in either direction, than the good outcome group.

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The impact of termination on RF

Another way to look at the decrease in RF at the end of treatment is to consider the impact of having a rupture so close to the termination of the treatment. It is surprising to look at the chart of the patients' RF over time (see chart 3). Several of the good outcome subjects' RF takes a steep decline at the last measurement of RF, a time during which the therapist has presumably begun to process the upcoming termination more frequently (Safran & Muran, 2000). It is easy to imagine that, especially if the patient is engaged in the treatment, the reality of the looming termination would have an impact on the way ruptures in the relationship are processed. Perhaps for those patients who are engaged in their treatments and who were attached to their therapists, processing a rupture with their therapists very close to termination may be more upsetting and difficult than a rupture at an earlier point. If we consider the therapeutic relationship to be an attachment relationship (Farber, 1995), especially for those patients who reported good outcome, then the artificial end to the relationship can be seen as quite powerful. In retrospect, it is plausible that the good outcome cases who were able to demonstrate increased RF in the face of ruptures in the middle third of treatment might have been more powerfully affected by the imminent loss of the therapist and thus less able to process a rupture near the end of treatment. A rupture near the termination of the relationship may prove to be a greater challenge to process, particularly with newly learned, still inchoate ways of processing and experiencing the self and others in times of conflict.

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Additionally, the nature and experience of a rupture is likely to be very different in the final third of treatment than earlier on. If the patient-therapist dyad had experienced and productively processed several ruptures already, they may either not feel the need for, or they may avoid, a more in-depth exploration of a rupture during the wrapping-up phase of the end of the treatment.

Length of treatment

RF appears to be affected by time limited therapy, even though it may not be changing in the way one would initially anticipate. The unexpected direction of change in RF during moments of tension might suggest that there is no linear progression of change in unconscious models of the self and other. Rather, change is possibly a "one step forward two steps back" oscillation. It may take more than thirty sessions before consistent change in fundamental, unconscious processes (as measured by RF), especially in the face of tension, can be affected. If this is the case, it would make sense to conduct a post-treatment follow-up measure of RF. This would allow researchers to see if the subjects' RF increased after the therapy had ended and the patients had time to consolidate the gains that were begun during treatment. Alternately, change in RF may simply be much slower than change in more conscious processes. Perhaps, for certain people, thirty sessions is not enough to completely impact these generalized representations of self and other and these people may require a longer term treatment. In terms of methodology of future studies, this interpretation of the impact of length of

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treatment on change in RF suggests that it would be useful to compare change in RF over the course of treatments of varying lengths.

Conclusion

The innovation of this study was to bring together two theoretical models: Reflective Functioning (RF), which emerged from attachment theory and research, and Brief Relational Therapy (BRT), which emerged from psychotherapy research and is informed by relational, intersubjective and cognitive theories. The aim of this study was to measure the change in patients' RF over the course of a thirty-session BRT treatment.

The unexpected findings here confirm what we as therapists already know: that understanding specifically how change occurs within the therapeutic process is a great challenge. Though the theoretical literature reviewed here supports that notion that RF would increase over the course of a productive treatment, the results here tell us that it is not that simple. The fact that the RF of the good outcome patients decreased at all, even if it was artificially emphasized by the methodology used here, is still noteworthy. From the relational and intersubjective stance of regarding the therapeutic relationship as the vehicle of change, the findings of this study imply that the patients who report good outcome are differently affected by the therapeutic relationship than those who report poor outcome. If RF is a way to measure a person's representations of the self and others, then those representations do seem to change over the course of psychotherapy if the patients report good outcome.

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Thus, a problem in the original methodological design was the study's failure to consider the full and complex impact of a rupture on RF, as well as the impact of the timing of the rupture on RF. While the design assumed that RF during a rupture would be indicative of a patient's overall capacity for RF, it appears that RF measures taken during a rupture are more limited in scope. That is they reveal less about a patient's overall capacity for RF than they do about RF in the specific context of a rupture.

Using RF to measure change via the therapeutic relationship brings us into uncharted territory. These findings, while exploratory, are nevertheless exciting. They lay groundwork for future research and suggest that using RF as a measure of change in therapy can be a promising area of study.

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Table 1: Demographic Variables for Subjects

Demographic Variables	All Subjects N=10	Good Outcome N = 5	Poor Outcome N = 5
Mean Age	38.7 (25-55)	32.8	44.6
Gender			
Female	7	3	4
Male	3	2	1
Marital Status			
Single/Never Married	4	2	2
Married/Remarried	4	2	2
Divorced/Separated	2	1	1
Currently Employed			
Yes	9	5	4
No	1	0	1
Education Level			
High School Diploma	4	2	2
College Degree	4	2	2
Some Graduate Stud	1	1	0
Graduate Degree	1	0	1
Race			
White	10	5	5
Early Loss or Trauma			
Yes	3	3	0
No	7	2	5

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Table 2: Diagnostic Variables for Subjects

Diagnostic Variables	All Subjects N = 10	Good Outcome N = 5	Poor Outcome N = 5
DSM-IIIR & DSM-IV Axis I			
Major Depression	2	1	1
Dysthymia	5	2	3
Social Phobia	1	1	0
Simple Phobia	1	0	1
Generalized Anxiety	1	1	0
DSM-IIIR & DSM-IV Axis II			
Avoidant Personality	3	2	1
Histrionic	1	1	0
Personality Disorder Not Otherwise Specified	5	2	3
No Axis II diagnosis	1	1	1

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Table 3: Demographic Variables for Therapists

