The Relationship between Patients' Early Perceptions of their Therapists and the Process and Outcome of Short-Term Psychotherapy

by

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Abstract

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This study examined the relationship between psychotherapy patients' initial perceptions of their therapist as dominant or affiliative and both the process and outcome of time-limited therapy. It was completed through the Brief Psychotherapy Research Program at Beth Israel Medical Center in New York City. Patients were treated with psychodynamically oriented therapy, cognitive therapy, or brief relational therapy, which focuses on the patient-therapist relationship. Of the 84 patients who began treatment, 62 of them completed the full 30-session treatment.

Patients' initial interpersonal perceptions of their therapist remained quite stable across treatment. Patients viewed their therapists as low in dominance and moderately affiliative. These interpersonal schemas of their therapist were highly desirable throughout treatment. The level of alliance, session depth, and session smoothness increased across treatment, with a linear trend for both the alliance and session depth, and with a quadratic U-shaped trend for session smoothness. Patients' symptoms, target complaints, and interpersonal problems decreased by the end of treatment.

Although the initial schemas of a mildly dominant and moderately warm therapist were associated with in-session process, they did not appear related to treatment outcome.

Dominance had a positive association with the alliance, session depth, session smoothness, less tension in sessions, and resolution of tension in sessions when tension occurred. Affiliation had a positive association with the alliance, session depth, and session smoothness.

When looking at the relationship between process and outcome, patients' early experience of smooth sessions and therapists' early experience of deep sessions were associated with patient improvement. Overall, more positive associations between in-session process and outcome occurred during the middle and terminal phases than during the initial phase: the alliance, session depth, session smoothness, and resolution of tension in these later phases were related to improvement.

The study indicated that very early in treatment patients begin to form interpersonal schemas of their therapist. For this group of patients their schemas were relatively benign and were associated with developing and maintaining a positive therapeutic alliance. Furthermore, patient improvement involved more than developing an alliance and appeared to relate to exploration and resolution of difficulties in the patient-therapist relationship.

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Introduction

Psychotherapy is an opportunity for us to change our experiences and perceptions of others in order to feel better and improve our lives.

This study investigated the relationship between psychotherapy patients' perceptions of their therapist early in treatment on one hand, and the development of treatment, the process and outcome of therapy on the other. The research addressed the questions of whether early perceptions affect the therapeutic alliance, whether psychotherapy patients' perceptions of their therapist change over the course of time-limited treatment, whether certain types of perceptions relate to processes in sessions, and whether these perceptions affect patients' symptoms, their view of themselves within interpersonal relationships, and their presenting problems by the end of treatment.

The study first examined psychotherapy patients' perceptions of their therapists and expectations about their interactions at the beginning of time-limited treatment. It was hypothesized that patients' early positive views of their therapists would be associated with the ability to develop and maintain an alliance. A positive perception of one's therapist is one that would be similar to any relationship that begins with a positive first impression. It would promote a bond: in this case, one between patient and therapist that would foster the process of therapy. Factors that might indicate the possibility of developing a good alliance would include viewing the therapist as open, straightforward, and warm. A patient who views a therapist in this light is more likely to view the therapist as confident and trustworthy, to feel enough emotional support to become

engaged in the process of therapy, and to explore conflictual issues or attempt to make changes.

A well-functioning alliance should facilitate therapeutic work that leads to positive outcomes. Therefore, the next step in the research was to see if there was a relationship between early perceptions and outcome. It was hypothesized that early positive views of one's therapist would correlate with positive outcomes. Research has demonstrated consistently that the quality of the therapeutic alliance early in treatment is a strong predictor of outcome (Horvath and Symonds, 1991; Martin, Garske, et.al., 2000). An early "good" therapeutic alliance is associated with positive outcomes. As a corollary, patients' early views of their therapists should be associated with outcome, with positive views correlated with positive outcomes.

This research took a multi-disciplinary approach to understanding the psychotherapeutic relationship. It developed from a psychodynamic understanding of psychotherapy and interpersonal relationships, then its design incorporated ideas from social and cognitive psychology. From a psychodynamic perspective both conscious and unconscious forces affect our experiences and perceptions. Tension between these forces can lead to conflict. In a psychotherapeutic relationship we typically think of the more conscious, non-conflictual nature of the relationship as the therapeutic alliance and the more unconscious, potentially conflict-laden aspect of the relationship as transference. As will be presented in the literature review, these two aspects of the therapy relationship are not mutually exclusive phenomena because their origins are the same. Both are derivatives of early object relationships. From our early experiences with significant others, in particular our parents, we internalize representations of self and other,

templates for relationships. These templates or interpersonal schemas color later interpersonal relationships and affect our understanding of ourselves. Using the cognitive concept of schema, the study looked at patients interpersonal schemas of their therapists and the relationship between these schemas and the process and outcome of therapy. The literature review presents the interrelationship between the therapeutic alliance and transference, focuses on the alliance from different psychodynamic perspectives, and concludes with the application of schema theory.

Literature Review

The literature review begins with the evolution of the term therapeutic alliance and concludes with schema theory as a way to look at patients' early perceptions of their therapists in relation to the therapeutic alliance. The review is divided into three sections: (1) Transference and the Therapeutic Alliance, (2) Ego-Psychological, Object Relational and Interpersonal Views of the Alliance, and (3) The Origins of Schema Theory and Its Application.

Transference and the Therapeutic Alliance

The concept of a therapeutic alliance has its earliest origins in Freud's technique papers on transference. Freud (1912) describes transference as arising from the patient's "prototypes" or "stereotype plate" of infantile imagos or complexes that are the genesis of the search for a love-object both to satisfy sexual longing and to fulfill the desire for love. These prototypes develop from early object relational experiences, creating for example a parental imago. Transference in therapy occurs when the patient projects these imagos onto the analyst. An example of such a prototype or schema, and a benign form of transference, would be Freud's helpful "'positive' transference of friendly and affectionate feelings which were admissible to consciousness" (1912, p. 105).

Freud notes that these projections can either block or help the psychoanalytic process of making the unconscious conscious, which was the primary goal of psychoanalysis at that time. Applying the concepts of the unconscious and conscious to transference, Freud distinguishes between an unconscious, hindering or obstructive

transference, a form of resistance, and a helpful, non-resistant transference, which is similar to the therapeutic alliance concept. The motivation for the helpful form of transference is conscious, reasonable, and non-conflictual. The patient wants to like and cooperate with the analyst in the hope of getting better. Further evidence of an early alliance concept is Freud's recommendation that an "effective transference," in which the analyst had a "*proper* rapport" with the patient (1913, p. 139), be established before the analyst presents psychoanalytic interpretations of unconscious motives. In other words, the patient and therapist must have a trusting relationship in order for psychoanalytic work to occur.

Both the resistant and helpful transference arise from early object relational experiences and their derivative imagos. Transference resistance occurs when the patient projects these imagos onto the analyst with the unconscious hope of recapturing the past in the present. The helpful transference arises from auspicious early relational experiences that the patient has had, the hallmark relationship being the mother-child bond. From these affiliative experiences one has come to trust others and expect support. From a foundation of trust, based on these earlier experiences, the patient expects to receive help and cooperates with treatment recommendations in order to be cured. The transformation of these early experiences into positive interpersonal schemas contribute to successful treatment.

Attempts to retain the idea of a "helpful transference" and to distinguish this aspect of the therapy relationship from transference as a resistance first led to carefully worded terminology. Bibring-Lehner (1936) described a "predominantly positive transference based on confidence." Fenichel (1941) used the term, "rational transference,"

for an aim-inhibited positive transference that induces the patient to be open to interpretations and helps to overcome resistance. Greenacre (1954) referred to a "basic transference." Zetzel finally transformed these terms and extended the thoughts of Bibring and Sterba to distinguish between transference and therapeutic alliance.

Zetzel (1956) originated the term, therapeutic alliance, by consolidating key observations of Sterba (1934), Strachey (1934), and Bibring (1937) on the psychoanalytic process. She noted that patient and therapist form an "alliance with the patient's ego," from which they work together to bring about a cure. It is important to recognize that the alliance is not strictly an ego function. The alliance stems from both an object relational bond between the therapeutic pair and the patient's utilization of ego resources. Freud's earlier term, "helping transference," describes a similar phenomenon.

Sterba (1934) wrote of the split or disassociation within the patient's ego that occurs when the patient reflects upon his experience. For example, while the patient experiences transferential feelings he partly disassociates so that his observing ego can both recognize the immediacy of the experience and reflect on its inappropriate displacement onto the therapist.

When writing of "mutative" transference interpretations, Strachey (1934) described the patient as making a partial identification with the analyst as an "auxiliary super-ego." This identification acts like a buffer, softening inhibitory judgments and reactions. For the patient experiencing transferential feelings or other conflictual thoughts and emotions, both the ability to reflect and benignly assess the experience come from a split in the ego from which to observe and be less negatively judgmental, relaxing a prohibitive attitude that then permits benign analysis of the experience.

Bibring (1937) placed both Sterba's and Strachey's points within the therapeutic relationship, emphasizing the analytic situation's secure atmosphere, one in which the patient can feel safe enough to trust the therapist, particularly when feeling anxious and vulnerable. Without a trusting relationship the psychoanalytic process cannot develop. For example, the analyst cannot serve as an auxiliary super-ego unless the patient feels safe with the analyst.

Zetzel then synthesized these ideas. The therapeutic alliance develops from a trusting relationship between patient and therapist (cf. Bibring, 1937). From this secure base of trust the patient feels safe enough to explore conflictual and anxiety arousing thoughts and feelings with the therapist. In this atmosphere the patient reflects on past and present experience in order to bring about change (cf. Sterba, 1934, and Strachey, 1937).

In her paper Zetzel is comparing two approaches to psychoanalytic treatment: ego-psychology and object-relations. She contrasts the ego-psychologist's emphasis on defense analysis and changes in ego functions with the Kleinian therapist's emphasis on the healing function of the therapeutic relationship. The intent of her paper is to contrast their different views of transference, therapeutic alliance, and transference neurosis, as well as promote an openness to each approach.

Her paper points to the intimate relationship between the concept of a therapeutic alliance and transference. Both phenomena are derivatives of the patient's early object relational experience. Their origins differ in the extent to which the relational experience was conflictual. To clarify, she differentiates between therapeutic alliance, a non-conflictual, basically neutral facilitative treatment factor, and transference. The ability to

relate to others, form a bond, work with someone, seek and expect help are all part of this non-conflictual transference that Freud describes, which we now would consider part of the therapeutic alliance.

Ego-Psychological, Object Relational and Interpersonal Views of the Alliance

Since Zetzel introduced the term, therapeutic alliance, its acceptance or relevance has depended on one's view of development and the therapeutic relationship. Much of development from an ego psychological orientation stems from compromise formations to resolve intra-psychic conflict. Pressure from ego and super-ego constraints controls one's wishes, needs, drives, and motives. A compromise is reached between an individual's internal demands and society's external restrictions. This dynamic is first experienced with one's parents. Although this dynamic begins in infancy, its full impact in determining intra-psychic conflict and establishing some form of resolution is presumed to occur during the Oedipal period.

In contrast to an ego-psychological emphasis on intra-psychic conflict, object relations theory places the interpersonal relationship at the core of human development. From the earliest dynamic experiences with parents one becomes aware of oneself in the context of this relationship. Healthy or inadequate development is cultivated within a two-person matrix. Furthermore, the effects of very early object relational experiences in infancy are assumed to impact development, so that oedipal problems are not necessarily the focus of difficulties.

These two theories about development influence one's view of treatment, particularly the nature of the therapy relationship and therapeutic technique. In the

following section, treatment from an ego-psychological perspective, with an emphasis on analysis of transference, precedes a discussion of an object relations or interpersonal approach, which conceptualizes treatment as a dyadic relationship. This section ends with early psychotherapy research that looks at the therapeutic relationship, as it relates to the alliance, general findings about the relationship between the alliance and outcome, and research that looks at the relationship between object relations, attachment theory, and the alliance.

Ego psychology: Treatment from a strict ego-psychological perspective focuses on understanding oedipal conflicts and their manifestation in the transference. For example, from a very narrow ego-psychological point of view therapeutic alliance is a misnomer because the patient's relationship to the therapist becomes manifest in the transference. When the patient is with the therapist, the manner in which the patient relates to the therapist is transference (Brenner, 1979; Curtis, 1979). Transference may have different qualities. It can be positive, negative, resistant, but it defines the patient's relationship to the therapist. Brenner (1979) in particular takes this position: "Both [therapeutic and working alliance] refer to aspects of the transference that neither deserve a special name nor require special treatment." Any phenomena that could be labeled as part of a therapeutic alliance is viewed and treated as transference. Friedman (1969) cogently presents another reason that a therapeutic alliance is problematic: it would be paradoxical. The patient's underlying motivation is to maintain symptoms rather than to give them up because they are a compromise formation, which raises the issue of how to explain a healthy motive to get better.

A simplified version of Brenner's perspective is a perfect or idealized form of psychoanalysis that could be distilled into patient's associations and therapist's interpretations. The patient's relationship to the therapist is only transference because the therapist understands and responds within this vacuum. The therapist makes interpretations based on an understanding of the patient's intrapsychic conflicts and the nature of the transference. In being neutral, the therapist does not act on counter-transferential impulses or fantasies and does not gratify the patient so as not to contaminate the transference. Overtures from the analyst that others might view as supportive of the patient and promoting an alliance could be possibly contaminating or stemming from the analyst's need to act nurturing. Although the analytic situation is not sterile, the recommendations and foundation for technique can appear to be. This view of treatment can readily be caricatured as a scientist working in a vacuum so as not to contaminate a specimen. Brenner's point in being critical of therapeutic and working alliance is that this aspect of the relationship should also be scrutinized as transference and the core nature of the patient's difficulties is intrapsychic.

Others, such as Greenson, who wrote extensively about the alliance, and uses the term "working alliance," take a more flexible and expanded view of the patient-therapist relationship. Greenson (1965; Greenson & Wexler, 1969) makes a distinction between the real relationship and transference. The working alliance has aspects of both because both actual and projected perceptions affect the way the patient and therapist work together. Greenson in essence is recommending that the analyst widen the analytic visual field to include the analyst and consider real aspects of the relationship (Stone, 1954, 1967). This position permits the analyst to promote the development of a working

alliance. Furthermore, it acknowledges real or genuine feelings of connection between the patient and analyst. Consider a non-therapeutic interpersonal relationship, such as a marriage, business or work partnership. Each partner has real feelings and thoughts about the other, as well as projected wishes and expectations that can be unrealistic. As the relationship develops, this amalgam also evolves and can be viewed as an alliance.

Object relations and interpersonal approaches: In contrast to an ego-psychological approach object relational or interpersonal views of development and treatment consider the therapeutic relationship as another relationship that is affected by transference-like perceptions, and one in which the therapist is also a participant, as opposed to just an observer. This point of view has its origins in Ferenczi's observation that from the patient's perspective the analyst can inadvertently re-enact a conflictual or anxiety-arousing relationship from the past. Ferenczi saw that what later would be labeled "analytic neutrality" could at times feel hostile or distant to the patient. Attempts on the part of the analyst to understand the patient's intrapsychic difficulties through waiting for and listening to the patient without comment or using only interpretations can leave the patient feeling at times literally at a loss for words. Ferenczi (1928) was open to acting more supportive and in essence fostering the development of the patient-therapist relationship. His "relaxation technique" (Ferenczi, 1929) was an attempt to create a safe milieu, one in which "the patient felt totally accepted by and trusting of the analyst, enabling the patient to re-experience the emotions originating in the traumatic experiences of childhood" (Hoffer, 1991, p. 467), which is a precursor to Alexander's "corrective emotional experience" and Roger's "unconditional positive regard." Hoffer summarized this with his metaphor of Freud and Ferenczi as the father and mother of

psychoanalysis with Freud's fundamental principle of abstinence, in line with a classical ego-psychological position, as deprivation and "essentially negative" recommendations and Ferenczi's recommendations as "'positives' which he felt Freud omitted, including 'tact', 'empathy' (Einfuehlung), elasticity, indulgence, warmth, candour, and responsiveness, in an egalitarian rather than in an authoritarian atmosphere." For example, a patient who experienced a distant or not fully trusting relationship with either parent might be wary to begin a new relationship unless he or she felt confident with the therapist. In this situation the therapist might need to work toward having the patient feel reassured that the therapist would be warm and supportive.

Interpersonal relationships or alliances are affected by transference-like perceptions and experiences. At times this alliance benefits from distortions, similar to transference in a therapeutic relationship. For example, at work when one anticipates one's supervisor to be an ideal figure to emulate, then views all of her actions as praiseworthy, particularly those involving oneself, the nature of this work relationship can help to motivate one toward greater achievement and a better partnership. Other times, distortions can hurt the alliance. Again, in the work setting when a supervisor corrects errors, if one is predisposed to hear these comments as harsh or punitive negative criticism, then problems can arise not only in the relationship, but also affect the quality of one's work. The main difference between these interpersonal experiences outside the consulting room and the therapeutic relationship is that in therapy the patient and therapist work on understanding both these extra-therapeutic experiences and the nature of their therapy relationship. The quality of this therapeutic work, the process between the patient and therapist, is the therapeutic alliance.

Similar transference-like experiences in all interpersonal relationships are part of Sullivan's interpersonal theory of personality development and psychopathology. Sullivan (1953, 1954) referred to transference-like phenomena in non-therapeutic relationships as "parataxic distortions," which emanate from "personifications" or self-other schemas. These personifications and distortions develop from experiences with others and attempts to feel secure. Very early in life the experience of anxiety may come from disturbances in the mother-child bond. For example, if the mother's anxiety is felt by the child through "empathic linkage," then the child attempts to decrease the anxiety in order to feel secure. Through repeated experiences with mother, both feeling secure and making adjustments to decrease one's anxiety in order to increase one's feeling of safety, personifications develop of oneself with mother. For example, positive, self-affirming experiences with mother would lead to "good-me" personifications. Anxiety arousing experiences might lead to "bad me" or "not me" personifications to decrease or disavow the conflictual feelings. These personifications or interpersonal schemas act like filters or underlying models that one anticipates re-enacting with other people. When the model fits, the experience is assimilated. When the filtered interpersonal experience does not match and one has difficulties accommodating the experience, then parataxic distortion might occur.

Attachment theory also addresses the effect of anxiety on the mother-child bond and personality development. Rather than look at the effect of early experiences of anxiety with mother, attachment theorists focus on the infant's response to separation from mother with the assumption that the quality of attachment modulates the experience of anxiety when separated from mother and its resolution upon being re-united. These

early experiences of separation and reunion generalize into working models of oneself and one's expectations of others. These working models help to regulate one's anxiety in response to one's expectations of others (Bowlby, 1973, 1988). Ideally, one feels secure and comes to expect others to be "responsive, helpful, and nurturing, versus unresponsive, aloof, and possibly harmful" (Mallinckrodt, et al 1995), whereas, insecure individuals' perception of others is "biased by their regulatory strategies" (Shaver & Mikulincer, 2002).

As one recognizes the impact of various relationships on development to viewing treatment as a relationship, one moves toward a more object relational approach to treatment. From an object relations perspective treatment and psychopathology flow from one's history of object relations. Treatment is embedded in the therapeutic relationship, which in turn is another object relationship. From an object relations perspective the therapeutic alliance is the therapeutic relationship in so many ways that the use of the term alliance is superfluous. Winnicott's "holding environment" and Bion's "container" capture aspects of the alliance that the therapist creates. In object relational treatment the relationship and the milieu that the therapist develops with the patient are as therapeutic as the ego psychologist's interpretations. A "holding environment" creates a place of safety through the therapist's empathic attunement and facilitates psychological growth. Similarly, as a protective container, the therapist provides a safe context for emotional discharge. The therapist both tolerates the patient's projections and creates a safe space to explore and understand these projections. The therapist becomes a transitional object, similar to Strachey's benign "auxiliary super-

ego," supporting the patient's exploration and helping the patient to create emotional space to experience and reflect.

Ego psychology and object relations: Later theories stemming from ego psychology also address directly the impact of early object relations on both normal and pathological development. Kernberg and Kohut describe different types of transferences that stem from early object relationships. Kernberg (1975, 1976) addresses primarily borderline pathology and integrates object relations, ego psychology, and drive theories. He refers to borderline patients pathologically splitting good and bad internal objects in order to decrease anxiety arising from a fear of the bad destroying the good. This process leads to inadequately regulated drives and poorly modulated feelings and representations about self and other. In treatment the therapist attempts to help the patient become aware of, and integrate, these split-off aspects through interpretative work that focuses on their here-and-now expression in the transference.

In contrast, Kohut's (1977, 1984) self psychology considers narcissism as a separate developmental line, similar to drives and instincts, and recognizes the impact of the other in nurturing a healthy sense of self through empathic mirroring and later idealization. Early experiences of validation through connection with one's mother and father lead to a cohesive sense of self. The parent reflects back affirming support of oneself. As one looks toward one's parents, one develops ideals or models of who one wants to become and feelings of confidence through empathic mirroring. One moves from a less cohesive sense of self, which is dependent on the other's mirroring to maintain a sense of self, to a complete sense of self and other with internalized representations of self and other. Problems in this process lead to an internal world of

selfobjects from inadequate development of a cohesive sense of self. One's sense of self is presumed to need to feel as if merged with the other, thus internalized selfobjects maintain a sense of cohesion, with inadequate development of internalized representations of self and other. In therapy it is assumed that to heal self defects patients will naturally form mirroring and idealizing transferences, striving toward healthier object relations and the development of a cohesive sense of self. The therapist provides empathic understanding and the possibility of the patient internalizing self and object representations. Similar to object relations theory much of what is therapeutic comes from the relationship and empathic attunement.

