PATIENT AND THERAPIST PERSONALITY, THERAPEUTIC ALLIANCE, AND OVERALL OUTCOME IN BRIEF RELATIONAL THERAPY

by

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Abstract

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Advisor: Professor Paul Wachtel, Ph.D.

The aim of this study was to explore the relationship between personality, early therapeutic alliance process and overall psychotherapy outcome in 32 patient-therapist dyads engaged in Brief Relational Therapy (BRT). Specifically, the study sought to examine the impact of attachment style and introject quality (as assessed by the Relationship Scale Questionnaire (RSQ, Griffin & Bartholomew, 1994) and the INTREX (Benjamin, 1988), respectively) on psychotherapy process and outcome. Patients were treated at Beth Israel Medical Center, and most met criteria for anxious or depressive personality disorders. Therapeutic alliance process was assessed with questions about perceived tension in the relationship from the Brief Project's Post-Session Questionnaire (PSQ); the Working Alliance Inventory, (WAI-12; Tracey & Kokotovic, 1989); and the Session Evaluation Questionnaire (SEQ; Stiles, 1980; Stiles & Snow, 1984). Outcome measures included the Symptom Checklist-90, Revised (SCL-90-R; Derogatis, 1983); the Inventory of Interpersonal Problems, as rated by patients (IIP-64; Alden, Wiggins, & Pincus, 1990), the Target Complaints

measure as completed independently by both patients and therapists (TC; Battle, Imber, Hoehn-Saric, Stone, Nash, & Frank, 1966), and the Global Assessment Scale (GAS; Endicott, Spitzer, Fleiss & Cohen, 1976). An additional focus of the study included the relationship between dyadic personality match and alliance process and overall outcome.

There were few significant findings from this study. Those results that were significant included: higher scores on the Affiliation subscale of the INTREX in therapists were related to positive alliance process; fearful attachment scores on the RSQ in patients were related to negative alliance process. Surprisingly, it was also found that secure attachment in patients and therapists was related to poorer outcome, and fearful and dismissing attachment in patients was related to better outcome. These latter findings can be explained in part by the methodological limitations of the study, including small sample size, and the exclusive use of self-report measures.

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Chapter I. Introduction

The question of what constitutes the therapeutic encounter, and who does what to whom in this "unique kind of interpersonal discourse full of paradox, poetry, and mystery" (Levy, 2000, p. xii), has preoccupied psychoanalytic dialogue since Freud's early conceptualizations of the bond between patient and analyst. In The Dynamics of Transference, Freud (1912) wrote that the analyst must have a "sympathetic understanding" of the patient in order to help him or her form a "positive attachment" to the analyst. He wrote that this attachment is essential for a successful analysis, and can be seen as a kind of beneficial or positive transference. Transference, for Freud, concerned the displacement of emotions from one person to another, and usually involved the transference of attitudes and feelings once associated with a parent. Additionally, transference could often be distinguished as positive or negative. Later, however, Freud (1937) wrote that the collaboration between patient and therapist is what enables the healthy, intact part of the patient to join with the therapist against the patient's neurosis, Samstag (1998) sees Freud's discussion of analytic collaboration as a recognition that not all aspects of the therapeutic relationship were subject to displacement and projection. Freud also referred to this as the "unobjectionable positive transference," acknowledging that friendliness and affection can be the elements that make an analysis successful.

Sterba (1934) was one of the first theorists after Freud to elaborate on the significance of the treatment alliance. He coined the term *ego alliance* to describe the patient's ability to observe himself rationally while at the same time being immersed in the treatment experience. This "therapeutic split in the ego" signaled a reality-based alliance with the therapist and was facilitated by the patient's important positive identification with the therapist. However, Fenichel (1941) disagreed with Sterba's concept, claiming that the degree to which the alliance is rational or irrational is quite ambiguous.

Significantly, in 1956, Zetzel introduced and refined the term *therapeutic alliance,* arguing that the patient must experience his or her relationship with the analyst as warm, empathic and trusting in order for the therapy to be successful. Zetzel felt that the patient's capacity to form an effective alliance is rooted in early developmental experiences; if the patient does not have this capacity at the beginning of the treatment, the therapist must support and facilitate the alliance until such a sense of trust has developed. Unlike Freud, Zetzel also considered the analyst to have an important role in creating a safe and trustworthy environment for the patient, thus acknowledging that the therapeutic relationship directly affects the treatment process.

Zetzel's formulations had a significant impact upon the work of Greenson (1967), who termed the relationship the *working alliance.* Greenson placed primary emphasis on the patient's ability to form an emotional bond with the therapist while working purposefully toward therapeutic change. The core of

the working alliance is a real relationship between patient and therapist, which includes undistorted perceptions and trust, and is at least theoretically distinct from the transference relationship. As Safran & Muran (1998) observe, like much of the ego-psychological tradition, the conceptualizations of the alliance found in Sterba, Zetzel, and Greenson, all underline the significance of rationality and objectivity in therapy.

However, there is another "emergent line" within psychoanalytic perspectives on the alliance that developed after Freud through the influence of Sandor Ferenczi (Safran & Muran, 1996; 1998). Ferenczi was a contemporary of Freud's who placed significantly greater emphasis on the personal relationship between therapist and patient (Aron & Harris, 1991). He believed that a focus on intellectual insight could overwhelm a treatment, thus obscuring the intensive, affective nature of the therapeutic relationship: "the physician's love cures the patient" (Ferenczi, 1912). In addition, as Safran & Muran (2000) point out, Ferenczi was the first to suggest that "it was essential for patients not merely to remember but actually to relive the problematic past in the therapeutic relationship" (p. 7). Ferenczi suggested that the analyst's personality and experiences were essential elements as well. Accordingly, his work emphasized mutuality, relationship, and communion, as well as the reciprocal processes between patient and therapist. For Ferenczi, reciprocal processes translated into experiments with transference-countertransference enactments, which included the therapist's admission of errors and analysis of countertransference with the

patient. These experiments paved the way for later thinkers to develop such ideas as "participant observation," which underscores the inevitably subjective nature of the therapist's contribution.

Ferenczi's ideas became part of a "paradigm shift" within psychoanalysis. In Freud's original drive theory a mind's *a priori* meaning consisted of drive-generated impulses and defenses which were manifestations of its biological nature (Greenberg & Mitchell, 1983). After Ferenczi, these earlier formulations of mind as a self-contained monadic entity shifted toward a perspective which incorporated the effect of real experiences and actual behaviors into a developmental model. Within the psychotherapeutic situation, this shift is often referred to as a movement from a one- person to a two-person psychology: a one-person psychology attends to intrapsychic structure and is "conceptualized as a relatively closed system," while a two-person psychology gives "primary attention....to the interaction between internal and external" (Gill, 1994, p. 32). The latter view implies that a stark dichotomy between "internal experience" and "external reality" has been eliminated. The mind and its desires have now come to be understood as having a multiplicity of meanings, derived from the cultural, social, and relational environment which formed them. Thus, the locus of meaning in an individual life is no longer exclusively psyche-bound, but is always found at least in part within the complex interplay of actions and reactions that constitute the relational world.

Similarly, the emphasis on rationality and objectivity present in ego-psychological conceptualizations of the therapeutic alliance has, within the contemporary relational tradition, been superseded by a concern for understanding both parties' contribution to and immersion in the alliance. The Literature Review that follows considers those object relations, interpersonal, and developmental theories that stem from Ferenczi's second "emergent line" within psychoanalysis. Including the work of Klein, Sullivan, Fairbairn, Winnicott, Kohut, Bowlby, and Stern, these theories share an understanding, expressed in various ways, that the therapist's experience and participation are inevitably part of the vicissitudes of the therapeutic encounter. This understanding is incorporated as well into the goals of this study, which will assess the role of *both* therapist and patient personality and how it relates to therapeutic alliance process and overall outcome. Additionally, this study will consider the role of the *match* between patient and therapist personality in process and outcome, in an attempt to elucidate mutative aspects of the therapeutic relationship.

Chapter II. Literature Review

Theoretical Perspectives on the Therapeutic Alliance

Developments in Psychodynamic Thinking

Ferenczi's emphasis on therapeutic mutuality as mutative in psychological change strongly influenced both British object relations theory and interpersonal and cultural psychoanalysis in North America. Within interpersonal psychoanalysis, his ideas about the transforming impact of experience and behavior on the therapeutic dyad became more fully developed within Sullivan's theory. Sullivan and much of the interpersonal psychoanalytic tradition (e.g., Karen Horney, Erich Fromm, Frieda Fromm-Reichmann, and Clara Thompson) believed that classical Freudian theory underemphasized external reality and social interactions; according to Greenberg & Mitchell (1983), the latter must "figure prominently in any theory attempting to account for the origins, development, and warpings of personality"(p. 80).

For Sullivan, not only is personality made manifest in interpersonal situations, but all knowledge of another person is mediated through interaction (1938). He described the self as moving dialectically between the need for interpersonal security and the need for authentic self-expression (Sullivan, 1953). In addition, people are motivated by "needs" which, for Sullivan, are separated into needs for satisfactions and needs for security. In this way, as Mitchell (1988) notes, personality develops through patterns that "reflect learned modes of

dealing with situations and are therefore always in some sense responsive to and shaped by the situations themselves" (p. 25). Sullivan's perspective focuses on the role of "personifications" in emotional development. These are representations that arise in the context of lived relationships with others, rather than in an exclusively intrapsychic field. Personifications become stable self-concepts through the process of "introjection," which assumes that individuals learn to treat themselves and relate to others as significant others from their past have treated them (Sullivan, 1953).

According to Sullivan, an individual's earliest organization of experience is founded on the distinction between anxious states and nonanxious states. Early in life, a child becomes attuned to his environment, and over time learns to "read signs" and match his behaviors to his mother's affective state. In this manner, then, a child uses his empathic connection with his mother to modulate his anxiety, developing parts of the personality that evoke a benevolent response ("good-me"), and also parts that trigger an anxious or inadequate response from the mother ("bad-me," or, for those parts of the personality that remain unintegrated due to severe anxiety, "not-me") (Sullivan, 1953). Since anxiety is so overwhelming to a helpless child, he will learn to avoid anxiety-provoking situations at all costs. Thus, an individual's sense of himself develops and is reinforced by whatever behaviors reduce anxiety and create a feeling of security. Sullivan termed these processes "security operations;" if they dominate an individual's life, they mark the degree to which past personifications still warp

present relationships (Sullivan (1953); also, see Greenberg & Mitchell's (1983) chapter on Sullivan and the role of anxiety).

Sullivan's conceptualization of personifications - as representations created in an earlier interactional field but still operating in and distorting present relationships - has important implications for understanding transference and countertransference within the analytic dyad. That is, Sullivan moved the emphasis from transference as patient distortion to an understanding of the analytic relationship as jointly constructed. However, as Wachtel (1987, 1993) observes, Sullivan and the interpersonalists did not delineate extensively enough how this basic shift in assumptions could be integrated into specific analytic practice, and how this would facilitate therapeutic change.

Wachtel's cyclical psychodynamic theory, a contemporary relational model, offers an elaboration of Sullivan's perspective. In his system, he emphasizes "the ongoing transactions, in *all* aspects of the person's functioning, between internal processes and previous functioning on the one hand, and the events and persons encountered at the moment on the other" (Wachtel, 1993, p. 55). In other words, one's "issues" are never just simply one's own, but represent the myriad ways in which an individual rewrites reality in his own image, so to speak. Wachtel (1993) notes further that "our thoughts, our perceptions, our associations, our actions, are always a joint product of 'internal' and 'external' influences and processes" (p. 56). Wachtel's reframing of the

transference (of the whole therapeutic process) is informed by the Piagetian concepts of schema, assimilation, and accommodation.

> As Piaget describes it, the psychological structures by which we apprehend and act upon the world are always characterized by two opposing, but complementary tendencies. Assimilation is the process by which we make the unfamiliar familiar, enabling us to approach new situations in a way that allows us to bring to bear what we have learned from our previous encounters with the world...[Yet although] we assimilate new experiences to our existing schemas..., any new situation, however, is never exactly the same as those we have encountered previously. All require some adjustment to their difference, some *accommodation* to the variation (Wachtel, 1987, p. 37).

Transference, thus, is a phenomenon which can be understood as the dominance of assimilation over accommodation (Wachtel, 1993); the patient's reaction to the therapist is, in the moment, determined more by his or her internal schemas than the specific qualities of the therapist. Yet, although the therapist may not be a fully differentiated figure from crucial persons in the patient's past, Wachtel points out that there must be some "actual characteristic or action that provides the initial basis for the patient's perception" (Wachtel, 1993, p. 58). Wachtel's formulation emphasizes not only the particularities of here-and-now thoughts, feelings, and interactions, but also the way such thoughts and feelings reveal fantasied expectations and the influence of past ways of thinking and relating. In so doing, this theory both draws upon and extends several aspects of Sullivan's contributions.

Ferenczi's influence extended to the British object relations school as well. In Klein's (1946) theory, a child develops an internal world of objects by

constantly internalizing real external others, and then reprojecting these internal objects onto external figures. Klein refined her understanding of this introjection-projection sequence in her work with children and severely disturbed adults who were previously considered unsuitable for psychoanalysis, and in so doing, elaborated a more expansive and nuanced understanding of countertransference. That is, countertransference was no longer simply considered a specific reaction to a patient's transference, but was expanded to include a whole range of intense emotional reactions evoked in the therapist. More specifically, her concept of projective identification offered an explanation for the intense emotions evoked in therapists by this population. In this process, an individual unconsciously "splits off" intolerable affect (or an intolerable internalized object) and projects it "outward" to another, who is implicitly asked to tolerate and hold this disavowed part of the self. This shift in conceptualizing countertransference as a more "totalistic" phenomenon marked an important move away from a view of transference as an exclusively one-person field (see also Samstag, 1998).

Fairbairn (1940, 1943, 1946) shares Klein's theoretical emphasis on the crucial role of internalized object relations in development. However, he moved outside the classical drive model with his central idea that a child's most fundamental need is to seek out and maintain an emotional bond with parents, and that psychic structure develops out of the child's experience of and internalization of a good-enough relationship. Scharff and Scharff (1994) observe that, for Fairbairn, the need for relatedness is a "far more important organizing

factor in human motivation and psychic structure than the force of the drives of sex and aggression that Freud used to explain instinctual tension and the need for its discharge" (p. 51). If human experience is inextricably linked to cultivating relationships with others, it follows, then, that self-destructive relationships and the distressing affects that accompany them are re-created and re-enacted throughout life as a way to maintain these primary connections to significant others, no matter how painful they are (Fairbairn, 1943). Thus, Fairbairn's shift toward object-seeking as primary motivation has important implications for adult motivation, experience, and behavior in the context of the therapeutic dyad. When patients begin to experience a different, fuller range of affective and relational possibilities with their therapists, they may withdraw from or try to destroy this (healthier) relationship out of fear that they are betraying their early ties to internal objects, however depressing, sadistic, demanding, or suffocating these representations might be. By being attuned to the patient's fears of isolation and abandonment, and exploring the moments when these fears are most acute, the therapist can help the patient experience a different form of relating and understand the repetition of destructive relational patterns. Greenberg & Mitchell (1983) note that in this way, the therapeutic relationship becomes the vehicle through which a patient can fulfill the capacity to make full contact with others, rather than resolve unconscious conflict over pleasure-seeking impulses.

Within the object relations tradition, Winnicott's (1960, 1965, 1971) ideas about the creative and empowering aspects of attuned relationships, whether

mother-infant or therapist-patient, represent another crucial elaboration of the interpersonal dimensions of development. Winnicott's description of the healthy aspects of illusion - that creative appropriation of objective phenomena which makes the external world internally meaningful - is part of his singular contribution to understanding individual creativity and its genesis in a relational matrix. His notion of transitional experience, as he referred to that space that gives rise to creative illusion, rests on a developmental premise. He notes that within the first months of an infant's life the child uses an object for self-pacification. Whether the object is a thumb or its mother's breast, such use is an initial step in separation from the "maternal matrix" (Winnicott, 1971). During each successive stage in the child's development, his attention turns gradually to another object, which also serves a soothing purpose. Unlike the mother, the chosen object is available at all times, and it is only the child who has the authority to change it (p. 5). The object becomes transitional insofar as the child does not mistake it for the mother, nor does the child believe that he has completely brought it into being, but invests it with his own significant, or illusory, meaning. In this sense, the context of the child's interactions with the object, which is neither totally the child's creation nor is it completely external to the child, constitutes a transitional space (p. 4).

According to Winnicott, such creative adaptation to the environment and its objects signifies the child's increasing ability to deal with objective reality. This transitional space is an intermediate area, to which both inner reality and

the external world contribute. Its indispensable function is to keep both "inner and outer reality separate yet interrelated" (Winnicott, 1971, p. 5). The way this reality, which is neither purely hallucinatory nor merely external, is achieved, concerns the child's use of illusion through play. Winnicott considered the child's ability to use illusion in this way the most important indication of his growing capacity for symbolism and a creative approach to life. What is crucial is that Winnicott realized that adults never lose the need for illusion. Indeed, as Meissner (1984) observes, this dialectic "between illusion and disillusionment plays itself out through the whole of human experience and human life" (p. 168). Transitional conceptualization, then, functions within the area of illusion, which is "neither subjective nor objective and lies open simultaneously to both subjective and objective poles of meaning without violation or exclusion of either" (Meissner, 1990, p. 19).

According to Winnicott (1965), a "good enough" mother facilitates the development of this transitional space and the empowering feeling in the child that reality is co-created. However, when a parent's preoccupation with her own needs forces her to assert prematurely for her child a "true" version of reality, the child is traumatically impinged upon and loses the capacity to distinguish for himself what is real and what is not real. When this happens, a child's relatedness to transitional objects becomes unhealthy; that is, the developmental process is thwarted and the transitional object can degenerate into a fetish object. Likewise, children who are not able to pass from one developmental stage to

another, with successive objects of transition, often cannot bear the disillusionment of letting an object go, and so the illusory aspect of transitional play can develop an hallucinatory dimension. The child cannot tolerate the constant and inevitable tension of relating inner and outer reality. In this situation, the child defensively develops a "false self" which enables him to comply with imposed parental demands while protecting the "true self" from exploitation (Winnicott, 1960).

Winnicott's understanding of the importance of transitional space and the capacity for symbolic play has profound implications for the therapy relationship as well. In treatment, the therapist's role is to encourage the expression of the patient's true self, which can be achieved through a negotiation of what is real and not real in the relational space. In other words, the therapist must refuse to indulge in asserting an authoritative version of who the patient is. By offering definitive interpretations which "uncover" the patient's "true" dynamic motivations, the therapist violates the patient's internal psychic space, impeding the patient's ability to make his own experience meaningful, and forcing him to isolate and disown vulnerable aspects of the self. In contrast, by focusing on the patient's exploration of what his true wishes are, and by helping the patient move between his personal world and the shared analytic space, the therapist facilitates the patient's capacity to relate symbolically through play. As Winnicott (1971) notes, "psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist. Psychotherapy has to do with two

people playing together" (p. 38). Pizer (1998) describes Winnicott's emphasis on analytic play as "honoring the paradox of our simultaneous separateness and relatedness," (p. 31), or as a profound appreciation of both the necessity of empathic attunement as well as the limits of therapeutic understanding across the chasm of two subjectivities. Pizer writes that

> [t]he essential therapeutic mission...may be seen as...the establishment...and creative elaboration of an intersubjective - and thereby an internal - space wherein [the patient] could symbolize, assemble, connect, feel, communicate, author, and share his personal experience. Indeed, the establishment, enlargement, and playful negotiation of potential space lies at the heart of therapeutic action in any analysis (1998, p. 30).

Since the patient will eventually become disillusioned with the therapist's inevitable failures at perfect "holding" or attunement, these events can provide non-traumatic occasions for exploration and growth. In this view, ruptures in the therapeutic alliance can be understood as an enactment of the patient's early developmental experiences of an impinging other (Newirth, 1995). Through an emphasis on immediate affective experience, the therapist's goal is to help the patient acknowledge and reintegrate disowned parts of the self. Impasses in therapy are therefore neither resistance nor a lack of cooperation, but instead opportunities for authentic relating (Newirth, 1995).

For Kohut (1971, 1977, 1984), establishing and maintaining relationships with others is as essential as it is for Sullivan, Fairbairn, and Winnicott. As a self psychologist, Kohut conceptualizes the self as having two essential polar needs: idealization and mirroring. For healthy development of the self, a crucial aspect

of parenting is attunement to the child's developmental thresholds, or needs for mirroring and/or idealizing. If the parent repetitively fails to empathize with these needs, the child does not internalize the structures needed to regulate his own self-esteem, resulting in a preponderance of shame over guilt, oscillation of self-esteem between grandiosity and devaluation, and secondary symptoms such as hypochondriasis. Repeated empathic failures in parenting could be due to a temperamental mismatch between parent and child or the result of traumatic and difficult life circumstances. In contrast, optimal failures, which are the parent's unavoidable failures at ideal attunement and which are not overwhelming to the child, help the child to develop internalized mental structures which regulate self-esteem during the equally unavoidable failures of present and future relationships.

Significantly, Kohut emphasized the importance of the therapist's ongoing empathic responsiveness to the patient. In a Kohutian treatment, the analyst or therapist doesn't "interpret resistance," but reflects and synthesizes the patient's experience, thus facilitating the development of a "selfobject transference." In doing so, the analyst becomes more fully immersed in the relational dimension of the analytic process, including a broader range of therapeutic interventions so that the analyst is sufficiently empathic and has sufficient "human presence" (Kohut, 1984). A selfobject transference allows for the patient either to mirror or idealize different facets of the self that were not addressed in childhood. As with Winnicott, exploration of unavoidable selfobject

ruptures, or empathic failures, between patient and analyst is for Kohut a necessary element in therapeutic change. Through the therapist's understanding and attending to the patient's experience of the rupture as a negative event, the patient is able to develop a capacity for self-regulation. The relationship between patient and analyst develops in a dialectical process in which each is affected and changed as a result of interaction with the other (Wolf, 1980).

