Measuring Interpersonal Process and Outcome in Psychotherapy:

The Client's Core Conflictual Relationship Theme and the Therapeutic Relationship

by

Robert G. Santos

A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

MASTER OF ARTS

Department of Psychology
University of Manitoba
Winnipeg, Manitoba

ISBN 0-612-16262-1

Name ROBERT G. SANTOS

Dissertation Abstracts International and *Masters Abstracts International* are arranged by broad, general subject categories. Please select the one subject which most nearly describes the content of your dissertation or thesis. Enter the corresponding four-digit code in the spaces provided.

SUBJECT TERM

PSYCHOLOGY - CLINICAL

SUBJECT CODE 0622

UMI

Subject Categories

THE HUMANITIES AND SOCIAL SCIENCES

COMMUNICATIONS AND THE ARTS
Architecture 0729
Art History 0377
Cinema 0900
Dance 0378
Design and Decorative Arts 0389
Fine Arts 0357
Information Science 0723
Journalism 0391
Landscape Architecture 0390
Library Science 0399
Mass Communications 0708
Music 0413
Speech Communication 0459
Theater 0465

EDUCATION
General 0515
Administration 0514
Adult and Continuing 0516
Agricultural 0517
Art 0273
Bilingual and Multicultural 0282
Business 0688
Community College 0275
Curriculum and Instruction 0727
Early Childhood 0518
Elementary 0524
Educational Psychology 0525
Finance 0277
Guidance and Counseling 0519
Health 0680
Higher 0745
History of 0520
Home Economics 0278
Industrial 0521
Language and Literature 0279
Mathematics 0280
Music 0522
Philosophy of 0998
Physical 0523
Reading 0535
Religious 0527
Sciences 0714
Secondary 0533
Social Sciences 0534
Sociology of 0340
Special 0529
Teacher Training 0530
Technology 0710
Tests and Measurements 0288
Vocational 0747

LANGUAGE, LITERATURE AND LINGUISTICS
Language
- General 0679
- Ancient 0289
- Linguistics 0290
- Modern 0291
- Rhetoric and Composition 0681

Literature
- General 0401
- Classical 0294
- Comparative 0295
- Medieval 0297
- Modern 0298
- African 0316
- American 0591
- Asian 0305
- Canadian (English) 0352
- Canadian (French) 0355
- Caribbean 0360
- English 0593
- Germanic 0311
- Latin American 0312
- Middle Eastern 0315
- Romance 0313
- Slavic and East European 0314

PHILOSOPHY, RELIGION AND THEOLOGY
Philosophy 0422
Religion
- General 0318
- Biblical Studies 0321
- Clergy 0319
- History of 0320
- Philosophy of 0322

Theology 0469

SOCIAL SCIENCES
American Studies 0323
Anthropology
- Archaeology 0324
- Cultural 0326
- Physical 0327

Business Administration
- General 0310
- Accounting 0272
- Banking 0770
- Management 0454
- Marketing 0338

Canadian Studies 0385
Economics
- General 0501
- Agricultural 0503
- Commerce-Business 0505
- Finance 0508
- History 0509
- Labor 0510
- Theory 0511

Folklore 0358
Geography 0366
Gerontology 0351
History
- General 0578
- Ancient 0579
- Medieval 0581
- Modern 0582
- Church 0330
- Black 0328
- African 0331
- Asia, Australia and Oceania 0332
- Canadian 0334
- European 0335
- Latin American 0336
- Middle Eastern 0333
- United States 0337

History of Science 0585
Law 0398
Political Science
- General 0615
- International Law and Relations 0616
- Public Administration 0617

Recreation 0814
Social Work 0452
Sociology
- General 0626
- Criminology and Penology 0627
- Demography 0938
- Ethnic and Racial Studies 0631
- Individual and Family Studies 0628
- Industrial and Labor Relations 0629
- Public and Social Welfare 0630
- Social Structure and Development 0700
- Theory and Methods 0344

Transportation 0709
Urban and Regional Planning 0999
Women's Studies 0453

THE SCIENCES AND ENGINEERING

BIOLOGICAL SCIENCES
Agriculture
- General 0473
- Agronomy 0285
- Animal Culture and Nutrition 0475
- Animal Pathology 0476
- Fisheries and Aquaculture 0792
- Food Science and Technology 0359
- Forestry and Wildlife 0478
- Plant Culture 0479
- Plant Pathology 0480
- Range Management 0777
- Soil Science 0481
- Wood Technology 0746