Interpersonal, object relational, and self psychology clearly open the therapy relationship to include the therapist as an influence on the relationship, which in turn affects the patient. Rather than attempt to avoid the risk of contaminating the transference, these approaches recognize that the therapist is a participant-observer who can, and when needed should, affect the development of the therapeutic relationship. As Zetzel noted, within ego psychology the concept of a therapeutic alliance creates a bridge between therapeutic work on intrapsychic issues and the therapeutic relationship. All these approaches, including ego psychology, maintain that representations of self and other become internalized through object relational experiences and the capacity to form object relationships. It is because of this process that a therapeutic alliance can develop.

*

The following section presents a brief, selective survey of psychotherapy research that has investigated the patient-therapist relationship as it relates to the alliance. It includes early work that looked at factors that might promote better quality therapeutic

process, which in turn would lead to better outcomes, Bordin's seminal work, the major alliance measures, and meta-analyses of the relationship between alliance and outcome. This section concludes with a review of research on the relationship between the therapeutic alliance, object relations, and patient attachment.

Early psychotherapy research: Although the concept of a therapeutic alliance originated in psychoanalysis, research on the alliance developed from studies on the effectiveness of psychotherapy. Early studies looked at the question of which type of treatment is most effective. These studies (Smith, Glass, & Miller, 1980; Lambert, Shapiro, & Bergin, 1986) indicated that therapy has a positive effect, but not that one particular treatment is necessarily better than another. The next question addressed was which treatment ingredients are most effective. Pioneering work in this area came from client-centered treatment (Rogers, 1951, 1957). At the heart of client-centered or Rogerian therapy is therapist genuineness and empathic communication, which are referred to as Rogerian Therapist-Offered Conditions (TOC). These conditions are regard, empathy, unconditionality, and congruency. Initial studies found a positive relationship between high levels of TOC and successful treatments (Barrett-Lennard, 1986; Gurman, 1977; Rogers, Gendlin, Kiesler, & Truax, 1967) Later reviews of these results found that when distinguishing between TOC and client perception of the therapist as empathic, client perception had stronger correlations with outcome (Orlinsky & Howard, 1986). More recent research (Salvio, Beutler, Wood, & Engle, 1992) also found a close relationship between TOC, particularly empathy, and the alliance.

Another early area of research where clients' perceptions of their therapists were investigated was the effect of social influence. Strong (1968) conceptualized the therapy

relationship as a process of "interpersonal influence," where therapist attributes or "source characteristics," such as social power, could leverage the client's engagement in therapy and affect the process and outcome of treatment. Typically, analog experiments that systematically varied the level of a characteristic would test the differential impact of these attributes. These studies would manipulate the credibility, expertness, or trustworthiness of the therapist by altering types of information available to a patient before treatment. For example, different conditions might be various levels of training or education. Although significant effects were found, the extent to which one can extrapolate from the results is limited because the studies used very limited subject and treatment analogues of a few sessions at most. In reviewing this extensive literature, Beutler, Crago, and Arizmendi (1986) note that "the generalized expectation of high credibility, expertness, and power that patients assign to anyone in the therapeutic role may initially outweigh the effects of any information that suggests that a particular therapist's credibility is low" (Beutler, et. al, p. 280).

To address the problem of analogue studies, La Crosse (1980) investigated the effect of social influence by looking at the relationship between 36 patients' first impressions of their therapist, using the Counselor Rating Form (CRF) to assess perceived expertness, attractiveness and trustworthiness, and outcome, which was assessed using global attainment scaling. When comparing initial perceptions and post-counseling outcomes, La Crosse found that the CRF variables accounted for 35.2% of the outcome variance with a positive relationship between high initial ratings and outcome. Stepwise analysis showed that expertness accounted for 31.1%, attractiveness for 2.8%, and trustworthiness for 1.3%. Positive perceptions of the therapist also increased so that

by the end of treatment the patients viewed their therapists as more expert, attractive, and trustworthy. Other naturalistic studies with clients and patients of varying degrees of psychopathology (Childress & Gillis, 1977; Heppner & Heesaker, 1982, 1983) found similar results.

Research on the therapeutic alliance: Luborksy's (1976) early research on the alliance further supports the positive effect of patients' early judgments of therapists in relation to both Rogerian TOC and social influence. He defined two types of alliances: "A therapeutic alliance based on the patient's experiencing the therapist as supportive and helpful with himself as a recipient" (Type 1, p. 94) and contrasted this with a type of collaborative alliance, in which the patient and therapist are "working together in a joint struggle against what is impeding the patient..." (Type 2, p. 94). He found that the strength of both types of alliances related to the likelihood of improvement in psychodynamic therapy and that Type 1 alliance appeared to be more crucial at the beginning of therapy. Type 1 alliance would be influenced by perceived warmth and caring, i.e. empathy; and therapist characteristics, such as expertness; as well as past experience in similar helper-helpee relationships.

Research on the therapeutic alliance moved the direction of research from focusing on either the patient or therapist toward looking at the manner in which they relate. For example, research on empathy focuses on looking at the ways in which the therapist is empathic or the effect of empathy on the patient. Research on the alliance that addresses the same concern would look at the bond or interpersonal connection between patient and therapist, which might develop from empathic understanding, rather than, for

example, the effect of the therapist's level of empathic communication on the patient's self-exploration.

Research investigating the therapeutic alliance began first with defining the term and developing different scales to measure it. Working from Greenson's view of the therapeutic alliance, Bordin's seminal paper (1976) presents the alliance as a three factor, pan-theoretical construct. His definition underscores the collaborative nature of the relationship, which allows both patient and therapist to overcome or work through the vicissitudes of therapy as the patient works toward change. Bordin's three factor definition became pivotal primarily because it is pan-theoretical. The three key factors in the alliance are bond, task, and goals. His definition encompasses ingredients of treatment, which can distinguish among different types of treatments. For example, treatments can have similar goals yet differ in how they meet them. Bond refers to the manner in which patient and therapist relate. Task refers to the way treatment is done. Goals refer to what patient and therapist plan to accomplish by the end of treatment. Treatments vary in their emphasis on these factors. For example, bond is crucial to client-centered or experiential therapy. Tasks, such as homework assignments, are important in cognitive therapy. The ultimate goal for classical psychoanalysis would be to resolve the transference neurosis.

In concert with Bordin's definition of the alliance was the development of scales to measure the alliance. A large majority of studies on the alliance use these five instruments (Horvath and Symonds, 1991): California Psychotherapy Alliance Scales (CALPAS/CALTRAS; Marmar, Weiss, & Gaston, 1989); the Penn Helping Alliance scales (Penn/HAQ/HA; Alexander & Luborsky, 1987; Luborsky, 1976); the Therapeutic

Alliance Scale (TAS; Marziali, 1984); the Vanderbilt Alliance Scale (VPPS/VTAS; Hartley & Strupp, 1983); and the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). Each scale is available in different versions: therapist or patient self-reports and observer ratings. The therapist-based measures are the most stable measures (r .93), whereas the observers' ratings (r .82) are the least reliable (Horvath and Symonds, 1991). When comparing the CALPAS, Penn, VTAS, and the 3 versions of the WAI, Tichenor and Hill (1989) found high internal consistency with alpha coefficients ranging from .90 on the CALPAS to .98 on the observer version of the WAI. All versions of the WAI had the highest internal consistency. Two core aspects of the patient therapist relationship are covered by each alliance measure: attachment, or Bordin's bond, and collaboration or investment in the therapeutic process, similar to engagement in Bordin's tasks and goals. The measures differ in their emphasis on the factors contributing to these variables. For example, the sense of collaboration on the Penn, CALTRAS, and VTAS is measured by active participation in therapy.

The main finding when looking at the relationship between levels of alliance and quality of outcome is that positive alliance, particularly at the beginning of treatment, correlates with successful outcomes. Meta-analytic techniques applied to 24 studies have documented average effect sizes (ES) of r = .3 between early alliance and outcome, ES = .26 for alliance and outcome, and ES = .2 for alliance measures averaged across sessions toward the middle of treatment and outcome (Horvath and Symonds, 1991). These results were consistent for a wide range of treatments, including behavioral therapy, cognitive therapy, gestalt therapy, and psychodynamic therapy.

Repeating Horvath and Symonds meta-analysis with the original data set expanded to include more recent studies, Martin, et al. (2000) found similar results when analyzing 79 studies. The overall alliance-outcome correlation was .22. Tests of homogeneity, using Hedges and Olkin's (1985) *Q* statistic, indicated that the population was homogeneous, thus no further analyses to find a moderator could lead to a better model to explain this relationship. They also found that patients' ratings tended to remain stable, whereas therapists' and observers' ratings changed over time. Thus, patients are more likely to view the alliance at termination as positive if they began treatment with this view. Once an effective alliance is established at the beginning of treatment it might become self-perpetuating from repeated reinforcement, similar to any mutually satisfying relationship continuing.

Object relations, attachment, and the alliance: Although these results confirm the alliance's association with positive outcomes, further study is needed to determine what factors contribute to or foster the development of an alliance, particularly at the beginning of treatment. This section ends with studies that address these questions by looking at patient's object relationships and patient attachment in relation to the alliance.

Research over the past 25 years (Moras and Strupp, 1982; Ryan and Cicchetti, 1985; Piper, Azim, et al., 1991; and Hersoug, Monsen, et al., 2002) has found a positive relationship between the development of a good therapeutic alliance and a patient's history of positive object relationships. Consistent with this relationship was one study (Kokotovic and Tracey, 1990) that found that a history of negative relationships correlated with poor alliance. These results might have been an artifact of therapists rating both quality of object relational history and alliance. All the other studies

evaluated history of object relationships with independent assessors. These studies have sampled a wide range of populations: college men (Moras and Strupp, 1982), university counseling centers (Ryan and Cicchetti, 1985; Kokotovic and Tracey, 1990), a Canadian out-patient clinic (Piper, Azim, et al., 1991), and Norwegian out-patient clinics (Hersoug, Monsen, et al., 2002). Moras & Strupp (1982) found that pretherapy interpersonal relations accounted for 25% of the variance in therapeutic alliance, with patients in the upper third of the distribution, i.e. with better history of object relationships, consistently having a positive therapeutic alliance on average across treatment. Ryan and Cicchetti (1985) found that based on evaluations from the initial session, quality of object relationships accounted for 30% of the variance in quality of therapeutic alliance when applying a step-wise multiple regression analysis that also included the predictor variables of psychological mindedness, pretreatment expectations, level of distress, and intrapsychic flexibility. The last four variables added 10% of the variance when combined with object relations. Piper, Azim, et al. (1991) found that quality of object relations was a better predictor of quality of therapeutic alliance than recent interpersonal functioning, accounting for 9% of the variance for early alliance. Herzoug, Monsen, et al. (2002) found that quality of both current and past relationships was associated with the alliance.

In contrast to the trend of a positive relationship between history of object relationships and therapeutic alliance, the relationship between attachment and alliance is less straightforward. It would appear that less attachment anxiety is associated with developing an adequate therapeutic alliance, however, because attachment theory has been applied in various ways and the concept overlaps with other interpersonal and

intrapsychic processes, studies' results suggest that attachment theory is another way of looking at psychotherapeutic processes rather than indicate a clear relationship to therapeutic alliance. For example, problems with intimacy touch on issues that can be construed as attachment problems, such as an anxiously avoidant style of relating. This construct might also relate to defensive style because the theory is based on ways in which one deals with separation anxiety. Furthermore, one's object relational history includes one's relationship to parents, which again relates to attachment concepts. Lastly, the strategies used to measure attachment vary, which raises the questions of what is being measured and are the data comparable (Bartholomew & Moretti, 2002; Griffin & Bartholomew, 1994; Shaver & Mikulincer, 2002). For example, part of the coding of attachment interviews, such as the Adult Attachment Interview, involves assessing unconscious defensive processes, whereas, self-report measures yield scores based on respondents' conscious evaluations of statements.

Studies have looked at patient-parent bonding (Malinckrodt, Coble, & Gantt, 1995), patient adult attachment (Satterfield & Lyddon, 1995; Kivlighan, Patton, & Foote, 1998, Eames & Roth, 2000, Kanninen, Salo, & Punamaki, 2000), and client-therapist attachment (Malinckrodt, Porter, & Kivlighan, 2005). All but one of the adult attachment studies used the Adult Attachment Scale (Collins & Read, 1990), which has three subscales: Depend (ability to rely on or trust others), Anxiety (fear of abandonment), and Close (comfort with intimacy). The Depend and Close subscales were related to therapeutic alliance (Satterfield et. al., 1995; and Kivlighan, et. al., 1998). Kanninen, et. al. found that for patients who had been torture victims the alliance varied over the course of therapy according to patients' attachment orientation. Eames and Roth (2000), using

the Relationship Scales Questionnaire (Griffin & Bartholomew, 1994), which distinguishes four attachment styles of secure, fearful, dismissive, and preoccupied, found that at the beginning of treatment securely attached patients formed effective alliances from the therapist's perspective, whereas fearful (anxious-avoidant) patients had lower alliance ratings from the perspectives of both patients and therapists. A dismissing style, where one tends to view the self as positive and the other as negative, was also positively correlated with alliance. In an attempt to distinguish among the impact of object relations, adult attachment, and patient-therapist attachment on therapeutic alliance and processes, Malinckrodt et. al. (2005) summarized their results as indicating that these concepts are closely linked and that client attachment to therapist might tap an aspect of the therapy relationship that measures of working alliance have not.

From both an ego-psychological and object relational perspective the effect of earlier relationships remains in the present through the process of internalization (Loewald, 1962, Meissner, 1981, Schafer, 1954). We develop mental structures, both conscious and unconscious memories that form the basis of who we are– how we conceive of ourselves and others, and how we perceive ourselves with others. Together they provide a sense of continuity. The application of schema theory as it has been used in social and cognitive psychology provides a mechanism to investigate this process.

The Origins of Schema Theory and Its Application

The last section of this review begins with a summary of the origins of schema theory and Piaget's concepts of assimilation and accommodation, continues with the

application of schematic approaches in social-cognitive psychology, and concludes with interpersonal schema theory.

Our memories from the past influence our experience of the present. We bring expectations about relationships to interpersonal situations. These expectations are mental representations or schemas. Bartlett (1932) presented the earliest theory of schemas and their influence on perception. In the early part of the 20th century memory was assumed to be like a lifeless memory trace: When we remember, we re-excite an indelible trace. Bartlett questioned this view and through a series of memory experiments demonstrated that subjects' previous knowledge influenced their recall. This previous knowledge or schema provides a way to organize new information. In his experiment subjects read a story about a different culture. When asked to recall the information, the subjects would fill in unfamiliar gaps in their knowledge with information about their own culture. Rather than reactivating a memory trace, remembering "is an imaginative reconstruction, or construction, built out of the relation of our attitude towards a whole active mass of organized past reactions or experience ...."

Since Bartlett's experiments, both cognitive and social branches of psychology have used the concept of schema to explain cognitive development and to understand the process of interpreting social information and the nature of interpersonal relationships. Recently the concept has been used to develop an interpersonal social-cognitive theory to understand transference (Andersen and Chen, 2002). Within clinical psychology and psychoanalysis the concept has been used to understand personality development, psychopathology, and the process of psychotherapy.

Cognitive Psychology: Piaget's theory of cognitive development (Piaget, 1964) focuses on the mental processes that lead us to acquire and manipulate knowledge. It is a dynamic process that leads to the development of mental schemas. From observation and interaction with his or her surroundings, the infant begins to understand the external world. From repeated experiences the child internalizes comprehension of the environment into memories and mental structures, which are akin to Bartlett's schemas. These schemas help us organize our experiences and understanding of the world. Cognitive development continues as we assimilate new information into established mental structures and accommodate new experiences by modulating the older structures. These established structures consist of mental schemas.

Piaget focused on intellectual development. Although he acknowledged that emotional development occurred in tandem with intellectual development, he viewed affect more as a drive or the energy behind behavior, whereas cognitive functions define the structure of behavior (Piaget, 1962). Affect might influence "the acceleration or retardation of the formation of structures" and the process of assimilation and accommodation. Thus, emotion and motivation can affect the process, but not by themselves cause the formation of mental structures. Similarly, "at no level can we find a behavior or a state which is purely cognitive without affect nor a purely affective state without a cognitive element involved." Piagetian research has looked at this relationship primarily in the realm of moral development, whereas social psychology has tried to understand the relationships among emotion, motivation, behavior and schemas within social situations.

Social Psychology: Within social psychology schema theory has been applied to understand the processing of social information. Examples of schemas that structure our social interactions and behavior (Planalp, 1987) are prototypes (Cantor and Mischel 1978, 1979), scripts (Schank and Abelson, 1977), and self-schemas (Markus 1977). Cantor and Mischel (1979) found parallel functions between object and person categorization. For example, both systems help to process information through selective attention, organizing information and efficiently attending to stimuli that then facilitate accessing knowledge (Bruner, 1957). Once an individual is perceived as a "prototypical category member" other associated attributes are more readily ascribed to the individual, and the category both facilitates memories and expectations about the person. For example, sex-role stereo-types influence one's perceptions of both self and other (Bem, 1981). These prototypes not only facilitate information processing, but also help to plan behavior in social interactions. Through imagining a prototypic person in different social situations (Snyder and Cantor, 1979), one can conceive of either one's own behavior or the behavior of the other person.

Scripts (Abelson, 1981, Shank and Abelson, 1977) represent cognitive structures that organize our understanding of event-based situations. Scripts allow us to make inferences about potential events within settings that are structurally similar. They are like procedural schemas. For example, when entering a restaurant or registering at a hotel, an underlying script informs our behavior and our expectations about those who work in these settings. Abelson (1981) further proposes a higher order script, or meta-script. Meta-scripts consist of more abstract constructs or generic scenes, such as "receiving help" or "things that happen at visits to a health professional." Tomkins'

(1978) nuclear scenes, repeated individual experiences, can develop into scripts imbued with affect. The experience of emotion during these nuclear scenes turns these experiences into over-generalized meta-scripts or personal narratives (Carlson, 1981).

Using this terminology to describe schematic processes, prototypes facilitate categorization of people. Within scripts we encode procedural information about events, which can be similar to narratives. Lastly, self-schemas (Markus, 1977) are "cognitive generalizations about the self, derived from past experience, that organize and guide the processing of self-related information contained in the individual's social experiences." They influence which stimuli we attend to, which we remember, and what inferences we draw (Markus, 1983). They also can affect aspirations and future behavior, as "possible selves" (Markus and Nurius, 1986), self-concepts of whom we would like to be or might be afraid we become. Although one can readily imagine how these different schemas might interact, for example, how we view others and ourselves affects the development of scripts, until relatively recently social psychological theory and research have focused on them in isolation (Baldwin, 1992). Integrating these different types of schemas, Andersen and Chen (2002) present an interpersonal social-cognitive theory of transference for social relationships. Transference can occur because of interpersonal experiences that become schemas. These experiences generate scripts or meta-scripts that incorporate our sense of self with our view of others. In contrast to the relational-schema approach (Baldwin, 1992), this model focuses on the effect of specific relationships generating schemas rather than the effect of general interpersonal relationships.

Social-cognitive theory of transference: In this interpersonal social-cognitive model (Andersen and Chen, 2002) transference occurs when a schema or mental

representation of a significant other becomes activated with another person. This definition of transference differs from the psychoanalytic definition of transference primarily because the authors apply their schema theory to general social situations rather than psychotherapeutic ones. These situations also are ostensibly non-conflictual. Their research investigates the possible occurrence of Sullivan's personifications in daily life

This transference schema is not strictly a prototype because it represents not only the significant other, but also the significant other in relation to the self, i.e. the perceiver. Furthermore, the perceiver responds emotionally, motivationally, and behaviorally to the new person in ways that arise from the previous relationship, similar to enacting a script. Their research investigates "linkages" that exist between the self and significant other representations: "when a significant-other representation is activated in an encounter with a new person, associated self-with-significant-other knowledge is set into motion" (Andersen and Chen, 2002, p.638). For example, in research testing this model the overall positive or negative affect that is associated with the significant other appears to color the view of a new person (Andersen et al., 1996; Andersen and Baum, 1994; Baum and Andersen, 1999). Subliminal research (Glassman and Andersen, 1999) has shown that the schema can be activated unconsciously. Furthermore, Hinkley and Andersen (1996) have found perceivers' descriptions of themselves shift toward their self-concept of themselves with a significant other when presented with a description of a new person with characteristics similar to the significant other. This effect occurs whether the significant other is viewed positively or negatively. "In the context of transference, people become in part who they are with the relevant significant other, verifying the claim that

variability in relational selves arises as a function of contexts that trigger transference" (Andersen and Chen, 2002, p. 632).

By and large the self-other relational knowledge is idiographic for the perceiver because it develops from the perceiver's idiosyncratic history. However, the process of transference also triggers nomothetic knowledge, such as normative role definitions (Baum & Andersen, 1999). A transferential schema is more apt to occur when the new person is in some ways similar to the significant other (Andersen, et. al., 1995; see also Cantor & Mischel, 1977, 1979). Moreover, research has shown that this effect is more pronounced for significant-other representations than for generic social categories or for non-significant others (Andersen et al., 1995; S. Chen et al., 1999).