Clinical Contributions of Attachment Theory

Like Fairbairn, Bowlby (1969, 1973, 1980, 1988) abandoned Klein's attempts to preserve classical drive theory, and strove to rethink the basic principles which define the parameters of classical theory. As Fairbairn sought to explain a longing for closeness and connection as the central motivation which permeates all human experience from birth, so Bowlby posited attachment and the need for the physical proximity to the mother as the essential need of the infant. However, at the forefront of a movement which was seeking empirical evidence for the significance of the mother-child relationship for later psychological development and functioning, Bowlby's attachment theory (as well as the work of Mahler, Ainsworth, Stern, etc.) represented a marked departure from object relations theory as well as drive theory. This developmental theory, which views the mother-infant bond as a "primary motivational system" and thus more significant instinctually than psychosexual libido, was an outgrowth of Bowlby's criticisms of psychoanalytic overemphasis

on internal experience rather than the external world (Samstag, 1998). Explicitly looking outside psychoanalysis, Bowlby grounded his theory within contemporary biology, particularly ethology and the Darwinian theory of natural selection.

Like interpersonal theory, attachment theory is comprised of cognitive-behavioral and emotional elements reciprocally interacting between individuals. Briefly, attachment theory posits the existence of an evolved emotional-behavioral-motivational system designed by natural selection to maintain proximity between helpless infants and their primary caregivers or attachment figures. Unlike Sullivan, who asserted that the child's first close and loving relationship occurs in preadolescence with the "chum," Bowlby noted proximity-seeking behavior in children as early as 6 months of age. The attachment figure functions as a "haven of safety" in situations of perceived danger and as a "secure base" from which to function in the absence of threat. After repeated experience with caregivers, infants and children develop internal working models that guide expectations and responses to interactions. These working models are mental representations of an individual's experience of himself and others as well as ways of processing various feelings and experiences (Belsky & Cassidy, 1994). The working model is distinctive to attachment theory, and is the construct that "mediates the influence of early relationship experience upon later psychological development" (Belsky & Cassidy, 1994). Safran (1993b) writes that the working model is a useful heuristic similar to an interpersonal schema, which

helps maintain interpersonal relatedness. Thus, if a child has a mother who is able to respond empathically to his attachment needs, he will experience enough of a sense of safety and security to explore his environment. Over time, the child will develop an internal working model of a loving, responsive, and available caregiver, and, in turn, a sense of himself as deserving of love and capable of inspiring that love from others.

Conversely, if a child's bids for attachment are only rarely or inconsistently responded to, that child will develop an internal working model marked by love and dependency, but also an intense fear of rejection. Bowlby (1973) notes that "whether a child or an adult is in a state of security, anxiety, or distress is determined in large part by the accessibility and responsiveness of his principle attachment figure" (p. 23). Since the relationship with the mother is primary, children will react to the loss (or unavailability) of the mother with "true mourning" (Bowlby, 1973). Given the centrality of attachment needs, then, anxiety can be understood as a reaction to separation from the caretaker, and anger can also be seen as a response to separation or loss. As in Winnicott's depiction of the false self, which develops to protect the true self and accommodate the caretaker's impinging expectations and unpredictable responses, an insecure attachment pattern develops into an unstable sense of self characterized by efforts to cope with the caregiver's behavior. This self-image is thus both distorting of the individual's true needs and feelings, and inaccurately representative of others' actions and feelings. Similar to Sullivan's (1953)

discussion of "security operations" that help an individual to manage anxiety-provoking situations, Bowlby (1973) described two interpersonal defenses as part of a model of anxiety reduction and avoidance. These defenses are used as coping strategies - avoidance and adherence - which develop respectively into avoidant and ambivalent attachments (see Ainsworth's (1978, 1991) research on the Strange Situation for a fuller description of childhood attachment patterns, which include, secure, insecure-avoidant, insecure-anxious/ambivalent, and insecure-disorganized/disoriented).

Bowlby's attachment theory has been extended by several researchers to describe attachment styles in adulthood that stem from individual differences in security of attachment in childhood (Dozier, 1990; Dozier, Cue, & Barnett, 1994; Fonagy, 1989, 1991; Fonagy, Steele, Steele, Leigh, Kennedy, Matton, Target, 1995; Main, Kaplan, and Cassidy, 1985). Slade (1992) notes that:

> Security of attachment - in adults or children - implies a flexible style of attending to feelings and memories relevant to attachment and to relationships. Flexibility in this sense implies the capacity to balance attention to attachment-related phenomena with interest in and exploration of the world....In adults, the evidence for such flexibility is manifested in patterns of thoughts, feelings, and memories of childhood attachments: They can support generalized representations of the quality of early relationships with convincing memories of such experiences (p. 163).

Conversely, insecure attachment is characterized by an individual's tendency to represent early attachment experiences in an incoherent and contradictory way, whether in the idealized, detached, or minimizing manner of the dismissively attached person, or the affectively overwhelmed style of the person who is

preoccupied with attachment experiences (see Slade, 1992, 1999). More specifically, different types of insecure attachment are characterized by the manner in which individuals experience the distortion of thoughts and feelings. Slade (1999) writes that

> ...Bowlby suggested that different patterns of attachment reflected differences in the degree of *access* an individual has to certain kinds of thoughts, feelings, and memories. Certain types of insecure models permit only limited access to attachment related thoughts, feelings, and memories, whereas others provide exaggerated or distorted access to attachment relevant information (p. 580).

West & Keller (1994) note that the most significant cause of insecure attachment "lies in the inability of the person to master the loss of an empathic relationship with the childhood caregiver...which create[s] relational distance and perpetual feelings of not being understood" (p. 326).

Like Sullivan and Kohut, Bowlby (1973) identified attachment needs, or the need for relatedness, as important throughout the life cycle. The therapeutic process, then, hinges on whether the analyst can establish herself as a secure base through reliability, responsiveness, affective expression, and encouragement of the patient's autonomy. In particular, Bowlby (1988) emphasized that the therapist must be particularly attuned to issues of separation and loss and other distressing emotions. Unlike Winnicott, who saw the unavoidable failures and disillusionments of caretaking as a potential opportunity for creativity and growth, Bowlby emphasized the potentially catastrophic effects of loss and the necessity of mourning as a resolution of that loss (see Holmes, 1995). However,

there are affinities between the way Winnicott (1971) conceived of a "good-enough" parent or therapist, and the way Bowlby imagined the therapist as a secure base. That is, for Winnicott a therapist should be an unobtrusive guide in helping the patient discover his own internal capacities for exploration, creativity, and solitude; similarly, Bowlby (1973) postulated that an external, secure base will help the patient seek out new relational worlds, and provide meaning for separation without a devastating sense of loss.

Even more, as Holmes (1995) notes, a patient will come to experience the therapist as a secure attachment figure if the therapist is able to help him or her modulate overwhelming negative feelings through attuned responses, and will thus begin to rely on her when stressed or anxious. Such modulation of affect will help the patient to internalize the therapist as a secure base, and ultimately help the patient to form new secure relationships with others. Samstag (1998) observes that Bowlby considers such dependence on the therapist as appropriate and real, rather than neurotic and transferential. The extent to which the patient is able to experience and use the therapist as a secure base is an indication of the patient's prior attachment patterns; the type of secure base the therapist becomes for the patient reflects the particularities of their specific match.

As discussed above, theorists and researchers such as Bowlby, Mahler, Ainsworth, and Main highlighted the centrality of the child's early relationship with the caregiver and the impact of this relationship on later development. In a series of empirical studies examining the actual processes of attachment, Daniel

Stern (1977, 1985, 1995, 1998a, 1998b) has further illuminated the attachment bond as inherently intersubjective, or reciprocal and interactional. Stern's research describes infants who are mutual, responsive, engaged, and complex, and who have a primitive sense of self-coherence and self-efficacy within the first months of life.

According to Stern an infant has only rare moments of consciousness that are not dyadic. His depiction of the developmentally appropriate achievements of infants and young children focuses not on autonomous moments in isolation from others, but rather on the way in which a child's achievements are integrally connected to the quality of his relatedness with his mother (Stern, 1985). Stern emphasizes that the nature of a child's relatedness with his mother is dependent upon the earlier development of a core sense of self. The basic unit of the core self is what Stern terms a "RIG" - the Representation of an Interaction that has been Generalized. The RIG is a generalized memory of interactive experiences, and an expectation of how things are likely to proceed on a moment to moment basis in any given relationship (p. 102). In Stern's words, a RIG is "averaged experience made prototypic" (p. 96). The RIG can be thought of as akin to the working model described by Bowlby, although Stern considers the RIG to be "the building block from which working models are constructed" (p. 114).

RIGs explain how the mother, or other primary caretaker, helps her child regulate basic self-experiences and sustain affective attunement, and, in so doing, how the child's subjective self develops and is brought into interactions with

others. One of the ways in which a RIG develops in a baby is through the mother's role as a "self-regulating other." A self-regulating other is an other who regulates the infant's self-experience, in relation to experiences as diverse as arousal, affect intensity, security or attachment (Stern, 1985, p. 102). Self-regulation by another presumes a stable sense of a core self that allows for mutual interpersonal creations. For example, if a child begins tentatively to explore his environment, and turns around to make eye contact with his mother as an expression of his hesitation, her response will affect not only his sense of mastery and curiosity about the world around him, but also how he learns to react to others in that process of exploration. Each experience like this and others, Stern reminds us, affirms inextricable relatedness. They literally cannot occur "unless elicited or maintained by the action or presence of an other;" moreover, the manner in which self-regulating acts are performed is even more crucial in creating strong feelings and important representations than the acts themselves (p. 102).

To reiterate, repeated experiences with a self-regulating other over time form RIGs. "These memories are retrievable whenever one of the attributes of the RIG is present. When an infant has a certain feeling, that feeling will call to mind the RIG of which the feeling is an attribute" (Stern, 1985, p. 110). Thus, with the activation of each different RIG the infant is re-experiencing different ways of being with a self-regulating other. The self-regulating other that is called to mind is done in the presence as well as the absence of the actual person. Thus,

Stern's theory speaks to the process by which central relationships become "internalized." The concept he uses to describe this process is the notion of being with an "evoked companion." He defines the evoked companion as "an experience of being with, or in the presence of, a self-regulating other, which may occur in or out of awareness" (p. 112). An evoked companion is activated in the midst of a lived experience and serves

> ...to evaluate the specific ongoing interactive episode... To the extent that a specific episode is unique it will result in some alteration in the RIG... The RIG will thus be slightly different when it is next encountered by the next specific episode, and so on. In this fashion RIGs are slowly updated by current experience (p. 113).

The evoked companion becomes "the bridge between the infant's subjective world and the mother's subjective world" (p. 119). The mother brings her own series of evoked companions to each interaction with her child; Stern notes that "maternal fantasies and attributions can influence not only the observable interaction but ultimately the shape of the infant's fantasies and attributions" (p. 121). The developmental process can go awry, then, when a mother is unable to negotiate the influential presence of evoked companions that trigger negative or overwhelming emotions. Indeed, a caregiver's own experience of secure or insecure attachment will determine, for example, whether she experiences her child as intolerably needy and demanding, or an object to be controlled omnipotently, or, conversely, as an independent, and creative person with his own hopes and desires.

Stern reminds us of the clues to a genuine intersubjective engagement between mother and child, including the sharing of joint attention, intentions, and, most significantly, affect. Stern considers affective attunement the hallmark of mutual relating, and the most important way of sharing subjectivity. He notes that "interaffectivity," or empathic responsiveness, is a way of expressing the feelings behind a shared affect state. That is, without imitating behavioral expressions, but by sharing a child's intensity, or rhythm, or tempo, a mother can help her child begin to recognize and articulate different aspects of his emotional experience (p. 140). Stern emphasizes that attunement of this kind is distinct from "mirroring," or simply participating in another's subjective experience. Rather, affect attunement implies that one has substantially changed the other through participating in his experience, either through giving him something he did not have, or helping him to consolidate what was already present (p. 144).

In Stern's view, affect attunement is an essential way of creating and participating in "interpersonal communion," or sharing "in another's experience with no attempt to change what that person is doing or believing" (p. 148). Such mutual regulation of a child's emotional expressions appears to be a major determinant in his development (Tronick, 1989). Interestingly, Tronick (1989, 1998a, 1998b) has found that healthy development is also associated with the experience of frequent reparation of interactive errors, or of affective miscoordination, in which negative emotions are transformed into positive ones. Conversely, dysfunctional mother-child dyads are those which are consistently

affectively misattuned and are unable to repair the miscoordination. Tronick (1989) suggests that in healthy dyads, the ongoing cycle of miscoordination and repair is useful because it helps the infant internalize a sense of the other as present, available, and willing to negotiate their relationship even in the face of a rupture in their interaction.

With the Boston-based Process of Change Study Group (see Lyons-Ruth, 1998; Modell, 1998; Stern, 1998a, 1998b; Tronick, 1998a, 1998b), Stern and others have used these insights about dyadic attunement, misattunement, and repair to inform an intersubjective model of change within psychoanalytic treatment. Stern (1998a) observes that "something more" than verbal interpretations must be mutative in therapy, and must be differentiated from other kinds of psychoanalytic processes. Interpretations are a kind of declarative knowledge, which is explicit, conscious, and frequently verbal. Conversely, procedural knowledge of relationships is implicit and functions outside of verbal experience or conscious awareness. Stern (1998a, 1998b) terms this way of knowing how "to be with" someone "implicit relational knowing;" it can include an individual's way of approaching another, or of expressing affection or displeasure. It occurs through "interactional, intersubjective processes that alter the relational field within the context of what we will call the 'shared implicit relationship'" (Stern, 1998a, p. 905). This implicit relationship - in which both parties move toward intersubjective sharing and understanding - occurs parallel to, and often in the

background of, the explicit verbal content which occupies the foreground of a session.

According to Stern, this shared implicit domain provides a unique opportunity for transforming the relationship between patient and therapist. When either partner in the dyad questions or responds to the other in a way that alters the usual intersubjective pattern of relating, there is a "now moment" which represents a rupture in the therapeutic framework, and which is frequently "too specific and personal" to be responded to with a typical technical maneuver (Stern, 1998a, p. 911). This "now moment" contains within it the potential for a "moment of meeting," or an authentic encounter between patient and therapist which transmutes their "implicit relational knowing" into something fundamentally different and more expansive. As Stern writes,

> [T]he actions that make up the 'moment of meeting' cannot be routine, habitual, or technical; they must be novel and fashioned to meet the singularity of the moment. Of course this implies a measure of empathy, an openness to affective and cognitive reappraisal, a signaled affect attunement, a viewpoint that reflects and ratifies that what is happening is occurring in the domain of the 'shared implicit relationship', i.e. a newly created dyadic state specific to the participants (p. 913).

This "newly created dyadic state" also has the effect of opening the intersubjective space between therapist and patient; akin to Winnicott's (1971) transitional space, this "open space" is born out of the new equilibrium in the dyad. Freed from the constraints of a habitual relational pattern, the "open space" leaves increased room for individual agency and creativity (Stern, 1998b).

Consequently, if the therapist is able to realize the "moment of meeting," it can play a key mutative role for the patient. Importantly, Stern (1998a) stipulates that a "'moment of meeting' cannot be realized with a transference interpretation..." because "other aspects of the relationship must be accessed" (p. 916). However, just as cycles of affective miscoordination and repair between mothers and infants can result in a new affect attunement (Tronick, 1989a), so failed "moments of meeting" between patient and analyst can be repaired and transformed into new opportunities, by staying with them, or returning to them, or in some way jointly resolving what transpired in the dyad (Stern, 1998a). Such exploration and reparation create anew the possibility of real encounter, in which both therapeutic partners emotionally respond to the other, and thus reveal more fully who they are in that moment.

Different Theoretical Perspectives on the Alliance

An important approach to the concept of the alliance outside of psychodynamic or attachment theory is that of Carl Rogers, who asserted that the therapist's capacity to be warm, empathic, and unconditionally accepting of the client was not just a necessary but a sufficient condition for therapeutic success (Rogers, 1951, 1957; Horvath & Luborsky, 1993). Significantly, Rogers' position states that the patient-therapist bond is the primary therapeutic agent.

Within the behavioral psychotherapeutic community, there was initially staunch opposition to the idea of the alliance effecting therapeutic change; all

change derived from behavioral techniques (Skinner, 1974). However, more recently some behavioral theorists have shown an interest in the dynamics of the therapeutic relationship (Raue & Goldfried, 1994), and in negotiating the relationship from a more flexible standpoint. Within cognitive therapy, the alliance is now viewed as a close collaboration, with the therapist occupying an explicit and active role. This collaborative relationship between the therapist and the patient is considered a prerequisite to effective therapy; patient and therapist should jointly choose the issues to be addressed over the course of the therapy, as well as in a particular session (Arkowitz & Hannah, 1989). Moreover, in discussing the non-specific ways that a therapist can contribute to the therapy, several writers emphasize the importance of warmth, sincerity, and capacity for empathy (Arkowitz & Hannah, 1989; Beck & Weishaar, 1989).

Significantly, despite the variation in theoretical views on the alliance, there have been consistent findings that different therapies produce similar amounts of therapeutic gains (Luborsky, 1994; Horvath & Luborsky, 1993). Bordin (1979, 1994) has articulated a broader reformulation of the working alliance that has become quite influential. His pantheoretical definition emphasizes the client's positive collaboration with the therapist against the client's defeating and self-destructive behaviors. The working alliance is "the ingredient that makes it possible for the patient to accept and follow treatment faithfully" (Bordin, 1979, p. 259). He proposed a tripartite model of the alliance, consisting of 1) the *tasks* of therapy, which are the "specific activities that the

partnership will engage in to instigate or facilitate change" (Bordin, 1994, p. 16). In a healthy therapeutic relationship, both patient and therapist agree about the value and relevance of the tasks. Moreover, there is concordance about 2) the *goals* of therapy, or what outcome both parties are working toward. Finally, there are 3) the *bonds* of therapy, which are the emotional attachments established between therapist and patient that include mutual trust, acceptance, and confidence (Bordin, 1979).

Contemporary Interpersonal Perspectives on Alliance Process

Drawing on the pantheoretical reformulation of the working alliance discussed above, many contemporary researchers conceptualize the therapeutic alliance as the central transaction within the dyad. That is, "the interpersonal process in the patient-therapist dyad is the therapeutic relationship or alliance, and the alliance so conceived is a sufficient agent of direct therapeutic change common to all psychotherapies" (Henry & Strupp, 1994, p. 64). From this perspective, the therapist's skill and history become crucial in shaping the quality of the alliance (Henry, Strupp, Schacht, & Gaston, 1994; Henry & Strupp, 1994). It is notable that this perspective is in contrast to one that views the alliance as primarily an intrapersonal (intrapsychic) phenomenon, dependent on the patient's inherent capacity for relatedness (Saketopoulou, 1999). If this process were solely intrapersonal, it would render the interpersonal process, and the therapist's contribution to that process, irrelevant or at least secondary

(Henry, Schacht, & Strupp, 1990; Henry & Strupp, 1994). In spite of this theoretical controversy about the alliance as interpersonal or intrapsychic, all current definitions emphasize the collaborative, negotiative components of the therapeutic relationship, and focus on the importance of mutuality between therapist and patient.

Underlying this definition of the alliance is a central theoretical mechanism that many dynamic and interpersonal theorists describe as the process of introjection. Some theorists describe introjects as working models (i.e. Bowlby, 1988), or as a type of interpersonal schema that helps to maintain interpersonal relatedness (Safran & Segal, 1990), or as internalized objects (Fairbairn, 1946; Ogden, 1986). As discussed earlier, Sullivan (1953) describes introjects as "personifications," or representations that arise in the context of lived relationships with others. These personifications become stable self-concepts over time, as individuals learn to treat themselves and relate to others as significant others from their past have treated them. Wachtel's (1987, 1993, 1997) perspective on this process emphasizes that speculations about "internal structures" "present a considerably greater danger of introducing a closed system mode of thought that is virtually impossible to disconfirm," unless such speculations are grounded in concrete clinical phenomena (p. 327). Thus, Wachtel is critiquing any account of "introjection" which is not explicitly attentive to how "internalized objects," or "introjects," are continually affecting

and in turn transformed by interpersonal transactions.[1] Despite these different conceptualizations, it is nonetheless significant that a wide range of theorists, from psychodynamic to humanistic to cognitive-behavioral and interpersonal, have all acknowledged the importance of these processes in therapy and have hypothesized that the way in which interpersonal events are internally represented is at the heart of both emotional experience and interpersonal behavior (Henry & Strupp, 1994; Safran, 1993).

Of particular significance in this discussion of introjection is the idea that individuals' intrapsychic representations of past relationships become a dynamic template that influences the way an individual relates to self and to other. The nature of one's early caregiving experiences – how consistent, attentive, loving, and confident one's parent has been – shapes the basic qualities of this template, or introject, which in turn affects current relationships. Various forms of adult psychopathology are believed to "involve fundamental impairments in representational structures," reflecting disruptions in the original caretaking interactions (Blatt, 1998, p. 1). In other words, if a caregiver responds to a child's needs inconsistently, for example, or in a tense and cold manner, the child internalizes the quality of this interaction, and may come to experience current

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[1] Because the term introject can represent a reified and static developmental construct in some theoretical accounts, it will here be used interchangeably with "interpersonal style." Since the current study is in part concerned with assessing the role of "introject quality" in both patient and therapist, as specified by one of the personality measures (INTREX), this discussion will continue to use this phrase at times, but in both this chapter as well as Chapter V, it will be rendered in quotation marks in deference to the limitations of the terminology.

relationships as unreliable, anxiety-provoking, and rejecting. Importantly, this introject remains active in and responsive to the present; as Wachtel (1987, 1993, 1997) notes, situations in the present not only reveal ancient and rigid distortions, but dynamically interact with and transform one's felt experience and behavior. In addition, contemporary interpersonal theory considers the flexibility or rigidity of one's interpersonal style as indicative of the relative health or pathology of the individual. That is, rigid "introjects" are part of what drives someone to seek out and elicit repetitively unsatisfactory relationships. Conversely, flexible "introjects" are those which allow a person to manifest a variety of behavioral responses to myriad interpersonal situations.