Biology
- General 0306
- Anatomy 0287
- Animal Physiology 0433
- Biostatistics 0308
- Botany 0309
- Cell 0379
- Ecology 0329
- Entomology 0353
- Genetics 0369
- Limnology 0793
- Microbiology 0410
- Molecular 0307
- Neuroscience 0317
- Oceanography 0416
- Plant Physiology 0817
- Veterinary Science 0778
- Zoology 0472

Biophysics
- General 0786
- Medical 0760

EARTH SCIENCES
Biogeochemistry 0425
Geochemistry 0996
Geodesy 0370
Geology 0372
Geophysics 0373
Hydrology 0388
Mineralogy 0411
Paleobotany 0345
Paleoecology 0426
Paleontology 0418
Paleozoology 0985
Palynology 0427
Physical Geography 0368
Physical Oceanography 0415

HEALTH AND ENVIRONMENTAL SCIENCES
Environmental Sciences 0768
Health Sciences
- General 0566
- Audiology 0300
- Dentistry 0567
- Education 0350
- Administration, Health Care 0769
- Human Development 0758
- Immunology 0982
- Medicine and Surgery 0564
- Mental Health 0347
- Nursing 0569
- Nutrition 0570
- Obstetrics and Gynecology 0380
- Occupational Health and Safety 0354
- Oncology 0992
- Ophthalmology 0381
- Pathology 0571
- Pharmacology 0419
- Pharmacy 0572
- Public Health 0573
- Radiology 0574
- Recreation 0575
- Rehabilitaion and Therapy 0382
- Speech Pathology 0460
- Toxicology 0383

Home Economics 0386

PHYSICAL SCIENCES
Pure Sciences
Chemistry
- General 0485
- Agricultural 0749
- Analytical 0486
- Biochemistry 0487
- Inorganic 0488
- Nuclear 0738
- Organic 0490
- Pharmaceutical 0491
- Physical 0494
- Polymer 0495
- Radiation 0754

Mathematics 0405
Physics
- General 0605
- Acoustics 0986
- Astronomy and Astrophysics 0606
- Atmospheric Science 0608
- Atomic 0748
- Condensed Matter 0611
- Electricity and Magnetism 0607
- Elementary Particles and High Energy 0798
- Fluid and Plasma 0759
- Molecular 0609
- Nuclear 0610
- Optics 0752
- Radiation 0756

Statistics 0463

Applied Sciences
Applied Mechanics 0346
Computer Science 0984
Engineering
- General 0537
- Aerospace 0538
- Agricultural 0539
- Automotive 0540
- Biomedical 0541
- Chemical 0542
- Civil 0543
- Electronics and Electrical 0544
- Environmental 0775
- Industrial 0546
- Marine and Ocean 0547
- Materials Science 0794
- Mechanical 0548
- Metallurgy 0743
- Mining 0551
- Nuclear 0552
- Packaging 0549
- Petroleum 0765
- Sanitary and Municipal 0554
- System Science 0790

Geotechnology 0428
Operations Research 0796
Plastics Technology 0795
Textile Technology 0994

PSYCHOLOGY
General 0621
Behavioral 0384
Clinical 0622
Cognitive 0633
Developmental 0620
Experimental 0623
Industrial 0624
Personality 0625
Physiological 0989
Psychobiology 0349
Psychometrics 0632
Social 0451

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

COPYRIGHT PERMISSION

MEASURING INTERPERSONAL PROCESS AND OUTCOME IN PSYCHOTHERAPY: THE CLIENT'S CORE CONFLICTUAL RELATIONSHIP THEME AND THE THERAPEUTIC RELATIONSHIP