Research has also demonstrated that one's preexisting beliefs about another person can elicit behavior in the other that is consistent with one's beliefs, leading to self-fulfilling prophecy (Rosenthal, 1994) or behavioral confirmation (Snyder, 1984, 1992). For example, Snyder et al. (1977) found behavioral confirmation or measurable differences in women's sociability and friendliness when speaking via intercom to men who either were led to believe the women were or were not attractive. Men who thought the women were attractive elicited more sociable and friendly behavior, as judged by independent raters. Behavioral confirmation is more likely to occur when a perceiver is motivated to "get to know" the other or when the other is motivated to "get along" with the perceiver. Berk and Andersen (2000) applied a similar procedure, using an intercom with women as perceivers. Naive participants expressed more positively toned affect when perceivers thought they were getting to know participants who resembled significant others whom they viewed positively as opposed to negatively, which did not

occur in the control condition. Under the control condition perceivers were led to believe that the person with whom they were speaking was like another subject's positive or negative significant other.

Interpersonal schema theory: Similar to this social-cognitive model of transference is Safran's (1990) interpersonal schema theory. Both theories posit internalized working models that develop from interpersonal experiences, which become generalized representations of self-other interactions. In contrast to the previous model, which encompasses self and significant-other schemas, interpersonal schema theory grounds the development of schemas within attachment relationships, such as with caregivers or parents, that then generalize to other relationships. Consistent with attachment theorists (Bowlby, 1969; Main, Kaplan, and Cassidy, 1985) this theory assumes that, in part for reasons of survival, we develop internal working models, which represent interpersonal interactions that foster and support attachment behavior. These models or interpersonal schemas are in response to satisfying a basic need for interpersonal relatedness. Interpersonal schemas persist through feedback from others. We experience the effect of our attempts at relating from others' responses. This feedback loop becomes a "self-perpetuating cognitive-interpersonal cycle." Beginning with our first primary attachment, later object relationships both radiate from it and enfold it, like a theme with variations, reincorporating interpersonal relationships.

Another difference between interpersonal schema theory and the social-cognitive model of transference is that it addresses maladaptive interpersonal interactions. Based on interpersonal theory (Kiesler, 1996), maladaptive patterns arise from an individual's rigid, constricted interpersonal repertoire. Whereas a healthy individual can flexibly

manage different social situations from awareness of the nuances of relationships and a broader repertoire of interpersonal behavior, the less adept become caught repeating patterns that might no longer be appropriate or that unfortunately perpetuate a detrimental experience with others. Wachtel (1977, 1987) refers to this interpersonal process as cyclical psychodynamics. Rigid patterns of inter-relating also reinforce constricted views of others and one's experience with others. Experiences like these can lead to faulty beliefs about oneself, which in turn can lead to symptoms of depression, or anxiety, if the individual begins to experience the pattern as dysfunctional because it does not meet relational needs, thus creating a fault-line in the attachment.

Similar to the social-cognitive model is the impact the interpersonal schema can have on interpersonal interactions. Not only are there interpersonal ways of relating, but they can pull for reinforcing responses that confirm the interpersonal schema, as in the behavioral confirmation study of transference (Berk and Andersen, 2000). Research using the interpersonal circumplex (Kiesler, 1996) tests various propositions about the nature of eliciting responses from others. The interpersonal circumplex (Leary, 1957; Kiesler, 1983, 1996) is a fruitful model that has its roots in Sullivan's interpersonal theory of personality and psychopathology.

Interpersonal circumplex: Working from the assumption that the essence of all interpersonal relationships can be summarized by the dimensions of control and affiliation, Leary (1957) created an interpersonal circle with a vertical axis of control and horizontal axis of affiliation. Control captures the relative power or influence between two people. For example, imagining the origin of the axes as a fulcrum, a state of equilibrium in relation to the control or vertical axis occurs when a line is drawn through

the fulcrum. If the line is vertical, then high dominance is balanced, or complemented, with its reciprocal of low dominance or submission. Gradations of this relationship occur as the line pivots on the fulcrum. Affiliation captures the relative bond or affective connection between two people on a continuum from warm to cold, where interpersonal warmth is complemented with supportive warmth and coldness with corresponding coldness, creating interpersonal distance. Returning to the image of a circle, the two different aspects of affiliation are the left and right semi-circles.

Kiesler (1983) further elaborated this circle into an interpersonal circumplex, by dividing the circle into 16 arcs or segments, which are represented by 16 points on the circumference of the circle. Imagining the origin, or center of the circle, as a fulcrum with sixteen equidistant lines radiating from the center, we have eight lines crossing the fulcrum. Opposite points on the circumference define these eight lines or transactional styles. These eight pairs are dominant-submissive for the vertical axis, friendly and hostile for the horizontal axis, then pivoting between these axes in quadrants I and III are sociable-detached, exhibitionistic-inhibited, assured-unassured, and in quadrants II and IV are competitive-deferent, mistrusting-trusting, and cold-warm. Among these sixteen points Kiesler defined complementary interpersonal transactions based on their relative position of control and affiliation. These relationships are friendly-friendly, sociable-warm, exhibitionistic-trusting, assured-deferent, dominant-submissive, competitive-unassured, mistrusting-inhibited, cold-detached, and hostile-hostile. These eight transactions represent the reciprocal interpersonal relationship for the vertical axis of dominance and the corresponding interpersonal relationship for the horizontal axis of affiliation. These transactions are complementary because one's attempts to meet basic

interpersonal needs are designed to elicit reactions from others that reinforce or validate one's self-perceptions and self-presentations (Kiesler, 1996), thus friendly behavior would receive a friendly response, dominance would be reinforced with submission, and hostility would be met with hostility.

Interpersonal Schema Questionnaire: To assess the interactional nature of interpersonal schemas Hill and Safran (1994) developed the Interpersonal Schema Questionnaire (ISQ), using Kiesler's circumplex to construct its dimensions. Both Safran's interpersonal schema theory and Kiesler's circumplex stem from Sullivan's interpersonal theory of personality. To represent the 16 points on the circumference of the circumplex, the ISQ has sixteen interpersonal scenarios for respondents to imagine. Each scenario captures the emotional or behavioral impulse for each of the points on the circumplex's circumference. Here are four examples:

- Hostility: "Imagine yourself feeling angry and argumentative towards____."
- Detached: "Imagine yourself being preoccupied with your own thoughts and detached with ___."
- Sociable: "Imagine yourself expressing genuine interest and concern for ____."
- Trusting: "Imagine yourself confiding in ____ something that is important to you."

For each scenario in the ISQ the respondent imagines being in the situation with someone, then decides from eight choices how this person would respond. These eight responses are also derived from the circumplex, by combining adjacent segments defined by the sixteen points on the circumference. For example, the response reflecting cold-hostile is "would be impatient, or quarrelsome." Deferent-trusting is "would respect me,

or trust me." These eight responses are controlling, mistrustful, hostile, distant, submissive, trusting, friendly, and interested. Initially, the ISQ had 16 responses for each point on the circumplex, but in pilot testing subjects found this too unwieldy, so the responses were condensed. After selecting an ending for the interpersonal scene, one decides how desirable this response would be on a 7-point Likert scale. Thus, each scenario stimulates a projected self-other interaction, representing various degrees of dominance and affiliation, that one then reflects upon to assess how desirable or conflictual the outcome is.

Responses on the ISQ generate 3 indices: control, affiliation, and desirability. Answers about the other are weighted for the level of control and affiliation, then summarized with a control and affiliation score. Desirability is a mean of all the desirability answers. Hill and Safran (1994) evaluated the validity and reliability of the ISQ on a sample of 344 college students. Participants completed the questionnaire three times, imagining being with their mother, father, and a romantic partner or close friend. The dimensions of control and affiliation had a correlation coefficient of .07, indicating that these dimensions have no relationship and supporting the assumption that they are orthogonal. Using chi-square tests, observed frequencies for all of the eight responses were significantly different from expected frequencies of chance or equally distributed cells, the mean number of responses for each of the 8 responses averaged for all 16 situations, supporting the assumption of complementary responses for the interactions.

The affiliation dimension more than the control dimension showed clearer and stronger consistent expected relationships derived from the circumplex assumptions: There was a greater likelihood of complementary, i.e. corresponding or similar, responses

anticipated from other. This relationship was strongest for a constellation of situations closest to feeling or acting friendly, i.e. warm, friendly, and sociable. Also, for expected interactions with mother when comparing friendly, hostile, dominant, and submissive responses, there were relatively high scores on the affiliation index for friendly situations and negative scores for hostile situations, representing expectations of hostile responses in hostile situations. The dominant situation was associated with a negative dominance score, i.e. low dominance, and the submissive situation was associated with a positive score on dominance. This relationship was not as great as for the affiliation range of scores. The dominance score in the submissive situation was lower than the affiliation score in the friendly situation. Thus the predicted complementary relationship was stronger for affiliation than dominance. Patterns of relationship on the indices were reported, as opposed to statistical tests. Desirability ratings correlated positively with the Affiliation index ($r = .71$), but not with the Control index ($r = -.07$).

Internal consistency of the indices was calculated using Cronbach's Alpha applied to all three sets of 16 situations. Analyses of these 48 items derived the following reliability coefficients: .62 for the Control Index, .81 for the Affiliation index, and .90 for the Desirability index. Thus the Affiliation and Desirability indices appear internally consistent, but not the Control index. Test-retest correlation coefficients were calculated with responses from thirty-four subjects who completed a second ISQ. The coefficients were .44 for the Control Index, .88 for the Affiliation Index, and .87 for the Desirability Index, repeating the same reliability pattern.

Empirical studies of the ISQ: The ISQ has been used to investigate the relationship between interpersonal expectations and psychiatric symptoms (Hill and

Safran, 1994), depression (Hill and Safran, 1994; Mongrain, 1998; Soygüt & Savasir, 2001b), self-esteem (Baldwin and Keelan, 1999), personality characteristics (Soygüt, Nelson, and Safran, 2001a), and history of abuse (Cloitre, Cohen, & Scarvalone, 2002). The studies' results lend support to interpersonal schema theory: The results identify expectations that would tend to reinforce symptoms and self-perceptions, as well as the possibility for the development of healthier schemas in the present that could counterbalance maladaptive ones from the past. Below is a review of these studies, followed by one study that used the ISQ to validate a measure of transference and another that used the ISQ to study the therapeutic alliance.

As part of their validity study, Hill and Safran (1994) also assessed psychiatric symptomology with 215 undergraduates, using the Symptom Check List-90, and depression with 62 students, using the Beck Depression Inventory (BDI). Less symptomatic participants anticipated more desirable responses from others, whereas highly symptomatic subjects expected significantly less friendliness with lower ratings of desirability. A similar, though weaker, trend occurred with the Affiliation index. These results suggest that healthier individuals anticipate more positive feedback from others than do those with symptoms. Of the 62 students who completed the BDI seven participants had BDI scores greater than 17. These depressed students (Hill & Safran, 1994) and 136 Turkish students with BDI scores above 17 (Soygüt & Savasir, 2001) tended to expect anti-complementary responses on the control index. Thus, in dominant situations they anticipated dominant responses and in submissive situations they anticipated submissive responses. Based on interpersonal theory, these expectations would lead to interpersonal failure, in that attempts to dominate are not reciprocated with

submission, nor are submissive behaviors supported with dominance. The experience of interpersonal failure, in turn, could lead to depressive symptoms.

In a sample of 107 undergraduates at risk for depression Mongrain (1998) found that self-critical individuals anticipated less affiliative and less accepting responses from both parents, suggesting that they associated negative feedback in interactions with parents. For dependent individuals, favorable responses from father were anticipated with their submissiveness. Dependent individuals also anticipated positive responses from mother in friendly situations. Both dependent and self-critical individuals appear to have relationships with their parents that reinforce their self-representations and personality style.

In a sample of 182 primarily female undergraduates Baldwin and Keelan (1999) found that students with high self-esteem reported "greater confidence that being friendly would draw affiliative responses from others," with women more than men expecting more affiliative responses, and also expecting affiliative responses to submissiveness. It is notable that those with high self-esteem did not anticipate positive responses in all situations. "Rather, interpersonal expectations showed clear if-then, behavior-outcome patterns" (p. 830). Both high and low self-esteem individuals anticipated affiliative responses to their friendly overtures, and less affiliative responses to hostile behavior. However, they differed in the extent to which they thought they could anticipate affiliation.

In a study of 67 women, comparing those who had been sexually abused as children with those who had never been abused and with those who had been abused both in childhood and adulthood, Cloitre, Cohen, & Scarvalone (2002) used the ISQ to assess

interpersonal schemas. They found differences between parental schemas and those for contemporary significant others. Women who had never been abused viewed parents and significant others as warm and submissive. Women who had been sexually abused as children and adults viewed both parents and significant others as hostile and controlling. Women who had only been abused as children viewed parents as hostile and submissive, but significant others as warm and submissive. These women appear to have been able to find appropriate supportive relationships. The authors suggest that the low level of parental control might have motivated these women as children to seek and establish relationships with other adults who could provide warm, supportive, and accepting interpersonal experiences. This research demonstrates that interpersonal schemas that have their origins in childhood do not necessarily generalize to all significant relationships, and that healthier schemas might be able to mitigate against maladaptive ones.

Soygüt, Nelson, and Safran (2001a) looked at the relationship between the ISQ and personality characteristics, assessed with the Millon Clinical Multiaxial Inventory (MCMI; Millon, 1983), among 92 patients in cognitive behavioral therapy. These patients had Axis-I diagnoses, but no Axis-II personality disorders, therefore significant findings are indicative of a personality style rather than psychopathology. They found significant correlations between the ISQ subscales and MCMI subscales of histrionic, schizotypal, and anti-social. The histrionic patients anticipated submissive responses from others in submissive situations. Often this personality style is portrayed as helpless and needy, which is not inconsistent with passively engendering others and not receiving support. Schizotypal patients anticipated hostility when acting friendly, which would

support their interpersonal detachment. Within interpersonal theory both these tendencies are anti-complementary. On the other hand, antisocial individuals expected complementary responses of friendliness when they were friendly, which might reflect their experience of others responding favorably to their charming or superficially friendly behavior. Further study of the relationship between the ISQ and personality characteristics would help to assess situationally specific interpersonal behaviors associated with different personality styles, which are similar to Baldwin and Keelan's (1999) if-then interpersonal contingencies or behavior-outcome patterns. Helping patients understand the impact of their behavior on others and ways in which they might contribute to maintaining their symptoms could aid in changing maladaptive patterns of relating.

Within a psychotherapeutic setting the ISQ has been used to assess transference and to look at the therapeutic alliance. As part of validating the Missouri Identifying Transference Scale (MITS), Multon, et al. (1996), used the ISQ to assess patients' interpersonal schemas of mother and father on a sample of 16 client-therapist pairs in 20 session psychoanalytic counseling treatment, yielding a total of 269 sessions. Internal consistency on the ISQ, using Cronbach's alpha, for mother was .91 and for father were .87. Therapists rated the clients' transference reactions using the MITS. The MITS consists of a list of 43 items that describe clients' unrealistic or irrational reactions to the therapist, using Greenson's (1967) examples. These items have either negative or positive connotations and are listed randomly to prevent response bias. Therapists rate the extent to which each item is present on a 5-point Likert scale. Using hierarchical linear modeling analyses in order to look at individual change or growth rather than

change in group means, Multon et al. found that negative transference reactions decreased across sessions with an overall U-shaped quadratic slope. The ISQ ratings for mother accounted for 43% of the base rate of negative transference reactions, and 4% of the positive reactions. Mother ratings only accounted for 4% of the variance for positive reactions. Father ratings did not contribute significantly to either negatively or positively rated transference reactions. These results suggest that "the more the client views his or her mother as controlling, untrustworthy, less affiliative, and less sociable, the more likely negative transference reactions will surface in mid treatment (p. 251)." They did not assess patient's view of the therapist on the ISQ, which could have looked at the relationship between patients' conscious perceptions and therapists' inferred transference reactions, as well as the relationship between interpersonal schemas of a parent and the therapist.

The ISQ has also been used to evaluate the relationship between pre-treatment interpersonal schemas and the therapeutic alliance early in short-term cognitive therapy (Soygüt, Nelson, & Safran, 2001b). Twenty six patients completed the ISQ, answering the questionnaire for 3 different significant others– a romantic partner or close friend, a friend of the same sex, and a friend of the opposite sex, before beginning therapy, and the working alliance inventory (WAI; Horvath & Greenberg, 1989) after the third session. The WAI has four subscales, based on Bordin's (1979) definition of the alliance: overall alliance, and subscales of task, goal, and bond agreement. When looking at complementarity for the control dimension, which are dominant or submissive situations, significant results were found. For submissive situations, patients who anticipated dominance perceived agreement on tasks and goals. For dominant situations, when

patients expected submissive responses, they did not perceive agreement on goals. For desirability, in dominant situations if patients expected less desirable responses in general, then they did not perceive agreement on goals. These results suggest that for the parts of the alliance that involve interpersonal cooperation and negotiation, at the beginning of cognitive therapy anticipating anti-complementary responses when feeling dominant, which according to interpersonal theory are not positively reinforcing, are associated with conflict or disagreement on the goals of treatment. Furthermore, if a patient tends to anticipate undesirable responses when feeling or acting dominant or assertive, then he or she will probably not experience the therapist agreeing on the goals of therapy. In this study interpersonal schemas of the patient with significant others who are peers were correlated with the alliance with the therapist. Peer relationships are very different from the relationship between a patient and therapist. They tend to be egalitarian, which is not the case in a therapeutic relationship, particularly at the beginning of treatment. Having patients complete the ISQ with their therapist as the significant other would directly assess the relationship between interpersonal schemas and the alliance.

Statement of the Problem

As noted in the literature review, patients' positive history of object relationships, assessed from different perspectives, correlates with the occurrence of positive therapeutic alliances. Furthermore, less attachment anxiety appears associated with the development of an adequate alliance. Unfortunately, many patients begin therapy with a poor history of object relationships or problems with intimacy that might tie into

attachment anxiety. The literature would indicate that they are poor candidates to engage in psychotherapy. Research also indicates the importance of forming a positive alliance early in treatment. Early perceptions of the therapist would affect this early development. These early perceptions would be affected by transferential schemas and are interpersonal in nature. The patient's perception arises from the therapist's manner, both interpersonal behavior and emotional quality, which could be captured by degrees of interpersonal dominance and affiliation. In addition, if certain types of early perceptions are associated with early positive alliances, then awareness of these types of perceptions might lead to ways to foster the development of a positive alliance. Moreover, if maladaptive schemas appear to be contributing to difficulties in developing an alliance, then learning how to address these early might facilitate engaging the patient in treatment.

Hypotheses

1. There will be a positive relationship between patient's perception of therapist's dominance at the beginning of treatment, controlling for the desirability of the perception, and outcome.

2. There will be a positive relationship between patient's perception of therapist's affiliation at the beginning of treatment and outcome.

3. There will be a positive relationship between patient's perception of therapist's dominance at the beginning of treatment, controlling for the desirability of the perception, and therapeutic alliance.

4. There will be a positive relationship between patient's perception of therapist's affiliation at the beginning of treatment and therapeutic alliance.

Methods

Sample

The data for this study were collected through the Brief Psychotherapy Research Program at Beth Israel Medical Center in New York City. Since the 1980's, this program has been examining the psychotherapeutic relationship in individual therapy of adults with long-standing character pathology with the aim of increasing the efficacy of the process of therapy and clinical training (Muran, 2002). The data were collected from 1992 to 2000.

Participants in this project are recruited through advertisements in the *New York Times* and *Village Voice*, referrals from mental health professionals, and from former participants. Participants had to meet the following criteria: (1) be between the ages of 18 and 65 years old, (2) have at least one close personal relationship, (3) have no evidence of mental retardation, organic brain syndrome, or psychosis, (4) do not have the diagnosis of paranoid, schizoid, schizotypal, narcissistic, or borderline personality disorder, according to the Diagnostic and Statistical Manual III-R or IV (DSM-IIIR or DSM-IV), (5) have no axis III, DSM-IIIR or DSM-IV, medical diagnosis, (6) have no evidence of current or recent substance abuse, (7) have no history of destructive impulse control problems or active suicidal ideation, (8) have no current or recent use of psychotropic medication, such as anti-depressants, neuroleptics or lithium, and (9) have no concurrent involvement in other forms of psychotherapy.

After an initial intake evaluation to assess suitability, patients provide informed consent, agreeing to the parameters of the study protocol, which includes being randomly assigned to a course of 30-session psychotherapy, completing self-report questionnaires

and video-taping of sessions. Patients also pay a nominal, income-sensitive fee per session to approximate a naturalistic treatment setting. No fee is charged for the initial evaluation.