One of the fundamental assumptions of interpersonal theory is that all human behavior represents the negotiation of two basic and often competing motivations: the need for control and the need for affiliation (Kiesler, 1996, p. 7-9; see also Leary, 1957; Safran, 1993a, 1993b; Wiggins, 1991). In the course of their everyday relationships, individuals are continually negotiating their own needs for dominance and closeness in relation to another's needs for the same. In other words, people engage with each other in a more or less friendly or hostile manner, and a more or less controlling or submissive manner, based on both the current situation, as well as the interpersonal history which helped to influence the quality of their relational history and thus their particular interactive pattern. As Kiesler writes,

> At an early developmental stage, a person settles on a distinctive interpersonal style, role, and/or self-definition that leads the person repeatedly to make interpersonal claims on others in terms of how close or intimate and how much in charge or dominant the person wants to be with others. In subsequent interactions, this relatively constant self-presentation is reciprocally reinforced or validated by responses the person pulls from interactants (Kiesler, 1996, p. 85).

Thus, in the broadest sense, individuals are continually trying to influence others and to evoke responses from them that validate their style of interacting. Wachtel (1982) writes: "Each person may be seen rather regularly to produce a particular skewing of responses from others that defines his idiosyncratic, interpersonal world" (p. 48). This pattern of interpersonal behavior and its consequent "skewing of responses from others" are often referred to within interpersonal theory as complementarity. Complementarity can be defined as interactions which confirm one's self-concept; thus, anticomplementarity is defined as interactions which disrupt one's self-concept (Henry et al., 1990; Kiesler, 1996; Talley, Strupp, & Morey, 1990). In addition, Kiesler (1996) notes that our actions are designed to evoke familiar responses from others at mostly unaware and automatic levels (p. 90). Individuals' conscious and unconscious efforts to re-enact these familiar patterns and elicit expected responses is driven in large part by the wish to minimize feelings of anxiety and maximize feelings of security (see Sullivan, 1953; see also Kiesler, 1996; Wachtel, 1982, 1987, 1997). An example of interpersonal complementarity might be when an individual's chronically hostile attempt to control others elicits an equivalently hostile but submissive response. This interactive pattern is pathological, in that it confirms

this person's distorted view of the world as hostile and punitive, but nonetheless dependent on his dominant self-assertion. Yet, he continues to re-enact and re-experience the same rigid but comfortingly familiar relational configuration, in order to avoid the anxiety of unknown ways of relating.

In psychotherapy research, much theorizing has been done about the relationship between introjective processes, the formation of the therapeutic alliance, and successful treatment outcome. In the therapeutic dyad, the introjection of different, healthier interactive patterns and experiences can occur through a healing interpersonal process. Initially, the patient may require a complementary response from the therapist in order to feel secure enough to remain in treatment and to form a stable alliance with the therapist[2]. For example, research has shown that "the utility of a warm, empathic approach quite possibly is limited to those clients who present themselves initially to the therapist as friendly and submissive, since they would constitute the only clients who would find the approach nonaversive" (Leary, 1957, p. 235).

Ultimately, in a successful treatment, the therapist must resist the pull to respond in a complementary fashion to a patient's maladaptive style of interacting, while at the same time helping the patient modulate the anxiety associated with new, untested modes of relating and behaving. This process has

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[2] It is also important to note, however, that if a therapist responds with hostility to a patient, even if this is a complementary response evoked by the patient's behavior, this is clearly detrimental to good outcome (Rudy, et al., 1985; see empirical section of literature review for further elaboration of this phenomenon).

been found to be a common factor underlying effective psychotherapies (Henry et al., 1990; 1994; see Alexander & French, 1946, for a discussion of the role of "corrective emotional experience"). Clearly, then, the particular match between patient and therapist "introject quality" is critical for positive treatment outcome.

Theoretical Summary

In sum, the wide range of theoretical perspectives discussed in the previous sections have all contributed to a greater understanding of the therapist's inevitable involvement in the therapeutic process, and therefore, to an increased variety of therapeutic interventions that might facilitate change in patients. These "two-person" psychologies were developed in part as an attempt to correct the preponderantly intrapsychic emphasis of earlier, classical, "one-person" models. The theories of Sullivan, Fairbairn, Kohut, Winnicott, Bowlby and others sought to include external reality and social interactions into their accounts of human development and psychopathology, as well as their rationale for therapeutic technique. Broadly speaking, these relational movements have been concerned with how the therapist's personality and choice of interventions and techniques contributes to the alliance in specific ways. The next section reviews a relational perspective on how to understand and repair breaches in the relationship.

Ruptures in the Therapeutic Alliance: "A Window into Core Themes"

Given that the alliance has come to be understood transtheoretically as a prerequisite for change in all forms of therapy (Bordin, 1979; Horvath & Symonds, 1991; Horvath & Luborsky, 1993), it is important to examine the factors that contribute to failures in the alliance. As Kohut, Winnicott, Stern, and others consider empathic failures or affective miscoordinations as an inevitable part of every relationship, so some theorists and researchers consider ruptures to be an important element of the alliance-building process, which can provide indispensable information about the core organizing principles that shape the meaning of interpersonal events for the patient (Horvath & Marx, 1991; Safran, 1993a, 1993b). Notably, Safran, Muran, and others (Safran, 1993b, 2002; Safran, Crocker, McMain, & Murray, 1990; Safran & Muran, 1996, 2000a, 2000b) have elaborated and implemented a form of brief treatment that considers the negotiation of ruptures in the alliance to be at the heart of the change process.

Safran and Muran's Brief Relational Therapy (BRT) is an intersubjective treatment model which understands therapeutic process as an ongoing cycle of negotiation between patient and therapist. In this integrative model, which includes psychodynamic, experiential, and cognitive components, the quality of the therapeutic alliance is considered the primary agent of change. BRT places particular emphasis on the here-and-now exploration of the patient's experience of the therapy and therapeutic relationship, as well as on the collaborative aspects of that exploration; the therapist's subjectivity is a crucial factor in

understanding the alliance process. BRT also assumes that the presence of a rupture or deterioration in the alliance presents a unique opportunity to examine the patient's maladaptive relational patterns. As Safran & Muran (2000) write, "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 schema" (p. 44).

Ruptures can be understood as empathic breaches, which often take the form of affective misattunements, such as attacking, blaming, or withdrawing states. Safran et al. (1990, 1993a, 1993b) assume that these empathic failures take place when the therapist has not adequately understood the patient's maladaptive beliefs about self-other interactions and thus confirms them. By exploring such ruptures, however, the therapist has an opportunity to gain access to crucial data that would otherwise be unavailable, as well as to provide a corrective interpersonal experience (Safran, 1993; Safran and Muran, 1998). It is important to note that how a therapist manages a rupture is the crucial factor in whether it becomes an arena of fruitful exploration or results in premature termination (Bordin, 1994; Foreman & Marmar, 1985; Henry & Strupp, 1994; Safran & Muran, 1996).

Moreover, Safran (1993a) considers breaches in the therapeutic bond a way of understanding a basic human tension between the wish for autonomy

and separateness and the wish to be both dependent upon and connected to others.[3] Safran describes the philosophical underpinnings of this perspective:

> [B]reaches in the alliance are particularly important junctures in therapy to explore, because they are paradigmatic of a fundamental dilemma of human existence, i.e. the need to reconcile our innate desire for interpersonal relatedness and the reality of our separateness...[W]orking though alliance ruptures can help to facilitate the reconciliation of this dilemma (Safran, 1993a, p. 12).

From this perspective, the rupture event is thus an opportunity for a genuine encounter, in the way that Stern (1998a) describes a "moment of meeting." Each patient will negotiate this existential dilemma in a way that reflects their unique sense of how it is to interact with others. For example, one patient might experience the therapist's interventions as critical, attacking, and intrusive, while another might find the same kind of intervention ineffectual or inadequate. The following sections will review the empirical literature about how an individual's personality affects the way they form relationships and interact with the other in therapy (both patient and therapist), and, in turn, how the quality of this alliance process is related to overall outcome.

[3] See Wiggins (1991) for a discussion of how the control and affiliation dimensions of interpersonal behavior, considered above in the section on introjection, are part of these two overarching personality domains, which Wiggins refers to as "agency and communion."

Empirical Evidence on the Relationship between Personality, Therapeutic Alliance, and Psychotherapy Outcome

In recent years, the psychotherapy research community has seen a resurgence of interest in the therapeutic alliance, which is attributed in part to the evidence that no particular treatment has been demonstrated to be consistently better than any other in effecting change (Smith, Glass, & Miller, 1980; Safran & Muran, 1998). In addition, Horvath (1994) notes that this burgeoning interest in the alliance stems from the finding that common factors (or factors shared by different types of therapy) such as warmth, empathy, support, and feedback are related to outcome. Most significantly, those factors pertaining to the quality of the therapeutic relationship are centrally implicated in therapeutic change, and have increased interest in the process of therapy (Lambert & Bergin, 1992, 1994; Strupp, 1993). Such renewed interest has generated a wide number of alliance measurement scales, each adhering to different definitions of the alliance as major groups of widely used measures, each based on related but distinct proposed by various theorists (Saketopoulou, 1999). Over the past 25 years, five approaches to the alliance, have been developed, expanded, and revised (Horvath 1994; Horvath & Symonds, 1991). These five groups of alliance assessment measures are as follows: 1) the Working Alliance Inventory, 1986, 1989); 2) the Vanderbilt Psychotherapy process Scale/ the Vanderbilt Therapeutic Alliance Scale (Hartley & Strupp, 1983; Sue, Strupp, & O'Malley, 1986); 3) the California Psychotherapy Alliance Scales (Gaston & Marmar, 1994;

Marmar, Horowitz, Weiss, & Marziali, 1986); 4) the Therapeutic Alliance Scales (Marziali, 1984); and 5) the Penn Helping Alliance Scales (Alexander & Luborsky, 1987). These measures assess the status of the alliance from a variety of perspectives (patient, therapist, or observer) and across various time spans (portions of therapy sessions, complete therapy sessions, or across several sessions).

Saketopoulou (1999) notes that although these instruments are based on different theoretical formulations of the alliance, researchers have nonetheless found high intercorrelations among them (Luborsky, 1994), with the WAI as the most widely used assessment that has consistently proven itself to be a highly valid measure of therapeutic alliance. Most importantly, the WAI measures the strength of the therapeutic alliance. Although there is variability in the magnitude of the association between alliance and outcome, often due to differing definitions of outcome or measures employed, the strength of the alliance has consistently been demonstrated to be a predictive factor in therapy outcome (Binder & Strupp, 1997; Crits-Christoph, 1998; Henry, Strupp, Schacht, & Gaston, 1994; Horvath & Symonds, 1991).

Various researchers have suggested that the magnitude of the alliance-outcome relationship is influenced by several factors including type of therapy, treatment length/duration, and both patient and therapist personality factors. Strength of alliance as a predictive factor in outcome has been demonstrated across theoretical perspectives. For example, Horvath and Symonds (1991) found

a significant association between alliance and outcome in brief dynamic psychotherapy, as well as Gestalt and eclectic psychotherapies. The association between alliance and outcome has also been empirically demonstrated in the context of cognitive and behavioral psychotherapy (Crits-Christoph & Beebe, 1988), as well as couples and family therapy (Quinn, Dotson, & Jordan, 1997).

There is some debate regarding duration of treatment as a factor found to affect the magnitude of the alliance-outcome correlation. Henry et al. (1994) has suggested that alliance in long-term psychotherapy is associated with better outcome. In contrast, Horvath and Symonds (1991) found no significant difference in outcome of 10- versus 50-session psychotherapy treatment.

Patient Factors

The role of patient factors in the formation of the alliance and subsequent therapy outcome has been demonstrated as significant. Those factors that have been demonstrated as significant for quality of alliance are level of premorbid functioning, presence of antisocial personality disorder, motivation, pretreatment perfectionism, perception of the locus of problems, hostility, quality of interpersonal relations, and degree of comfort trusting others (Blatt, 1999; DiGiuseppe, Tafrate, & Eckhardt, 1994; Gaston, Marmar, Thompson, & Gallagher, 1988; Horvath, 1994; Kokotovic & Tracey, 1990; Luborsky, 1994; Mallinckrodt, 1991; Safran, 1999; Svartberg, 1993). The quality of object relations (QOR), or a patient's "internal enduring tendency to establish certain types of

relationships, ranging from primitive to mature" (Piper, Joyce, McCallum, & Azim, 1993) has been cited as especially significant in the patient's ability to form an alliance within the early phases of treatment (Hartley & Strupp, 1983; Luborsky, Barber, & Beutler, 1993). In fact, Henry et al. (1994) reported that a patient's object relatedness is predictive of both premature termination and successful completion of therapy. Horvath (1994) discusses the role of early experiences with parental figures in affecting a patient's capacity for intimacy and trust, which are crucial components of the therapeutic alliance. Thus, if an individual's close relationships have been instrumentally shaped by a caretaker's warmth, affective range, and encouragement of autonomy, that patient will be more able to form a trusting attachment within the therapeutic relationship (Bowlby, 1988; Mallinckrodt, 1991). More specifically, in a study of outpatients with a variety of Axis I disorders, it was found that secure attachment style, as opposed to various insecure attachment styles, was related to fewer symptoms prior to the initiation of treatment and with greater improvement following treatment (Meyer, Pilkonis, Proietti, Heape, & Egan, 2001). Conversely, several recent studies have related insecure adult attachment categories with personality disorders and unsuccessful overall psychotherapy outcome (Dozier, 1990; Dozier et al., 1996; Fonagy et al., 1996, Fonagy et al., 1995).

Therapist Factors

Because of the recent theoretical shift towards a two-person psychology described earlier, which emphasizes the equivalent importance of the role of the therapist, there has been a growing body of research that considers the crucial contribution of therapist characteristics. Therapist factors that have been demonstrated as important include personal attributes such as rigidity and distance, level of self-disclosure, perceived expertise, commitment to the work enhanced by warmth and understanding, attachment organization, quality of introject, and misapplication of techniques such as use of silence and interpretation (Binder & Strupp, 1997; Dozier, 1990; Hartley & Strupp, 1983; Henry & Strupp, 1994; Horvath & Greenberg, 1994; Luborsky, 1994). Significantly, Henry and Strupp (1994) demonstrated that therapists with hostile interpersonal styles, as measured by the INTREX, were more than three times as likely to respond to their patients with hostility as those therapists without hostile "introjects." Similarly, Henry et al. (1990) demonstrated that therapists with hostile or disaffiliative styles tend to engage in a much higher level of problematic interpersonal processes associated with poor outcome. In a study that considered the relationship between developmental history and therapeutic process and outcome, the early parental relations of both patients and therapists were found to have a significant impact on psychotherapy success (Hilliard, Henry, & Strupp, 2000). Specifically, Hilliard et al. found that extensive training in psychotherapy was often not adequate in correcting the effect of therapists'

own interpersonal histories on their therapeutic work. This finding is consistent with the above study (Henry et al. 1990), which found that the quality of the therapist's "introject style" is related to the therapist's tendency to engage in problematic interpersonal process. In another study that assessed the role of the interpersonal styles of therapists and clients, Rudy, McLemore, & Gorsuch (1985) found that therapist hostility was clearly detrimental to good outcome, but when clients rated their therapists as affiliative and freeing, they reported more satisfaction with therapy.

Patient-Therapist Match

The match between patient and therapist is a significant domain within the clinical and research literature. More specifically, match refers to the interpersonal compatibility within the therapeutic relationship, and reflects the aforementioned theoretical shift regarding the importance of relationship and both parties' contribution to the alliance. Although different therapeutic approaches vary in their degree of emphasis on patient and therapist characteristics, all collectively assume that both patient and therapist factors contribute to and affect outcome. For example, psychodynamic treatments often consider the patient's level of "treatability" or "analyzability" to be a significant factor in predicting successful outcome. Other therapies such as behavioral treatments emphasize the importance of a specific technique to be more influential than the therapeutic relationship in treatment success. Still other

schools such as the humanistic perspective emphasize the personal qualities of the therapist such as warmth, empathy, and unconditional acceptance rather than any particular patient characteristic.

Several studies have investigated the utility of using interpersonal variables to optimize patient-therapist matching in psychotherapy, including Berzins (1977), Stuart, Pilkonis, Heape, Smith, & Fisher (1992), and Talley, Strupp, and Morey (1990). The most extensive interpersonal study of patient-therapist matching to date was that of the Indiana Matching Project, reported by Berzins (1977). This study attempted to identify optimal matches between patient-therapist dyads during short-term crisis-intervention oriented psychotherapy. Patients' role orientations (avoidance of others, turning against the self, dependency on others, and turning toward others) were measured and obtained prior to therapy, and were then related to measures of therapist activity within the sessions. Findings indicated dyadic complementarity for the first three patient role orientations, suggesting that improvement in brief psychotherapy "was facilitated by pairing patients with therapists whose personalities embodied ingredients that complemented the patient's needs, deficits, expectations, or interpersonal stances" (Berzins, 1977, p. 243). As discussed earlier in this literature review, complementarity is defined as interactions which confirm one's self-concept; anticomplementarity is defined as interactions which disrupt one's self-concept.

Stuart et al. (1992) also examined the role of patient-therapist match in psychotherapy, focusing on the effects of security of attachment and interpersonal style as related to the early stages of therapy. Using attachment assessment measures adapted from Bowlby (1988), Stuart et al. found that there were significant difference between the personality styles and attachment status of patients and therapists. Namely, patients were less securely attached than therapists and more dependent in personality style. These factors were found to be predictive of perceptions of the other and in-therapy behaviors. For example, patients identified as dependent were more likely to rate their therapists as dominant and inhibited and, if they were paired with autonomous therapists, had a high rate of termination. Similarly, insecurely attached patients who were paired with less securely attached therapists also had a high rate of dropout. Stuart et al.'s (1992) work demonstrates the utility of attachment status as an important consideration when examining therapeutic dynamics, and highlights the importance of match as a causal factor in outcome.

In another study of particular significance for this research, Talley et al. (1990) examined patient-therapist matching in psychotherapy. They tested hypotheses related to treatment outcome through the use of an interpersonal or circumplex assessment measure known as the Structural Analysis of Social Behavior (SASB). The SASB has been described as the "most detailed, conceptually rigorous, and empirically validated of current models" (Henry et al., 1986, p. 27). A well-established body of literature employing interpersonal or

circumplex models has been based on studies examining the effects of matching therapist and patient interpersonal and intrapsychic styles (Samstag, 1998). In fact, in her development of the SASB, Benjamin (1974) furthered the efficacy of the circumplex model by designing this system comprised of two interpersonal domains and one intrapsychic domain, as compared to the single domain of other models.

In their study, Talley et al. (1990) found that the interaction between patient and therapist self-concept, or introject, is related to treatment outcome. More specifically, this interaction occurred when patient and therapist ratings of introject were measured in terms of the affiliation dimension of the circumplex model. Patients who rated themselves as less affiliative, or more hostile, were unaffected by degree of therapists' introject affiliation scores. However, patients who rated themselves as more affiliative were found to have better treatment outcome when their therapists' self-ratings were also affiliative. For these authors, high self-affiliation scores indicate "better self-adjustment", and that better adjusted patients have more successful treatments with better-adjusted therapists. Conversely, level of therapist self-adjustment had less influence on more poorly adjusted patients, or those with hostile introjects. In other words, for patients who were considered better adjusted, or as having more affiliative introject quality, match was a significant variable affecting outcome.

The findings of Talley et al. (1990) also suggested that greater degrees of anticomplementarity between the therapist's self-concept and the therapist's

perception of patient behaviors is associated with less clinical improvement or poorer outcome (Kiesler, 1996). That is, when therapists' self-concepts are disrupted, they appear to be rendered therapeutically less effective. Conversely, for patients, greater degrees of anticomplementarity between the patient's self-concept and the patient's perception of the therapist's behaviors are associated with better outcome. In other words, for patients, when anticomplementary therapist behaviors disrupt their self-concept, therapeutic change is facilitated.

Another matching study was recently completed at The Brief Psychotherapy Research Project at Beth Israel Medical Center in New York; its design was based in part on this dissertation research (Bruck, Aderholt, Muran, Gorman, & Winston, A., 2004). As in the current study, patient and therapist attachment style and "introject quality" were considered both independently and dyadically in relation to early treatment process and overall outcome in short-term psychotherapy. Unlike the current study, which examined process and outcome in Brief Relational Therapy (BRT), Bruck et al.'s study used treatment protocols from Cognitive-Behavioral Therapy (CBT) and Short Term Dynamic Psychotherapy (STDP). Bruck et al. found that therapist introject quality and attachment style appear to have predictive value in early process and ultimate outcome. More specifically, therapists with higher scores on the Affiliation dimension of the INTREX – with "friendlier " introject styles – appear to have better outcomes, and therapists with preoccupied, fearful, or dismissing attachment styles seem to have worse outcomes. Interestingly, patients' introject

and attachment styles had no predictive relationship to outcome. The matching portion of the study, which also assessed match using difference scores, found that greater differences in attachment style and "introject quality," with the therapist as the more loving, self-nourishing, and secure member of the dyad, suggested better outcomes.