BY

ROBERT G. SANTOS

A Thesis/Practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of

MASTER OF ARTS

Table of Contents

Chapter Five
Results and Discussion

Chapter Six
Conclusion 42

Abstract

Psychotherapy theoretically comprises the client's enduring core relationship theme (*transference* pattern), and the therapeutic relationship (*alliance*). In a confirmatory single–case quantitative analysis, using the Revised Core Conflictual Relationship Theme (CCRT) method and therapy session transcripts as data, independent raters reliably measured a client's early CCRT (problem), the alliance (treatment), and the later CCRT (outcome). After 40 sessions, the CCRT remained unchanged in *pattern*, but changed in *pervasiveness*. Effect sizes replicated the group outcomes of the Penn Psychotherapy Project: decreases in the client's negative responses of self (RSs) (– .87 *SD*) and negative responses from others (ROs) (– .40 *SD*); and increases in positive RSs (+ .46 *SD*) and positive ROs (+ 1.47 *SD*). Correlation patterns suggest that a positive therapeutic alliance is associated with clinically significant improvements in the client's CCRT.

Acknowledgements

The importance of human relationships in fostering a person's growth and development, a lesson central to this thesis, is one I have also learned from those who have importantly influenced its completion. To the following individuals I offer my heartfelt thanks:

To my tireless thesis committee: Drs. Marvin Brodsky, Edward Johnson, and Garry Fisher, for their time, honesty, and integrity: hallmarks of all true scientists and therapists.

To my two first teachers of psychotherapy: Prof. David Martin and Dr. Marianne Johnson, the first reflections of my desire to understand psychotherapy.

To my stalwart research raters: Lisa Ballegeer, Christopher Kepron, Mary Ellen de Leon, and Kerri Taverner, the four pillars upon which this thesis stands (we did it!).

To my mom, Dr. Helen Guzman, for inspiring my entering the helping profession, and for her loving patience and presence, especially as I forged this thesis in the quiet hours of the night.

To my dad, Dr. Conrado Santos, for inspiring my passion for studying and learning (even if this means a long graduate program!).

To the fine, kind folks at the Faculty of Graduate Studies: especially Ilse Krentz, Awards Officer; Helen Agar, Thesis Officer; Bonnie Stovel, Assistant to the Dean; and Stan Straw, Associate Dean; for their warmth, understanding, advice, and support (very therapeutic!).

To my "support group" in the fall of '95: Nahlah Ayed, Lisa Ballegeer, Dorothy Chitty, Donna Gamble, Dr. Helen Guzman, Dean Hofer, Cindy Hanna, Ellen de Leon, Carrie Lionberg, Rocio Quinonez, Elisa Romano, Tracey Sewell, Denise Smith, Gregg Tkachuk, and Adrienne Toogood, in whom courage and caring are clearly contained (and quite contagious).

To my first clients, especially the client who graciously participated in this research, for teaching me that although the world is full of suffering, it is also full of the overcoming of it.

To the discipline of psychology: I hope that this work enhances understanding about psychotherapy, one place of change and growth amidst a world of relationships.

Measuring Interpersonal Process and Outcome in Psychotherapy:
The Client's Core Conflictual Relationship Theme and the Therapeutic Relationship

So we beat on, boats against the current, borne back
ceaselessly into the past.

–*The Great Gatsby*
(F. Scott Fitzgerald, 1925/1986, p. 182)

The great events of world history are at bottom profoundly unimportant. In the last analysis, the essential thing is the life of the individual. This alone makes history; here alone do the great transformations take place . . . in our most private and most subjective lives we are not only the passive witnesses of our age, and its sufferers, but also its makers.

–*Civilization in Transition*
(Carl Jung, 1934/1970, p. 149)

All actual life is encounter.

–*I and Thou*
(Martin Buber, 1923/1970, p. 62)

Preface

The idea that earlier interpersonal relationships exert an influence on later relationships is one of the oldest ideas in psychology. Expressed in another way, there has been a perennial belief in Shakespeare's famous observation that "all the world's a stage": Like stage directors, we often cast new individuals, acquaintances, and significant others in the roles of important people from the past. Also, like actors, we sometimes play out these roles (often unwittingly) in the scenarios of other people in our lives. Freud (1895/1955) was perhaps the first to observe this phenomenon–emerging during psychoanalysis – noting how his patients frequently came to regard him as they did important figures from their earlier lives. Considerable empirical evidence suggests that individuals develop internal representations of interpersonal relationships (*relational schemas*) to navigate their social worlds (Baldwin, 1992), and that this occurs largely in an effort to fulfill the fundamental human need for interpersonal relatedness (Baumeister & Leary, 1995). In this effort, both positive and negative interpersonal patterns – guided by relational schemas – tend to persist or transfer across relationships; this process is referred to as *transference.*