Patients: The sample consists of 84 patients, 38 men and 46 women. Sixty-two patients completed all 30 sessions. Twenty-two patients stopped therapy before the 30th session. Their ages ranged from 24 to 71 (M = 39.54, SD = 11.46). Sixty-one percent were single, 16% married, 21% divorced or separated, and 2% widowed. Thirteen percent attended college, 46% graduated college, 6% attended graduate school, and 35% had graduate degrees. Sixty-five patients were employed. Their self-identified ethnicity was 83% white, 7% black, not of Hispanic origin, 5% Latino, 2% Asian, and 3% other. They presented with a variety of longstanding difficulties related to depression, anxiety, and interpersonal functioning. Axis I, DSM-IV diagnoses were 42% mood disorders, 4% past history of major depressive episode, 28% anxiety disorders, 7% adjustment disorders, 17% V codes, and 2% diagnosis deferred. Forty-eight patients received a primary DSM-IV Axis II diagnosis. For the entire sample diagnoses were 27% Personality Disorder, Not Otherwise Specified (23 patients), 18% Avoidant (15), 11% Obsessive Compulsive (9), and Dependent (1).

Therapists: The 84 patients were seen by 70 therapists, 48 women and 22 men, ranging in age from 25 to 52 (M = 35.41, SD = 6.49). Their self-identified ethnicity was 88% white, 3% black, not of Hispanic origin, 3% Latino, and 5% Asian. Fifty-nine percent were single, 35% married, and 6% divorced or separated. Their professional training was as follows: 57% masters level psychology trainees, 21% psychiatrists, 17% psychologists, and 5% masters level social workers. Clinical experience was less than

one year for 73%, 1 to 10 years for 20%, 15 to 21 years for 7%. Therapists also provided informed consent for the parameters of the research protocol.

Treatment

Patients received one of three forms of brief psychotherapy: psychodynamic, cognitive-behavioral, or brief relational therapy, an interpersonal-experiential approach, developed from research of the Beth Israel Psychotherapy Program. Each type of therapy was manualized and designed to treat personality-disordered patients in a 30 session format of weekly 45 minute appointments. All sessions were videotaped and took place in the psychiatric outpatient clinic. A brief description of each type of treatment follows.

Short-Term Dynamic Therapy: Sixteen patients received this treatment, eight of whom stopped before the 30th session. Short-term dynamic psychotherapy (STDP; Pollack, Flegenheimer, & Kaufman, 1992) is based on standard psychodynamic principles for limited treatment periods, such as the manualized treatments developed at Vanderbilt University (Strupp & Binder, 1984) and the University of Pennsylvania (Luborsky, 1984) in conjunction with their psychotherapy research programs. These forms of treatment have their roots in ego psychological formulations of treatment. At the beginning of STDP the therapist develops a case formulation that focuses on a major maladaptive pattern in the patient's life. Persistent interpretation of transferential relationships helps the patient gain insight into this pattern. Resolution of the conflict occurs by making unconscious, maladaptive processes conscious and available to adaptive ego resources. The therapeutic relationship and ruptures in the alliance are conceptualized as transference.

Cognitive Behavioral Therapy: Twenty-nine patients received this treatment, five of whom stopped before the 30th session. The cognitive behavioral therapy (CBT; Turner & Muran, 1992) also begins with a case formulation based on a core belief system, but elaborated as a schema. The treatment has two phases: (1) Symptom Reduction, when initial Axis I concerns are addressed, and (2) Schema Change, when core beliefs are modified or restructured. Both phases entail traditional cognitive behavioral methods, such as self-monitoring, cognitive restructuring, behavioral exercises, and experimentation. The therapeutic relationship is conceived as "collaborative empiricism" (Beck, Rush, Shaw, & Emery, 1979).

Brief Relational Therapy: Thirty-nine patients received this treatment, nine of whom stopped before the 30th session. Brief relational therapy (BRT; Muran & Safran, 2002; Safran, 2002; Safran & Muran, 2000) is a psychotherapeutic approach that integrates principles from relational psychoanalysis and humanistic psychotherapy. Within this framework, research on the process of rupture resolution (Safran & Muran, 1996) has informed the nature and rationale of interventions. In comparison to the other two treatment modalities, BRT focuses more on the interactional process between patient and therapist, with the therapist monitoring and addressing ruptures in the alliance. Rather than develop a specific case formulation, it is assumed that interpersonal difficulties or conflicts will surface through tension in the therapeutic relationship. From exploration of these ruptures through mutual meta-communication about the relationship, both the patient and therapist will understand the conflict and the patient will begin to express him or herself more openly with genuine awareness and assertion of emotions and needs.

Measures and Assessment Procedure

Initial Evaluation: The Structured Interview for DSM-IV-Axis I & II (SCID: First, Spitzer, Gibbon, & Williams, 1995) was used to determine the diagnostic status of each patient. The SCID is a semi-structured interview used to make diagnoses on Axis I and Axis II of the DSM-IV. The interview was administered by first to fourth year clinical psychology graduate students. Training consisted of viewing a demonstration video, role-playing, observation of a live administration, and completion of an inter-rater reliability test that involved rating videotaped samples of previous interviews. These samples included patients presenting with anxiety and mood disorders, as well as personality disorders. The standard for completing training was an intraclass correlation .90 for both sections (Axis I & II) of a reliability test.

Patient's Perceptions of Therapist: The Interpersonal Schema Questionnaire was used to assess patients' perceptions and expectations of their therapists. Patients complete the Interpersonal Schema Questionnaire (ISQ; Hill and Safran, 1994) after sessions 3, 15, and 30. This instrument assesses object relations by having one imagine interpersonal situations that have a self-other structure. Here, the patient, or "self", imagines being in a situation with an "other". For this study the "other" is the therapist. For each situation the patient decides how the therapist would act, and rates how desirable that action is. The situations and responses from other are derived from Kiesler's 1982 interpersonal circle. The ISQ has three subscales: control, affiliation, and desirability.

Treatment Outcome: At the beginning, middle, and end of treatment patients completed the Symptom Checklist-90 Revised (SCL-90-R; Derogatis, 1983), the

Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, et. al., 1988), and Target Complaints (TC; Battle, et. al., 1966). At the beginning and end of treatment therapists completed the Global Assessment Scale (GAS; Endicott, Spitzer, et. al., 1976), Inventory of Interpersonal Problems, and Target Complaints. All these instruments are frequently used to assess overall outcome in psychotherapy research. A brief description of each measures follows.

Symptom Checklist-90 Revised (SCL-90-R; Derogatis, 1983) is a patient-report inventory that assesses general psychiatric symptomology. The 90 items are scaled in a 5-point Likert-type format, evaluating degree of severity of symptoms from "not at all" to "extremely." Normative data and adequate psychometric properties have been reported for nine primary dimensions (somatization, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychosis), including test-retest reliability coefficients ranging from .78 to .90, and internal consistency coefficients ranging form .80 to .90. The Global Severity Index (GSI), which is an overall mean score with stability coefficient of .90 and considered the most sensitive of the three global indices, will be used to measure general psychopathology.

The Inventory of Interpersonal Problems (IIP-64; Alden, Wiggins, & Pincus, 1990; Horowitz, Rosenberg, et. al., 1988) assesses patient adjustment and interpersonal difficulties. The IIP-64 is a revised version of the original 127 item scale developed by Horowitz, Rosenberg, et.al. (1988). The 64-item version consists of 8 items for each of 8 subscales, derived from principal components analysis to represent 8 points on the circumplex of interpersonal problems. These 8 subscales are domineering, vindictive, cold, socially avoidant, nonassertive, exploitable, overly nurturant, and intrusive. This

inventory consists of statements that begin with either the stem “It is hard for me to...” or “These are things I do too much...” Each item is rated on a 5-point Likert-type scale. The scaling was explicitly structured to model the SCL-90-R. Both patient and therapist versions of this instrument will be used.

Target Complaints (TC; Battle, et. al., 1966) is an idiographic instrument designed to assess patients’ particular presenting problems. Each patient lists three problems and rates each one on a 5-point Likert-type scale for level of severity. The ratings are worse, no change, a little better, somewhat better, and a lot better. Both patients and therapists independently rate each problem. The therapist ratings are worse, no change, mild improvement, moderate improvement, and marked improvement.

The Global Assessment Scale (GAS; Endicott, Spitzer, et. al., 1976) assesses the patient’s mental health and adaptive functioning. Therapists evaluate the patient with a single rating. The values range from 1 to 100, representing the hypothetically sickest to healthiest individual. Adequate psychometric properties have been reported. Therapists are trained to reliable standards (intraclass correlation .90).

Session Evaluations: Patients and therapists also complete a post-session questionnaire (PSQ) after each session. This measure was used to look at the processes within sessions. The patient version of the questionnaire consists of items that have the patient reflect on the therapy relationship and therapeutic progress. It includes the short version of the Working Alliance Inventory (WAI; Horvath and Greenberg, 1989, Tracey and Kokotovic, 1989), the Session Evaluation Questionnaire (SEQ; Stiles, 1980), as well as questions about how the patient feels about the therapist and how the patient felt during the session. For example, the questionnaire asks for ratings on the level of tension

experienced in the session and the extent to which this was discussed. Both the WAI and the SEQ are widely used in psychotherapy research and have sound psychometric properties, including internal consistency and predictive validity in relation to a variety of outcome indices. The therapist version of the PSQ will also be used.

The Working Alliance Inventory (WAI; Horvath and Greenberg, 1989, Tracey and Kokotovic, 1989) is derived from Bordin's (1979) pantheoretical conception of the therapeutic alliance, consisting of bond, agreement on tasks, and goals. It has a total of 12 items with three subscales– bond, task, and goals with four items for each subscale. Confirmatory factor analysis determined that a bilevel factor structure, with a General Alliance factor as it primary factor and 3 secondary specific factors, is the best fit. Each item is a first-person statement that one rates on a 7-point Likert type scale for level of presence in the session from "never" to "always." An example of the patient and therapist version of a bond item is "My therapist and I seemed to trust one another" and "My patient and I seemed to trust one another." This instrument has high internal consistency (> .85) and robust predictive validity. It has correlated significantly with a variety of outcome indices (Fenton, Cecero, et al., 2001; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2002).

The Session Evaluation Questionnaire (SEQ; Stiles, 1980) was developed to measure individual session impact. It is a 12 item bipolar measure scaled as a semantic differential. Along a 7-point continuum one indicates which adjective more closely describes the session. Two examples are bad to good and full to empty. It yields two subscales, session smoothness and session depth.

Overview of Procedure

After recruitment patients go through an intake process that includes the administration of the SCID interview, completion of a demographic questionnaire, and the following measures: the Symptom Check List-90-R, the patient's version of the Target Complaints, Inventory of Interpersonal Problems, and Interpersonal Schema Questionnaire, which is administered after the 3rd session. These measures are also administered after the 15th session and the 30th session. After each session they complete the Post Session Questionnaire. Therapists complete the therapist's version of the Target Complaints and Inventory of Interpersonal Problems, and the Global Assessment Scale at the beginning, middle, and end of treatment, as well as the Post Session Questionnaire after each session.

Results

The results of the study are organized into two sections. The first section summarizes the obtained values on all measures and looks at whether these values changed across treatment. The second section addresses the hypotheses of the study, looking at the correlational relationship between the patients' perceptions of their therapists and the process and outcome of therapy.

Preliminary Analyses of the ISQ, Process, and Outcome Measures

This section summarizes any changes in patients' perceptions of their therapists, in the process measures from the post-session questionnaires, and in the outcome measures across all treatments combined. Analyses of variance of the Interpersonal Schema Questionnaire (ISQ) subscales, of each of the process measures, and of each of the outcomes measures were done. The three administrations of the ISQ and the outcomes measures were compared. For the process measures means for the initial 5 sessions, the middle 20 sessions, and the final 5 sessions were compared. The sections ends with analyses completed to assess possible treatment effects.

To determine whether changes in ISQ ratings occurred, analyses of variance were performed for each subscale-- dominance, affiliation, and desirability. The dominance and affiliation indices are calculated by summing the dominance or affiliation weights for each answer. These weights represent the relative dominant or affiliative quality that each answer has. The weights range from -.875 to +.875. Their absolute values are .125, .375, .625, and .875. The maximum absolute value for either of these indices is 14. Negative values represent less dominance or more submission, and less warmth and

friendliness or more coldness and hostility. For example, the answer "would take charge, or try to influence me" has a dominance weight of .875 and an affiliation weight of .125, whereas "would be warm, or friendly" has a dominance weight of -.125 and an affiliation weight of .875. The desirability index is the average of all the desirability ratings for each answer. Desirability ratings could range from 1 to 7. Also, to measure dominance and control for desirability, a weighted dominance score was created by multiplying the dominance weight for each answer with the level of desirability for that answer, then averaging the answers for each administration. The weighted dominance score could range from -6.125 to 6.125.

Analyses of variance found no significant changes in any of the Interpersonal Schema Questionnaire (ISQ) subscales or the weighted dominance score between the administrations (see Table 1). The patients' schemas of their therapists remained stable across treatment.

Table 1. Interpersonal Schema Questionnaire - Subscales and Weighted Dominance Score

	Initial		Middle		Termination					
	M	SD	M	SD	M	SD	n	F	df	p
Dominance	1.70	3.34	2.16	2.70	1.70	3.71	38	0.61	2, 36	0.610
Affiliation	6.72	2.29	6.84	2.19	7.21	2.73	38	0.72	2, 36	0.490
Desirability	5.72	0.73	5.89	0.75	5.97	1.10	38	5.97	2, 36	0.400
Desire Dominance	0.31	1.16	0.33	0.93	0.27	1.09	40	0.07	2, 38	0.940

The analyses of variance of the process measures for both patient and therapist (see Table 2) found a significant change in the Working Alliance Inventory-mean with a large linear trend (patient: η^2 = .28; observed power = 0.99; therapist: η^2 = .45; observed power = 1.00), in the Session Evaluation Questionnaire-Depth subscale with a large linear trend (patient: η^2 = .28; observed power = 0.99; therapist: η^2 = .34; observed power = 1.00), and in the Session Evaluation Questionnaire-Smoothness subscale with a large quadratic trend (patient: η^2 = .29; observed power = 0.99; therapist: η^2 = .45; observed

power = 0.97). For both patients and therapists the alliance and session depth increased from beginning to end of treatment. Although session smoothness also increased when comparing the first and last five sessions of therapy, sessions were less smooth in the middle of treatment.

Table 2. Process Measures										
	Initial		Middle		Termination					
	M	SD	M	SD	M	SD	n	F	df	p
Patient										
WAI	**5.13**	**0.86**	**5.46**	**0.80**	**5.80**	**1.07**	**52**	**10.15**	**2, 49**	**0.000**
SEQ Depth	**5.08**	**0.71**	**5.34**	**0.68**	**5.59**	**0.92**	**52**	**10.74**	**2, 49**	**0.000**
SEQ Smooth	**4.62**	**0.80**	**4.39**	**0.80**	**4.81**	**1.14**	**52**	**11.75**	**2, 49**	**0.000**
Rupture Intensity	3.08	0.91	2.90	0.91	3.18	0.85	15	0.62	2, 13	0.550
Resolution	2.90	1.07	3.09	0.65	3.05	1.24	14	0.16	2, 12	0.860
Therapist										
WAI	**4.71**	**0.64**	**5.00**	**0.65**	**5.39**	**0.86**	**60**	**23.54**	**2, 58**	**0.000**
SEQ Depth	**4.82**	**0.62**	**5.03**	**0.58**	**5.29**	**0.69**	**60**	**14.84**	**2, 58**	**0.000**
SEQ Smooth	**4.45**	**0.77**	**4.30**	**0.63**	**4.62**	**0.88**	**60**	**7.92**	**2, 58**	**0.001**
Rupture Intensity	2.49	0.73	2.78	0.64	2.65	0.99	34	2.92	2, 32	0.070
Resolution	2.76	1.08	2.92	0.73	2.98	1.00	31	0.53	2, 29	0.600

The analyses of variance of the outcome measures found significant change in all the measures except the Global Assessment Scale (see Table 3). Patient improvement occurred from both the perspectives of patients and therapists.

Table 3. Outcome Measures										
	Initial		Middle		Termination					
	M	SD	M	SD	M	SD	n	F	df	p
Symptom Check List	**0.80**	**0.43**	**0.64**	**0.38**	**0.58**	**0.47**	**45**	**4.73**	**2, 43**	**0.010**
Global Assessment Scale	64.06	11.14	65.91	7.19	67.67	12.59	53	1.71	2, 51	0.190
Pt-Target Complaints	**9.79**	**1.68**	**7.58**	**2.47**	**6.09**	**2.53**	**43**	**32.10**	**2, 41**	**0.000**
Th-Target Complaints	**9.53**	**1.43**	**7.16**	**1.85**	**5.83**	**1.83**	**48**	**75.21**	**2, 46**	**0.000**
Pt-Inv Interpers'l Prob	**1.41**	**0.46**	**1.43**	**0.49**	**0.90**	**0.69**	**46**	**17.94**	**2, 44**	**0.000**
Th-Inv Interpers'l Prob	**1.63**	**0.54**	**1.52**	**0.62**	**1.32**	**0.60**	**51**	**7.60**	**2, 49**	**0.000**

Lastly, to see whether any differences related to treatment effects, analyses of variance were done with paired comparisons of the three treatments in relation to each of the Interpersonal Schema Questionnaire (ISQ) subscales, including the weighted dominance score, each of the process measures, and the residual gains on the outcome measures. Residual gains were used to look at the relationship between treatment

outcome and both the ISQ and the process measures (see below). One-way analyses of variance of the treatments were done for each administration of the ISQ. For the process measures one-way analyses of variance were done of the initial, middle, and termination phases. And, one-way analyses of variance of the treatments were done for each outcome measure's residual gain. Except for one process measure significant results were limited to only the psychodynamic treatment (STDP). On the ISQ only the affiliation subscale for STDP was significantly lower than Brief Relational Therapy (BRT) for the initial ($F(2, 77) = 5.09$, $p < .01$) and middle administration ($F(2, 46) = 6.47$, $p < .01$). For all the process measures only the Smooth subscale of the Session Evaluation Questionnaire (SEQ) and the measure of tension had significant treatment differences. The middle phase for the STDP patient ratings of the SEQ-Smooth was significantly lower than both the cognitive behavioral treatment (CBT) and the BRT. For the measure of tension in the sessions for each phase of treatment CBT therapists experienced less tension than the other therapists (Initial phase: $F(2, 69) = 5.25$, $p < .01$; Middle phase: $F(2, 71) = 3.58$ $p < .05$; Termination phase: $F(2, 35) = 3.85$, $p < .05$). Among all the outcome measures only the residual gain on the Global Assessment scale (GAS) for the psychodynamic treatment was significantly lower than both CBT and the Brief Relational Treatment ($F(2, 44) = 4.85$, $p < .05$). In sum, the psychodynamic therapists were perceived as less affiliative than the brief relational therapists. The psychodynamic patients also experienced the middle sessions as less smooth than the other patients. And, the psychodynamic therapists did not observe as large a change on the GAS as the other therapists. Lastly, the cognitive therapists experienced less tension in the sessions than the other therapists.

Relationship of the ISQ with the Process and Outcome Measures

This section summarizes correlational relationships between the patients' perceptions of their therapists and both the process measures and outcome measures.

To test the hypotheses that there would be a positive relationship between patients' initial perceptions of their therapists as dominant, controlling for desirability, and both the therapeutic alliance and outcome, correlational analyses of the dominance index and the desire-dominance score with both the process and outcome measures were completed. To account for differences on the outcome measures between the beginning and end of treatment, residual gain scores were calculated. Residual gains, rather than difference scores, were used in order to account for gains relative to patients' level of functioning at the beginning of treatment. There was a positive relationship between patients' initial perception of their therapists as dominant and the initial patient ratings of the WAI and SEQ-Depth (see Table 4), and the final therapist ratings of the SEQ-Depth (see Table 6). There was a negative relationship between patients' initial perception of their therapists as dominant and the therapist ratings of tension in the termination sessions (see Table 6). There was a positive relationship between the patients' initial perception of dominance, controlling for desirability, and the initial therapist ratings of SEQ-Depth (see Table 4); the middle patient ratings of the WAI, and both the SEQ-Depth and Smoothness (see table 5); and the patient ratings of resolution in the termination sessions (see Table 6); and a negative relationship with the therapist ratings of level of tension in the termination sessions (see Table 6). In general, when looking at patients' perceptions of dominance, with or without controlling for desirability, there were more positive correlations for the process variables from the patients' perspective than from the

therapists' perspective throughout the different phases of treatment (see Tables 4, 5, and 6). No relationship appeared between early perceptions of the therapist as dominant, with or without controlling for desirability, and the outcome measures (see Table 7). Overall, dominance had a positive association with the alliance, session depth, session smoothness, less tension in sessions, and resolution of tension in sessions when tension occurred.

Similarly, to test the hypotheses that there would be a positive relationship between patients' perceptions of their therapists as affiliative and both the therapeutic alliance and outcome, correlational analyses between the affiliation index and both the process and outcome measures were completed. There was a positive relationship between the patients' initial view of their therapists as affiliative and both initial and middle patient ratings of the WAI, SEQ-Depth, and SEQ-Smooth (see Table 4 and 5, respectively). There was a positive relationship between the patients' initial view of their therapists as affiliative and the therapists' terminal ratings of the WAI (see Table 6). For all administrations of the ISQ there were more positive correlations between the affiliation index and the patients' ratings of the WAI and SEQ for all phases of treatment than with the therapists' ratings (see Tables 4, 5, and 6). No relationship appeared between early perceptions of the therapist as affiliative and the outcome measures (see Table 7). In sum, there was a positive association between affiliation and the alliance, session depth, and session smoothness.