In another recent study considering the interaction between therapist and patient personality styles, Dozier et al. (1994) examined how clinicians' attachment strategies affected their ability to respond therapeutically to patients with severe psychopathology (and therefore insecure attachment strategies). First, it was found that secure clinicians intervened with patients very differently than insecure clinicians; the latter intervened in greater depth with "hyperactivating" (similar to preoccupied attachment), whereas secure clinicians tended to intervene in greater depth with more deactivating (similar to dismissing attachment) patients. This suggests that insecure clinicians intervened in a complementary fashion, or in ways that confirmed patients' usual interpersonal strategies; secure clinicians, in contrast, were able to respond in an anticomplementary manner, which disconfirmed patients' typical interpersonal repertoire (Dozier et al., 1994, p. 799). Dozier & Tyrrell (1998) speculate that those clinicians with secure attachment styles had enough internal resources - ego strength and flexibility - to tolerate the interpersonal discomfort involved in challenging their patients. In another study, Tyrrell & Dozier (1997) considered the impact of client and clinician attachment strategies on both

treatment process and outcome. (In this study, clinicians were case managers and their clients were identified as having serious psychopathology). They found that clients who were more deactivating had stronger treatment alliances, and reported better quality of life and higher levels of functioning when working with case managers who were less deactivating. Clients who were less deactivating had stronger alliances, better quality of life and higher functioning when paired with those case managers who were more deactivating. Tyrrell & Dozier argue that these results are suggestive of a "noncomplementary process," in which case managers are able to intervene with clients more effectively when their interpersonal behavior is discordant with clients in terms of attachment strategies. The above studies highlight the significance for treatment process and outcome of considering patient and therapist attachment styles individually as well as in terms of the dyadic interaction of these styles.

Alliance Ruptures

Safran and Muran (1996) define an alliance rupture as a strain or "deterioration in the relationship between patient and therapist" (p. 447). Considerable empirical evidence suggests that weakened alliances are related to unilateral termination and therefore negative treatment outcome (Samstag, Batchelder, Muran, Safran, & Winston, 1998). Since ruptures increase the risk for premature termination (Safran et al., 1994), they are considered to be a focal

event which offers the opportunity to understand and change the patient's maladaptive interpersonal schema.

Among those clinicians and researchers who consider the breach of the alliance as significant, some maintain that the specific timing of the strain provides useful information (Safran et al., 1994). Others emphasize that ruptures occur when a therapist is unable to encourage a patient's burgeoning autonomy (Henry & Strupp, 1994). Still others suggest that the therapist's misattunement with the patient's needs may cause a crisis in the alliance. These empathic failures may manifest as poorly timed interpretations (Bordin, 1994). Conversely, a crisis in the alliance may be resolved when a therapist is able to point out the presence of the rupture to the patient (Kivlighan & Schmitz, 1992), and subsequently address its relevance to problematic relationship patterns in the patient's life (Foreman & Marmar, 1985).

A significant body of research conducted by Safran & Muran (1996, 2000a, 2000b) and others (Horvath & Marx, 1991) demonstrates that successful therapy involves cycles of rupture and repair. Given this, research on the match between patient and therapist has recently focused not only on those factors that contribute to the development of the alliance, but more specifically, on the processes by which ruptures in the alliance are repaired or resolved. In a recent meta-analytic review of the alliance research literature, Safran, Muran, Samstag, & Stevens (2001) identified a four-staged model of the rupture repair process, which includes both patient and therapist components. Namely, these stages

include: 1) attending to the rupture marker, 2) exploring the rupture experience, 3) exploring the avoidance, and 4) emergence of wish or need. Notably, Safran et al. (2001) have distinguished withdrawal-based patient communications from confrontation-based patient communications as independent types of rupture markers. Interestingly, Safran et al. (2001) have found that regardless of specific rupture type, all ruptures are rooted in patients' anxieties and self-doubts about aggression or vulnerability, as related to their fear of loss or punitive action by the therapist.

Based on this conceptualization of the rupture-resolution process, Safran, Muran, and colleagues (see Muran, 2002; Safran, 2002; Safran & Muran, 2000b) developed a manualized short-term treatment model. This treatment model, known as Brief Relational Therapy (BRT), assimilates aspects of several therapeutic approaches (e.g., relational psychoanalysis, humanistic psychotherapy) and employs interventions geared toward the process of rupture resolution (the BRT model is described in Chapter III: Method, as well as earlier in this literature review). In a significant study of 128 personality-disordered patients, BRT was found to be either equivalent or superior to other treatments in terms of clinical significance and drop-out rates. Additionally, a smaller study demonstrated preliminary evidence of the superiority of BRT as a treatment for patients who had difficulty establishing alliances and were at risk for treatment failure (Safran et al., 2001).

Despite a limited number of studies in this area, research on alliance rupture and repair has yielded tentative conclusions. These conclusions indicate that specific processes involving patient and therapist behaviors do in fact play an important role in resolving alliance ruptures, and there is a relationship between these processes, improved alliance and consequently, improved outcome. Safran et al. (2001) note that it may "be the case that different types of alliance development are important for different types of patients... and that different patterns of alliance development are associated with different types of change processes and different types of outcome" (p. 410). Preliminary research results indicate that for some, a cyclical pattern of rupture and repair is associated with positive outcome. Further, although positive outcome may be associated with patient's expression of negative feelings for their therapist, preliminary evidence also suggests that when therapists become aware of their patients' negative feelings, they are more likely to respond with hostility and defensiveness. Safran et al. (2001) note that poor outcome in therapy may be related to patient-therapist dyads in which the therapist responds to a patient's hostility with complementary hostility. These latter points have driven researchers to seek additional ways to help therapists avoid such vicious cycles of communication.

In addition to their contributions to the empirical literature, Safran et al.'s (2001) research has generated important provisional guidelines for therapeutic practice. These include the importance of therapists' awareness of patients'

negative feelings and the possibility of subtle rupture markers in the alliance, the importance of encouraging the patient to express negative feelings about the therapy to the therapist, the therapist's non-defensive response to these communications, and exploration of the patient's fears about asserting their difficult or hostile feelings about the therapy.

Research Questions

Understanding the myriad factors that contribute to the quality of the therapeutic alliance, as well as to overall therapeutic outcome, is an important part of psychotherapy research. The present study seeks to examine some of these factors, focusing specifically on how patient and therapist personality factors affect therapeutic success. The role of patient and therapist personality factors will be considered both independently and dyadically (the latter is intended to consider the personality "match" between patient and therapist).

Both patient and therapist subscale scores on each of the personality measures (RSQ, INTREX) will be related independently to several process and outcome variables. Additional analyses will explore the role that the interaction of patient and therapist personality factors have on process and outcome. Specifically, this part of the study will consider:

A. Attachment style vs. process and outcome measures – patient

1) the relationship between a secure attachment style in patients and a) alliance process in terms of rupture events, alliance strength, and session depth and smoothness, and b) therapeutic outcome in terms of symptom change, change in target complaint, and change in interpersonal and global functioning.

2) the relationship between a preoccupied attachment style in patients and a) alliance process in terms of rupture events, alliance strength, and session depth and smoothness, and b) therapeutic outcome in terms of symptom change, change in target complaint, and change in interpersonal and global functioning.

3) the relationship between a fearful attachment style in patients and a) alliance process in terms of rupture events, alliance strength, and session depth and smoothness, and b) therapeutic outcome in terms of symptom change, change in target complaint, and change in interpersonal and global functioning.

4) the relationship between a dismissing attachment style in patients and a) alliance process in terms of rupture events, alliance strength, and session depth and smoothness, and b) therapeutic outcome in terms of symptom change, change in target complaint, and change in interpersonal and global functioning.

B. Attachment style vs. process and outcome measures – therapist

5) the relationship between a secure attachment style in therapists and a) alliance process in terms of rupture events, alliance strength, and session depth and smoothness, and b) therapeutic outcome in terms of symptom change, change in target complaint, and change in interpersonal and global functioning.

6) the relationship between a preoccupied attachment style in therapists and a) alliance process in terms of rupture events, alliance strength, and session depth and smoothness, and b) therapeutic outcome in terms of symptom change, change in target complaint, and change in interpersonal and global functioning.

7) the relationship between a fearful attachment style in therapists and a) alliance process in terms of rupture events, alliance strength, and session depth and smoothness, and b) therapeutic outcome in terms of symptom change, change in target complaint, and change in interpersonal and global functioning.

8) the relationship between a dismissing attachment style in therapists and a) alliance process in terms of rupture events, alliance strength, and session depth and smoothness, and b) therapeutic outcome in terms of symptom change, change in target complaint, and change in interpersonal and global functioning.

C. Introject quality vs. process and outcome measures – patient

9) the relationship between an affiliative introject in patients and a) alliance process in terms of rupture events, alliance strength, and session depth and smoothness, and b) therapeutic outcome in terms of symptom change, change in target complaint, and change in interpersonal and global functioning.

10) the relationship between an autonomous introject in patients and a) alliance process in terms of rupture events, alliance strength, and session depth and smoothness, and b) therapeutic outcome in terms of symptom change, change in target complaint, and change in interpersonal and global functioning.

D. Introject quality vs. process and outcome measures – therapist

11) the relationship between an affiliative introject in therapists and a) alliance process in terms of rupture events, alliance strength, and session depth and smoothness, and b) therapeutic outcome in terms of symptom change, change in target complaint, and change in interpersonal and global functioning.

12) the relationship between an autonomous introject in therapists and a) alliance process in terms of rupture events, alliance strength, and session depth and smoothness, and b) therapeutic outcome in terms of symptom change, change in target complaint, and change in interpersonal and global functioning.

E. Attachment style differences vs. process and outcome measures

13) the relationship between the difference in secure attachment scores between patient and therapist in each dyad, and a) alliance process in terms of rupture events, alliance strength, and session depth and smoothness, as rated by both patients and therapists, and b) therapeutic outcome in terms of symptom change, change in target complaint, and change in interpersonal and global functioning.

14) the relationship between the difference in preoccupied attachment scores between patient and therapist in each dyad, and a) alliance process in terms of rupture events, alliance strength, and session depth and smoothness, as rated by both patients and therapists, and b) therapeutic outcome in terms of symptom change, change in target complaint, and change in interpersonal and global functioning.

15) the relationship between the difference in fearful attachment scores between patient and therapist in each dyad, and a) alliance process in terms of rupture events, alliance strength, and session depth and smoothness, as rated by both patients and therapists, and b) therapeutic outcome in terms of symptom change, change in target complaint, and change in interpersonal and global functioning.

16) the relationship between the difference in dismissing attachment scores between patient and therapist in each dyad, and a) alliance process in terms of rupture events, alliance strength, and session depth and smoothness, as rated by both patients and therapists, and b) therapeutic outcome in terms of symptom change, change in target complaint, and change in interpersonal and global functioning.

F. Introject quality differences vs. process and outcome measures

17) the relationship between the difference in affiliation scores between patient and therapist in each dyad, and a) alliance process in terms of rupture events, alliance strength, and session depth and smoothness, as rated by both patients and therapists, and b) therapeutic outcome in terms of symptom change, change in target complaint, and change in interpersonal and global functioning.

18) the relationship between the difference in autonomy scores between patient and therapist in each dyad, and a) alliance process in terms of rupture events, alliance strength, and session depth and smoothness, as rated by both patients and therapists, and b) therapeutic outcome in terms of symptom change, change in target complaint, and change in interpersonal and global functioning.

G. Attachment style vs. rupture process differences - patient

19) the relationship between secure attachment style in patients, and the difference between patient and therapist rating of rupture events.

20) the relationship between preoccupied attachment style in patients, and the difference between patient and therapist rating of rupture events.

21) the relationship between fearful attachment style in patients, and the difference between patient and therapist rating of rupture events.

22) the relationship between dismissing attachment style in patients, and the difference between patient and therapist rating of rupture events.

H. Attachment style vs. rupture process differences - therapist

23) the relationship between secure attachment style in therapists, and the difference between patient and therapist rating of rupture events.

24) the relationship between preoccupied attachment style in therapists, and the difference between patient and therapist rating of rupture events.

25) the relationship between fearful attachment style in therapists, and the difference between patient and therapist rating of rupture events.

26) the relationship between dismissing attachment style in therapists, and the difference between patient and therapist rating of rupture events.

I. Attachment style differences vs. rupture process differences

27) the relationship between the difference in secure attachment scores in each dyad, and the difference between patient and therapist rating of rupture events.

28) the relationship between the difference in preoccupied attachment scores in each dyad, and the difference between patient and therapist rating of rupture events.

29) the relationship between the difference in fearful attachment scores in each dyad, and the difference between patient and therapist rating of rupture events.

30) the relationship between the difference in dismissing attachment scores in each dyad, and the difference between patient and therapist rating of rupture events.

J. Introject quality vs. rupture process differences – patient

31) the relationship between an affiliative introject in patients, and the difference between patient and therapist rating of rupture events.

32) the relationship between an autonomous introject in patients, and the difference between patient and therapist rating of rupture events.

K. Introject quality vs. rupture process differences – therapist

33) the relationship between an affiliative introject in therapists, and the difference between patient and therapist rating of rupture events.

34) the relationship between an autonomous introject in therapists, and the difference between patient and therapist rating of rupture events.

L. Introject quality differences vs. rupture process differences

35) the relationship between the difference in affiliation scores in each dyad, and the difference between patient and therapist rating of rupture events.

36) the relationship between the difference in autonomy scores in each dyad, and the difference between patient and therapist rating of rupture events.

Because there are so many measures generating so many correlations, this study will state a general structure of expectations regarding findings rather than specific hypotheses. That is, it is expected that higher scores on secure attachment in both patients and therapists will be related to more positive alliance process and better overall outcome; higher scores on both autonomous and affiliative "introject quality" will be related to more positive alliance process and better overall outcome; and dyads whose scores on secure attachment and autonomous and affiliative introject quality are more closely matched, will have more positive alliance process and better overall outcome.

Chapter III. Method

Design

The present study used data from a larger research project at Beth Israel Medical Center's Brief Psychotherapy Research Program in New York City. For more than 15 years, the program has operated as a center for both process and outcome research, and has treated individuals with character pathology. The program also offers clinical training in various brief psychotherapies (McCullough and Winston, 1991). Participants used in the current study participated in the program between 1997 and 2002.

Patients come to the Brief Psychotherapy Research Project through advertisements in local newspapers, referrals from mental health professionals, and word of mouth. Inclusion criteria for patients in this study are as follows: (1) willingness to provide informed consent to the research protocol, (2) age between 18 and 65 years, and (3) evidence of at least one close personal relationship. Exclusion criteria include: (1) evidence of organic brain syndrome or mental retardation, (2) psychosis or need for hospitalization, (3) DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 1994) Axis II diagnosis of paranoid, schizoid, schizotypal, narcissistic, or borderline personality disorder (some exceptions made regarding inclusion of these diagnoses if there is evidence that patient is able to form positive therapeutic treatment alliance, and if it is thought that the patient might benefit from a time-limited approach), (4)

DSM-IV Axis III medical diagnosis, (5) evidence of active or recent substance abuse, (6) history of violence or impulse control problems, (7) active suicidal behavior, (8) current or recent use of psychotropic medication, or (9) concurrent participation in other forms of psychotherapy. Patients are screened for inclusion and exclusion criteria using a thorough intake procedure that includes a packet of intake questionnaires (measures relevant to this study will be described below), and two structured diagnostic interviews (the Structured Clinical Interview for the DSM-IV (SCID; Spitzer, Gibbon, Williams, First, 1995), and the Structured Clinical Interview for the DSM-IV Personality Disorders (SCID-II; Spitzer, Gibbon, Williams, First, 1995). If a patient agrees to participate in the research project, he or she signs an informed consent to the research protocol (see Appendix A). Patients in the Brief Psychotherapy Research Project also completed self-report interpersonal and symptom measures (See Assessment Instruments section).

Intake assessment interviews are conducted by clinical psychology graduate students who have been extensively trained with these instruments, including study of the SCID manual and videotaped interviews, and observation of several live interviews by skilled diagnosticians. Graduate students are also supervised by skilled diagnosticians.

Treatment

Each participant in this study received a minimum of 3 and a maximum of 30 sessions of once-weekly, low-cost, brief psychotherapy (with fees determined on a sliding scale based on subjects' income). Patients were randomly assigned to a therapist in the brief relational modality (Safran & Segal, 1990; Safran & Muran, 1996). Brief Relational Therapy (BRT) focuses on negative process in psychotherapy, specifically ruptures or impasses in the therapeutic alliance. As discussed in the Literature Review, BRT is an integrative model that draws from cognitive and experiential approaches and an amalgam of contemporary psychoanalytic theories. These latter theories are referred to broadly as "relational theory." Conceptualized as a set of therapeutic principles and techniques used to help patient and therapist collaborate in the treatment, BRT emphasizes a phenomenological approach to the patient-therapist interaction, highlighting dysfunctional aspects of that relationship. In so doing, this treatment seeks to disconfirm maladaptive emotional schemas and simultaneously provide corrective emotional experiences (Safran & Muran, 2000; Samstag, 1998).

Participants

The subjects included in the current study were 32 patient-therapist dyads that were accepted for a 30-session protocol of Brief Relational Therapy. Twenty-seven dyads completed the 30 session protocol, while 5 dyads are drop-out cases

(did not complete the 30 session protocol). The 32 dyads included 32 patients who were treated by 29 therapists. The patients had a mean age of 38.1 (range 24 - 56). Twenty-two of the patients were female. Four were married, seven were divorced or separated, and 21 were single and never married. Twenty-seven of the patients were White, two were Black, two were Asian, and one was Hispanic. Twenty-nine patients had completed college or a graduate-level degree; two had taken some college courses; one was a high school graduate. Twenty-nine reported being employed (see Table 1 below). Primary Axis I (DSM-IV) diagnoses included relationship problems (10), depression (10), dysthymia (6), generalized anxiety disorder (2), social phobia (1), adjustment disorder (1), panic disorder (1), and posttraumatic stress disorder (1). Primary Axis II diagnoses included personality disorder not otherwise specified with cluster C features (15), no diagnosis (10), avoidant personality (4), and obsessive personality (3) (see Table 2 below).

The therapists were all recruited from the Department of Psychiatry at Beth Israel Medical Center. Twenty-four had Masters degrees in clinical psychology and 5 had Ph.D. degrees in clinical psychology. The 29 therapists had a mean age of 38.9 (range 25 - 49), with a mean of 1.7 years of clinical experience. Sixteen of the therapists were female. Twenty-four were White, 3 were Asian, 1 was Hispanic, and 1 was Black (see Table 3 below). The Masters-level therapists participated in didactic seminars and weekly group supervision for BRT.

Table 1: Demographic Variables for Patients

Demographic Variables	All Patients N=32
Mean Age	38.1 (24-56)
Gender	
Female	22
Male	10
Marital Status	
Single/Never Married	21
Married/Remarried	4
Divorced/Separated	7
Currently Employed	
Yes	29
No	3
Education Level	
Graduate Degree	8
College Degree	21
Some College Courses	2
High School Diploma	1
Race	
White	27
Black	2
Asian	2
Hispanic	1

Table 2: Diagnostic Variables for Patients

Diagnostic Variables	All Subjects
DSM-IV Axis I	
Relationship Problems	10
Depression	10
Dysthymia	6
Generalized Anxiety Disorder	2
Social Phobia	1
Adjustment Disorder	1
Panic Disorder	1
Posttraumatic Stress Disorder	1
DSM-IV Axis II	
Personality Disorder Not Otherwise Specified (with Cluster C features)	15
Avoidant Personality	4
Obsessive Personality	3
No Axis II Diagnosis	10

Table 3: Demographic Variables for Therapists

Demographic Variables	All Therapists N=29
Mean Age	38.9 (25-49)
Gender	
Female	16
Male	13
Race	
White	24
Black	1
Asian	3
Hispanic	1
Degree	
M.A.	24
Ph.D.	5
Years Clinical Experience	1.7

Assessment Instruments

Personality Measures

Both patients and therapists were administered personality measures prior to the beginning of treatment. Specific personality measures included the Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994) and the INTREX, Short Form (INTREX; Benjamin, 1988).

The RSQ is a 32-item self-report measure that assesses adult attachment status. Items are rated on a 7-point, Likert-type scale where 1 = "not at all like me," 4 = "somewhat like me," and 7 = "very much like me." The RSQ yields scores in four dimensions of attachment style: secure, preoccupied, fearful, and dismissing. Bartholomew's attachment styles[1] are defined as a combination of one's self-image as either worthy or unworthy of love, and one's image of others as either trustworthy and available, or untrustworthy and unavailable. Within

[1] See Literature Review (pp. 20-21) for a fuller description of attachment styles.

this model, a securely attached person has a positive self-regard and an accepting view of others, and his style of relating is warm and flexible. An individual who is preoccupied with attachment feels unworthy of love, and dependent upon others for self-esteem, and has a clingy and emotionally reactive style of relating. An individual who is fearful of attachment feels unlikeable and fears that others will reject him; this person's style tends to be insecure, hesitant, and self-conscious. Finally, an individual who is dismissive of attachment has a sense of self-worth but is disparaging toward others, and tends to have a cold, critical, and distant style of relating. The RSQ is completed by the patient at intake, midphase, termination and follow-up; this study will consider the patient's RSQ at intake. The therapist completes the RSQ one time before the beginning of the therapist's first treatment case in the research project. This study will also consider the therapist's RSQ scores.