Psychotherapy is inherently interpersonal. Moreover, psychotherapy is one of the few contexts distinguished by three important features. First, the development and dissolution of an interpersonal relationship is designed to occur. Second, this relationship may span periods of time as brief as ten hours over ten weeks (as in short-term therapy) to those as long as thousands of hours over several years (as in classical psychoanalysis). Third, one participant in the relationship (the therapist) is singularly focused on the development of the other participant (the client). Thus, the therapeutic relationship presents investigators with a special opportunity to naturalistically study two focal interpersonal processes: (a) how one person's (the client's) relational schemas influence his or her participation in a new relationship (the therapeutic relationship or *alliance*), and (b) how that new relationship influences the person's preexisting relational schemas. This reciprocal interpersonal process is the central focus of this thesis.

Chapter One
Transference and Alliance: Introduction and Overview

Research Questions and Thesis Overview

This thesis investigates three questions concerning psychotherapy: (a) What is the nature of the transference pattern (clinical problem)? (b) How does the alliance influence the transference pattern (treatment process)? and (c) What happens to the transference pattern following psychotherapy (clinical outcome)? In this chapter, hypotheses concerning these questions are drawn from from the literature.

In Chapter 2, the research questions are framed by a broader review of the literature, followed by a discussion of the conceptual foundations of the research methodology in Chapter 3, and a description of the research method in Chapter 4. In Chapter 5 the study's findings are presented. Finally, a general discussion of the findings in Chapter 6 concludes the thesis.

What is the Nature of the Transference Pattern?

The relational schema hypothesis. A century ago, Freud (1895/1955) introduced the concept of *transference*, the idea that patterns from important earlier relationships are frequently repeated in current relationships. Thus, the concept is as old as modern psychotherapy itself. In the decades which followed Freud, conceptions of transference proliferated, leading to widespread confusion about the meaning of the term: "As with many other analytic concepts introduced by Freud, what appeared to be relatively simple in the beginning now turns out to be very complicated indeed" (Sandler, Holder, Kawenoka, Kennedy, & Neurath, 1969, p. 637). Thus, to the present day, there is no general consensus as to how transference should be defined (Henry, Strupp, Schacht, & Gaston, 1994).

Initially, Freud (1905/1953) focused on the *transference neurosis*, the irrational displacement of the patient's relationship patterns to the relationship with the therapist. Over time, it became apparent that Freud came to favor a broader definition of the concept, wherein the therapeutic relationship is but one of many current relationships which recapitulate earlier—often maladaptive—interpersonal patterns; in short,

transference was viewed as universal, dominating interpersonal relationships (Freud, 1912/1958). This broader definition, traditionally termed *character transference* (Sandler et al., 1969), has been the most widely used. Moreover, recent theoretical[1] developments and empirical studies make a compelling case for this definition. Hereafter, the term *transference* refers to character transference. Freud's hypothesis (in modern terms, the *relational schema* hypothesis) that the transference pattern constitutes an enduring structure of personality is tested in the study described later in this thesis.

The Alliance Between Client and Therapist

The second key concept is the therapeutic *alliance*, originally described as a positive transference (Freud, 1912/1958), a facilitative patient-therapist relationship which drew upon prior caring relationships in the patient's early life. Eventually the concept developed into a therapeutic relationship which had less to do with relationships from the patient's past, and more to do with the reality-based, here-and-now transactions with the therapist. In Freud's final work, in addition to the reenactment of the patient's life story during therapy (transference), it is clear that he viewed an alliance with the conscious, healthy portion of the patient's psyche as an absolute necessity for therapeutic change (Freud, 1940/1964).