Looking at all phases of treatment (Tables 4, 5, and 6), the ISQ subscales for each administration had a consistent positive correlation with the patient ratings of the Working Alliance Inventory (WAI) and both subscales of the Session Evaluation

Questionnaire (SEQ). However, significant correlations were limited between the ISQ subscales and therapists' ratings of these process measures. Significant correlations for these therapist rated process measures occurred only in the initial and terminal phases of treatment. For the initial phase there was a positive correlation between the WAI and initial Desirability index, the SEQ-Smooth and Mid-point Desirability index, the SEQ-Depth and initial weighted Dominance score. For the termination phase there were positive correlations between the WAI and the initial Affiliation index, and the initial and mid-point Desirability index. The SEQ-Depth during termination had a positive correlation with the initial Dominance index. Overall, patient ratings of alliance, session depth, and session smoothness had more positive associations with the ISQ subscales for all phases of treatment than the therapist ratings, which were limited to the initial and terminal phases.

In contrast, for the measures of tension and resolution in the sessions there were more significant correlations between the ISQ subscales and the therapist ratings. There was a negative correlation between the initial level of tension from the therapists' perspective (Table 4) and the Desirability index at intake and mid-point of treatment and Desire-Dominance at termination; between the middle phase level of tension from the therapists' perspective (Table 5) and the Dominance index at intake and mid-point; and between the terminal level of tension (Table 6) and the Desirability index at mid-point. The only significant correlation between the tension and resolution measures from the patients' perspective was the positive correlation between Desire-Dominance at intake and level of resolution during termination (Table 6). Generally, therapists' experience of

less tension in the sessions was associated with patients' desirable and dominant views of their therapists.

Although there were no significant correlations between any of the initial ISQ subscales, including the Desire-Dominance score, and the outcome measures, there were significant correlations between the middle and terminal administrations of the ISQ and residual gains. Dominance at these points in treatment related to decreases in symptoms. There was a negative correlation between the Dominance index at the mid-point of treatment and patient interpersonal problems. This relationship occurred also for the Dominance index at termination. Furthermore, the Dominance index at termination had a negative correlation with residual gains on the Symptom Check List. Also at termination there was a negative correlation between the Desire-Dominance score and patient interpersonal problems. Patients' perception of dominance after the beginning phase of treatment was associated with patient improvement.

Correlational analyses between the process measures for each phase of treatment and the residual gain scores were done (see Tables 8, 9, and 10). The significant differences for the process and outcome measures across treatment led to correlational analyses to understand better their relationship and specifically to address whether there would be a positive relationship between early therapeutic alliance and outcome, which would be consistent with earlier research (Horvath and Symonds, 1991; Martin, Garske, et.al., 2000). There was a negative relationship between patient's initial ratings on the SEQ-Smooth and residual gains on patient target complaints and patient interpersonal problems. Patients' experience of the initial sessions as smooth correlated with decreases in patients' view of their target complaints and interpersonal problems. There was a

negative relationship between therapists' initial rating on the SEQ-Depth and residual gains on patient and therapist target complaints, and the symptom checklist. Therapists' view that the initial sessions have psychotherapeutic depth correlated with decreases in both patients' and therapists' view of the patient's target complaints, decreases in the patients' symptoms, and both patients' and therapists' view of patient improvement. In sum, patients' early experience of smooth sessions and therapists' early experience of deep sessions were associated with patient improvement.

To look at possible factors contributing to these relationships with the residual gains, correlational analyses for the middle and terminal phases were done (see Tables 9 and 10, respectively). For the middle phase patient ratings of the SEQ-Smooth continued to have a negative correlation with patient interpersonal problems. There also was a negative correlation between patients' experience of resolution and therapist target complaints. For the middle phase of treatment the therapist ratings of the SEQ-Depth continued to have a negative correlation with therapist target complaints. In addition there were significant correlations with various residual gains and the therapist ratings of the WAI, SEQ-Smooth, tension, and resolution during the middle phase of treatment. For the termination phase there were significant correlations for the residual gains with patient ratings of the WAI, SEQ-Depth, SEQ-Smooth, and resolution. For this last phase of treatment therapists' ratings of the WAI and SEQ-Depth correlated significantly with residual gains. Generally, there were more positive associations between in-session process and outcome during the middle and terminal phases than during the initial phase. From both the patients' and therapists' perspectives, the alliance, session depth, session smoothness, and resolution of tension were related to improvement.

Table 4. Correlations of ISQ Subscales and Process Measures from Initial Phase

ISQ by Phase		Initial Phase									
		Patient					Therapist				
		WAI	SEQ Depth	SEQ Smooth	Tension Level	Resolu-tion	WAI	SEQ Depth	SEQ Smooth	Tension Level	Resolu-tion
Dominance at intake	Pears	.39***	.36***	0.16	-0.02	-0.02	0.13	0.09	0.12	-0.20	0.01
	Sig.	**0.000**	**0.001**	0.157	0.890	0.921	0.256	0.440	0.297	0.101	0.914
	N	80	80	80	44	43	81	81	81	72	71
Affiliation at intake	Pears	.47***	.42***	.39***	-0.22	0.03	0.17	-0.05	0.20	-0.17	0.02
	Sig.	**0.000**	**0.000**	**0.000**	0.145	0.874	0.122	0.656	0.074	0.159	0.896
	N	80	80	80	44	43	81	81	81	72	71
Desirability at intake	Pears	.69***	.52***	.44***	-0.19	-0.04	.24*	0.08	0.22	-.23*	0.16
	Sig.	**0.000**	**0.000**	**0.000**	0.209	0.804	**0.029**	0.502	0.051	**0.049**	0.172
	N	80	80	80	44	43	81	81	81	72	71
Desire Dominance at intake	Pears	0.10	0.15	0.15	0.27	-0.11	0.07	.25*	0.11	-0.18	0.08
	Sig.	0.418	0.203	0.219	0.085	0.498	0.547	**0.028**	0.358	0.137	0.517
	N	74	74	74	42	42	75	75	75	68	67
Dominance at midphase	Pears	.48***	.46***	.34*	0.09	0.17	0.11	0.08	0.14	-0.19	0.23
	Sig.	**0.000**	**0.001**	**0.017**	0.626	0.368	0.443	0.609	0.351	0.224	0.139
	N	49	49	49	29	29	49	49	49	45	44
Affiliation at midphase	Pears	0.18	0.13	.36*	-0.12	0.14	0.01	-0.01	0.13	-0.22	0.07
	Sig.	0.217	0.363	**0.011**	0.554	0.456	0.926	0.947	0.391	0.154	0.638
	N	49	49	49	29	29	49	49	49	45	44
Desirability at midphase	Pears	.43**	.41**	.37**	-0.13	0.06	0.22	-0.04	.29*	-.38**	0.14
	Sig.	**0.002**	**0.004**	**0.009**	0.491	0.756	0.122	0.812	**0.047**	**0.010**	0.360
	N	49	49	49	29	29	49	49	49	45	44
Desire Dominance at midphase	Pears	.49**	.40**	0.21	0.22	0.22	0.11	0.04	0.16	-0.17	0.17
	Sig.	**0.000**	**0.004**	0.152	0.250	0.238	0.468	0.796	0.263	0.264	0.260
	N	50	50	50	30	30	50	50	50	45	44
Dominance at termination	Pears	0.06	0.00	0.13	0.07	0.11	0.01	-0.22	0.00	-0.23	-0.18
	Sig.	0.685	0.977	0.412	0.745	0.593	0.941	0.142	0.995	0.152	0.281
	N	45	45	45	26	26	45	45	45	40	39
Affiliation at termination	Pears	0.06	0.03	0.19	-0.09	0.28	-0.07	-0.18	0.14	-0.01	-0.55
	Sig.	0.705	0.862	0.214	0.666	0.163	0.660	0.242	0.374	0.977	0.741
	N	45	45	45	26	26	45	45	45	40	39
Desirability at termination	Pears	0.07	0.09	0.15	-0.04	0.18	0.00	-0.02	0.18	-0.12	0.02
	Sig.	0.663	0.541	0.341	0.846	0.372	0.993	0.900	0.246	0.456	0.913
	N	45	45	45	26	26	45	45	45	40	39
Desire Dominance termination	Pears	0.09	0.04	0.15	0.08	0.08	0.01	-0.12	-0.03	-.39*	-0.13
	Sig.	0.542	0.817	0.306	0.683	0.692	0.948	0.414	0.844	**0.012**	0.416
	N	47	47	47	27	27	47	47	47	42	41

* p < .05, ** p < .01, *** p < .001

Table 5. Correlations of ISQ Subscales and Process Measures from Middle Phase

ISQ by Phase		Middle Phase									
		Patient					Therapist				
		WAI	SEQ Depth	SEQ Smooth	Tension Level	Resolu-tion	WAI	SEQ Depth	SEQ Smooth	Tension Level	Resolu-tion
Dominance at intake	Pears	0.22	0.20	0.16	0.01	-0.08	0.09	0.09	0.07	-0.17	0.09
	Sig.	0.057	0.082	0.168	0.960	0.579	0.440	0.419	0.523	0.159	0.451
	N	76	76	76	56	55	78	78	78	74	74
Affiliation at intake	Pears	.31**	.27*	.40***	-0.01	0.01	0.00	-0.14	0.07	-0.14	-0.20
	Sig.	**0.007**	**0.020**	**0.000**	0.396	0.922	0.984	0.222	0.567	0.226	0.088
	N	76	76	76	56	55	78	78	78	74	74
Desirability at intake	Pears	0.07	-0.08	0.09	-0.09	0.07	0.21	0.09	0.12	0.08	0.01
	Sig.	0.554	0.484	0.433	0.519	0.637	0.060	0.424	0.286	0.516	0.942
	N	76	76	76	56	55	78	78	78	74	74
Desire Dominance at intake	Pears	.48***	.35***	.50***	0.14	-0.01	0.03	-0.06	0.04	-0.10	0.17
	Sig.	**0.000**	**0.002**	**0.000**	0.312	0.934	0.816	0.579	0.734	0.390	0.153
	N	76	76	76	54	53	78	78	78	70	70
Dominance at midphase	Pears	0.20	0.09	0.07	-0.17	0.12	0.03	0.20	0.06	-0.17	0.20
	Sig.	0.093	0.444	0.560	0.322	0.481	0.813	0.093	0.643	0.261	0.183
	N	72	72	72	37	36	74	74	74	45	45
Affiliation at midphase	Pears	.44**	.46***	.47***	-0.23	0.04	0.16	0.04	0.16	-0.19	-0.16
	Sig.	**0.002**	**0.001**	**0.001**	0.172	0.820	0.269	0.789	0.282	0.210	0.286
	N	49	49	49	37	36	49	49	49	45	45
Desirability at midphase	Pears	0.09	0.02	.39**	-0.14	0.05	-0.14	-0.20	-0.02	-.30*	-0.10
	Sig.	0.542	0.900	**0.006**	0.399	0.766	0.345	0.166	0.908	**0.044**	0.506
	N	49	49	49	37	36	49	49	49	45	45
Desire Dominance at midphase	Pears	0.15	0.08	0.00	-0.04	0.18	0.18	0.21	0.22	-0.05	0.13
	Sig.	0.295	0.582	0.997	0.795	0.271	0.215	0.145	0.138	0.756	0.385
	N	49	49	49	39	38	49	49	49	46	46
Dominance at termination	Pears	.44**	.38**	.47***	-0.16	-0.05	0.21	-0.15	0.22	-0.18	0.12
	Sig.	**0.002**	**0.007**	**0.001**	0.357	0.773	0.154	0.292	0.136	0.249	0.467
	N	49	49	49	36	35	49	49	49	42	42
Affiliation at termination	Pears	.47***	.49***	0.26	-0.26	0.27	0.15	0.04	0.16	-0.14	0.10
	Sig.	**0.001**	**0.000**	0.066	0.119	0.112	0.311	0.794	0.254	0.386	0.544
	N	50	50	50	36	35	50	50	50	42	42
Desirability at termination	Pears	0.24	0.15	0.17	0.09	-0.07	0.08	-0.03	.32*	-0.16	-0.03
	Sig.	0.111	0.328	0.277	0.595	0.699	0.605	0.849	**0.031**	0.314	0.851
	N	45	45	45	36	35	45	45	45	42	42
Desire Dominance termination	Pears	0.27	0.19	.43**	-0.13	-0.12	-0.04	-0.25	0.08	-0.16	0.12
	Sig.	0.072	0.201	**0.003**	0.421	0.472	0.803	0.093	0.616	0.290	0.436
	N	45	45	45	38	37	45	45	45	44	44

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

Table 6. Correlations of ISQ Subscales and Process Measures from Termination Phase

ISQ by Phase		Termination Phase									
		Patient					Therapist				
		WAI	SEQ Depth	SEQ Smooth	Tension Level	Resolu-tion	WAI	SEQ Depth	SEQ Smooth	Tension Level	Resolu-tion
Dominance at intake	Pears	-0.06	0.04	0.05	-0.06	0.29	0.13	.26*	0.12	-.38*	0.27
	Sig.	0.674	0.760	0.713	0.803	0.241	0.307	**0.047**	0.371	**0.019**	0.119
	N	52	52	52	19	18	60	60	60	38	36
Affiliation at intake	Pears	0.10	0.07	0.25	0.31	-0.08	.26*	0.12	0.25	-0.27	0.33
	Sig.	0.500	0.639	0.069	0.197	0.739	**0.048**	0.372	0.058	0.107	0.051
	N	52	52	52	19	18	60	60	60	38	36
Desirability at intake	Pears	.29*	0.23	0.16	0.04	0.04	0.17	0.07	0.08	-0.32	0.26
	Sig.	**0.034**	0.102	0.256	0.886	0.889	0.200	0.597	0.524	0.054	0.127
	N	52	52	52	19	18	60	60	60	38	36
Desire Dominance at intake	Pears	-0.01	0.00	0.06	-0.23	.52*	0.09	0.23	0.07	-.33*	0.08
	Sig.	0.949	0.987	0.701	0.349	**0.027**	0.482	0.088	0.618	**0.043**	0.663
	N	52	52	52	19	18	58	58	58	37	35
Dominance at midphase	Pears	0.29	.44**	0.29	0.36	-0.09	0.14	0.01	0.15	-.41*	-0.21
	Sig.	0.059	**0.004**	0.066	0.201	0.772	0.357	0.944	0.329	**0.031**	0.298
	N	42	42	42	14	14	44	44	44	28	27
Affiliation at midphase	Pears	0.06	0.06	0.15	-0.16	-0.19	0.15	0.14	0.13	0.09	-0.99
	Sig.	0.727	0.690	0.332	0.589	0.515	0.320	0.364	0.420	0.657	0.624
	N	42	42	42	14	14	44	44	44	28	27
Desirability at midphase	Pears	0.30	.40**	0.16	0.23	-0.09	.43**	0.16	0.18	-0.26	0.17
	Sig.	0.052	**0.009**	0.305	0.431	0.756	**0.004**	0.314	0.234	0.178	0.398
	N	42	42	42	14	14	44	44	44	28	27
Desire Dominance at midphase	Pears	.38*	.53***	0.28	0.31	-0.05	0.02	-0.10	0.07	-0.38	-0.68
	Sig.	**0.011**	**0.000**	0.064	0.267	0.873	0.924	0.528	0.671	0.053	0.741
	N	44	44	44	15	15	44	44	44	27	26
Dominance at termination	Pears	.43**	.39*	.41**	0.09	0.34	0.07	0.12	0.19	-0.34	-0.46
	Sig.	**0.007**	**0.016**	**0.009**	0.740	0.219	0.653	0.451	0.223	0.084	0.823
	N	39	39	39	15	15	44	44	44	27	26
Affiliation at termination	Pears	.46**	.44**	.44**	-0.20	0.06	0.02	-0.10	0.10	-0.06	-0.25
	Sig.	**0.003**	**0.006**	**0.005**	0.486	0.841	0.920	0.511	0.506	0.771	0.213
	N	39	39	39	15	15	44	44	44	27	26
Desirability at termination	Pears	.44**	.58***	.49***	0.01	0.15	0.17	0.03	0.12	-0.36	-0.58
	Sig.	**0.006**	**0.000**	**0.001**	0.987	0.598	0.276	0.843	0.445	0.069	0.778
	N	39	39	39	15	15	44	44	44	27	26
Desire Dominance termination	Pears	.34*	0.26	.37*	-0.05	0.31	0.03	0.11	0.14	-.445(*)	0.11
	Sig.	**0.026**	0.102	**0.017**	0.844	0.238	0.850	0.475	0.349	**0.018**	0.584
	N	42	42	42	16	16	45	45	45	28	27

* p < .05, ** p < .01, *** p < .001

Table 7. Correlations - ISQ Subscales and Residual Gains for Outcome Measures

ISQ Phases		Pt Target Complaints	Th Target Complaints	Symptom Check List	Global Assessment Scale	Pt Inventory Interper-sonal Problems	Th Inventory Interper-sonal Problems
Dominance at intake	Pearson	-0.15	-0.08	0.05	0.07	-0.20	-0.07
	Signif.	0.306	0.566	0.726	0.603	0.165	0.645
	N	48	49	50	54	50	51
Affiliation at intake	Pearson	-0.05	0.06	0.04	-0.21	-0.27	0.19
	Signif.	0.758	0.691	0.809	0.125	0.054	0.184
	N	48	49	50	54	50	51
Desirability at intake	Pearson	-0.03	0.05	0.13	-0.09	-0.13	0.19
	Siginif.	0.864	0.751	0.381	0.543	0.382	0.185
	N	48	49	50	54	50	51
Desire Dominance at intake	Pearson	-0.11	-0.10	0.10	-0.27	-0.22	0.00
	Signif.	0.471	0.487	0.526	0.062	0.139	0.981
	N	46	47	47	50	47	48
Dominance at midphase	Pearson	-0.16	-0.21	0.10	0.09	-.32*	0.02
	Signif.	0.331	0.206	0.545	0.604	**0.047**	0.890
	N	39	37	40	40	40	38
Affiliation at midphase	Pearson	0.00	-0.14	-0.01	-0.07	-0.12	-0.06
	Signif.	0.996	0.404	0.967	0.687	0.470	0.744
	N	39	37	40	40	40	38
Desirability at midphase	Pearson	0.11	0.11	-0.04	-0.01	-0.23	-0.10
	Signif.	0.523	0.503	0.831	0.968	0.159	0.572
	N	39	37	40	40	40	38
Desire Dominance midphase	Pearson	-0.08	-0.14	0.16	0.07	-0.30	0.10
	Signif.	0.642	0.411	0.325	0.656	0.062	0.572
	N	39	37	40	39	40	38
Dominance at termination	Pearson	-0.23	-0.28	-.34*	0.13	-.32*	-0.09
	Signif.	0.123	0.077	**0.019**	0.410	**0.030**	0.593
	N	45	41	46	44	46	42
Affiliation at termination	Pearson	-0.14	-0.14	-0.17	-0.10	-0.15	0.05
	Signif.	0.359	0.391	0.262	0.506	0.331	0.762
	N	45	41	46	44	46	42
Desirability at termination	Pearson	-0.16	-0.09	-0.29	-0.08	-0.10	-0.12
	Signif.	0.302	0.597	0.053	0.626	0.502	0.460
	N	45	41	46	44	46	42
Desire Dominance termination	Pearson	-0.25	-0.27	-0.28	0.08	-.36*	-0.09
	Signif.	0.099	0.090	0.063	0.620	**0.015**	0.588
	N	45	41	45	43	45	41

* $p < .05$

Table 8. Correlations of Initial Process Measures and Residual Gain on Outcome Measures

Initial Phase		Pt Target Complaint	Th Target Complaint	Symptom Check List	Global Assessment Scale	Pt Inventory Interper-sonal Problems	Th Inventory Interper-sonal Problems
Pt WAI	Pearson Corr	-0.04	-0.14	0.08	0.06	-0.08	0.05
	Sig.	0.783	0.344	0.598	0.698	0.606	0.746
	N	47	48	48	51	48	49
Pt SEQ-Depth	Pearson Corr	-0.16	-0.20	0.01	0.14	-0.10	-0.15
	Sig.	0.281	0.175	0.956	0.347	0.511	0.297
	N	47	48	48	51	48	49
Pt SEQ-Smooth	Pearson Corr	-.33*	-0.18	-0.18	0.05	-.34*	-0.04
	Sig.	**0.022**	0.228	0.235	0.742	**0.018**	0.803
	N	47	48	48	51	48	49
Pt Tension Level	Pearson Corr	0.09	-0.31	0.22	-0.26	0.01	0.03
	Sig.	0.651	0.110	0.270	0.186	0.948	0.875
	N	27	28	28	28	28	27
Pt Resolution	Pearson Corr	0.09	-0.06	0.34	-0.03	0.07	0.08
	Sig.	0.673	0.753	0.080	0.890	0.718	0.676
	N	27	27	28	28	28	27
Th WAI	Pearson Corr	-0.08	-0.12	-0.11	0.19	-0.02	-0.16
	Sig.	0.617	0.420	0.458	0.181	0.916	0.268
	N	47	48	48	51	48	49
Th SEQ-Depth	Pearson Corr	-.37**	-.33*	-.29*	0.12	-0.14	-0.18
	Sig.	**0.010**	**0.020**	**0.045**	0.419	0.337	0.221
	N	47	48	48	51	48	49
Th SEQ-Smooth	Pearson Corr	-0.06	-0.13	-0.20	-0.05	-0.17	-0.12
	Sig.	0.714	0.377	0.168	0.744	0.262	0.418
	N	47	48	48	51	48	49
Th Tension Level	Pearson Corr	-0.21	-0.22	-0.13	0.06	-0.04	0.12
	Sig.	0.179	0.162	0.403	0.682	0.789	0.427
	N	41	42	42	45	42	44
Th Resolution	Pearson Corr	-0.20	-0.11	0.12	0.19	-0.14	-0.03
	Sig.	0.216	0.484	0.465	0.217	0.399	0.838
	N	40	41	41	44	41	43