The INTREX is a 16-item patient self-report questionnaire that conforms to the dimensions of interpersonal complementarity established by the Structural Analysis of Social Behavior, a circumplex model of interpersonal transactions (SASB; Benjamin, 1974). Items are divided into two groups of eight, one of which asks the respondent to rate "yourself at your best," and the other to rate "yourself at your worst," in response to items such as "Without considering what might happen, I hatefully reject and destroy myself." This study will only consider the latter ratings of "yourself at your worst[2]." Items are rated on an 11-

[2] In order to reduce the number of potential correlations obtained in the study, and to prevent

point, Likert-type scale that progresses from 0 to 100; a score of 0 through 50 indicates that the statement is "false," and a rating of 50 or more indicates "true." This measure aims to assess respondents' positive and negative introjects[3] when functioning interpersonally at their best and their worst, and yields scores along three dimensions: attack, control and conflict. More recently, the INTREX has been reinterpreted to yield a two-dimensional structure: affiliation and autonomy (Pincus, Newes, Dickinson, & Ruiz, 1998); these latter two subscales will be considered in this study. These subscales represent the quality of certain types of interpersonal interactions, or models of how affiliative (friendly) and autonomous (freeing) one is toward self and other. The INTREX subscales are analyzed according to a circumplex model that locates an individual's affiliation and autonomy scores along vertical and horizontal axes. The vertical axis describes the Autonomous "introject," which goes from "freeing of the self" on the positive half of the axis, to "controlling of the self" on the negative side of the axis. The horizontal axis describes the Affiliative "introject," which goes from "self-loving" on the positive side of the axis, to "self-hating" on the negative side. The INTREX is completed by the patient at intake, midphase, termination and follow-up; this study will consider the patient's INTREX at intake. The therapist completes the INTREX one time before the beginning of the therapist's first

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their being so large that interpretation would be difficult and somewhat arbitrary, only the "at your worst" scores for the INTREX were used, not the "at your best." Previous research (Muran, personal communication, June 2003) had indicated that the "at your worst" scores yielded more meaningful and reliable correlations with other variables.

[3] See Literature Review (pp. 31-37) for a fuller consideration of this term.

treatment case in the research project. This study will also consider the therapist's INTREX scores.

It should be noted that therapist personality data from both the INTREX and the RSQ was collected with the strictest efforts to protect privacy and establish confidentiality, and encourage valid reporting. Therapists were assigned confidential identification numbers, and all therapist personality data was directed to J. Christopher Muran, Ph.D., Director of the Brief Psychotherapy Research Program.

Process Measures

Both patients and therapists independently completed psychotherapy process measures after each session of the treatment protocol. All of these measures are part of the Post-Session Questionnaire (PSQ), which was developed by The Brief Psychotherapy Research Project. Specifically, this study is using: 1) a 12 item version of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989; WAI-12; Tracey & Kokotovic, 1989), 2) the Session Evaluation Questionnaire (SEQ; Stiles, 1980; Stiles and Snow, 1984), and 3) two items addressing perceived tension in the relationship between patient and therapist (Safran, 2002; Safran & Muran, 2000b). Patient and therapist complete parallel forms of the PSQ; they complete these independently of each other, and remain blind to the other's responses throughout the course of the treatment. This study will explore early therapeutic process. For 27 completed 30-session cases, early process is defined as patient and therapist self-report on the PSQs for the first six

sessions. For five drop-out cases, early process is defined as patient and therapist self-report on at least three of the first six PSQs, in a treatment that lasted at least six sessions.

The WAI assesses the strength of the working alliance from a pantheoretical perspective. The WAI-12, derived from the 36-item scale developed by Horvath & Greenberg (1986), assesses various aspects of the therapeutic alliance, including the emotional bond between patient and therapist and its effect on the tasks and goals of treatment. Items are rated on a 7-point, Likert-type scale where 1 = "never" and 7 = "always." This measure has been consistently reported to be both psychometrically reliable and valid (Horvath & Greenberg, 1986; Horvath & Symonds, 1991). In addition, the 12-item short form used in this study has been consistently found to be highly intercorrelated with the long form (Horvath & Greenberg, 1986, 1989; Safran & Wallner, 1991).

The SEQ is a semantic differential test that measures the impact of psychotherapy sessions in terms of "depth" of exploration and "smoothness" in relating. These criteria have been demonstrated to be distinct and independent dimensions of psychotherapy session impact, and are reliably measured by the SEQ. In the current study, patients and therapists rate psychotherapy sessions on 12 bipolar adjective scales, which are presented in seven-point semantic differential format.

The two items on the PSQ which address patient-therapist tension inquire about the severity of any problem in the therapeutic relationship (Rupture

Intensity), and the degree to which the problem was resolved by the end of the session (Rupture Resolution). In three previous studies, these scales were found to be some of the most predictive of overall treatment outcome (Winston, Muran, Safran, Samstag, & Twining, 1992; Samstag et al, 1995; Samstag et al, 1998). These two items ("Please rate the highest degree of tension you felt during the session as a result of this problem" and "To what degree do you feel this problem was resolved by the end of the session?") are rated on a 5-point, Likert-type scale where 1 = "low" or "not at all" and 5 = "high" or "very much."

For the current study, indices were computed for each of these five process variables described above. These indices represent a composite score of early process for each patient and each therapist in all of the 32 dyads, which were then correlated with patient personality and outcome variables, and therapist personality and outcome variables. On the PSQ, rupture intensity is scored on a Likert scale of 1-5, with 1 designated "low" and 5 designated "high." This scale was adjusted to 0-5, with 0 indicating no ruptures were reported for that session. A Rupture Intensity Index (RII) was then calculated by averaging the total scores of reported intensity for the first six sessions (or, for the drop-out cases, a minimum of the first three sessions). A Rupture Resolution Index (RRI) was calculated by averaging the percentage of rupture resolutions in those early sessions with reported ruptures. An alliance index was derived for the WAI-12 by computing an overall mean score for the 12 items in this measure, averaged across the first six sessions. Finally, separate indices for session depth and

session smoothness, as measured by the SEQ, were computed by obtaining a mean score for the four items correlated with depth, and the four items correlated with smoothness, respectively, in early treatment sessions. All of the above indices were calculated independently for both patients and therapists.

Outcome Measures

Outcome measures include the Symptom Checklist-90, Revised (SCL-90-R; Derogatis, 1983), the Inventory of Interpersonal Problems, as rated by patients (IIP-64; Alden, Wiggins, & Pincus, 1990), the Target Complaints measure as completed independently by both patients and therapists (TC; Battle, Imber, Hoehn-Saric, Stone, Nash, & Frank, 1966), and the Global Assessment Scale (GAS; Endicott, Spitzer, Fleiss & Cohen, 1976).

The SCL-90-R is a self-report inventory developed to assess general psychiatric symptomatology. It asks patients to rate symptoms that they have experienced over the past week, such as feeling annoyed or tense, or having difficulty remembering things, as well as how intensely they have experienced them. This measure is frequently used in the assessment of overall outcome in psychotherapy research, and has been shown to have adequate psychometric properties. It consists of 90 items scaled in a Likert-type format on degree of severity, where 0 = "not at all," and 5 = "extremely." The SCL-90-R is completed by the patient at intake, midphase, termination and follow-up; the current study

will use the patient's SCL-90-R scores at intake and termination to calculate outcome.

The IIP-64 is a revised version of the original 127-self-report inventory developed by Horowitz, Rosenberg, Baer, Ureno, & Villasenor (1988) to assess difficulties in a broad range of interpersonal domains. It is a 64-item test scaled in a Likert-type format, which asks subjects to describe the amount of distress they have experienced in a given interpersonal problem on a 5-point scale ranging from "not at all" (0) to "extremely" (4). The IIP-64 has demonstrated high internal consistency and test-retest reliability coefficients (Alden et al., 1990). On this inventory, responses were scored using a circumplex method that categorizes subjects' responses within a two-dimensional interpersonal space (dimensions are warmth and dominance). The IIP-64 is completed by the patient at intake, midphase, termination and follow-up; this study will consider the patient's IIP-64 scores at intake and termination in order to calculate outcome.

The TC measure is an idiographic self-report instrument developed to assess the content and severity of patients' particular presenting problems. The measure asks patients to identify the three most significant problems they would like help with. Each problem is rated on a Likert-type scale of 1 to 13, where 1 = "not at all" and 13 = "couldn't be worse." Both patients and therapists independently rate the severity of problems. The TC form is completed by the patient at intake, midphase, termination and follow-up, and is completed by the therapist at intake, midphase, and termination. The current study will use

patients' and therapists' TC ratings at intake and termination in order to calculate outcome.

The GAS is a widely used therapist-rated scale for evaluating the overall mental health of a patient. Ratings are made on a continuum from 1 - 100, with 1 representing hypothetically the sickest individual, and 100, the hypothetically healthiest. Psychological, social, and occupational functioning are all considered in making these ratings. The GAS is completed by the therapist at intake, midphase and termination; the current study will use intake and termination ratings in order to calculate outcome.

For all of the above measures, outcome was determined by calculating the residual gain scores between time one (intake) and time two (termination). The residual gain score is a statistical calculation that accounts for the extent to which the amount of raw gain is linked to initial level. That is, "the residual gain score rescales the gain score for each subject relative to the mean gain for subjects with the same initial level" (Cohen, 1988).

Analysis Plan

After each participant was given a process variable index score, as described above, each personality score was correlated (using Pearson *r*'s) with process indices and outcome scores. Because both the RSQ and the INTREX generate continuous scores, each participant received a score on each of the six subscales (affiliation and autonomy for the INTREX, and secure, preoccupied,

fearful, and dismissing attachment for the RSQ), and all of these will be correlated with process and outcome. These correlational analyses, which are described below, will be conducted separately for each patient and each therapist.

A. RSQ vs. process and outcome measures - patient

1) the correlation between a secure attachment style in patients, as measured by the RSQ, and a) mean intensity of reported ruptures (RII), mean percentage of resolved ruptures (RRI), mean WAI-12 scores, and mean scores for depth and smoothness on the SEQ, and b) outcome scores on the SCL-90-R, IIP-64, patient and therapist TC, and the GAS.

2) the correlation between a preoccupied attachment style in patients, as measured by the RSQ, and a) mean intensity of reported ruptures (RII), mean percentage of resolved ruptures (RRI), mean WAI-12 scores, and mean scores for depth and smoothness on the SEQ, and b) outcome scores on the SCL-90-R, IIP-64, patient and therapist TC, and the GAS.

3) the correlation between a fearful attachment style in patients, as measured by the RSQ, and a) mean intensity of reported ruptures (RII), mean percentage of resolved ruptures (RRI), mean WAI-12 scores, and mean scores for depth and smoothness on the SEQ, and b) outcome scores on the SCL-90-R, IIP-64, patient and therapist TC, and the GAS.

4) the correlation between a dismissing attachment style in patients, as measured by the RSQ, and a) mean intensity of reported ruptures (RII), mean percentage of resolved ruptures (RRI), mean WAI-12 scores, and mean scores for depth and smoothness on the SEQ, and b) outcome scores on the SCL-90-R, IIP-64, patient and therapist TC, and the GAS.

B. RSQ vs. process and outcome measures - therapist

5) the correlation between a secure attachment style in therapists, as measured by the RSQ, and a) mean intensity of reported ruptures (RII), mean percentage of resolved ruptures (RRI), mean WAI-12 scores, and mean scores for depth and smoothness on the SEQ, and b) outcome scores on the SCL-90-R, IIP-64, patient and therapist TC, and the GAS.

6) the correlation between a preoccupied attachment style in therapists, as measured by the RSQ, and a) mean intensity of reported ruptures (RII), mean percentage of resolved ruptures (RRI), mean WAI-12 scores, and mean scores for depth and smoothness on the SEQ, and b) outcome scores on the SCL-90-R, IIP-64, patient and therapist TC, and the GAS.

7) the correlation between a fearful attachment style in therapists, as measured by the RSQ, and a) mean intensity of reported ruptures (RII), mean percentage of resolved ruptures (RRI), mean WAI-12 scores, and mean scores for depth and smoothness on the SEQ, and b) outcome scores on the SCL-90-R, IIP-64, patient and therapist TC, and the GAS.

8) the correlation between a dismissing attachment style in therapists, as measured by the RSQ, and a) mean intensity of reported ruptures (RII), mean percentage of resolved ruptures (RRI), mean WAI-12 scores, and mean scores for depth and smoothness on the SEQ, and b) outcome scores on the SCL-90-R, IIP-64, patient and therapist TC, and the GAS.

C. INTREX vs. process and outcome measures - patient

9) the correlation between an affiliation score in patients, as measured by the INTREX, and a) mean intensity (RII) of reported ruptures, mean percentage of resolved ruptures (RRI), mean WAI-12 scores, and mean scores for depth and smoothness on the SEQ, and b) outcome scores on the SCL-90-R, IIP-64, patient and therapist TC, and the GAS.

10) the correlation between an autonomy score in patients, as measured by the INTREX, and a) mean intensity (RII) of reported ruptures, mean percentage of resolved ruptures (RRI), mean WAI-12 scores, and mean scores for depth and smoothness on the SEQ, and b) outcome scores on the SCL-90-R, IIP-64, patient and therapist TC, and the GAS.

D. INTREX vs. process and outcome measures - therapist

11) the correlation between an affiliation score in therapists, as measured by the INTREX, and a) mean intensity (RII) of reported ruptures, mean percentage of resolved ruptures (RRI), mean WAI-12 scores, and mean scores for depth and smoothness on the SEQ, and b) outcome scores on the SCL-90-R, IIP-64, patient and therapist TC, and the GAS.

12) the correlation between an autonomy score in therapists, as measured by the INTREX, and a) mean intensity (RII) of reported ruptures, mean percentage of resolved ruptures (RRI), mean WAI-12 scores, and mean scores for depth and smoothness on the SEQ, and b) outcome scores on the SCL-90-R, IIP-64, patient and therapist TC, and the GAS.

In order to assess the relationship between dyadic personality match and process and outcome, a difference index was calculated for each dyad for each of the six personality subscale scores. This index was generated by subtracting therapist personality scores from patient personality scores on corresponding scales, and then obtaining the absolute value of this score. Thus, for the INTREX, a difference index was created independently for both affiliation and autonomy dimensions. For the RSQ, difference indices were created for each of the four subscale variables (secure, preoccupied, fearful, and dismissing). All of the INTREX and RSQ index differences were then correlated with both patient and therapist process, and overall outcome.

E. RSQ differences vs. process and outcome measures

13) the correlation of the difference in secure attachment style between patient and therapists, as measured by the RSQ, and a) mean intensity of reported ruptures (RII), mean percentage of resolved ruptures (RRI), mean WAI-12 scores, and mean scores for depth and smoothness on the SEQ, as rated by both patients and therapists, and b) outcome scores on the SCL-90-R, IIP-64, patient and therapist TC, and the GAS.

14) the correlation of the difference in preoccupied attachment style between patient and therapists, as measured by the RSQ, and a) mean intensity of reported ruptures (RII), mean percentage of resolved ruptures (RRI), mean WAI-12 scores, and mean scores for depth and smoothness on the SEQ, as rated by both patients and therapists, and b) outcome scores on the SCL-90-R, IIP-64, patient and therapist TC, and the GAS.

15) the correlation of the difference in fearful attachment style between patient and therapists, as measured by the RSQ, and a) mean intensity of reported ruptures (RII), mean percentage of resolved ruptures (RRI), mean WAI-12 scores, and mean scores for depth and smoothness on the SEQ, as rated by both patients and therapists, and b) outcome scores on the SCL-90-R, IIP-64, patient and therapist TC, and the GAS.

16) the correlation of the difference in dismissing attachment style between patient and therapists, as measured by the RSQ, and a) mean intensity of reported ruptures (RII), mean percentage of resolved ruptures (RRI), mean WAI-12 scores, and mean scores for depth and smoothness on the SEQ, as rated by both patients and therapists, and b) outcome scores on the SCL-90-R, IIP-64, patient and therapist TC, and the GAS.

F. INTREX differences vs. process and outcome measures

17) the correlation of the difference in affiliation between patient and therapists, as measured by the INTREX, and a) mean intensity of reported ruptures (RII), mean percentage of resolved ruptures (RRI), mean WAI-12 scores, and mean scores for depth and smoothness on the SEQ, as rated by both patients and therapists, and b) outcome scores on the SCL-90-R, IIP-64, patient and therapist TC, and the GAS.

18) the correlation of the difference in autonomy between patient and therapists, as measured by the INTREX, and a) mean intensity of reported ruptures (RII), mean percentage of resolved ruptures (RRI), mean WAI-12 scores, and mean scores for depth and smoothness on the SEQ, as rated by both patients and therapists, and b) outcome scores on the SCL-90-R, IIP-64, patient and therapist TC, and the GAS.

Finally, a difference index was also calculated for patient and therapist process scores in each dyad, which assesses how similar or different patient and therapist perceptions are about the rupture events which occur between them (specifically, the intensity and percentage of resolution of reported ruptures). These indices were generated by subtracting therapist process scores from patient process scores for both of the rupture process variables

mentioned above, and then obtaining the absolute value of these scores. The indices were then correlated with 1) both RSQ and INTREX personality subscale scores, in order to ascertain the relationship between patient and therapist personality styles (considered independently) and dyadic perception and rating of rupture process events, and 2) both RSQ and INTREX personality difference indices, in order to ascertain the relationship between dyadic personality match and dyadic perception and rating of rupture process events. These correlations were intended to explore the role of independent and dyadic personality in perception of process differences, and are listed below.

G. RSQ vs. rupture process differences - patient

19) the correlation between secure attachment style in patients, as measured by the RSQ, and the difference between patient and therapist ratings of rupture intensity (RII), and resolution of reported ruptures (RRI).

20) the correlation between preoccupied attachment style in patients, as measured by the RSQ, and the difference between patient and therapist ratings of rupture intensity (RII), and resolution of reported ruptures (RRI).

21) the correlation between fearful attachment style in patients, as measured by the RSQ, and the difference between patient and therapist ratings of rupture intensity (RII), and resolution of reported ruptures (RRI).

22) the correlation between dismissing attachment style in patients, as measured by the RSQ, and the difference between patient and therapist ratings of rupture intensity (RII), and resolution of reported ruptures (RRI).

H. RSQ vs. rupture process differences - therapist

23) the correlation between secure attachment style in therapists, as measured by the RSQ, and the difference between patient and therapist ratings of rupture intensity (RII), and resolution of reported ruptures (RRI).

24) the correlation between preoccupied attachment style in therapists, as measured by the RSQ, and the difference between patient and therapist ratings of rupture intensity (RII), and resolution of reported ruptures (RRI).

25) the correlation between fearful attachment style in therapists, as measured by the RSQ, and the difference between patient and therapist ratings of rupture intensity (RII), and resolution of reported ruptures (RRI) .

26) the correlation between dismissing attachment style in therapists, as measured by the RSQ, and the difference between patient and therapist ratings of rupture intensity (RII), and resolution of reported ruptures (RRI).

I. RSQ differences vs. rupture process differences

27) the correlation of the difference in secure attachment style between patient and therapists, as measured by the RSQ, and the difference between patient and therapist ratings of rupture intensity (RII), and resolution of reported ruptures (RRI) .

28) the correlation of the difference in preoccupied attachment style between patient and therapists, as measured by the RSQ, and the difference between patient and therapist ratings of rupture intensity (RII), and resolution of reported ruptures (RRI) .

29) the correlation of the difference in fearful attachment style between patient and therapists, as measured by the RSQ, and the difference between patient and therapist ratings of rupture intensity (RII), and resolution of reported ruptures (RRI) .

30) the correlation of the difference in dismissing attachment style between patient and therapists, as measured by the RSQ, and the difference between patient and therapist ratings of rupture intensity (RII), and resolution of reported ruptures (RRI).

J. INTREX vs. rupture process differences - patient

31) the correlation between affiliation in patients, as measured by the INTREX, and the difference between patient and therapist ratings rupture intensity (RII), and resolution of reported ruptures (RRI).

32) the correlation between autonomy in patients, as measured by the INTREX, and the difference between patient and therapist ratings rupture intensity (RII), and resolution of reported ruptures (RRI).

K. INTREX vs. rupture process differences - therapist

33) the correlation between affiliation in therapists, as measured by the INTREX, and the difference between patient and therapist ratings of rupture intensity (RII), and resolution of reported ruptures (RRI).

34) the correlation between autonomy in therapists, as measured by the INTREX, and the difference between patient and therapist ratings of rupture intensity (RII), and resolution of reported ruptures (RRI).

L. INTREX differences vs. rupture process differences

35) the correlation of the difference in affiliation between patients and therapists, as measured by the INTREX, and the difference between patient and therapist ratings of rupture intensity (RII), and resolution of reported ruptures (RRI).

36) the correlation of the difference in autonomy between patients and therapists, as measured by the INTREX, and the difference between patient and therapist ratings of rupture intensity (RII), and resolution of reported ruptures (RRI).

Chapter IV. Results

In this study, the personality styles of 32 patient-therapist dyads in Brief Relational Therapy were related to early therapeutic alliance process and outcome as described in Chapter III. In addition to exploring the role of personality in process and outcome, this study also considered the correspondence between patients' and therapists' perceptions of particular aspects of therapeutic process: ruptures and rupture resolutions within the therapeutic alliance. In order to explore these questions, bivariate (Pearson) correlations were generated, and are described below. Corresponding tables include correlations of statistical significance, as well as those which are not statistically significant but are of what is typically considered "moderate" strength (Cohen, 1988).

The means and standard deviations for each group of variables were calculated and are presented in Tables 4a through 4c. Variables include patient and therapist personality (attachment style and "introject quality") considered both independently and in terms of the match within each dyad, magnitude of patient-therapist personality match, patient and therapist process, and overall patient outcome.

Table 4a[1]: Clinical variables for patients and therapists: personality *(N=32 dyads)*

	Mean	Standard Deviation
Patient Attachment Style		
Secure	3.93	1.04
Preoccupied	4.23	1.44
Fearful	3.71	1.23
Dismissing	4.07	1.17
Therapist Attachment Style		
Secure	5.00	.82
Preoccupied	3.63	.72
Fearful	3.09	1.16
Dismissing	3.34	1.01
Patient-Therapist Match - Attachment Style		
Secure	1.37	.97
Preoccupied	1.28	1.04
Fearful	1.45	1.03
Dismissing	1.31	1.12
Patient Introject Quality		
Affiliation	-11.00	33.15
Autonomy	-12.97	29.59
Therapist Introject Quality		
Affiliation	-7.24	32.34
Autonomy	-13.03	29.84
Patient-Therapist Match - Introject Quality		
Affiliation	32.56	31.88
Autonomy	36.00	29.31

[1] To recapitulate briefly, attachment style subscale scores range from 1 - 7, where 1 = "not at all like me," 4 = "somewhat like me," and 7 = "very much like me." Thus, the higher the score on each subscale, the more strongly the individual is considered to have that specific attachment style. Introject quality subscale scores can be both positive and negative; on the Affiliation scale, the higher the score, the more self-loving the individual's introject is considered to be, and the lower the negative score, the more self-hating the individual's introject is considered to be. On the Autonomy scale, the more positive the score, the more self-freeing the individual's introject is considered to be, and the more negative the score, the more self-restraining the individual's introject is considered to be.