Over the next several decades, writers from the psychoanalytic tradition were primarily responsible for the theoretical development of the alliance concept; to the present, this has been variously referred to as the ego alliance (Sterba, 1934), the therapeutic alliance (Zetzel, 1956), the helping alliance (Luborsky, 1976), and the working alliance (Bordin, 1979; Greenson, 1965). At present, the alliance enjoys the twofold distinction of being one of the most widely researched clinical constructs (see Horvath & Greenberg, 1994, for a review of this literature) and one of the best predictors of outcome across several brands of psychotherapy (Henry et al., 1994; Orlinsky, Grawe, & Parks, 1994). Among integrative and transtheoretical perspectives (e.g., Norcross & Goldfried, 1992), the alliance has been the focus of much excited discussion.

---

[1] Perhaps due to early difficulties in reliably measuring the transference construct (Seitz, 1966), most of the development of the construct has been theoretical, rather than empirical. One review estimates the ratio of theoretical to empirical articles to be 500 to 1 (Henry et al., 1994).

It should be noted that although a conceptual distinction[2] has been drawn between transference and alliance, particularly since Greenson's (1965) influential paper, in practice the two may be inseparable:

> Although it is clear that we can distinguish between the treatment alliance and what we normally call transference, there can be little doubt that the success or failure of a treatment alliance depends, among other things, on the existence of what Greenacre (1954) has called a 'basic' or 'primary' transference. . . . The point we wish to emphasize is that even though we may (and from a technical point of view, *should*) contrast the treatment alliance with transference, *a form of transference itself appears to be an essential ingredient of the treatment alliance* [emphasis added]. Indeed, the phrase 'positive transference' has often been used to denote the establishment of the basic transference to which Greenacre refers. (Sandler et al., 1969, p. 641)

The Transference Pattern in the Therapeutic Relationship

Immediate vs. emergent perspectives. Following Freud (1917/1963) some theoretical writers have also been convinced that transference is present in the very first meeting with the therapist. Many years ago, for example, British analyst Ella Freeman Sharpe (1930) observed, "Transference begins with the very first analytical session . . . just because everyone has thoughts about another human being when brought into close contact" (quoted in Sandler et al., 1969, p. 636). More contemporary writers agree with this view, hereafter termed the *immediate transference* perspective (Davanloo, 1980; Gill, 1982; Strupp & Binder, 1984): This asserts that transference shapes the form of the alliance from the beginning of psychotherapy. In contrast, others consider transference as emerging much later in therapy (M. J. Horowitz, 1986; Mann, 1973; Sifneos, 1979). From this perspective, the therapeutic relationship is processed more transferentially as the patient and therapist become closer to one another over time. This assertion, that transference shapes the alliance much later in therapy, is hereafter termed the *emergent transference* perspective.

The handful of extant empirical studies of transference tends to corroborate the latter position, with the content of narratives told by the patient about the therapist coming to resemble narratives about other people in the patient's life (Crits-Christoph,

---

[2] As for empirical distinctions, Henry et al (1994) could locate only a single study (Gaston, 1990) directly comparing the two constructs: Here reliable transference ratings were uncorrelated with reliable therapeutic and working alliance ratings ($rs = .05$ and $.07$, $p > .05$).

Demorest, & Connolly, 1990; Fried, Crits-Christoph, & Luborsky, 1992). This is consistent with several other studies which have shown that "people process information about close relationship partners differently from the way they process information about strangers or distant acquaintances" (Baumeister & Leary, 1995, p. 503). No empirical evidence exists for the immediate transference perspective. Furthermore, almost no research has looked beyond the narrative level to the behavioral interaction of the client's transference pattern and the therapeutic alliance.

How Does the Alliance Influence the Transference Pattern?

The interpersonal process perspective. The considerable amount of research on the alliance has led to the publication of several empirically-supported treatment manuals that all, to differing degrees, focus intervention around the patient's relationship with the therapist (Benjamin, 1993b; Luborsky, 1984; Safran & Segal, 1990; Strupp & Binder, 1984; Weiss, 1993). These all share the general view that positive client-therapist interactions (rather than specific therapist techniques) are the primary determinants of positive therapeutic outcome. This view can be termed the *interpersonal process* perspective on the alliance (after Henry & Strupp, 1994).

According to this perspective, there are two important therapeutic goals (Benjamin, 1993b; Strupp & Binder, 1984). The first goal is to facilitate the client's awareness and learning (i.e., insight) regarding the self-defeating interpersonal patterns, thus improving the client's ability to change his or her contribution to these patterns. Without an increased awareness of the self-defeating cycle, the client will remain an unwitting participant in that cycle.