* $p < .05$, ** $p < .01$

Table 9. Correlations of Middle Process Measures and Residual Gain on Outcome Measures

Middle Phase		Pt Target Complaint	Th Target Complaint	Symptom Check List	Global Assessment Scale	Pt Inventory Interper-sonal Problems	Th Inventory Interper-sonal Problems
Pt WAI	Pearson Corr	-0.18	-0.11	-0.02	-0.01	0.00	0.00
	Sig.	0.215	0.462	0.908	0.925	0.995	0.985
	N	47	47	48	50	48	48
Pt SEQ-Depth	Pearson Corr	-0.24	-0.12	0.07	0.20	0.07	-0.26
	Sig.	0.105	0.422	0.640	0.171	0.656	0.079
	N	47	47	48	50	48	48
Pt SEQ-Smooth	Pearson Corr	-0.16	0.02	-0.23	0.01	-.30*	0.10
	Sig.	0.270	0.916	0.120	0.975	**0.039**	0.498
	N	47	47	48	50	48	48
Pt Tension Level	Pearson Corr	0.13	0.09	0.08	-0.20	0.22	0.11
	Sig.	0.458	0.604	0.646	0.240	0.195	0.534
	N	37	35	38	37	38	36
Pt Resolution	Pearson Corr	-0.30	-.48**	-0.29	0.06	0.21	-0.25
	Sig.	0.078	**0.005**	0.082	0.725	0.209	0.144
	N	36	33	37	36	37	35
Th WAI	Pearson Corr	-0.12	-.29*	-0.10	0.25	-0.12	-0.25
	Sig.	0.415	**0.044**	0.508	0.083	0.418	0.082
	N	47	48	48	51	48	49
Th SEQ-Depth	Pearson Corr	-0.18	-.40**	-0.12	0.26	-0.22	-0.16
	Sig.	0.225	**0.005**	0.438	0.061	0.136	0.286
	N	47	48	48	51	48	49
Th SEQ-Smooth	Pearson Corr	-0.04	-0.14	-0.22	0.08	-.37**	-0.01
	Sig.	0.811	0.347	0.137	0.561	**0.009**	0.952
	N	47	48	48	51	48	49
Th Tension Level	Pearson Corr	0.03	-0.01	0.14	0.09	0.10	.35*
	Sig.	0.861	0.930	0.381	0.559	0.528	**0.019**
	N	43	44	44	47	44	45
Th Resolution	Pearson Corr	-.35*	-.45**	-0.18	0.02	-0.11	0.01
	Sig.	**0.023**	**0.002**	0.244	0.921	0.490	0.972
	N	43	44	44	47	44	45

* p < .05, ** p < .01

Table 10. Correlations of Termination Process Measures and Residual Gain on Outcome Measures

Termination Phase		Pt Target Complaint	Th Target Complaint	Symptom Check List	Global Assessment Scale	Pt Inventory Interper-sonal Problems	Th Inventory Interper-sonal Problems
Pt WAI	Pearson Corr	-.32*	-0.24	-0.26	0.04	0.05	-0.10
	Sig.	**0.040**	0.124	0.095	0.823	0.751	0.515
	N	41	41	42	43	42	42
Pt SEQ-Depth	Pearson Corr	-.41**	-0.27	-0.30	0.12	-0.10	-0.29
	Sig.	**0.008**	0.085	0.055	0.461	0.516	0.065
	N	41	41	42	43	42	42
Pt SEQ-Smooth	Pearson Corr	-.41**	-.34*	-.39*	-0.14	-.51***	-0.14
	Sig.	**0.008**	**0.032**	**0.010**	0.369	**0.001**	0.367
	N	41	41	42	43	42	42
Pt Tension Level	Pearson Corr	0.26	-0.02	0.09	0.03	0.36	-0.01
	Sig.	0.329	0.940	0.752	0.925	0.174	0.976
	N	16	17	16	17	16	17
Pt Resolution	Pearson Corr	-.54*	-0.17	-0.41	-0.18	-0.24	-0.06
	Sig.	**0.031**	0.541	0.115	0.507	0.375	0.813
	N	16	16	16	16	16	16
Th WAI	Pearson Corr	-0.21	-.34*	-0.19	0.25	-0.02	-.43**
	Sig.	0.157	**0.017**	0.203	0.078	0.872	**0.002**
	N	46	48	46	51	46	49
Th SEQ-Depth	Pearson Corr	-0.23	-.39**	-0.11	.33*	-0.18	-.42**
	Sig.	0.122	**0.006**	0.482	**0.020**	0.242	**0.003**
	N	46	48	46	51	46	49
Th SEQ-Smooth	Pearson Corr	-0.02	-0.22	-0.19	0.04	-0.16	-0.20
	Sig.	0.922	0.140	0.215	0.778	0.295	0.173
	N	46	48	46	51	46	49
Th Tension Level	Pearson Corr	-0.03	-0.03	-0.01	0.04	0.08	0.04
	Sig.	0.873	0.896	0.949	0.850	0.698	0.828
	N	28	28	28	31	28	30
Th Resolution	Pearson Corr	0.00	0.02	0.28	0.13	0.11	-0.14
	Sig.	0.997	0.932	0.152	0.498	0.602	0.480
	N	27	27	27	29	27	28

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

Discussion

This study looked at the relationship between patients' initial perceptions of their therapists as dominant or affiliative and the process and outcome of time-limited therapy. Patients' initial views of their therapist remained quite stable. Patients considered their therapists as low in dominance and moderately affiliative. Patients' interpersonal expectations of their therapists were highly desirable throughout treatment. Although these images of the therapist were associated with in-session process, they did not appear related to treatment outcome. Specifically, the results did not support the hypotheses that an early view of one's therapist as dominant, controlling for desirability, or as affiliative would have a positive relationship to treatment outcome.

The results of the study did support the hypothesis that patients' early perception of affiliation would have a positive relationship to the therapeutic alliance. A moderate level of affiliation was associated with a positive therapeutic alliance in all phases of treatment. Once this pattern began it continued through the three phases of treatment, shifting from phase to phase. An initial view of the therapist as affiliative was associated with a positive alliance in the initial and middle phases of treatment. Affiliation at the mid-point of treatment was also positively related to the alliance during the middle phase. And, a final view of the therapist as affiliative related positively to the alliance in the termination phase.

The results of the study also supported the hypothesis that dominance, controlling for desirability, would have a positive relationship with the therapeutic alliance. However, unlike affiliation, the association occurred in relation to process measured in an

adjacent phase and tended to occur after the experience of a positive alliance. Initial perceptions of dominance, controlling for desirability, had a positive relationship to the alliance in the middle phase. This perception at the mid-point of treatment had a positive relationship to the alliance in both the initial and terminal phase. After the last session of therapy this perception was associated with a positive alliance during the middle and termination phases.

Patient and therapist experience of sessions in relation to affiliation and dominance

Generally, initial perceptions of the therapist as affiliative and all phases of therapy related to patients' experience of the sessions, but not therapists' experience. There was only one relationship between affiliation and any therapist ratings of the process measures: a positive correlation between initial affiliation and the alliance during termination. In contrast, patients' experience of an affiliative therapist related positively to the process measures for each of the three phases. The expectation of positive affiliation at the beginning of therapy probably developed into a bond connected to positive associations with the alliance. The experience of an alliance and session depth preceded the additional experience of session smoothness, suggesting that patients became accustomed and possibly more adept with the process of therapy. As they continued in therapy, they gained comfort or facility in working psychotherapeutically. These are the specific findings for the relationship between affiliation and the patient process ratings. In the initial sessions affiliation at intake was associated with both the alliance and session depth. In the middle sessions alliance, session depth, and session smoothness was associated with affiliation at both intake and the mid-point of treatment.

This pattern continued through the terminal sessions. Alliance, session depth, and session smoothness during the terminal sessions related to affiliation at termination.

Comparably, initial perceptions of the therapist as dominant, with or without accounting for desirability, and the initial and middle phases of therapy related more to patients' experience of the sessions than therapists' view of the sessions. These are the correlations of desired dominance, then dominance only, and phase-by-phase process: Initial views of dominance, which was desirable, related to patients' experience of a positive alliance and both depth and smoothness in the middle sessions, and resolution of tension during termination. These desirable views also related to therapist's experience of depth in the initial sessions and less tension during termination. Desired dominance at the mid-point of treatment related to patients' experience of a positive alliance and session depth during both the initial and terminal phases. Desired dominance at the end of therapy was associated with session smoothness during the middle phase and both the alliance and session smoothness during termination for the patients. Also, this perception at termination was linked with less tension in the terminal sessions from the therapists' perspective. Similarly, dominance early in treatment related to a positive alliance and session depth in the initial phase for patients, but depth and less tension at termination for therapists. This relationship for patients continued to the end of treatment with the additional association of dominance and session smoothness both at the mid-point of therapy and at termination.

Patients' initial view of their therapists, particularly if it's a desirable view, would be one that they anticipate favorably. It was assumed that patients would prefer affiliation. The positive relationship between moderate affiliation and the process variables through

all phases of treatment would support this assumption. For desired dominance it would appear that for most of treatment patients experienced a positive experience with their therapist in part from favorably anticipating a mildly dominant therapist. They experienced a positive alliance with depth and smoothness in the sessions. Session depth might have come in part from the manner in which the therapist conveyed low dominance, such as making interventions that would deepen psychotherapeutic exploration. Being positively disposed toward the perception of low dominance would facilitate developing an alliance. By the end of treatment it would appear that this relationship had continued in a way that led to ease in the psychotherapeutic relationship or the capacity to work through or overcome minor conflicts in the sessions.

To understand further the relationship of affiliation, desired dominance, and dominance with the process measures, we will look at these perceptions in relation to treatment phases that had concurrent patient experience of a positive alliance, session depth, and session smoothness, which would represent a very positive, auspicious patient relationship with the therapist. From the patient's perspective there would be a psychotherapeutic or workable alliance, one in which the sessions have depth of content and interpersonal smoothness. The initial moderate level of affiliation was associated with a positive alliance, session depth, and session smoothness during the middle phase, sessions 6 through 25. This relationship continued to the end of therapy. Both at the mid-point of treatment and at termination moderate affiliation was associated with these three process measures. Patient's initial favorable view of the therapist as dominant was associated with a positive alliance, session depth, and session smoothness during the middle phase of therapy. Initial experience of a positive alliance, session depth, and

session smoothness was followed by a view of the therapist as dominant at the mid-point of therapy. A final view of the therapist as dominant was preceded by a positive alliance, session depth, and session smoothness through the middle and terminal phases. One interpretation would be that patients who initially favored a mildly dominant therapist, who was also moderately warm, became engaged in therapy so that the middle phase had a workable alliance with session depth and smoothness. By the mid-point of therapy preference for dominance was not as critical. Only the recognition or anticipation of low dominance was associated with a workable alliance. It could be that the therapist met or confirmed the patient's initial favorable expectations for both dominance and affiliation by the middle of therapy.

Even though there would be a tendency for Interpersonal Schema Questionnaire ratings to be related to the other patient rated measures because patients were making all these ratings, there was therapist concurrent experience of session depth in the initial sessions and desired dominance at intake; the alliance in the initial sessions and desirability at intake; session smoothness in the middle sessions and desirability at termination; the alliance in the terminal sessions in relation to affiliation at intake and desirability at mid-point; and session depth in the terminal sessions and dominance at intake. Additional coexistent relationships occurred between the process measures and the residual gains, which will be discussed in the following section.

Treatment Outcome - Residual Gains

Although the results did not support the hypotheses that an early view of one's therapist as dominant, controlling for desirability, or as affiliative would have a positive

relationship to treatment outcome, there were limited associations between perceived dominance later in treatment and residual gains. Dominance at the mid-point of treatment related to a decrease in patients' view of interpersonal problems; and dominance at termination related to a decrease in patients' view of interpersonal problems and symptoms. Desired dominance at termination was associated with a decrease in interpersonal problems. Although these correlations were significant, they only accounted for 10 to 13% of the variance.

The more meaningful relationship with outcome was between in-session process and the residual gains. In contrast to meta-analyses of the relationship between the alliance and outcome (Horvath and Symonds, 1991; Martin, Garske, et.al., 2000), which found the most consistent relationship between the alliance early in treatment and outcome, this study found greater associations between the alliance, measured from various perspectives, later in treatment and outcome. Although there was some relationship between outcome and early experience of session smoothness for patients and session depth for therapists, a greater number of significant correlations, which also accounted for more of the variance, occurred during the middle and terminal phases between the process measures and residual gains. The correlations during the middle phase indicated that therapist experience of depth (variance of 16%) and both therapist and patient experience of resolution of tension (variance of 20% and 23%, respectively) related to decreases in target complaints. The variance for these correlations was the highest for this phase. Although therapist experience of a positive alliance in this phase also correlated with decreases in target complaint, the variance was only 8%. Lastly, in the terminal sessions decreases both in target complaints and interpersonal problems had

the largest number of associations with the process measures. Of these, those that accounted for the most variance were patient experience of resolution and decreases in target complaints (variance of 29%), patient experience of session smoothness and decreases in interpersonal problems (variance of 26%), therapist experience of a positive alliance and session depth with decreases in interpersonal problems (variance of 18% for both).

This is a summary of the correlations between the process measures and residual gains by phases. For the initial phase patient experience of smoothness was associated with decreases in patients' view of target complaints and interpersonal problems. For this early phase therapist experience of session depth related to decreases in patient and therapist view of target complaints, and patients' view of symptoms. The variance for these correlations ranged from 8 to 14%. The middle phase, which was two-thirds of the treatment, had more significant relationships between therapist rated process measures and residual gains than for patient rated process measures. For therapists the alliance and session depth related to decreases in therapists' view of target complaints, session smoothness related to decreases in patients' view of target complaints. Although therapists' experience of tension was positively related to their view of interpersonal problems, resolution was related to decreases in target complaints from the perspective of both patients and therapists. The variance for these correlations ranged from 8 to 20%. For patients the experience of session smoothness in the middle phase was related to decreases in patients' view of interpersonal problems, accounting for 9% of the variance. Patient experience of resolution in this phase was related to decreases in patients' target complaints, accounting for 23% of the variance. The termination phase had the most

significant relationships between process and outcome for both patients and therapists. For patients the variance for the six correlations ranged from 10 to 29%. For therapists the variance for the five correlations ranged from 11 to 18%.

Overall, looking at the correlations of residual gains and both dominance and the process measures, improvement in target complaints and interpersonal problems appeared to relate primarily to both patient and therapist experience of some resolution in tense sessions, therapist experience of depth in sessions, and patient experience of smooth sessions. These relationships were in the context of the association between patients' perception of the therapist as dominant and improvement in interpersonal problems.

Interpersonal Theory and Earlier Research

The relationship between the Interpersonal Schema Questionnaire (ISQ) subscales of dominance and affiliation and the process measures for the alliance could be interpreted as complementarity in the patient-therapist relationship. The ISQ was developed from interpersonal theory. Based on this theory, complementarity posits the type of interpersonal pattern that reinforces the relationship. Complementarity in interpersonal relationships predicts the following for dominance and affiliation. Dominant behavior is elicited or reinforced by submissive behavior. Warm affiliative responses are elicited or reinforced in kind by affiliation, creating a mutually warm relationship. This interpersonal pattern is the common doctor-patient relationship. The doctor is the more dominant figure and typically doctor and patient do not feel hostility toward each other. Based on complementarity, the patients' view of their therapist as slightly dominant would indicate the possibility of a mildly submissive patient, perhaps

someone acting receptive to the therapist. Patients' view of their therapists as warm might arise in part from their own feelings of affiliation. This type of interpersonal pattern would be indicative of a workable therapeutic alliance, one in which sessions would also be experienced as having depth and smoothness, which was what occurred. It was possible that depth came from the patient's receptivity to the therapist's interventions and smoothness from warmth in the relationship. Theoretically complementarity would lend stability to the interpersonal relationship.

In this sample the stability of the patient views of dominance and affiliation might also have stemmed from the high level of desirability. It was possible that complementarity occurred because the interpersonal schema was an acceptable or desired one and related to therapists' experience of a positive alliance. Of all the ISQ subscales desirability appeared to be a critical factor in the experience of a positive alliance from the therapists' perspective. Among the fifteen significant relationships between the ISQ subscales and the therapist rated process measures throughout the treatment phases, 80% of these correlations were either with the subscale of desirability or the weighted dominance score that controlled for desirability. Therapists ratings might in part have been from patients communicating some aspect of desirability, perhaps indications of liking therapy or their therapists. Together these experiences, the patients' interpersonal schema of the therapists and the manner in which the schema and its desirability resonated with the therapists, would support a reciprocal bond or alliance.

This view of the therapist as low in dominance and moderately warm also was congruent with the early research on Rogerian Therapist Offered Conditions (TOC), which looked at therapist genuineness and empathy, social influence (Beutler, et. al.

1986), and Luborsky's Type I and II alliance (1976). The findings of desirable views and experience of a warm therapist were consistent with the review of research on TOC (Orlinsky & Howard, 1986; Salvio, Beutler, Wood, & Engle, 1992). The remainder of this section will look at the results of this study in relation to this research, focusing on the phases of treatment and their relationship to outcome.

It is notable that in general the therapist was not perceived as overly dominant. Initial sessions of short-term therapy set the parameters of treatment, which include educating the patient about therapy, describing the process of therapy, assessing presenting problems, determining the focus of therapy and setting treatment goals. All these parameters are guided by the therapist so that the therapist would naturally have a more dominant role in the initial sessions. Clearly with short-term therapy, as opposed to treatment without a set number of sessions, the time-constraint might create added pressure to establish these parameters very quickly and could lead to patients experiencing the therapist as domineering or controlling, which did not occur. The relatively low level of dominance might reflect the patient experiencing the therapist as comfortably assertive, firm or straightforward in manner. It might also represent a feeling of confidence in the therapist, that the therapist is competent and in control, as opposed to controlling. This perception would confirm one's natural expectations at the beginning of treatment, which Beutler, et. al. (1986, p. 280) refer to as "the generalized expectation of high credibility, expertness, and power that patients assign to anyone in the therapeutic role," when summarizing the results from the social influence research.

The patient's view of the therapist as mildly dominant and experience of the early sessions as deep while having a positive alliance with the therapist suggest that from the

patient's perspective an aspect of perceived dominance is that the therapist is making statements that lend depth to the session or that encourage the patient to explore. Additional support of this interpretation and its importance was that therapist experience of depth in the initial sessions correlated with decreases in patient symptoms and in both patient and therapist target complaints. Furthermore, the experience of moderate affiliation might promote exploration from a feeling of support and safety, very much like the Rogerian Therapist Offered Conditions. The feeling of support might also relate to the association between patients' experience of session smoothness in this initial phase and decreases both in patient target complaints and in patient interpersonal problems. All these perceptions might reflect an initial experience of trust in the therapist, which could also reflect complementarity in the relationship. As noted earlier, a patient's perception of low dominance in the therapist would be complemented with low submission from the patient that might have been from the patient being receptive toward the therapist. This receptivity could have come from feelings of trust. This experience of therapy might be the initial stage that leads to the patient becoming engaged in therapy and ultimately committing to treatment. Further support of this interpretation was the continued association of alliance, session depth, and session smoothness in the middle and terminal phases with both affiliation and dominance.

At a minimum for all types of treatment the therapist was probably making statements that communicated to the patient that the therapist understood the patient's difficulties, which then might have led the patient to explore these difficulties further. This type of interaction or therapy relationship is like Luborsky's Type I alliance (1976, p. 94), "a therapeutic alliance based on the patient's experiencing the therapist as

supportive and helpful with himself as a recipient," which was found to be important at the beginning of therapy. For each type of treatment these might be ways that the therapists acted dominant and brought depth to the sessions. Within the psychodynamic treatments the therapist might be making tentative interpretations, suggesting links between the present and the past. For the cognitive treatment the therapist might be pointing out how the patient's thoughts are detrimentally impacting quality of life. In the relational treatment the therapist might be indicating how the patient-therapist relationship might be a way to understand other interpersonal relationships.

During the middle phase, sessions six through 25, of working through the issues that brought the patient to therapy, the initial establishment of a therapeutic relationship appeared to continue. As noted earlier, the patient's perception of the therapist did not change significantly. This stability might have contributed to maintaining a positive alliance. Patients continued to experience the sessions as deep and now also experienced them as smooth, suggesting comfort with the process of therapy. These experiences in the middle phase related to the patients' initial experience of affiliation and dominance, which was desirable, plus the experience of affiliation during the middle phase. Furthermore, when looking at the relationship between the process measures and residual gains to understand what experiences of these middle sessions related to change, the middle phase was the only one in which both patient and therapist experienced resolution within tense sessions that correlated with residual gains. Patients' experience of resolution related to therapists' recognition of decreases in the target complaints. Therapists' experience of resolution related to both patients' and therapists' recognition of decreases in the target complaints. The therapeutic relationship during this middle

phase might represent Luborsky's Type II alliance, a type of collaborative alliance, in which the patient and therapist are "working together in a joint struggle against what is impeding the patient..." (1976, p. 94). He found that the strength of both types of alliances were more apt to be related to improvement in psychodynamic therapy. Other relationships between process during the middle phase and residual gains were patient experience of smooth session and decreases in patient perceived interpersonal problems, therapist experience of positive alliance and session depth with decreases in therapist rated target complaints, and therapist experience of smooth sessions and decreases in patient perception of interpersonal problems.