Table 4b[2]: Clinical variables for patients and therapists: therapeutic process (*N*=32 *dyads*)

	Mean	Standard Deviation
Patient Process Variables		
Rupture intensity	.90	1.10
Resolved ruptures *(N=15 dyads)*	3.21	1.15
Working alliance strength	4.56	.79
Session depth	3.74	.26
Session smoothness	4.01	.38
Therapist Process Variables		
Rupture intensity	1.67	.75
Resolved ruptures *(N=30 dyads)*	2.81	.99
Working alliance strength	4.25	.50
Session depth	3.75	.24
Session smoothness	4.15	.26

Table 4c[3]: Clinical variables for patients and therapists: overall outcome

	Intake M (SD)	Termination M (SD)	t-Value	DF	Signif. Level
Outcome Variables					
SCL-90-R *(N=22 dyads)*	.76 (.50)	.51 (.39)	2.01	21	.057
IIP-64 *(N=22 dyads)*	1.26 (.46)	1.04 (.48)	1.71	21	.102
TC - *Patient (N=22 dyads)*	10.02 (1.73)	5.87 (2.39)	6.30	21	<.001
TC - *Therapist (N=25 dyads)*	10.01 (1.45)	5.84 (1.57)	10.22	24	<.001
GAS *(N=25 dyads)*	64.00 (7.84)	68.73 (5.94)	-2.21	25	.045

Additionally, correlational analyses were conducted between process scores and outcome scores (calculated by using residual gain scores, as described in Chapter III) (See Table 5). This was done in order to determine if the cases used in this study yielded process-outcome correlations consistent with the

[2] Rupture intensity and rupture resolutions are rated on a 5-point scale where 1 = "low" or "not at all" and 5 = "high" or "very much." Working alliance strength is rated on a 7-point scale where 1 = "never" and 7 = "always." Session depth and smoothness are assessed from questions in a 7-point semantic differential scale; with 1 representing less depth and smoothness and 7 representing more.

[3] On the SCL-90-R, where 0 represents no psychiatric symptomatology, and 5 represents more extreme (severe) symptomatology. On the IIP-64, 0 = no interpersonal distress, and 4 = extreme interpersonal distress. On the TC, as rated by both patients and therapists, 1 = no severity in patients' presenting problems, and 13 represents extreme severity. On the GAS, 1 represents the sickest individual and 100 the healthiest.

literature; that is, that alliance process is at least moderately predictive of outcome (r = .20 - .40). [4]

Table 5: Relationships between therapeutic process and outcome

	Overall Outcome				
	SCl-90-R	IIP-64	TC-Pt.	TC-Th.	GAS
Rupture Intensity – *Patient*	**.32**	**.26**	**.25**	**.22**	.07
Rupture Intensity – *Therapist*	-.02	.02	-.10	-.06	**-.25**
Resolved Ruptures – *Patient*	**.22**	.17	.09	-.14	**-.29**
Resolved Ruptures – *Therapist*	**.21**	**.39**	.06	**.21**	**-.31**
Session Depth – *Patient*	.04	.10	.04	-.05	**-.26**
Session Depth – *Therapist*	-.04	**-.29**	.00	.01	**.25**
Session Smoothness - *Patient*	-.06	-.14	-.07	.10	-.06
Session Smoothness - *Therapist*	.10	.18	.09	.09	.16
Working Alliance – *Patient*	.16	.18	**.29**	**.41***	-.16
Working Alliance – *Therapist*	.02	.16	.03	**.32**	**.20**

Analysis of Impact of Independent Variables

Patient attachment style

The first correlational analysis intended to evaluate the relationship between patients' attachment style at intake and both early therapeutic alliance process, and therapeutic outcome (including changes in symptomatology, target complaints, and interpersonal and global functioning) (see Table 6[5]). As described in the Method section, indices of rupture process were derived for both

[4] In Table 5, moderate correlations (r = .20 - .40) are indicated in boldface. Significant correlations are indicated in boldface and underlined. Significant relationships with one asterisk (*) indicate $p < .05$.

[5] In Tables 6 - 16, significant relationships are indicated in boldface and underlined, and relationships of moderate strength (> .30) are indicated in boldface. Significant relationships with one asterisk (*) indicate $p < .05$; two asterisks (**) indicate $p < .01$. However, it is very important to note that chance produces significant correlations 5% of the time. In Table 6, for example, there are only 5 significant correlations out of 60 possibilities, or about 8%, which is only slightly higher than chance. Therefore, although this chapter notes all significant results, and the next chapter discusses their implications, these discussions are of necessity speculative, given the very limited number of significant findings.

of the rupture variables, and means were computed for the WAI-12 and the SEQ. Surprisingly, none of the correlations between secure attachment and patient- or therapist-rated process variables was significant. However, preoccupied attachment in patients was significantly related to a lesser intensity of patient-reported ruptures, and fearful attachment was significantly related to patient rating of sessions as less smooth.

With respect to outcome variables, the relationship between patient attachment styles and patient-rated Target Complaints was also statistically significant, though unexpected. That is, those patients who entered treatment relatively more securely attached reported poorer outcome in terms of their presenting complaints. Additionally, both fearful and dismissing attachment in patients was found to be significantly related to better outcome in patient-rated presenting complaints.

Table 6: Relationships between patient attachment styles and therapeutic process and outcome

	Patient Attachment Styles			
	Secure	**Preoccupied**	**Fearful**	**Dismissing**
Rupture Intensity – *Patient*	.09	-.39*	-.16	-.06
Rupture Intensity – *Therapist*	-.33	-.23	.03	.16
Resolved Ruptures – *Patient*	-.01	-.38	-.10	-.10
Resolved Ruptures –*Therapist*	-.04	-.21	-.03	.14
Session Depth – *Patient*	.18	.23	.07	-.11
Session Depth – *Therapist*	.08	-.15	.08	.08
Session Smoothness - *Patient*	.20	.15	-.36*	.06
Session Smoothness -*Therapist*	.28	.20	-.02	-.31
Working Alliance – *Patient*	.25	.22	-.02	-.20
Working Alliance – *Therapist*	.04	.28	.13	-.04
SCL-90	.24	-.16	-.19	-.40
IIP-64	.40	-.31	-.10	-.15
Target Complaints – *Patient*	.66**	-.00	-.45*	-.62**
Target Complaints – *Therapist*	.34	.25	-.08	-.31
GAS	.10	.11	.22	.16

Therapist attachment style

Therapist attachment style was found to be significantly related to two process variables (see Table 7). Secure attachment in therapists was correlated with a higher therapist rating of rupture intensity, and fearful attachment was related to a lower patient rating of session smoothness. Secure attachment style in therapists was significantly related to two outcome variables in an unexpected way; more securely attached therapists rated their patients' change in overall functioning lower at termination, and patients of more securely attached therapists reported more distress in interpersonal functioning at termination.

Table 7: Relationships between therapist attachment styles and therapeutic process and outcome

	Therapist Attachment Styles			
	Secure	**Preoccupied**	**Fearful**	**Dismissing**
Rupture Intensity – *Patient*	.07	**-.35**	-.24	-.22
Rupture Intensity – *Therapist*	**.52****	-.12	-.15	-.21
Resolved Ruptures – *Patient*	-.09	.20	.25	.44
Resolved Ruptures –*Therapist*	.29	.01	-.14	.22
Session Depth – *Patient*	-.23	.21	.28	.18
Session Depth – *Therapist*	-.05	.09	.15	**.31**
Session Smoothness - *Patient*	.20	.15	**-.36***	.06
Session Smoothness -*Therapist*	-.29	-.19	-.05	**.32**
Working Alliance – *Patient*	-.07	**.30**	.23	.11
Working Alliance – *Therapist*	-.10	.16	.15	.16
SCL-90	**.42**	-.22	**-.40**	-.06
IIP-64	**.45***	-.13	-.22	.26
Target Complaints – *Patient*	.26	.07	-.06	-.05
Target Complaints – *Therapist*	-.18	.26	.21	.02
GAS	**-.50***	-.07	**.30**	.20

Patient-therapist match: attachment style

A preliminary analysis was conducted that assessed the relationship between patient and therapist scores on each subscale of the RSQ (see Table 8). Specifically, in each dyad it was determined whether therapist or patient scored higher on each subscale. These frequency scores reveal that almost 63% of therapists overall scored higher on secure attachment than their patients; almost 13% of dyads had no difference in their level of secure attachment. A majority of patients had a higher level of preoccupied attachment than their therapists, and more than two-thirds of patients were more fearfully attached than their therapists. Almost equal numbers of patients and therapists had higher levels of dismissing attachment than the other member of their dyad.

Table 8: Comparison of therapist attachment subscale scores with patient attachment subscale scores: Frequency of higher scores *(N=32 dyads)*

		Therapist higher (# of dyads)	Patient higher (# of dyads)	No difference (# of dyads)
RSQ	Secure	20	8	4
	Preoccupied	13	18	1
	Fearful	10	22	0
	Dismissing	15	16	1

Further analyses were conducted in order to ascertain the role of these differences between patient and therapist attachment styles in each dyad. First, patient-therapist difference indices were derived by computing a difference score that measured the discrepancy between patients' and therapists' scores on each attachment subscale, as described in the Method section. The indices were then correlated with therapeutic process and outcome variables (see Table 9). These indices are "absolute" scores, which indicate the magnitude of the difference

between patient and therapist scores in each category, but do not reveal which member of the dyad has scored more or less highly than the other. Analyses found that a greater difference between patient and therapist in secure attachment was related to a higher intensity of therapist-rated ruptures. If there was a greater difference between patient and therapist in fearful attachment, both patients and therapists were less likely to experience the resolution of reported ruptures. A greater difference between patient and therapist in preoccupied attachment was also related to therapist perception of early sessions as less deep. In addition, a greater difference between patient and therapist in dismissing attachment was related to therapist perception of sessions as less smooth.

Table 9: Relationships between patient-therapist attachment style match and therapeutic process and outcome

	Patient-Therapist Match: Attachment Styles			
	Absolute Secure Difference	**Absolute Preoccupied Difference**	**Absolute Fearful Difference**	**Absolute Dismissing Difference**
Rupture Intensity – *Patient*	-.14	-.05	-.06	.08
Rupture Intensity – *Therapist*	.38*	-.22	.06	.23
Resolved Ruptures – *Patient*	.05	-.40	-.66**	-.18
Resolved Ruptures –*Therapist*	-.12	-.07	-.36*	-.03
Session Depth – *Patient*	-.02	-.18	-.12	-.17
Session Depth – *Therapist*	-.02	-.44*	-.13	-.07
Session Smoothness - *Patient*	-.09	-.07	-.28	-.10
Session Smoothness -*Therapist*	-.22	-.02	-.24	-.40*
Working Alliance – *Patient*	.05	-.16	-.13	-.22
Working Alliance – *Therapist*	-.08	-.06	.10	-.09
SCL-90	.00	.15	-.20	-.16
IIP-64	-.29	-.03	-.26	-.13
Target Complaints – *Patient*	-.28	-.04	-.01	-.37
Target Complaints – *Therapist*	-.30	-.03	-.20	-.30
GAS	-.19	-.16	.11	.04

Patient introject quality

Patient introject quality was found to be significantly related to one element of therapeutic process (see Table 10). A higher score on the autonomy scale was related to lower patient rating of reported ruptures as resolved.

Table 10: Relationships between patient introject quality and therapeutic process and outcome

	Patient Introject Quality	
	Affiliation	**Autonomy**
Rupture Intensity – *Patient*	.08	-.08
Rupture Intensity – *Therapist*	.18	.02
Resolved Ruptures – *Patient*	.18	**-.47***
Resolved Ruptures –*Therapist*	-.04	.07
Session Depth – *Patient*	.09	.04
Session Depth – *Therapist*	.09	.11
Session Smoothness – *Patient*	**.31**	**.33**
Session Smoothness –*Therapist*	.09	.03
Working Alliance – *Patient*	**.30**	.07
Working Alliance – *Therapist*	-.09	.18
SCL-90	.01	.26
IIP-64	-.01	**.33**
Target Complaints – *Patient*	-.15	**.35**
Target Complaints – *Therapist*	.07	-.05
GAS	-.09	.02

Therapist introject quality

Therapist INTREX scores were significantly related to one therapist process variable: higher scores on the affiliation scale were related to a greater percentage of therapist-rated rupture resolutions (see Table 11). Higher scores on both the affiliation and autonomy subscales were also related to patient rating of more severe distress in interpersonal functioning at termination.

Table 11: Relationships between therapist introject quality and therapeutic process and outcome

	Therapist Introject Quality	
	Affiliation	Autonomy
Rupture Intensity - *Patient*	-.15	.02
Rupture Intensity - *Therapist*	-.08	-.12
Resolved Ruptures - *Patient*	**.33**	**.38**
Resolved Ruptures -*Therapist*	**.37***	.28
Session Depth - *Patient*	.02	.22
Session Depth - *Therapist*	-.06	-.22
Session Smoothness - *Patient*	.12	.00
Session Smoothness -*Therapist*	.17	-.04
Working Alliance - *Patient*	.07	.21
Working Alliance - *Therapist*	.07	-.02
SCL-90	**.31**	**.30**
IIP-64	**.48***	**.43***
Target Complaints - *Patient*	.13	.24
Target Complaints - *Therapist*	-.13	.01
GAS	**-.37**	**-.30**

Patient-therapist match: introject quality

As with the attachment measure, a preliminary analysis was conducted that assessed the relationship between patient and therapist scores on both subscales of the INTREX (see Table 12). Specifically, in each dyad it was determined whether therapist or patient scored higher on either affiliation or autonomy. These frequency scores reveal that slightly more than half of all therapists scored higher on the affiliation subscale than their patients, while only 31% of therapists scored more highly than their patients on the autonomy subscale.

Table 12: Comparison of therapist introject quality subscale scores with patient introject quality subscale scores: Frequency of higher scores *(N=32 dyads)*

		Therapist higher (# of dyads)	Patient higher (# of dyads)	No difference (# of dyads)
INTREX	Affiliation	17	15	0
	Autonomy	10	22	0

When considering the match between patient and therapist introject quality, only the subscale of affiliation was found to be significantly related to patient and therapist process and overall outcome (see Table 13). Specifically, when there was a greater difference in affiliation scores between patient and therapist, patients were less likely to rate sessions as smooth. A greater difference in affiliation scores was also related to more distress in patient-rated interpersonal functioning at termination.

Table 13: Relationships between patient-therapist introject quality match and therapeutic process and outcome

	Patient-Therapist Match: Introject Quality	
	Absolute Affiliation Difference	**Absolute Autonomy Difference**
Rupture Intensity – *Patient*	.07	-.10
Rupture Intensity – *Therapist*	.02	.05
Resolved Ruptures – *Patient*	.18	-.12
Resolved Ruptures –*Therapist*	**.33**	-.19
Session Depth – *Patient*	.06	.09
Session Depth – *Therapist*	.10	-.04
Session Smoothness - *Patient*	-.36*	.07
Session Smoothness -*Therapist*	.14	.03
Working Alliance – *Patient*	.05	.15
Working Alliance – *Therapist*	.12	.13
SCL-90	.28	**-.33**
IIP-64	.54**	**-.30**
Target Complaints – *Patient*	.10	**-.41**
Target Complaints – *Therapist*	-.03	-.03
GAS	-.14	.17

Personality difference variables correlated with rupture process difference variables

Some of the analyses described above were conducted in order to assess how personality style and personality match (similarity or difference) in each dyad contribute to independent patient and therapist rating of therapeutic

alliance process as well as to overall outcome. As described in the Method section, several additional correlations using Pearson *r*'s were also conducted, in exploration of related but different questions: what is the relationship between the individual personality characteristics of patient and therapist and the likelihood that they will perceive ruptures and rupture resolutions between them similarly or differently? Additionally, does the similarity or difference between personality characteristics in each dyad affect the similarity or difference between the way each patient and therapist perceives and reports rupture processes in the alliance?

In the first set of analyses (see Tables 14 and 15), patient and therapist scores on each personality subscale (secure, preoccupied, fearful, and dismissing for the RSQ and affiliation and autonomy for the INTREX) were correlated independently with the difference between patient and therapist ratings of rupture intensity and rupture resolutions. For these latter difference scores, "non-signed" scores were used, as described in the Method section; these indicate the magnitude of the difference between patient and therapist scores on each rupture process variable, but do not reveal which member of the dyad has scored the rupture event more or less highly than the other. In the second set of analyses (see Table 16), these same difference scores were related not to individual scores of patients and therapists but to the differences between patient and therapist in each dyad on the six personality subscales. Non-signed scores were also used for both these sets of difference scores.

There were no significant relationships between attachment style, considered independently or dyadically, and differences in rupture process ratings.

In terms of introject quality, there was a significant relationship found between a greater difference in patient and therapist autonomy scores and a greater difference in dyadic rating of reported ruptures as resolved.

Table 14: Relationships between patient attachment style and patient introject quality and differences in patient-therapist rupture process ratings

	Patient Attachment Style				*Patient Introject Quality*	
	Secure	Preocc.	Fearful	Dismissing	Affiliation	Autonomy
Absolute Diff. in Rupture Intensity	-.27	.19	.21	.15	.09	.02
Absolute Diff. in Resolved Ruptures	.11	.20	.11	.04	**.35**	.01

Table 15: Relationships between therapist attachment style and therapist introject quality and differences in patient-therapist rupture process ratings

	Therapist Attachment Style				*Ther. Introject Quality*	
	Secure	Preocc.	Fearful	Dismissing	Affiliation	Autonomy
Absolute Diff. in Rupture Intensity	.10	**.30**	.17	.05	-.18	.04
Absolute Diff. in Resolved Ruptures	**-.32**	.08	.26	.10	**-.41**	-.09

Table 16: Relationships between differences in patient-therapist attachment style and patient-therapist introject quality and differences in patient-therapist rupture process ratings

	Patient-Therapist Match: Attachment Style				*Patient-Therapist Match: Introject Quality*	
	Absolute Secure Diff.	**Absolute Preocc. Diff.**	**Absolute Fearful Diff.**	**Absolute Dismissing Diff.**	**Absolute Affiliation Diff.**	**Absolute Autonomy Diff.**
Absolute Diff. in Rupture Intensity	.24	.02	.10	.07	-.11	.23
Absolute Diff. in Resolved Ruptures	.05	-.15	-.17	.00	**-.41**	**.57***

Chapter V. Discussion

The aim of this study was to explore the relationship between personality, early therapeutic alliance process and overall psychotherapy outcome in 32 patient-therapist dyads engaged in Brief Relational Therapy (BRT). Specifically, the study sought to examine the impact of attachment style and "introject quality" (as assessed by the Relationship Scale Questionnaire (RSQ, Griffin & Bartholomew, 1994) and the INTREX (Benjamin, 1988), respectively) on psychotherapy process and outcome. Most of the 32 patients had anxiety and depressive disorders co-morbid with personality disorders. The majority of the 29 therapists were Masters-level clinicians, and the remainder were Ph.D.s. Mean clinical experience was 1.7 years. Therapeutic alliance process was rated independently by both patients and therapists after each session, using questions about perceived tension in the relationship from the Brief Project's Post-Session Questionnaire (PSQ); the Working Alliance Inventory, (WAI-12; Tracey & Kokotovic, 1989); and the Session Evaluation Questionnaire (SEQ; Stiles, 1980; Stiles & Snow, 1984). For this study, indices were computed for each of these process variables. These indices represent a composite score of early process, which were then correlated independently with patient personality and outcome variables, and therapist personality and outcome variables. Outcome measures included the Symptom Checklist-90, Revised (SCL-90-R; Derogatis, 1983); the Inventory of Interpersonal Problems, as rated by patients (IIP-64; Alden,

Wiggins, & Pincus, 1990), the Target Complaints measure as completed independently by both patients and therapists (TC; Battle, Imber, Hoehn-Saric, Stone, Nash, & Frank, 1966), and the Global Assessment Scale (GAS; Endicott, Spitzer, Fleiss & Cohen, 1976). For all of the above measures, outcome was determined by calculating the residual gain scores between intake and termination assessments.

An additional focus of the study included the relationship between dyadic personality match and alliance process and overall outcome. A match index was created by calculating the differences between patient and therapist personality and process scores and correlating these differences with each other and with overall outcome. The aim of these latter correlations was to elucidate the interaction between patient and therapist personality styles and process ratings and assess its relationship to outcome, in addition to considering the impact of patient and therapist personality and process considered independently.

Summary of Results

Overall, this study had few significant findings and those that were significant were frequently counterintuitive. There was only one significant relationship found between patient introject quality and alliance process, and no significant relationships found between patient introject quality and outcome. In addition, there were no relationships found between secure attachment in

patients and alliance process, as rated by either patient or therapist. It would be expected that patients who entered treatment with higher levels of insecure attachment would have more negative alliance process and poorer overall outcome. Similarly, it would be expected that more securely attached patients would have more positive alliance process and better overall outcome. Surprisingly, none of these results were found. In fact, secure attachment was related to poorer outcome in terms of patient-rated resolution of presenting complaints, and both fearful and dismissing attachment was related to better outcome, also in terms of patient-rated resolution of presenting complaints.