Demographic Variables	Therapist Mean	Therapist 1	Therapist 2	Therapist 3	Therapist 4
Mean Age	33.25	42*	27.5*	30.5*	33*
Gender		Female	Male	Female	Female
Race		White	White	White	White
Degree		Ph.D.	M.A.	M.A.	M.A.
Years Clinical Experience	3.8	6.5*	3*	3*	3*

*Averaged across therapist's treatments

Table 4: Reliable Change Index

Subject	Outcome Group	Reliable Change Index
#1	Good	4.96
#3	Good	3.25
#4	Good	3.32
#5	Good	2.83
#9	Good	3.76
#2	Poor	.68
#6	Poor	.51
#7	Poor	1.27
#8	Poor	.84
#10	Poor	.11

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Table 5 : Case Selection Criteria

Criteria	Good Outcome	Poor Outcome
Treatment Modality	Brief Relational Therapy	Brief Relational Therapy
Sessions Completed	30	30
Patient completed pre- and post treatment assessment batteries	Patient completed pre- and post treatment assessment batteries	Patient completed pre- and post treatment assessment batteries
RC index	RC index > 1.96	RC index < 1.96
Therapist	Equal number of good and poor outcome cases	Equal number of good and poor outcome cases

Table 6 : Session Selection Criteria

Criteria for all selected sessions for both Good and Poor Outcome cases
Reported tension by either patient or therapist on Part B of the Post Session Questionnaire (see Appendix D). *Did you experience any problem or tension with your patient/therapist during this session?*
Neither session one nor session two may be selected.
One session chosen from each third of treatment: Eligible sessions from first third of treatment = sessions 3 - 10 Eligible sessions from second third of treatment = sessions 11-20 Eligible sessions from third third of treatment = sessions 21-30
Selected sessions must be at least five sessions apart from each other.

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Appendix A: Patient Consent Form

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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

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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

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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.

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Appendix B: Inventory of Interpersonal Problems - 64 (IIP-64)

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Appendix B
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Appendix D
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Appendix E: Reflective Functioning Coding Manual

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Reflective Function Scale Points

- 1) Negative RF

Response must:

1) be distinctly anti-reflective (i.e. hostile or actively evasive)

Or

2) be bizarre (impossible to understand without making the assumption of irrationality on part of the subject)

Or

3) be inappropriate in the context of the setting (i.e. complete non-sequitors, over-familiarity, gross assumptions about the other)

1) Absent but not repudiated RF

Response must:

1) be passively rather than actively evasive.
2) be accompanied by little or no hostility.
3) contain no evidence of:
   a) awareness of the nature of mental states;
   b) explicit effort to tease out mental states underlying behavior;
   c) recognition of the developmental nature of mental states;
   d) interaction indicative of the awareness of the other's mental states.
4) leave the reader no better off in terms of knowledge of the mental states of the subject after having read the passage that he/she was before reading it.

Response may include:

1) concrete explanations of behavior in terms avoiding reference to mental states (i.e. explanations may be sociological, excessively general, or framed in terms of external, physical circumstances, etc.).
2) self-serving distortion (recollections which are highly ego-centric, self-aggrandizing and/or contain extraordinarily arrogant claims to insight).

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3) Questionable or low RF

Response must:

1) contain some suggestion of mentalising efforts on the part of the subject that is nevertheless,

2) devoid of any element that makes reflective functioning explicit (i.e., it never reflects mixed emotions, conflict or uncertainty about beliefs and feelings of others).

Responses may frequently:

1) make use of mental state language without making clear or explicit that the subject genuinely understands the implications of the statement.

2) appear somewhat clichéd, banal, superficial or 'canned.'

3) be excessively deep and detailed yet unconvincing and/or irrelevant to discussion.

5) Definite or ordinary RF

Response must:

1) contain some feature which makes reflection explicit (i.e., explicit reference to the nature or properties of mental states, how mental states relate to behavior, or mental states in relation to the therapist).

2) not be a cliché (though it does not need to reflect sophistication).

Response may:

1) show evidence of one of the six features (listed below) for assigning a '7' in the context of a very simple observation of mental states, which would otherwise rate only a '3.'

7) Marked RF

Response must:

1) contain some feature which makes reflection explicit (i.e., explicit reference to the nature or properties of mental states, how mental states relate to behavior, or mental states in relation to the interviewer).

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2) meet at least one of the following. The passage:
- is sophisticated (meeting at least two of the qualities which suggest moderate to high RF).
- is unusual or surprising, casting an original perspective (which is nonetheless readily understandable).
- is complex or elaborate, described in unusual detail with indication that multiple mental states attributed to a person are considered in relation to one another.
- places mental states within a causal sequence. Subject considers how the mental states arose, how they influenced behavior and what impact they have on subsequent perceptions, beliefs, and desires.
- provides evidence of an interactional perspective (outlining interactions of mental states between two people or within one person's mind).
- contains an acknowledgement of a particularly painful situation, with appropriate thoughts and feelings.

9) Full or exceptional RF

Response must:

1) show the above features of a '7' to an unusually high degree (i.e., this response would be in the top 10% or less)

Or

be given for a particularly charged and emotionally difficult subject in which maintaining even ordinary levels of RF could be considered exceptional.

2) have a strikingly personal character; it should enable the rater to feel confident that it is experienced as personally significant and meaningful.

Response may frequently:

1) demonstrate full awareness of important aspects of all protagonists within an interaction, such that the protagonists are placed in relation to one another in terms of their feelings and beliefs and these are

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sufficiently complex and elaborate to convince the rater of their accuracy.

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