In the termination phase the relationship between process measures and residual gains suggests that psychotherapeutic work in the middle phase continued into these last five sessions of treatment. As noted above, the experience of resolution in tense sessions for both patients and therapists during the middle phase was associated with decreases in target complaints from both their perspectives. Termination focuses on consolidating treatment and reinforcing gains, which probably occurred in this sample. The termination phase had the largest percentage of correlations between process measures and residual gains. For patients the majority of these correlations were with patients' experience of session smoothness and resolution, whereas for therapists this correlational relationship occurred with the experience of session depth. Improvement in target complaints, interpersonal problems, and symptoms were tied to these processes.

Implications

In summary the results of this study supported the hypotheses that patients' early perception of dominance and affiliation have a positive relationship to the therapeutic alliance. Although the results did not find a relationship between an early view of one's therapist as dominant or affiliative and treatment outcome, there was a relationship between in-session process, alliance and the qualities of session depth and smoothness, and outcome. Given that the patients' perception of therapist dominance and affiliation remained fairly stable through out treatment and was very desirable, these attributes appeared to be an initial assessment that became confirmed, or at least was not discomfirmed, as treatment progressed. Furthermore, this image of one's therapist was an acceptable one that might help one to stay in therapy. But, it did not appear sufficient to relate to gains in treatment. Gains from treatment appeared tied to therapeutic processes in the sessions, such as resolving tension in the relationship.

The relationship between the patients' schema of their therapists and the quality of the sessions might involve patients both feeling taken care of and working to care for themselves. The experience of a moderately warm and mildly dominant therapist would provide a therapeutic milieu that could lend itself to a patient feeling cared for from feeling the attentive warm genuine interest of the therapist. Within this interpersonal schematic frame psychotherapeutic work that had depth of exploration and smooth interpersonal interaction would promote patient openness to work on conflictual interpersonal processes in the present, such as resolving tension in sessions, which in turn would enhance the development of a capacity to care for oneself. Being nurtured could evolve into self-nurturance through identification and internalization.

Establishing an internal psychotherapeutic dialogue with a benign figure would increase the likelihood of maintaining gains from therapy. Research on long-term psychodynamic therapy by Geller and his associates (Arnold, Farber, & Geller, 2000; Arnold, Farber, & Geller, 2004; Geller & Farber, 1993; Rosenzweig, Farber, & Geller, 1993) has found a relationship between internalized representations of one's therapist and patients utilization of these internalizations. For example, Arnold, et. al. (2004) found a positive relationship between successful internalization of the therapist, described as a positive affective bond with the therapist or "benign internalization," and successful outcomes. Patients with better outcomes reported utilizing images and interpersonal experiences with their therapists, continuing the "therapeutic dialogue" as a way to work through difficulties in their lives, which was consistent with earlier work (Geller & Farber, 1993). In conjunction with this work Rosenzweig, et. al. (1993) found a relationship between good outcome and patients' tendency to internalize "self-analytic functions of the therapist as well as the therapist's soothing and benevolent feelings and attitudes toward themselves."

Although this study did not directly address the relationship between patients' interpersonal schemas of their therapists and their utilization, the positive relationship between the schemas and the alliance suggest that interplay between internalization of a benign, possibly nurturant, figure and the interpersonal process in sessions, such as deep and smooth sessions, support the establishment, and probably maintenance, of a positive alliance. Furthermore, gains from treatment that were tied to in-session processes might also stem from the process of internalization of psychotherapy, as presented by Geller et.

al, as opposed to gains being directly associated with schemas of the therapists' relative dominance and affiliation.

The process of internalizing psychotherapy may be akin to the process of attachment, which would help explain the connection between the interpersonal schemas and in-session process and lack of relationship between the schemas and outcome. As presented earlier, interpersonal schema theory assumes that schemas develop within attachment relationships. The qualities of mother-infant attachment develop from mother-infant interaction. In therapy we are exposed to new and different ways to think and feel about our selves and others through the process of being with and responding to the therapist. This interactional process is reminiscent of the attachment process. As Slade (1999, 2000, 2004) suggests, attachment theory and its language can be a metaphor that describes both the quality of the patient-therapist relationship and the patient's difficulties. Similar to mother-infant attachment and the quality of their interactional bond leading to personality development, psychic growth can come from an analogous process in therapy. As occurred in this study, positive change was related to in-session process, not to the relatively static schema.

The interpersonal schema might have been an aspect of positive transference. Perhaps it represented a part of the alliance that could be viewed as positive transference, given its high level of desirability and the positive relationship between the schema and the alliance. If viewed this way, then the lack of relationship between the schema and outcome would also be understandable. One does not associate transference with outcome. Rather, work on or related to the transference is assumed to effect change.

Limitations and Future Research

The extent to which one can generalize from the results of this study are constrained by the sample: its small size (62 patients completed the full course of treatment); the participants' willingness to be part of an extensive research project that involved being video-taped and completing numerous self-report measures; the large percentage of white patients (83%) and therapists (88%); patients' high educational level (all had attended college, more than 46% had graduated or completed post-graduate work); the relatively inexperienced therapists (73% of the therapists had less than one year of experience); the brevity of the treatments (30 sessions); the type of psychopathology (patients had both Axis I and Axis II diagnoses of Cluster C or Not Otherwise Specified Personality Disorders); and the decision to combine three different treatment groups.

Although there were treatment differences on the measures, they were very limited, and occurred primarily with the psychodynamic therapy. Analyses to assess whether schemas of the therapist differed by treatment found only that the psychodynamic therapists in relation to the other therapists were viewed as less affiliative at the beginning and middle of treatment, which would account for these sample means being slightly, but not significantly, lower than the mean level of affiliation at termination. For the middle phase patients viewed sessions with the psychodynamic therapists as less smooth than the other two types of treatments, which probably contributed to the significant quadratic trend for the three phases. Less smooth sessions might relate to viewing these therapists as less warm in relation to the other therapists. Psychodynamic therapists ratings on the Global Assessment Scale had significantly smaller gains when compared to the other

treatments. For the entire sample there were no significant gains on this measure, which is not unexpected. On this measure patients began treatment relatively healthy so that statistically significant change would be difficult to discern on this scale. The only other treatment difference was that cognitive therapists experienced less tension in the sessions than the other therapists, which might reflect different theoretical orientations. The psychodynamic and brief relational therapists would be more attuned to their interactions with their patients because these treatments focus on interpersonal dynamics more than cognitive behavioral therapy.

Treatment differences might have also played a role in the number of patients that did not complete all 30 sessions. Differences in interpersonal qualities might have been the contributing factors. Of the 22 patients that chose to end treatment before the thirtieth session, eight patients were in psychodynamic therapy, nine patients were in the relational therapy, and five were in cognitive therapy. Of the eight patients in psychodynamic treatment, four left therapy between the 6^{th} and 10^{th} sessions and three stopped therapy between the 11^{th} and 20^{th} sessions, which falls within the middle phase of treatment. The eighth patient stopped with the 28^{th} session. The middle phase was the only phase that had significant treatment differences on any of the process measures: The patients found the psychodynamic sessions less smooth than the other patients. They also viewed the therapists as less warm both initially and at the mid-point of treatment. Most of the patients in the relational therapy stopped therapy during the middle phase, eight patients ended therapy between the 12^{th} and 25^{th} session. One patient stopped after the fourth session. In comparison to the psychodynamic group of patients, those in relational therapy might have stayed longer, then chose to stop in part because this form of

treatment more than the other two focuses on the patient-therapist relationship. It could be that an initial focus on the relationship facilitated patient involvement, then from the patients' perspective became too uncomfortable. The reverse process, lack of tension in the relationship, might have led to fewer patients in cognitive therapy ending therapy early.

The diagnostic characteristics of the sample also limits the extent to which one can generalize. Patients had a combination of Axis I and Axis II diagnoses. On Axis II they were limited to either Cluster C or Not Otherwise Specified Personality Disorders. Cluster A and B diagnoses were excluded because these would be patients that would more likely benefit from longer-term treatment. Even with this exclusion, the sample consisted of patients who had long-standing interpersonal difficulties.

Another limiting factor comes from the fact that all the measures were self-report instruments and provide one way to view the patient-therapist relationship. The actual interactions between patient and therapist, their statements and body language during the sessions were not part of this study. Desirability, which probably reflected the patient liking the therapist and appeared to relate to therapist ratings of the process measures, was only evaluated from the patients' perspective. A fuller picture of the relationship would come from the therapists' view of the patients on the ISQ subscales. It could help to look at the extent to which there was complementarity in the relationship, or whether other interpersonal patterns create reciprocal relationships. Further work could be done by viewing the videotapes of the sessions. Incongruencies between the patient's view of the therapist and the therapist's behavior might indicate attempts at wish fulfillment and possible transference distortion.

Another difficulty in extrapolating from the ISQ is that the measure is similar to a projective. When answering, one first needs to imagine both being in a particular situation and feeling a particular emotion, then envision how the other person would respond. Some of the interpersonal situations are ones that do not directly relate to the therapeutic relationship. They are situations from everyday life, for example, collaborating on a project or playing a competitive game. One patient wrote a note that she could not imagine being with her therapist in a few of the situations, which could come from the lack of congruence between the situations and the sessions.

The nature of the experience of dominance within a doctor-patient relationship might be better represented by measures of perceived competence or the experience of confidence in the doctor's expertise. The low level of perceived dominance makes it difficult to determine what the patients were relating to, what in the therapists' demeanor resonated with dominance. A high level of dominance would be an indication of acting controlling and a higher level would suggest being domineering. But, is a low level of dominance akin to gentle guidance, prompting, or even beginning a session asking how the patient is, indirectly setting an agenda for a session.

Further work to understand the relationship between the interpersonal schemas and the process of internalization could come from assessing the extent to which patients internalized their therapies. As part of measuring outcome, at follow-up one could use the Therapist Representation Inventory developed by Geller and his associates (1981, 1993) to assess the nature of patients' internalization of the therapeutic experience and of their therapists. Also, to look at possible transferential origins of the schemas patients could complete the ISQ for their mother and father, then look at the relationship between

these parental ratings and the ones of the therapist, which was the element missing from the validation study of the Missouri Identifying Transference Scales (Multon, et. al., 1996).

Although there are limitations to the conclusions one can make from this study, it does indicate that very early in treatment patients begin to form interpersonal schemas of their therapist. For this group of patients these schemas were generally benign. Patients' experience of a mildly dominant and moderately affiliative therapist may facilitate developing a workable alliance that promotes psychotherapeutic work in the sessions. The study indicates the importance of patients beginning therapy with a positive impression and raises the question of whether less benign schemas would sabotage the possibility of even beginning.

Conclusion

The results of this study suggest that patients in time-limited treatment will more likely become engaged in therapy when they view their therapists as mildly dominant and moderately affiliative. Creating this therapeutic milieu could help a new patient begin psychotherapy and cooperate in a way that leads to the development of a therapeutic alliance. Early attempts to educate a patient about treatment and the process of therapy might be a mechanism to communicate both these qualities. Dominance and affiliation would be felt from the therapist's care in de-mystifying the process of therapy.

The results also indicate that becoming engaged in therapy in a way that relates to improvement involves more than developing a therapeutic alliance. For example, patients' experience of interpersonally smooth sessions and therapists' experience of

sessions with depth appeared to play a role not only in developing and maintaining an alliance, but also in decreasing target complaints. Furthermore, the alliance appeared to be a medium within which change could occur. Improvement also related to exploration and resolution of difficulties in the patient-therapist relationship.

As a whole, the results of this study were clinically reassuring. Psychotherapists gravitate toward being empathic, and through training acquire competence in doing psychotherapy. By and large this prototypical therapist embodies the impressions of the patients in this study-- warm and mildly dominant psychotherapists. Even though a large majority of the therapists in this study were relatively inexperienced, the patients improved from the perspectives of both patient and therapist. Aspects of the therapeutic alliance and patient-therapist work on their relationship related to this change.

Appendix A:

Patient and Therapist Consent Forms

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, (5) brief relational therapy. We are attempting to learn more about different aspects of short-term psychotherapy so that you and others like you can receive the benefit of the best available treatment.

Treatment conditions:

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

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

1. Not to participate in other psychotherapy or take psychoactive medication while receiving treatment in this program.
2. Be available for 30 sessions.
3. Take two evaluation interviews and complete a package of questionnaires

to evaluate how you are doing in treatment:

a. Before beginning treatment

b. Midway during treatment

c. At termination of treatment

d. Six months after treatment is completed.

4. Complete a post-session questionnaire after each session.

5. Agree to have evaluation and treatment sessions videotaped.

6. Consent to have information obtained from videotaped recordings of sessions used for scientific purposes, such as research study, professional publication, educational presentations in transcribed, audio taped, or videotaped format by program staff.

Possible risks:

We know of no inherent risks associated with these treatments. Each 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 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 have 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.

BRIEF PSYCHOTHERAPY RESEARCH PROGRAM
BETH ISRAEL MEDICAL CENTER

CONFIDENTIAL

Therapist Information

Date: Therapist ID #:

Name:

Home Address:

Home Phone:

Date of Birth:

Marital Status:

Currently living with: spouse, partner, roommate, alone, parents, children, other

Ethnicity:

Cultural or religious affiliation:

Personal therapy (current or past): Yes / No
If yes, orientation of therapy:

Degree: Date degree received:

Years of clinical experience (MD: post residency, Ph.D./Psy.D. post internship, M.S.W./M.A. post degree):

Orientation of formal training:

Therapist Consent

Purpose of program

The purpose of this study is to explore the factors that contribute to the success of psychotherapy. There is one form of psychotherapy used in this study: A time-limited (30 session), integrative therapy, including cognitive-behavioral and relational principles.

Conditions of participation

As a therapist taking part in this study, you will practive psychotherapy in this therapeutic modality. Therapy consists of weekly, individual, fifty-minute sessions. Each therapist is responsible for videotaping therapy sessions, for completing a post-session questionnaire after every session and for making patient assessments during the admission, mid-phase, and termination phases of therapy. Some of this data, as well as information obtained from videotaped recordings of sessions, may be used by the research staff for scientific purposes, such as professional publications or educational presentations in the transcribed, audio taped, or videotaped format. Therapists also are required to attend weekly individual and group supervision meetings. Certain patient information, such as patient post-session questionnaires, will be kept confidential.

Questions

If you have any questions, you may contact the Brief Psychotherapy Research office at 420-3819 or Chris Muran, Ph.D. at 420-4662. You may request a copy of this form at any time.

_____

Therapist Date

_____

Witness Date

_____

Principal Investigator Date

Appendix B:
Interpersonal Schema Questionnaire

ISQ

Name:
ID #:
Date:

Instructions

This questionnaire calls for you to imagine yourself in various situations. First, we will ask you to imagine yourself in several different situations with your therapist, and then with two other people in your life. Please close your eyes and imagine yourself in each of the situations, and imagine how the person you are with would respond to you. In order to get accurate answers it is important that you try to imagine the event rather than just answering the question "off the top of your head."

At the top of each page is a list of possible responses. For each situation please circle the letter of the response that SEEMS CLOSEST to how you think the person in question would react. Please note that each response contains two or more descriptions of the other person's feelings or behavior. It is only necessary that the person fit ONE of the descriptions. For instance, if the person would be "impatient" but not necessarily "quarrelsome," you would choose response B.

Then, on the next scale, indicate how much you like or dislike the other person's response. If the other person's response would make you feel good circle a number toward the desirable end of the scale. If it would make you feel unhappy, uncomfortable, or if it is something you would prefer to avoid, circle a number toward the undesirable end of the scale. If you are completely neutral about the response circle number 4.

EXAMPLE:

Imagine yourself feeling frightened about something and turning to your therapist for reassurance.

If you think your therapist would try to take charge in this situation, circle A, the letter corresponding at the top of the page to the response "would try to take charge or try to influence me."

A B C D E F G H

(**Circle only one**)

Then indicate how desirable this response would be for you on the numbered scale provided. If you would be, say, mildly relieved if your therapist were to take charge of the situation when you were frightened, you would mark 5. If you would be very grateful, you might mark 7.

1 2 3 4 5 6 7

Undesirable Desirable

Some of the questions may ask you to imagine situations that have never actually happened between yourself and the other person. If this happens, please try to imagine the described situation anyway and answer the best that you can.

RESPONSES:

A Would take charge or try to influence me..
B Would b disappointed, resentful, or critical.
C Would be impatient, or quarrelsome.
D Would be distant or unresponsive.
E Would go along with me, or act unsure.
F Would respect me or trust me.
G Would be warm or friendly.
H Would show interest, or let me know what he/she thinks

For the following situations please imagine yourself with your current therapist.

1. Imagine that you and your therapist are collaborating on something. You have more knowledge and expertise in this area than your therapist so you take the lead in making decisions.

How do you think your therapist would respond to this? A B C D E F G H

This response would be: 1-------2-------3------4-------5------6------7
Undesirable Desirable

2. Imagine yourself feeling angry and argumentative towards your therapist.

How do you think your therapist would respond to this? A B C D E F G H

This response would be: 1-------2-------3------4-------5------6------7
Undesirable Desirable

3. Imagine yourself feeling weak or pasive and wanting your therapist to take the lead.

How do you think your therapist would respond to this? A B C D E F G H

This response would be: 1-------2-------3------4-------5------6------7
Undesirable Desirable

4. Imagine yourself being friendly and helpful with your therapist.

How do you think your therapist would respond to this? A B C D E F G H

This response would be: 1-------2-------3------4-------5------6------7
Undesirable Desirable

RESPONSES:

A Would take charge or try to influence me..
B Would b disappointed, resentful, or critical.
C Would be impatient, or quarrelsome.
D Would be distant or unresponsive.
E Would go along with me, or act unsure.
F Would respect me or trust me.
G Would be warm or friendly.
H Would show interest, or let me know what he/she thinks

For the following situations please imagine yourself with your current therapist.

5. Imagine yourself in a game where you are competing against your therapist. You act very competitive and work hard to win the game.

How do you think your therapist would respond to this? A B C D E F G H

This response would be: 1-------2-------3------4-------5------6------7
Undesirable Desirable

6. Imagine yourself being preoccupied with your own thoughts and detached with your therapist.

How do you think your therapist would respond to this? A B C D E F G H

This response would be: 1-------2-------3------4-------5------6------7
Undesirable Desirable

7. Imagine yourself in an unmotivated or lazy mood where you feel like just going along with whatever your therapist is doing.

How do you think your therapist would respond to this? A B C D E F G H

This response would be: 1-------2-------3------4-------5------6------7
Undesirable Desirable

8. Imagine yourself expressing genuine interest and concern for your therapist.

How do you think your therapist would respond to this? A B C D E F G H

This response would be: 1-------2-------3------4-------5------6------7
Undesirable Desirable

RESPONSES:

A Would take charge or try to influence me..
B Would b disappointed, resentful, or critical.
C Would be impatient, or quarrelsome.
D Would be distant or unresponsive.
E Would go along with me, or act unsure.
F Would respect me or trust me.
G Would be warm or friendly.
H Would show interest, or let me know what he/she thinks

For the following situations please imagine yourself with your current therapist.

9. Imagine a situation where you feel that your therapist has disappointed you.

How do you think your therapist would respond to this? A B C D E F G H

This response would be: 1-------2-------3------4-------5------6------7
Undesirable Desirable

10. Imagine yourself in a serious mood where you are reserved and not sociable with your therapist.

How do you think your therapist would respond to this? A B C D E F G H

This response would be: 1-------2-------3------4-------5------6------7
Undesirable Desirable

11. Imagine yourself confiding in your therapist something that is important to you.

How do you think your therapist would respond to this? A B C D E F G H

This response would be: 1-------2-------3------4-------5------6------7
Undesirable Desirable

12. Imagine feeling uninhibited and spontaneous with your therapist.

How do you think your therapist would respond to this? A B C D E F G H

This response would be: 1-------2-------3------4-------5------6------7
Undesirable Desirable

RESPONSES:

A Would take charge or try to influence me..
B Would b disappointed, resentful, or critical.
C Would be impatient, or quarrelsome.
D Would be distant or unresponsive.
E Would go along with me, or act unsure.
F Would respect me or trust me.
G Would be warm or friendly.
H Would show interest, or let me know what he/she thinks

For the following situations please imagine yourself with your current therapist.

13. Imagine that you have had a terrible day and are feeling peeved off with the whole world. You are definitely not feeling affectionate or cordial toward anyone.

How do you think your therapist would respond to this? A B C D E F G H

This response would be: 1-------2-------3------4-------5------6------7
Undesirable Desirable

14. Imagine feeling not very confident or sure of yourself and feelings dependent on your therapist.

How do you think your therapist would respond to this? A B C D E F G H

This response would be: 1-------2-------3------4-------5------6------7
Undesirable Desirable

15. Imagine yourself feeling warm and affectionate towards your therapist.

How do you think your therapist would respond to this? A B C D E F G H

This response would be: 1-------2-------3------4-------5------6------7
Undesirable Desirable

16. Imagine yourself acting independently and confidently about something you have never done before and not feeling that you need assistance from your therapist.