The analyses of the relationships between therapist personality and the alliance process yielded some interesting results. Secure attachment in the therapist was related to greater rupture intensity, as rated by therapists, and fearful attachment was related to lower session smoothness, as rated by patients. In terms of introject quality, higher scores on the affiliation scale were related to a greater percentage of rupture resolutions, as rated by therapists, and higher therapist scores on both the affiliation and autonomy subscales were related to patient rating of more distress in interpersonal functioning. However, the relationships between therapist personality and outcome were as counterintuitive as between patient personality and outcome. Namely, secure attachment was related to a lower rating by therapists of patient's overall functioning, and to patient report of more distress in interpersonal functioning.

There were even fewer significant results from the analyses between patient-therapist personality match and alliance process and outcome. In fact, there were only two significant relationships between introject quality match and alliance process and outcome: a greater difference between patient and therapist scores on the affiliation scale was related to patient rating of sessions as less smooth, and a greater difference on the affiliation scale was related to more distress in interpersonal functioning at termination as rated by patients. There were no significant relationships between differences on the autonomy scale and either process or outcome. There were no significant relationships between differences in attachment and outcome. There were, however, several findings concerning the relationship between attachment and alliance process. That is, a greater difference in secure attachment was related to more intense ruptures, as rated by therapists; a greater difference in fearful attachment was related to a lower percentage of resolved ruptures, as rated by both patients and therapists; a greater difference in preoccupied attachment was related to less session depth, as rated by therapists, and a greater difference in dismissing attachment was related to less session smoothness, as rated by therapists.

Both theoretical and methodological conceptualizations will be explored below in an attempt to explain these findings, many of which are unexpected[1].

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[1] It is crucial to reiterate here a caveat from the Results section. Namely, chance produces significant correlations 5% of the time, and many of the correlation matrices in this study produced significant results at a rate only slightly higher than chance. Therefore, the arguments in the current chapter which attempt to explain the study's findings are of necessity speculative, given the very limited number of significant findings.

Attachment Style

Since psychotherapy is a context in which myriad relationship issues can develop and play out, it seems likely that an individual's attachment history will have a significant impact upon both treatment process and outcome (Clarkin & Levy, 2004; Dozier & Tyrrell, 1998). Based on Bowlby's (1969) seminal theory about the development of attachment between mothers and infants, the role of attachment behaviors in adulthood has been explored as well. Specifically, the relationship between a distressed patient seeking solace from a therapist has been considered analogous to an infant's bids for comfort and attachment from his mother. The quality of the adult caregiver's response to the infant - how attuned and consistent these responses are - is the crucial factor in what types of internal working models, and therefore, what types of attachment patterns the child develops (Slade, 1999; Stern, 1985). This also has important implications for the patient-therapist dyad, since the therapist is uniquely situated to become a new "source of security" for the patient, or someone on whom the patient can rely who does not have to rely on the patient in a reciprocal way (Farber, Lippert, & Nevas, 1995).

In a secure individual, who has had consistently responsive caregiving, these internal working models allow him to respond adaptively and creatively - in other words, with a range of flexible behavioral strategies - to different interpersonal environments. Bartholomew et al. (Bartholomew, 1997; Bartholomew & Horowitz, 1991; Griffin & Bartholomew, 1994) note that securely

attached individuals tend to see themselves as competent in relating to others, and in turn expect others to respond to them positively. This flexible and positive approach to relationships extends to the psychotherapeutic environment; secure-autonomous individuals have been found to be better able to participate in therapy, and are more emotionally committed to therapy (Egeland et al., 1995; Korfmacher et al., 1997). Security of attachment in patients has also been found to be related to positive scores on the Working Alliance Inventory (Satterfeld & Lyddon, 1998). Fonagy et al. (1991) speculate that a favorable response to treatment in such individuals is in part due to the capacity for reflecting on the mental states of self and others, which is related to the capacity to establish relatively unambivalent relationships (see also Main, 1991; 1995).

Given the evidence supporting the relationship between secure attachment and positive treatment process and outcome, it is all the more surprising that this study found that higher levels of secure attachment in both patients and therapists were related to negative alliance process, as rated by therapists, and poorer overall outcome, as rated by both patients and therapists. There are both theoretical and methodological possibilities for these findings; the latter will be discussed below in a separate section addressing the methodological limitations of this study.

It is possible that these findings, which consider the effects of personality on process and outcome independently for both patients and therapists, are counterintuitive because they do not account for how the therapist's own

attachment history interacts with the patient's attachment style, influencing patient behavior and the development of the therapeutic relationship. In a study assessing the relationship between client attachment style and the psychotherapist's interpersonal stance, Dolan, Arnkoff, & Glass (1993) found that ratings of the working alliance were related to perceptions of therapist-client differences, and suggest that therapist and client attachment styles are interdependent. Moreover, they note that if therapists alter their interpersonal stance based on their perception of client attachment style, treatment outcome can be positively enhanced.

In psychopathology, individuals develop insecure patterns of attachment as the sequelae of early caretaker unresponsiveness and emotional deprivation or inconsistency. In insecure attachment, an individual's internal working models are marked by rigidity and denial, and he engages in defensive and distorted behaviors which protect him from intolerable feelings of anxiety, shame, and rage. Within psychotherapy, insecure individuals were significantly more likely to drop out of treatment prematurely (Fonagy & Tallandini, 1993). These patients had a tendency to be "confused, lacking in objectivity, preoccupied with past relationships ...and [their interactions were characterized by] "a vague, inchoate negativity" (Fonagy et al., 1995, p. 266). More specifically, there is evidence that preoccupied attachment is related to more frequent reports of alliance ruptures, and fearful attachment is associated with lower alliance ratings (Eames & Roth, 2000). Dismissing patients have been found to be resistant to treatment and to be

reluctant in asking for help, and when faced with emotional issues in therapy were found to become disorganized (Dozier, 1990; Dozier, Lomax, & Tyrrell, 1996). These relationships between attachment style and treatment process and outcome illuminate several findings from the current study, in both straightforward as well as more nuanced ways. This study found that fearful attachment in patients was related to negative alliance process (patients rated sessions as less smooth), as Eames & Roth (2000) also found. However, this study found that preoccupied attachment was related to patient rating of ruptures as less intense, which directly contradicts Eames & Roth's (2000) finding. Yet, the latter study also found that preoccupied attachment was initially related to lower alliance ratings, but that these ratings improved over time. Clarkin & Levy (2004) interpret this as evidence of the strong drive for intimacy of preoccupied individuals, which might facilitate the eventual development of a strong alliance. The current study's contradictory findings in this and other instances will be discussed later in the methodological review.

One of the surprising findings of this study was that both fearful and dismissing attachment in patients is related to better outcome. Although the literature offers evidence for the relationship between fearful attachment and poorer, rather than stronger, alliance process ratings (Dozier, 1990; Eames & Roth, 2000), there are interesting findings regarding dismissing attachment. In a study of patients diagnosed with borderline personality disorder, those classified by the Adult Attachment Interview as dismissive had the best response to

interventions compared to other attachment groups (Fonagy et al., 1996). In contrast to Dozier et al.'s findings regarding the relationship between dismissing attachment and negative alliance process and poor outcome, Eames and Roth (2000) found some evidence that dismissing attachment was associated with improvement in alliance ratings over time, and with fewer reports of ruptures.

A therapist's ability to respond consistently to patients, coupled with the requisite level of attunement to the particular issues each patient presents, is a central component of psychotherapy. Clinicians' own attachment issues are an important aspect of their capacity to respond to patients, and directly affect therapeutic process and outcome. Although the effects of these issues have only begun to be explored, initial findings support the assumption that securely attached therapists appear best able to respond to patients in a way that challenges rigid and insecure attachment patterns (Dozier et al., 1994; Tyrrell, Dozier, et al., 1999). In the current study, fearful attachment in therapists was related to patient rating of negative alliance process (lower rating of session smoothness). One can imagine how a therapist whose attachment style is dominated by a fear of rejection by others might have difficulty negotiating a patient's anger, or striving toward independence, which the patient might experience as "rough" alliance process. Interestingly, this study also found that secure attachment in therapists was related to a higher therapist rating of rupture intensity. Although this may initially seem counterintuitive, one could speculate that a higher rating of rupture intensity by a therapist might signal an engaged

clinician who is particularly attuned to the vicissitudes of the alliance process, and who does not deny the occurrence of negative process with patients. The lack of any positive association between secure attachment and any of the measures of positive therapeutic change, however, remains puzzling. Whether this was an anomaly remains to be seen pending efforts at replication of these findings. Indeed, Bruck et al.'s (2004) matching study, conducted at the Brief Psychotherapy Research Project at Beth Israel Medical Center, and which design is identical to the current study with the exception of the treatment protocol, did not yield such unexpected results. This study found that friendlier and more secure therapist personality styles were predictive of better therapeutic outcome.

The current study also found several relationships between differences in patient and therapist levels of insecure attachment and negative alliance process. That is, greater differences in fearful attachment were related to both patients and therapists being less likely to experience the resolution of reported ruptures; greater differences in preoccupied attachment were related to therapist perception of early sessions as less deep; and greater differences in dismissing attachment were related to therapist perception of sessions as less smooth. Although additional research has not addressed the match between attachment styles in terms of greater or lesser differences, the current study has begun an exploration of this dimension. These findings seem to emphasize that when one member of the dyad is significantly more insecurely attached than the other, there is a preponderance of negative alliance process.

There is a growing body of research that seeks to understand the impact of the similarities and differences between patient and therapist attachment styles (Dozier et al., 1990; 1994; Stuart et al. 1992; Tyrrell, Dozier et al. 1999). This study found that when patients and therapists are significantly different in levels of secure attachment styles, therapists rate ruptures as having a higher intensity. This finding is interesting in light of alliance process research (Safran, Muran et al., 2000b; Safran, Muran et al., 1994; Safran, Muran et al., 2001) which emphasizes that the occurrence of ruptures - even intense ruptures or impasses - does not necessarily signal a weak alliance. Rather, the capacity to negotiate or resolve difficulties in the alliance seems to be more indicative of a strong therapeutic relationship. More straightforwardly, this finding also suggests that when one member of the dyad is significantly more secure, and therefore, by implication, the other member is significantly more insecure, ruptures are perceived as more intense due to the difficulties negotiating closeness or distance with others that is a hallmark of insecure attachment. Additionally, this study analyzed another aspect of the impact of patient-therapist attachment style differences on therapeutic process. Specifically, the study considered whether differences in attachment style are related to differences in the way patients and therapists perceive ruptures and rupture resolutions. Although there were no significant findings with regard to this data, this remains a pertinent area for future research.

Given this study's small sample size, as well as the fact that a correlational methodology was used to assess the role of personality, it was not possible to determine the "direction" of these differences in security of attachment (see critical review of methodology below). That is, the matching methodology utilized "absolute" differences between patient and therapist, rather than "signed" differences. Signed differences would have revealed not just the magnitude of the difference in each dyad, but whether these differences were related to therapist security matched with patient insecurity, or any permutation thereof. Such information would further our understanding of the specifics of more or less successful patient-therapist matches. To this end, a post hoc analysis was conducted, and data from all of the dyads' attachment styles was reviewed. All of the dyads were categorized in terms of whether the patient was more insecure than the therapist, or vice versa, and the relationship between these specific matches and rupture process variables was observed[2]. Of the 32 dyads, 11 had patients and therapists whose scores on secure attachment were separated by more than two points on a response scale of 1 to 7. In these 11 dyads, "secure" was defined as any raw score above 4, and insecure as any score below 4. Given these criteria, there were three dyads in which the patient scored higher on secure attachment than their therapists, and eight dyads in which therapists scored higher on secure attachment than their patients.

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[2] Rupture process variables were chosen since this study's more formal analysis (whether differences in attachment style are related to differences in the way patients and therapists perceive ruptures and rupture resolutions) yielded no significant findings.

This analysis revealed some interesting trends with regard to insecure patients matched with secure therapists. In three of the eight dyads, neither patients nor therapists reported many ruptures; when they did, they tended to report similar levels of both rupture intensity and rupture resolution. However, in the other five of these eight dyads, patients reported no ruptures, and therefore neither rupture intensity nor resolution of ruptures. Their therapists generally tended to report ruptures of medium intensity, with a moderate level of rupture resolution. A further analysis of these five patients revealed that all but one had high levels of dismissing attachment style. One could theorize that someone who dismisses the importance of relationships would tend either to deny or ignore the nuances of interpersonal process. In this way, a dismissively attached patient might disregard some aspect of the treatment framework – being chronically late for sessions, for example, or "forgetting" to pay on many occasions – and would be unaware of the interpersonal impact of these actions on his or her relationship with the therapist. In such instances, a more securely attached therapist might be better able to understand these events as ruptures, and therefore as an inevitable part of the therapeutic process, whereas the dismissively attached patient might not be able to acknowledge them as such.

These observational findings may offer further clarification of the more formal analyses conducted in this study. Whereas the correlational analyses discussed earlier found that greater differences in dismissing attachment were related to therapist perception of more negative alliance process, they did not

identify which participant had a more dismissive attachment style. While these findings raised a number of possibilities about aspects of therapeutic process in the dyad, the post hoc observations provide a fuller picture of what contributes to disparities in patient and therapist perception of rupture process. Knowing that patients who have a more dismissive attachment style than their therapists tend to report fewer ruptures and therefore fewer rupture resolutions lends clarity to what is actually happening in the dyad. That is, in this light, the therapist's reporting of more ruptures than his or her patient seems diagnostic of the patient, and perhaps indicative of the heightened attunement of the more securely attached therapist, rather than evidence of the therapist's problematic interpersonal style.

Further post hoc analyses included observations of three dyads in which the therapist scored lower on secure attachment than his or her patient. Surprisingly, in all three dyads, there was minimal reporting of both ruptures and rupture resolutions. At this point, it remains unclear how to account for these findings.

"Introject Quality"

Despite numerous and widely varying approaches to the theory and practice of therapy, there is widespread agreement that the quality of the therapeutic relationship is one of the most important dimensions of psychotherapy process (Henry et al., 1986; Gurman, 1977). Although there has

been some empirical clarification of what specific qualities in the therapeutic relationship are related to positive outcome (i.e. "warmth," "non-judgmentalness," etc.), it has been remarkably difficult to pinpoint the exact *role* of that relationship in achieving positive therapeutic outcome. By examining moment-by-moment transactions between patient and therapist with the SASB (Benjamin, 1974), Henry et al. (1986) demonstrated that the therapeutic relationship is a specific technique in itself, and that dyadic interpersonal process is a crucial component of therapeutic change (see also Henry et al., 1990; O'Malley, Suh, & Strupp, 1983).

The way in which interpersonal transactions effect outcome change has been the topic of much theoretical as well as empirical speculation, and remains a salient question. As discussed in the literature review, the interpersonal theory of introjection offers some hypotheses about this process. To recapitulate, introjection has been defined by a range of psychodynamic, developmental, and interpersonal theories as the process by which an individual learns to treat himself as he has been treated by significant others (Henry et al., 1990; Sullivan, 1953). In this way, personality develops through patterns that "reflect learned modes of dealing with situations and are therefore always in some sense responsive to and shaped by the situations themselves" (Mitchell, 1988, p. 25). For each individual, the capacity for fulfilling interpersonal interactions is based in large part on the quality of this "introject" (see Benjamin 1974, 1988). Individuals with more autonomous and affiliative introject styles tend to

respond to various interpersonal interactions with spontaneity, flexibility and enjoyment, evidencing interactive patterns that are self-accepting and self-freeing most of the time. However, this study found, surprisingly, that when patients scored more highly on the autonomy scale they reported fewer ruptures as resolved in early treatment sessions. This finding contradicts the expectation that a "self-freeing," spontaneous introject style would facilitate the collaborative process of rupture resolution.

In the context of a psychotherapeutic relationship, a flexible, spontaneous and nurturing style in therapists - higher scores on affiliation and autonomy as measured by the INTREX -- has been found to be related to better treatment outcome (Bruck, Aderholt, Muran, Gorman, & Winston, 2004). Again, findings from this study were unexpected: higher therapist affiliation and autonomy scores on the INTREX were related to patient rating of more severe distress in interpersonal functioning at termination rather than positive outcome. One possible explanation for this counterintuitive finding concerns the impact of loss inherent in brief treatment. That is, it might be possible that a patient is particularly attached to a therapist who is more spontaneous and nurturing, but the rapid termination, even in a treatment that focuses on ending from the outset, might nonetheless leave a patient with unresolved feelings of loss and abandonment, thus perceiving more interpersonal distress at termination. Again, it seems of paramount importance to understand the personality style of the patient who is matched with a therapist who has highly affiliative and

autonomous styles. As Leary (1957) writes, "the utility of a warm, empathic approach quite possibly is limited to those clients who present themselves initially to the therapist as friendly and submissive, since they would constitute the only clients who would find the approach nonaversive" (p. 235).

Another finding of this study concerned the match between patient and therapist introject styles. Greater differences in affiliation scores between patient and therapist were related to patient rating of sessions as less smooth, as well as patient rating of more distress in interpersonal functioning at termination. It is possible that these differences highlight the impact of the "mismatch" that occurs when hostile behaviors are expressed in the same dyad as more friendly or affiliative behaviors. In fact, Henry et al. (1986) found that negative complementarity (a hostile and controlling patient-therapist exchange (see Kiesler, 1996)) was disruptive of desirable therapy process and outcome. Henry et al. (1986) also found that positive complementarity (a friendly or autonomy-enhancing exchange) is related to positive therapy process and successful treatment outcome. Similarly, Muran (1993) found that friendliness or affiliation between patient and therapist was related to positive alliance process but hostility was negatively related to both process and outcome.

As suggested above, the particularities of the match between patient and therapist introject styles - how complementary or anti-complementary their personality styles are - are a crucial aspect of understanding what facilitates positive alliance process and successful treatment outcome. The current study's

limited sample size prevented the consideration of patient-therapist "introject quality" match in terms of complementarity. In future studies, such an analysis might yield further clarification about, for example, why patients scoring higher on the autonomy scale experienced fewer rupture resolutions.

In addition, this study analyzed another aspect of the impact of patient-therapist "introject quality" differences on therapeutic process. Specifically, the study considered whether differences in introject quality affect the way in which patients and therapists perceive ruptures and resolutions. These analyses yielded one significant finding: a greater difference between patients and therapists on the autonomy scale was related to a greater difference in dyadic rating of reported ruptures as resolved. That is, when one member of the dyad was significantly more spontaneous and "self-freeing" than the other, there was a substantial disparity between how each member perceived strains in the relationship. Perhaps this finding is indicative of the way in which spontaneity – and its converse, a constricted, rigid, controlling stance toward self and other – affects the ability to engage in the kind of collaborative dialogue necessary to repair breaches in the alliance.

Critical analysis of methodology

In general, many of the findings of this study are at odds with the theoretical positions discussed earlier. One would expect, for example, that secure attachment in both patients and therapists would be related to positive

process and outcome. In addition to the efforts offered thus far to account for these surprising findings, they can also be explained, in part, in light of the methodology used in this study. In this section I will discuss aspects of the methodology that seem to have contributed to the unexpected nature of the findings.

The methodological limitations of this study's parameters should be noted. First, the small sample size (32 patient-therapist dyads), means that any interpretation of the data is provisional, and therefore the results are not necessarily generalizable. Also, because certain patient populations are excluded, the study's results also may not be generalizable to the larger mental health population. The fact that the only treatment used in this study is Brief Relational Therapy limits the generalizability of the results to other treatments. Demographically, the study's generalizability is also limited in terms of gender, race, and education level, since the majority of patients and therapists are white and female, with a high level of education. It must also be emphasized that the majority of therapists in the study were Masters-level graduate students with varying amounts of clinical experience. These therapists may have had less clinical sophistication than more experienced therapists, which could have affected their ability to detect and respond to the complexities and nuances of the interpersonal treatment process.

Further, given that another recent study (Bruck et al., 2004), using the identical methodology to this study with a different data sample from the Brief

Psychotherapy Research Program at Beth Israel, had more expected results,[3] it seems possible that other aspects of this particular patient-therapist sample are relevant. For example, unlike Bruck et al.'s therapist sample, the therapists in *this* sample have a constricted range of scores on secure attachment, and on average, scored in the self-critical introject quadrant on the INTREX (Bruck et al.'s therapist sample scored on average in the friendly controlling quadrant). Moreover, overall outcome for the sample used in this study had very limited significance, and contrary to typical findings discussed in the Literature Review, alliance strength was inversely related to outcome (here, predictive of poorer outcome) (see Table 4c, p. 86).

Another important limitation of this study's methodology concerns the assessment of match within each patient and therapist dyad. In this study, match was assessed through the calculation of a difference index for each dyad which determined the magnitude of the difference between each partner's score on each personality subcategory (see Chapter III, Method). This methodological choice enabled this researcher to explore in a preliminary way how differences in personality style between each patient and therapist dyad were related to differences in alliance process quality and therapeutic outcome. However, this methodological approach did not provide information about the direction of the difference in personality scores within each patient therapist dyad (i.e., who

[3] See pp. 50-51 for a fuller delineation of Bruck et al.'s results.

scored higher than whom on specific personality subcategories). In addition, it did not provide information that allowed comparisons between different personality subcategories within each patient and therapist dyad. This limited the ability of this research to illuminate the significance, if any, of matches between different personality styles (i.e., whether higher therapist scores on affiliation were related to more positive treatment outcome when matched with more autonomous introject styles in patients). Furthermore, it seems it would be important to understand not just the absolute difference between therapist and patient scores, but how patient and therapist "match." In other words, it could not be ascertained, for example, whether we are looking at a securely attached patient and a less securely attached therapist, or vice versa, or alternatively, at a match between a dismissing participant and a preoccupied participant, etc. Given the small sample size (see below), it was not possible to tease out this aspect of the match between patient and therapist.

Self-report measures of process and outcome

There are also important methodological questions concerning the present study's exclusive use of self-report measures to assess process and determine outcome. The choice of measures was based on the availability of measures utilized in a larger ongoing project. Future studies would benefit from a more diverse battery of assessments in order to capture more varied elements of therapeutic process and outcome. Specifically, the addition of observer-rated

measures seems crucial. In the attachment literature, for example, there is a growing body of evidence that considers the differences between self-report questionnaires and observer-rated measures of interviews to be quite significant (Bartholomew & Shaver, 1998; Dozier & Tyrrell, 1998).