The alliance transfer hypothesis. The second goal is to provide the client with new interpersonal experiences that disconfirm the client's maladaptive cycle. This in turn, it is hypothesized, elicits new, more adaptive behaviors in the client and subsequently generalizes to the client's other significant relationships, through the same transferential process that originally led to the client's distress. That is, the interpersonal process of the alliance is directly internalized (Henry & Strupp, 1994; Orlinsky, Geller, Tarragona, & Farber, 1993)). Extant evidence relates this process to

positive changes in clients' relational schemas (introjects), symptoms, and psychological functioning (Harrist, Quintana, Strupp, & Henry, 1994; Henry, Schacht, & Strupp, 1990; Quintana & Meara, 1990). Hereafter, this proposed pattern of change[3] is termed the *alliance transfer* hypothesis.

A corollary to the second therapeutic goal is that if the therapist is unwittingly drawn into the maladaptive interpersonal drama that constitutes the client's problem, and recapitulates the negative actions of others in the client's life, problem resolution becomes difficult, if not impossible (Strupp & Binder, 1984). There is empirical support for this theory of negative outcome. For example, in her extensive review of the interpersonal relationship literature, Berscheid (1994) reports that "the general finding [is] that people are unlikely to turn the other cheek when their partner has behaved badly" (p. 98). That is, negative behaviors on the part of one person in a relationship are associated with reciprocal negative behaviors from the other; in short, negative interpersonal patterns are perpetuated. From the therapy process–outcome literature, it has become increasingly apparent that a little bit of negative process can go a long way in producing negative outcomes (Henry & Strupp, 1994).

An unusual feature of the transference literature is a near-complete absence of empirical studies comparing formulations of the patient's central relationship patterns with the alliance (therapeutic process): the relationship patterns that are enacted between patient and therapist (cf. Henry et al., 1994). Extant research (Crits-Christoph et al., 1990; Fried et al., 1992) has tended to focus on the *content* of the patient's communications. An exception is Hartley's (1991) study, which used Benjamin's (1974) Structural Analysis of Social Behavior for such a comparison, and found evidence of transference enactments in the therapeutic relationship during later sessions, implying little impact of the alliance on the transference pattern. No studies have examined patient-therapist transactions in the very first sessions of therapy, nor have any studies examined transactional patterns which lead to the excellent predictions of outcome by alliance measures made in the third and fifth sessions (Henry & Strupp, 1994; Luborsky, 1994). Thus, among the highest future research priorities outlined by prominent

[3] The more general process has been variously referred to as *introjection* (Henry & Strupp, 1994), *internalization*, *interiorization*, and *identification* (see Orlinsky et al., 1993 for a review).

researchers in the field is the investigation of transference at the level of psychotherapy *process*—the comparison of "actual *enactments of relationship events between patient and therapist in the session* with the usual *narratives told to the therapist about relationship events*" (Luborsky, Popp, Luborsky, & Mark, 1994, pp. 181-182, emphasis in original). This important transference-alliance comparison is made in the study reported later in the present thesis: The therapeutic process and the transference pattern are compared over time, in the early "critical period" (Henry & Strupp, 1994) at the beginning of therapy, and in a later period, 40 sessions after. In other words, this comparison tests the alliance transfer hypothesis.

What Happens to the Transference Pattern Following Psychotherapy?

The resolution hypothesis vs. the stability hypothesis. Clinical perspectives on changes in the transference pattern over the course of psychoanalysis and psychodynamic psychotherapy can be divided into two competing viewpoints (Crits-Christoph & Luborsky, 1990). The first view, hereafter termed the *resolution* hypothesis, asserts that, after psychotherapy, the transference patterns and the conflicts therein are resolved (Davanloo, 1980; Ekstein, 1956). The second view, hereafter termed the *stability* hypothesis, maintains that the transference pattern and its associated conflicts remain, even following the most successful psychotherapy (Pfeffer, 1963; Schlessinger & Robbins, 1975). Extant evidence supports the stability hypothesis (Baguet, Gerin, Sali, & Marie-Cardine, 1984; Crits-Christoph & Luborsky, 1990). These two competing hypotheses are tested against one another in the study reported later in this thesis.