How do you think your therapist would respond to this? A B C D E F G H

This response would be: 1-------2-------3------4-------5------6------7
Undesirable Desirable

Appendix C:
Key to Interpersonal Schema Questionnaire

KEY TO INTERPSERONAL SCHEMA QUESTIONNAIRE

(Jan. 1991)

SITUATION	CIRCLE SEGMENT	COMPLEM* RESPONSE
1. Imagine that you and your _____ are collaborating on something. You have more knowledge and expertise in this area than your _____, so you take the lead in making decisions.	A (DOMINANT)	E
2. Imagine yourself feeling angry and argumentative towards your _____.	E (HOSTILE)	C
3. Imagine yourself feeling weak or passive and wanting your _____ to take the lead.	I (SUBMISSIVE)	A
4. Imagine yourself being friendly and helpful with your _____.	M (FRIENDLY)	G
5. Imagine yourself in a game (tennis, scrabble, etc.) with your _____. You act very competitive and work hard to win the game.	B (COMPETITIVE)	E
6. Imagine yourself being preoccupied with your own thoughts and detached with your _____.	F (DETACHED)	C
7. Imagine yourself in an unmotivated or lazy mood where you feel like just going along with whatever your _____ is doing.	J (DEFERENT)	A
8. Imagine yourself expressing genuine interest and concern for your _____.	N (SOCIABLE)	G
9. Imagine a situation where you feel that your _____ has disappointed you.	C (MISTRUSTING)	D
10. Imagine yourself in a serious mood where you are reserved and not sociable with your _____.	G (INHIBITED)	B
11. Imagine yourself confiding in your _____ something that is important to you.	K (TRUSTING)	H
12. Imagine feeling uninhibited and spontaneous with your _____.	O (EXHIBITIONIST)	F

* The letter refers to complementary responses within the questionnaire, not on the circle.

SITUATION	CIRCLE SEGMENT	COMPLEM RESPONSE
13. Imagine that you have had a terrible day and are feeling peeved off with the whole world. You are definitely not feeling affectionate or cordial toward anyone.	D (COLD)	D
14. Imagine feeling not very confident or sure of yourself and feeling dependent on your _____.	H (UNASSURED)	B
15. Imagine yourself feeling warm and affectionate towards your _____.	L (WARM)	H
16. Imagine yourself acting independently and confidently about something you have never done before and not feeling that you need assistance from your _____.	P (ASSURED)	F

RESPONSE		CIRCLE SEGMENT
A	Would take charge, or try to influence me.	P (ASSURED) A (DOMINANT)
B	Would be disappointed, resentful, or critical.	B (COMPETITIVE) C (MISTRUSTING)
C	Would be impatient, or quarrelsome.	D (COLD) E (HOSTILE)
D	Would be distant, or unresponsive.	F (DETACHED) G (INHIBITED)
E	Would go along with me, or act unsure.	H (UNASSURED) I (SUBMISSIVE)
F	Would respect me, or trust me.	J (DEFERENT) K (TRUSTING)
G	Would be warm, or friendly.	L (WARM) M (FRIENDLY)
H	Would show interest, or let me know what he/she thinks.	N (SOCIABLE) O (EXHBITIONISTIC)

Appendix D:
Patient and Therapist Versions of the
Post-Session Questionnaire

PATIENT POST-SESSION QUESTIONNAIRE - V2002 *Complete immediately after session. Please answer all questions.*			
Your initials:	Your therapist initials:	Session number:	Date of session:

SECTION A

1. Please rate how helpful or hindering to you this session was overall by circling the appropriate number below.

1	2	3	4	5	6	7	8	9
Extremely hindering				**Neutral**				**Extremely helpful**

2. Please rate to what extent you feel the problems you had at the beginning of therapy are resolved.

1	2	3	4	5	6	7	8	9
Not at all				**Moderately**				**Completely**

SECTION B: *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

SECTION C: *The following items reflect your working relationship with your therapist based on your most recent session. Please circle the appropriate number to indicate how you felt about this session.*

	Not at all			**Somewhat**			**Completely**
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
2. What we are doing in therapy gave me new ways of looking at my problem.	1	2	3	4	5	6	7
3. I believed that my therapist liked me.	1	2	3	4	5	6	7
4. My therapist did not understand what I am trying to accomplish in therapy.	1	2	3	4	5	6	7
5. I was confident in my My therapist's ability to help me.	1	2	3	4	5	6	7
6. My therapist and I worked toward mutually agreed-upon goals.	1	2	3	4	5	6	7
7. I felt that my therapist appreciates me.	1	2	3	4	5	6	7
8. We agreed on what is important for me to work on.	1	2	3	4	5	6	7
9. My therapist and I seemed to trust one another.	1	2	3	4	5	6	7
10. My therapist and I seemed to have different ideas on what my problems are.	1	2	3	4	5	6	7
11. We have established a good understanding of the kind of changes that would be good for me.	1	2	3	4	5	6	7
12. My therapist believed the way we were working with his/her problem was correct.	1	2	3	4	5	6	7

SECTION D

	Not at all		**Occasionally**		**Constantly**
Did you experience any tension or problem, any misunderstanding, conflict or disagreement, in your relationship with your therapist during the session?	1	2	3	4	5
	Mildly		**Moderately**		**Extremely**
If yes, please rate how tense or upset you felt about the problem during the session:	1	2	3	4	5
	Not at all		**Somewhat**		**Very much**
To what extent did you find yourself and your therapist overly accommodating or overly protective of each other?	1	2	3	4	5

Please describe the problem:

_____

_____

_____

_____

	Not at all		**Somewhat**		**Very much**
To what extent was this problem addressed in this session?	1	2	3	4	5
To what degree do you feel this problem was resolved by the end of the session?	1	2	3	4	5

What do you think contributed to the resolution of the problem? Please describe:

_____

_____

_____

_____

Please rate the extent to which each of the following statements reflects your experience during this session.

	Not at all		**Somewhat**		**Definitely**
a. I felt a closer connection with my therapist.	1	2	3	4	5
b. I discovered feelings toward my therapist that I had not been fully aware of.	1	2	3	4	5
c. My therapist and I were able to work through a conflict and connect in a stronger way.	1	2	3	4	5
d. I saw how I was contributing to the difficulties my therapist and I were having.	1	2	3	4	5
e. I acted in a way that felt more authentic or genuine for me.	1	2	3	4	5
f. I recognized and accepted my therapist's limitations.	1	2	3	4	5
g. I felt freer to make mistakes with my therapist.	1	2	3	4	5
h. I became aware of ways in which I avoid creating conflicts and misunderstandings with my therapist.	1	2	3	4	5
i. I saw that I can expose risky feelings and not be rejected/criticized by my therapist.	1	2	3	4	5
j. I began to get the sense that I don't have to protect my therapist.	1	2	3	4	5
k. I felt more comfortable with expressing vulnerability or anger towards my therapist.	1	2	3	4	5
l. I told my therapist something I had been hesitant to say.	1	2	3	4	5
m. I felt able to disagree with my therapist.	1	2	3	4	5
n. I began to accept a part of myself, which I had not fully acknowledged before.	1	2	3	4	5
o. I said something to my therapist, which I had felt for a while and it left me with a sense of relief.	1	2	3	4	5
p. I saw that I was doing something to distance myself from my therapist or push him/her away.	1	2	3	4	5
q. I felt more trusting of my therapist.	1	2	3	4	5
r. I was afraid something I said would upset or hurt my therapist but I found out that it did not.	1	2	3	4	5

SECTION E: *Please check any of the following adjectives to describe how you felt in this session with your therapist. A check beside the word means "Yes." You may check as many or as few adjectives as you would like.*

1____HELPFUL	11____SURPRISED	21____HAPPY
2____TIRED	12____ANGRY	22____THREATENED
3____ENTHUSIASTIC	13____RECEPTIVE	23____ANXIOUS
4____OBJECTIVE	14____STRONG	24____OVERWHELMED
5____MANIPULATED	15____BORED	25____RELAXED
6____MOTHERLY	16____CAUTIOUS	26____CONFUSED
7____DISAPPOINTED	17____EMBARRASSED	27____INDIFFERENT
8____INTERESTED	18____AFFECTIONATE	28____ALOOF
9____SUSPICIOUS	19____SAD	29____SYMPATHETIC
10___INADEQUATE	20____DISLIKED	30____FRUSTRATED

THERAPIST POST-SESSION QUESTIONNAIRE - V2002 *Complete immediately after session. Please answer all questions.*			
Your initials:	Your patient's initials:	Session number:	Date of session:

SECTION A

1. Please rate how helpful or hindering to your patient this session was overall by circling the appropriate number below.

1	2	3	4	5	6	7	8	9
Extremely hindering				**Neutral**				**Extremely helpful**

2. Please rate to what extent your patient's problems are resolved.

1	2	3	4	5	6	7	8	9
Not at all				**Moderately**				**Completely**

SECTION B: *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

SECTION C: *The following items reflect your working relationship with your patient based on your most recent session. Please circle the appropriate number to indicate how you felt about this session.*

	Not at all			**Somewhat**			**Completely**
1. My patient and I agreed about the things he/she needs to do in therapy to help improve his/her situation.	1	2	3	4	5	6	7
2. My patient believed that what we are doing in therapy gave him/her new ways of looking at his/her problem.	1	2	3	4	5	6	7
3. My patient believed that I like him/her.	1	2	3	4	5	6	7
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
5. My patient was confident in my ability to help him/her.	1	2	3	4	5	6	7
6. My patient and I worked toward mutually agreed-upon goals.	1	2	3	4	5	6	7
7. My patient felt appreciated by me.	1	2	3	4	5	6	7
8. We agreed on what is important for him/her to work on.	1	2	3	4	5	6	7
9. My patient and I seemed to trust one another.	1	2	3	4	5	6	7
10. My patient and I seemed to have different ideas on what his/her problems are.	1	2	3	4	5	6	7
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
12. My patient believed the way we were working with his/her problem was correct.	1	2	3	4	5	6	7

SECTION D

	Not at all		Occasionally		Constantly
Did you experience any tension or problem, any misunderstanding, conflict or disagreement, in your relationship with your patient during the session?	1	2	3	4	5
	Mildly		**Moderately**		**Extremely**
If yes, please rate how tense or upset you felt about the problem during the session:	1	2	3	4	5
	Not at all		**Somewhat**		**Very much**
To what extent did you find yourself and your patient overly accommodating or overly protective of each other?	1	2	3	4	5

Please describe the problem:

_____

_____

_____

_____

	Not at all		Somewhat		Very much
To what extent was this problem addressed in this session?	1	2	3	4	5
To what degree do you feel this problem was resolved by the end of the session?	1	2	3	4	5

What do you think contributed to the resolution of the problem? Please describe:

_____

_____

_____

_____

Please rate the extent to which each of the following statements reflects your experience during this session.

	Not at all		Somewhat		Definitely
a. I felt a closer connection with my patient.	1	2	3	4	5
b. I found myself talking about feelings I didn't know I had.	1	2	3	4	5
c. My patient and I were able to work through a conflict and connect in a stronger way.	1	2	3	4	5
d. I saw how I was contributing to the difficulties my patient and I were having.	1	2	3	4	5
e. I acted in a way that felt more authentic or genuine for me.	1	2	3	4	5
f. I recognized and accepted my patient's limitations.	1	2	3	4	5
g. I felt freer to make mistakes with my patient.	1	2	3	4	5
I. became aware of ways in which I avoid creating conflicts and misunderstandings with my patient	1	2	3	4	5
i. I saw that I can expose risky feelings and not be rejected/criticized by my patient.	1	2	3	4	5
j. I began to get the sense that I don't have to protect my patient.	1	2	3	4	5
k. I felt more comfortable with expressing vulnerability or anger towards my patient.	1	2	3	4	5
l. I told my patient something I had been hesitant to say.	1	2	3	4	5
m. I felt able to disagree with my patient.	1	2	3	4	5
n. I began to accept a part of myself, which I had not fully acknowledged before.	1	2	3	4	5
o. I said something to my patient, which I had felt for a while and it left me with a sense of relief.	1	2	3	4	5
p. I saw that I was doing something to distance myself from my patient or push him/her away.	1	2	3	4	5
q. I felt more trusting of my patient.	1	2	3	4	5
r. I was afraid something I said would upset or hurt my patient but I found out that it did not.	1	2	3	4	5

SECTION E: *Please check any of the following adjectives to describe how you felt in this session with your patient. A check beside the word means "Yes." You may check as many or as few adjectives as you would like.*

1____HELPFUL	11____SURPRISED	21____HAPPY
2____TIRED	12____ANGRY	22____THREATENED
3____ENTHUSIASTIC	13____RECEPTIVE	23____ANXIOUS
4____OBJECTIVE	14____STRONG	24____OVERWHELMED
5____MANIPULATED	15____BORED	25____RELAXED
6____MOTHERLY	16____CAUTIOUS	26____CONFUSED
7____DISAPPOINTED	17____EMBARRASSED	27____INDIFFERENT
8____INTERESTED	18____AFFECTIONATE	28____ALOOF
9____SUSPICIOUS	19____SAD	29____SYMPATHETIC
10___INADEQUATE	20____DISLIKED	30____FRUSTRATED

Progress Note:

Please write a few sentences about the session.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SIGNATURE: _____

Appendix E:
Symptom Check List

SCL—90—R®

SIDE 1

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.

SEX

MALE ○

FEMALE ○

NAME: _____

LOCATION: _____

EDUCATION: _____

MARITAL STATUS: MAR___SEP___DIV___WID___SING___

DATE			ID. NUMBER	AGE
MO	DAY	YEAR		

VISIT NUMBER: _____

EXAMPLE HOW MUCH WERE YOU DISTRESSED BY:	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Bodyaches	0	1	2	(3)	4

HOW MUCH WERE YOU DISTRESSED BY:		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Headaches	1	0	1	2	3	4
2. Nervousness or shakiness inside	2	0	1	2	3	4
3. Repeated unpleasant thoughts that won't leave your mind	3	0	1	2	3	4
4. Faintness or dizziness	4	0	1	2	3	4
5. Loss of sexual interest or pleasure	5	0	1	2	3	4
6. Feeling critical of others	6	0	1	2	3	4
7. The idea that someone else can control your thoughts	7	0	1	2	3	4
8. Feeling others are to blame for most of your troubles	8	0	1	2	3	4
9. Trouble remembering things	9	0	1	2	3	4
10. Worried about sloppiness or carelessness	10	0	1	2	3	4
11. Feeling easily annoyed or irritated	11	0	1	2	3	4
12. Pains in heart or chest	12	0	1	2	3	4
13. Feeling afraid in open spaces or on the streets	13	0	1	2	3	4
14. Feeling low in energy or slowed down	14	0	1	2	3	4
15. Thoughts of ending your life	15	0	1	2	3	4
16. Hearing voices that other people do not hear	16	0	1	2	3	4
17. Trembling	17	0	1	2	3	4
18. Feeling that most people cannot be trusted	18	0	1	2	3	4
19. Poor appetite	19	0	1	2	3	4
20. Crying easily	20	0	1	2	3	4
21. Feeling shy or uneasy with the opposite sex	21	0	1	2	3	4
22. Feelings of being trapped or caught	22	0	1	2	3	4
23. Suddenly scared for no reason	23	0	1	2	3	4
24. Temper outbursts that you could not control	24	0	1	2	3	4
25. Feeling afraid to go out of your house alone	25	0	1	2	3	4
26. Blaming yourself for things	26	0	1	2	3	4
27. Pains in lower back	27	0	1	2	3	4
28. Feeling blocked in getting things done	28	0	1	2	3	4
29. Feeling lonely	29	0	1	2	3	4
30. Feeling blue	30	0	1	2	3	4
31. Worrying too much about things	31	0	1	2	3	4
32. Feeling no interest in things	32	0	1	2	3	4
33. Feeling fearful	33	0	1	2	3	4
34. Your feelings being easily hurt	34	0	1	2	3	4
35. Other people being aware of your private thoughts	35	0	1	2	3	4

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Please continue on the following page ▸

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SIDE 2

HOW MUCH WERE YOU DISTRESSED BY:		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
36. Feeling others do not understand you or are unsympathetic	36	0	1	2	3	4
37. Feeling that people are unfriendly or dislike you	37	0	1	2	3	4
38. Having to do things very slowly to insure correctness	38	0	1	2	3	4
39. Heart pounding or racing	39	0	1	2	3	4
40. Nausea or upset stomach	40	0	1	2	3	4
41. Feeling inferior to others	41	0	1	2	3	4
42. Soreness of your muscles	42	0	1	2	3	4
43. Feeling that you are watched or talked about by others	43	0	1	2	3	4
44. Trouble falling asleep	44	0	1	2	3	4
45. Having to check and double-check what you do	45	0	1	2	3	4
46. Difficulty making decisions	46	0	1	2	3	4
47. Feeling afraid to travel on buses, subways, or trains	47	0	1	2	3	4
48. Trouble getting your breath	48	0	1	2	3	4
49. Hot or cold spells	49	0	1	2	3	4
50. Having to avoid certain things, places, or activities because they frighten you	50	0	1	2	3	4
51. Your mind going blank	51	0	1	2	3	4
52. Numbness or tingling in parts of your body	52	0	1	2	3	4
53. A lump in your throat	53	0	1	2	3	4
54. Feeling hopeless about the future	54	0	1	2	3	4
55. Trouble concentrating	55	0	1	2	3	4
56. Feeling weak in parts of your body	56	0	1	2	3	4
57. Feeling tense or keyed up	57	0	1	2	3	4
58. Heavy feelings in your arms or legs	58	0	1	2	3	4
59. Thoughts of death or dying	59	0	1	2	3	4
60. Overeating	60	0	1	2	3	4
61. Feeling uneasy when people are watching or talking about you	61	0	1	2	3	4
62. Having thoughts that are not your own	62	0	1	2	3	4
63. Having urges to beat, injure, or harm someone	63	0	1	2	3	4
64. Awakening in the early morning	64	0	1	2	3	4
65. Having to repeat the same actions such as touching, counting, or washing	65	0	1	2	3	4
66. Sleep that is restless or disturbed	66	0	1	2	3	4
67. Having urges to break or smash things	67	0	1	2	3	4
68. Having ideas or beliefs that others do not share	68	0	1	2	3	4
69. Feeling very self-conscious with others	69	0	1	2	3	4
70. Feeling uneasy in crowds, such as shopping or at a movie	70	0	1	2	3	4
71. Feeling everything is an effort	71	0	1	2	3	4
72. Spells of terror or panic	72	0	1	2	3	4
73. Feeling uncomfortable about eating or drinking in public	73	0	1	2	3	4
74. Getting into frequent arguments	74	0	1	2	3	4
75. Feeling nervous when you are left alone	75	0	1	2	3	4
76. Others not giving you proper credit for your achievements	76	0	1	2	3	4
77. Feeling lonely even when you are with people	77	0	1	2	3	4
78. Feeling so restless you couldn't sit still	78	0	1	2	3	4
79. Feelings of worthlessness	79	0	1	2	3	4
80. The feeling that something bad is going to happen to you	80	0	1	2	3	4
81. Shouting or throwing things	81	0	1	2	3	4
82. Feeling afraid you will faint in public	82	0	1	2	3	4
83. Feeling that people will take advantage of you if you let them	83	0	1	2	3	4
84. Having thoughts about sex that bother you a lot	84	0	1	2	3	4
85. The idea that you should be punished for your sins	85	0	1	2	3	4
86. Thoughts and images of a frightening nature	86	0	1	2	3	4
87. The idea that something serious is wrong with your body	87	0	1	2	3	4
88. Never feeling close to another person	88	0	1	2	3	4
89. Feelings of guilt	89	0	1	2	3	4
90. The idea that something is wrong with your mind	90	0	1	2	3	4

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Appendix F:
Global Assessment Scale

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 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.
91 No Symptoms.

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

80 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
71 present.

70 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
61 meaningful interpersonal relationships and most untrained people would not consider
him "sick".

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

50 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
41 behavior, compulsive drinking, mild but definite manic syndrome).

40 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
31 is at times obscure, illogical or irrelevant), OR single suicide attempt.

30 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
21 judgment (e.g. acts grossly inappropriately).

20 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
11 incoherent or mute).

10 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
1 attempt to maintain minimal personal hygiene, or serious suicide act with clear
intent and expectation of death.

Appendix G:
Inventory of Interpersonal Problems

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 H:
Patient and Therapist Versions of the Target Complaints

TARGET COMPLAINTS (P/I)

Name: _____ Date: _____

What are the main problems or difficulties that you have which you would like help with in treatment? Please describe them briefly and rate in general how much each problem bothers you by circling the appropriate number.

(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 (I)

Name: _____ Date: _____

Target Complaint 1:
What is your current understanding of how this problem developed? When did it develop? Why does it continue?

Target Complaint 2:
What is your current understanding of how this problem developed? When did it develop? Why does it continue?

Target Complaint 3:
What is your current understanding of how this problem developed? When did it develop? Why does it continue?

TARGET COMPLAINTS FORM - THERAPIST / INTAKE

Pt. Name: _____ Date: _____

These are the main problems or difficulties that your patient would like help with in treatment. Please rate in general how much each problem seems to bother your patient 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

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