Relatedly, several attachment researchers have elaborated on the distinction between internal working models of attachment (IWMs) and attachment *style* (the latter is considered in this study) (Bartholomew & Shaver, 1998; Dozier & Tyrrell, 1998; Hazan & Shaver, 1987). According to Main, Kaplan, & Cassidy (1985), the working model of attachment is a "set of conscious and/or unconscious rules for the organization of information relevant to attachment and for obtaining or limiting access to that information (p. 66). Dozier and Tyrrell note that the defensive *exclusion* of information from awareness is an integral part of the "unconscious rules" which help to define internal working models. In addition,

> ...because of the role that unconscious rules and defensive exclusion are thought to play, this conceptualization of adult attachment does not lend itself to assessment through self-report. Rather...working models are assessed through discourse analysis of subjects' discussion of their early attachment relationships...and thoughts and feelings regarding attachment figures....This analysis considers the role of unconscious processes in the recall and manipulation of attachment-related information (Dozier & Tyrrell, 1998, pp. 224-225).

Conversely, attachment style, which was proposed by Hazan & Shaver (1987) in their conceptualization of adult romantic love as an attachment process, is assumed to be accessible to conscious awareness, and thus able to be assessed

through self-report. Additionally, attachment style is also assessed in relation to current significant others, rather than earlier attachment figures. Importantly, the empirical literature does not support a strong relationship between these two variables (Waters, Merrick, Albersheim, & Treboux, 1995), so internal working models and attachment style do indeed seem to be measuring different aspects of attachment processes (Dozier & Tyrrell, 1998). Moreover, an important dimension of what observer-rated measures, most notably the Adult Attachment Interview (AAI), are assessing is "narrative coherency," or the patient's ability to articulate the emotional aspects of past relationships with caregivers (Main et al., 1985). Given this, Samstag (1998) raises an interesting question about what it is that self-report questionnaires are actually assessing, since these measures do not include a third-party assessment of a speaker's narrative.

Further, Bartholomew and Shaver describe the differences between these types of assessments as related to the difference between conscious and unconscious self-experience:

> Self-report measures focus on consciously, potentially inaccurate summaries by a person of his or her own experiences and behaviors. The [Adult Attachment Interview] focuses primarily on the way a person talks about childhood attachment experiences, with major distinction 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).

In other words, one's consciously held self-image is inevitably influenced by one's defensive style and this limitation would, by extension, apply to all self-report measures assessing personality and outcome. For example, the INTREX measures the qualities of an individual's "internalized objects," or relational history, through self-report, but in many studies it is often used in conjunction with the observer-rated portion of the SASB system. The observer-rated portion of the SASB assesses moment-by-moment interactions between therapist and patient and provides a behavioral component which can be compared with the findings of the self-report questionnaires. In so doing, it offers a perspective that is not distorted by an individual's unconscious processes and therefore offers more empirically based data about the relationship between patient and therapist. Had attachment ratings based on the AAI, or interpersonal style ratings based on the SASB's observer-rated moment-by-moment interaction been available for this study, the findings might have been quite different.

Just as self-report measures of personality are limited in what they assess, so it follows that patient-rated outcome measures such as the SCL-90R, IIP-64 and patient-rated Target Complaint scores which were used in this study are also limited for these same reasons. We can hypothesize that the limitations of self-report measures as discussed above were a contributing factor in some of the counterintuitive findings of this study, namely that secure attachment in patients was significantly related to poorer outcome and insecure attachment was significantly related to better outcome. For example, consider a patient who is

unconsciously conflicted about seeking treatment. He could consciously dismiss the centrality of his need for closeness, yet also unconsciously yearn for it. This patient would score high on dismissing attachment yet might also respond well to treatment, given that the treatment provides for his disavowed wish for a close relationship. In an instance like this, a third party observation of the minute interactions between patient and therapist might provide much needed information about what is behaviorally manifest but consciously hidden from view. Put differently, there are limitations to categorical classifications, which may not capture conflicted tendencies that respond differentially to different contingencies and interactive experiences. Especially with a small N, the effects of these unrecognized conflictual tendencies may yield seemingly anomalous or even absurd findings in self-report data based exclusively on conscious experience and its simplifying linearity.

Conclusion and Future Directions

Therapist qualities are among the most frequently studied contributors to therapeutic change (Bruck et al., 2004); indeed, the magnitude of the benefit is statistically more closely associated with the identity of the therapist than with the type of psychotherapy that the therapist practices (Crits-Christoph et al., 1991). However difficult it is to select valuable therapist personality dimensions from among the thousands possible (Beutler et al., 2004), the central and inevitable involvement of the therapist in the therapeutic process makes it

essential to continue to identify and elaborate those aspects of personality that render his or her participation unique. As important as specific therapist qualities are, this study attempted to address the issue of which qualities either enhance or impede therapeutic change for which patients. Although the assessment of patient-therapist match was a key aim of this study, methodological limitations rendered this much more difficult than anticipated, and required initial assessment of individual characteristics for both patients and therapists. Given these limitations, the assessment of match in future studies might take a different approach. For example, it might be possible to choose one or two completed 30-session treatments based on the specific personality configuration of the patient-therapist dyad, and explore in depth how such a match affected the course of the treatment over time. Such an analysis might pay particular attention to third-person observation of process, especially rupture events. Or, if larger data samples become available, it might be possible to conduct a regression analysis which takes into account a more three-dimensional relationship between different elements of personality and how they interact with therapeutic process and outcome, offering a more complex understanding of what transpires in the dyad.

Despite these difficulties, this study's focus on the interweaving of therapist personality factors with patient factors reflects the conviction implicit in contemporary relational thinking that the tenor of that interaction constitutes the richest dimension of the therapeutic encounter. Future studies should continue

efforts to understand the way in which treatment process and outcome are shaped by the interaction between patients' and therapists' personality styles. More generally, another domain which would advance this research concerns the underlying affinities between attachment styles and interpersonal styles (see Griffin & Bartholomew, 1994b). This might illuminate facets of personality and behavior that would offer a more finely tuned recommendation for who, ultimately, works best with whom. For it is the particularity of an individual's history and pattern of relating that creates continuities and discontinuities in the way self finds meaning and encounters the other. It seems to this author that the therapeutic situation, at its best, offers the kind of intersection of forces which encourages and clarifies this search for meaning and attunement: we are allowed to explore the truths of our immediate lived experience, as we are sustained by another who relates to us with empathy and acceptance.

Appendix A: Patient Consent Form

Beth Israel Medical Center

Consent for Participation in Scientific Investigations

Title of project: Brief Psychotherapy Research Program

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

Purpose and nature of program:

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

Treatment conditions:

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

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

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

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

Program risks:

We know of no inherent risks associated with these treatments. Each type 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 videotaped recordings, will be held in the strictest confidence and would be voluntarily disclosed only with your explicit permission. We will share such information only with other members of our research and treatment team at Beth Israel. The only exception is the post-session questionnaire, which will not be available to your therapist and which will be identified solely by your id

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

Possible benefits:

All treatment groups offer 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.

Appendix B: Relationship Scales Questionnaire (RSQ)

RELATIONSHIP QUESTIONNAIRE

Following are questions about relationships. Please rate each of the questions according to the extent to which you think each question corresponds to your beliefs on a 1 to 7 scale where **1 = Not at all like me; 4 = Somewhat like me;** and **7 = Very much like me.**

1.	It is relatively easy for me to become emotionally close to others.	1	2	3	4	5	6	7
2.	I am comfortable depending on others and having others depend on me.	1	2	3	4	5	6	7
3.	I don't worry about being alone or having others not accept me.	1	2	3	4	5	6	7
4.	I am somewhat uncomfortable getting close to others.	1	2	3	4	5	6	7
5.	I want emotionally close relationships.	1	2	3	4	5	6	7
6.	I find it difficult to trust others completely, or to depend on them.	1	2	3	4	5	6	7
7.	I sometimes worry that I will be hurt if I allow myself to become too close to others.	1	2	3	4	5	6	7
8.	I want to be completely emotionally intimate with others.	1	2	3	4	5	6	7
9.	I often find others are reluctant to get as close as I would like.	1	2	3	4	5	6	7
10.	I am uncomfortable being without close relationships.	1	2	3	4	5	6	7
11.	I sometimes worry that others don't value me as much as I value them.	1	2	3	4	5	6	7
12.	I am comfortable without close emotional relationships.	1	2	3	4	5	6	7
13.	It is very important to me to feel independent and self-sufficient.	1	2	3	4	5	6	7
14.	I prefer not to depend on others or have others depend on me.	1	2	3	4	5	6	7
15.	I find it difficult to allow myself to depend on others.	1	2	3	4	5	6	7
16.	People are never there when you need them.	1	2	3	4	5	6	7
17.	I am comfortable depending on others.	1	2	3	4	5	6	7
18.	I know that others will be there when I need them.	1	2	3	4	5	6	7
19.	I find it difficult to trust others completely.	1	2	3	4	5	6	7
20.	I am not sure that I can always depend on others to be there when I need them.	1	2	3	4	5	6	7

1 = Not at all like me; 4 = Somewhat like me; and **7 = Very much like me.**

21.	I do not often worry about being abandoned.	1	2	3	4	5	6	7
22.	I often worry that my partner does not really love me.	1	2	3	4	5	6	7
23.	I find others are reluctant to get as close as I would like.	1	2	3	4	5	6	7
24.	I often worry my partner will not want to stay with me.	1	2	3	4	5	6	7
25.	I want to merge completely with another person.	1	2	3	4	5	6	7
26.	My desire to merge sometimes scares people away.	1	2	3	4	5	6	7
27.	I find it relatively easy to get close to others.	1	2	3	4	5	6	7
28.	I do not worry about someone getting too close to me.	1	2	3	4	5	6	7
29.	I am somewhat uncomfortable being close to others.	1	2	3	4	5	6	7
30.	I am nervous when anyone gets too close.	1	2	3	4	5	6	7
31.	I am comfortable having others depend on me.	1	2	3	4	5	6	7
32.	Often, love partners want me to be more intimate than I feel comfortable being.	1	2	3	4	5	6	7

Appendix C: INTREX

INTREX, Short Form

Rate yourself twice: at your best, and at your worst. First, try to remember a specific time a few months ago when you were at your best, and while thinking of that time, rate the best version. Then think of a specific time a few months ago when you were at your worst, and rate the worst version. Please do not go back in time further than one year. A rating of less than 50 indicates "false"; a rating of 50 or more indicates "true."

YOURSELF AT YOUR BEST (Circle the appropriate number after each answer)

1.	Without concern or thought, I let myself do and be whatever I feel like.	0--10--20--30--40--50--60--70--80--90--100
2.	Without considering what might happen, I hatefully reject and destroy myself.	0--10--20--30--40--50--60--70--80--90--100
3.	I tenderly, lovingly cherish myself.	0--10--20--30--40--50--60--70--80--90--100
4.	I put energy into providing for, looking after, and developing myself.	0--10--20--30--40--50--60--70--80--90--100
5.	I punish myself by blaming myself and putting myself down.	0--10--20--30--40--50--60--70--80--90--100
6.	Aware of my personal shortcomings as well as my good points, I comfortably let myself be "as is."	0--10--20--30--40--50--60--70--80--90--100
7.	I am recklessly neglectful of myself, sometimes completely "spacing out."	0--10--20--30--40--50--60--70--80--90--100
8.	To make sure I do things right, I tightly control and watch over myself.	0--10--20--30--40--50--60--70--80--90--100

Now change to rating: **YOURSELF AT YOUR WORST**

1.	Without concern or thought, I let myself do and be whatever I feel like.	0--10--20--30--40--50--60--70--80--90--100
2.	Without considering what might happen, I hatefully reject and destroy myself.	0--10--20--30--40--50--60--70--80--90--100
3.	I tenderly, lovingly cherish myself.	0--10--20--30--40--50--60--70--80--90--100

4.	I put energy into providing for, looking after, and developing myself.	0--10--20--30--40--50--60--70--80--90--100
5.	I punish myself by blaming myself and putting myself down.	0--10--20--30--40--50--60--70--80--90--100
6.	Aware of my personal shortcomings as well as my good points, I comfortably let myself be "as is."	0--10--20--30--40--50--60--70--80--90--100
7.	I am recklessly neglectful of myself, sometimes completely "spacing out."	0--10--20--30--40--50--60--70--80--90--100
8.	To make sure I do things right, I tightly control and watch over myself.	0--10--20--30--40--50--60--70--80--90--100

You have just described yourself in what you consider to be your best and worst states. Think back on these states and answer the following:

1. What percent of the time in the past month have you found yourself at your:

   Best _____ Worst _____

2. Where are your right now on the best-worst scale?

   Worst 1 2 3 4 5 6 7 8 9 10 Best

3. To what extent are you able to move yourself from worst to best?

   Not at all able 1 2 3 4 5 6 7 8 9 10 Very Able

Appendix D: Post Session Questionnaire (PSQ)

Therapist and Patient Versions

PSQ: THERAPIST VERSION

PART A

1. Please rate the highest degree of tension you felt during the session as a result of this problem:

   1 2 3 4 5
   Low Medium High

2. To what extent was this problem addressed in this session?

   1 2 3 4 5
   Low Medium High

PART B
Working Alliance Inventory – 12

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

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

   1 2 3 4 5 6 7
   Never Sometimes Always

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

   1 2 3 4 5 6 7
   Never Sometimes Always

3. My patient believed that I like him/her.

   1 2 3 4 5 6 7
   Never Sometimes Always

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

   1 2 3 4 5 6 7
   Never Sometimes Always

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

1	2	3	4	5	6	7
Never			Sometimes			Always

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

1	2	3	4	5	6	7
Never			Sometimes			Always

7. My patient felt appreciated by me.

1	2	3	4	5	6	7
Never			Sometimes			Always

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

1	2	3	4	5	6	7
Never			Sometimes			Always

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

1	2	3	4	5	6	7
Never			Sometimes			Always

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

1	2	3	4	5	6	7
Never			Sometimes			Always

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

1	2	3	4	5	6	7
Never			Sometimes			Always

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

1	2	3	4	5	6	7
Never			Sometimes			Always

PART C
Session Evaluation Questionnaire

Please circle the appropriate number to show how you feel about this session.

This session was:

Bad	1	2	3	4	5	6	7	Good
Safe	1	2	3	4	5	6	7	Dangerous
Difficult	1	2	3	4	5	6	7	Easy
Valuable	1	2	3	4	5	6	7	Worthless
Shallow	1	2	3	4	5	6	7	Deep
Relaxed	1	2	3	4	5	6	7	Tense
Unpleasant	1	2	3	4	5	6	7	Pleasant
Full	1	2	3	4	5	6	7	Empty
Weak	1	2	3	4	5	6	7	Powerful
Special	1	2	3	4	5	6	7	Ordinary
Rough	1	2	3	4	5	6	7	Smooth
Comfortable	1	2	3	4	5	6	7	Uncomfortable

PSQ: PATIENT VERSION

PART A

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

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

PART B
Working Alliance Inventory – 12

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

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

   1 2 3 4 5 6 7
   Never Sometimes Always

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

   1 2 3 4 5 6 7
   Never Sometimes Always

3. I believed that my therapist likes me.

   1 2 3 4 5 6 7
   Never Sometimes Always

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

   1 2 3 4 5 6 7
   Never Sometimes Always

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

1	2	3	4	5	6	7
Never			Sometimes			Always

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

1	2	3	4	5	6	7
Never			Sometimes			Always

7. I felt that my therapist appreciates me.

1	2	3	4	5	6	7
Never			Sometimes			Always

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

1	2	3	4	5	6	7
Never			Sometimes			Always

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

1	2	3	4	5	6	7
Never			Sometimes			Always

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

1	2	3	4	5	6	7
Never			Sometimes			Always

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

1	2	3	4	5	6	7
Never			Sometimes			Always

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

1	2	3	4	5	6	7
Never			Sometimes			Always

PART C
Session Evaluation Questionnaire

Please circle the appropriate number to show how you feel about this session.

This session was:

Bad	1	2	3	4	5	6	7	Good
Safe	1	2	3	4	5	6	7	Dangerous
Difficult	1	2	3	4	5	6	7	Easy
Valuable	1	2	3	4	5	6	7	Worthless
Shallow	1	2	3	4	5	6	7	Deep
Relaxed	1	2	3	4	5	6	7	Tense
Unpleasant	1	2	3	4	5	6	7	Pleasant
Full	1	2	3	4	5	6	7	Empty
Weak	1	2	3	4	5	6	7	Powerful
Special	1	2	3	4	5	6	7	Ordinary
Rough	1	2	3	4	5	6	7	Smooth
Comfortable	1	2	3	4	5	6	7	Uncomfortable

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

Inventory of Interpersonal Problems

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

EXAMPLE

How much have you been distressed by this problem?

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

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

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

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

38. be assertive without worrying about hurting the other person's feelings.	0	1	2	3	4
39. be self-confident when I am with other people.	0	1	2	3	4

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

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

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

Appendix G: Symptom Checklist-90 Revised (SCL-90R)

SCL-90-R

INSTRUCTIONS:

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

EXAMPLE

HOW MUCH WERE YOU DISTRESSED BY:

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

HOW MUCH WERE YOU DISTRESSED BY:

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

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

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

HOW MUCH WERE YOU DISTRESSED BY:

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

HOW MUCH WERE YOU DISTRESSED BY:

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

Appendix H: Target Complaints (TC)

TARGET COMPLAINTS

Name: _____ Date: _____

These are the main problems or difficulties that you described at the beginning of therapy. Please rate how much each problem still bothers you.

(1) _____

_____

_____

In general, how much does this problem bother you?

1	2	3	4	5	6	7	8	9	10	11	12	13
not at all			a little			pretty much			very much			couldn't be worse

(2) _____

_____

_____

In general, how much does this problem bother you?

1	2	3	4	5	6	7	8	9	10	11	12	13
not at all			a little			pretty much			very much			couldn't be worse

(3) _____

_____

_____

In general, how much does this problem bother you?

1	2	3	4	5	6	7	8	9	10	11	12	13
not at all			a little			pretty much			very much			couldn't be worse

TARGET COMPLAINTS FORM - THERAPIST

Pt. Name: _____ Date: _____

These are the main problems or difficulties that your patient previously reported. Please rate in general how much each problem seems to bother your patient currently by circling the appropriate number?

(1) _____

_____

_____

In general, how much does this problem bother your patient?

1	2	3	4	5	6	7	8	9	10	11	12	13
not at all			a little			pretty much			very much			couldn't be worse

(2) _____

_____

_____

In general, how much does this problem bother your patient?

1	2	3	4	5	6	7	8	9	10	11	12	13
not at all			a little			pretty much			very much			couldn't be worse

(3) _____

_____

_____

In general, how much does this problem bother your patient?

1	2	3	4	5	6	7	8	9	10	11	12	13
not at all			a little			pretty much			very much			couldn't be worse

Appendix I: Global Assessment Scale (GAS)

Global Assessment Scale (GAS)

Robert L. Spitzer M.D., Miriam Gibbon M.S.W., Jean Endicott Ph.D

Rate the subject's lowest level of functioning in the last week by selecting the lowest range which describes his functioning on a hypothetical continuum of mental health-illness. For example, a subject whose "behavior is considerably influenced by delusions" (range 21-30) should be given a rating in that range even though he has "major impairment in several areas" (range 31-40). Use intermediary levels when appropriate (e.g. 35,58,62). Rate actual functioning independent of whether or not subject is receiving and may be helped by medication or some other form of treatment.

Name of Patient _____ ID No. _____ Group code _____

Admission Date _____ Date of rating _____ Rater _____

GAS Rating _____

100 | 91 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his warmth and integrity. No Symptoms.

90 | 81 Good functioning in all areas, many interests, socially effective, generally satisfied with life. There may or may not be transient symptoms and "everyday" worries that only occasionally get out of hand.

80 | 71 No more than slight impairment in functioning, varying degrees of "everyday" worries and problems that sometimes get out of hand. Minimal symptoms may or may not be present.

70 | 61 Some mild symptoms (e.g. depressive mood and mild insomnia) OR some difficulty in several areas of functioning, but generally functioning pretty well, has some meaningful interpersonal relationships and most untrained people would not consider him "sick".

60 | 51 Moderate symptoms OR generally functioning with some difficulty (e.g. few friends and flat affect, depressed mood and pathological self-doubt, euphoric mood and pressure of speech, moderately severe antisocial behavior).

50 | | 41 Any serious symptomatology or impairment in functioning that most clinicians would think obviously requires treatment or attention (e.g. suicidal preoccupation or gesture, severe obsessional rituals, frequent anxiety attacks, serious antisocial behavior, compulsive drinking, mild but definite manic syndrome).

40 | | 31 Major impairment in several areas, such as work, family relations, judgment, thinking or mood (e.g. depressed woman avoids friends, neglects family, unable to do housework) OR some impairment in reality testing or communications (e.g. speech is at times obscure, illogical or irrelevant), OR single suicide attempt.

30 | | 21 Unable to function in almost all areas (e.g. stays in bed all day) OR behavior is considerably influenced by either delusions or hallucinations OR serious impairment in communication (e.g. sometimes incoherent or unresponsive) or judgment (e.g. acts grossly inappropriately).

20 | | 11 Needs some supervision to prevent hurting self or others, or to maintain minimal personal hygiene (e.g. repeated suicide attempts, frequently violent, manic excitement, smears feces) OR gross impairment in communication (e.g. largely incoherent or mute).

10 | 1 Needs constant supervision for several days to prevent hurting self or others (e.g. requires an intensive care unit with special observation by staff), makes no attempt to maintain minimal personal hygiene, or serious suicide act with clear intent and expectation of death.

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