Chapter Summary

An important guiding assumption of this research is that the therapeutic relationship follows fundamental interpersonal principles that underlie other forms of close relationship. In this chapter, the study's theoretical framework was founded on psychodynamic and interpersonal clinical traditions. Viewed from this theoretical framework, the therapeutic relationship was seen to comprise (a) *transference*, the implicit influence of previous relationships, and (b) *alliance*, the influence of the actual

client-therapist relationship. Viewed from the interpersonal process perspective, changes in the client's interpersonal structure (consisting of internal representations and behavior, i.e., the transference pattern) are associated with the construction of a new transference pattern – that of a positive alliance – which generalizes (that is, transfers) to other current relationships. This construction occurs via interpersonal process, the manner wherein the therapist and client relate to each other in the therapeutic relationship. In other words, the client's original transference pattern (clinical problem) is influenced positively by the "transference" of the therapeutic alliance (treatment process) into the client's other relationships, leading to positive changes in the transference pattern (clinical outcome). In the next chapter, this framework is grounded in basic psychological findings drawn from developmental, interpersonal, and social cognitive approaches.

Chapter Two
Review of the Literature: Further Research Foundations

First, some preliminary assertions: Scientific understanding of psychotherapy will advance if the field conceptualizes psychotherapy as an essentially interpersonal phenomenon and attends to the theoretical and hypothesis validity of its investigations, paying special attention to the theoretical congruence of its methods. Moreover, all psychotherapy research should be grounded in psychological research.[4]

Because the psychological research relevant to psychotherapy is potentially enormous, this review relies heavily on a number of recent and extensive reviews of empirical studies. To understand transference and alliance in psychotherapy, it is useful to review our current general state of knowledge regarding how (and why) individuals develop interpersonal relationships, how they represent, think about, and maintain these relationships, and how these relationships might best be studied. The vast literature explored in the following review originates from a wide array of theoretical traditions: psychoanalytic and psychodynamic, interpersonal and object relational, social psychological and social cognitive. In recent years there has been much interest in integrating several of these traditions, particularly psychodynamics and social cognition, in spite of earlier doubts that psychoanalytic concepts could ever be scientifically studied (Grünbaum, 1984; Popper, 1963).

The Not-So-Great Divide? Psychodynamics and Social Cognition

Nearly half a century ago, Dollard and Miller (1950) published a groundbreaking attempt at reconciling psychoanalytic and behaviorist perspectives on personality and psychotherapy. For reasons lost to history, their work was mysteriously abandoned (Erdelyi, 1994). In recent years, similar efforts have been made toward integrating psychodynamic and cognitive approaches (Epstein, 1994; M. J. Horowitz, 1991). An important development of the cognitive revolution in psychology was the

[4] Some arguments behind these assertions are discussed in Appendix A, placing the present research in broader perspective. Readers may find it useful to consider how psychotherapy research came to develop as an area of scientific inquiry. Several lessons have become apparent as the field approaches maturity. New questions and, more importantly, new ways of answering those questions, have emerged (see Appendix A).

reconsideration of the concept of the unconscious (Bowers & Meichenbaum, 1984), a concept crucial to the advance of psychology (Kihlstrom, 1987). Recent commentary in a special issue of the *Journal of Personality* suggests that these integrative efforts hold much promise:

> The point is that at its most general level of explanation, psychoanalytic theory doesn't look much different from other psychological theories of mind and behavior. Of course, at this level the theory is also untestable. But it is not untestable in principle: Nestled under the metapsychological propositions is a hierarchy of general, specific, and empirical propositions which are increasingly amenable to testing by means of conventional scientific procedures (Kihlstrom, 1994, p. 686).

> Though the irony may not be immediately apparent, mainstream psychology's prodigal re-embracing of mentalistic theories has confirmed the worst fears of the behaviorist tradition. Considering the meaning of a stimulus for the individual when attempting to predict the person's behavior inevitably opens the floodgates for the study of such decidedly messy topics as wants, needs, and conflicts – the things most people say are most important to them, and, perhaps not coincidentally, the stuff of psychoanalytic theory. (Strauman, 1994, p. 452)

> Coupled with his emphases on transference, identification and introjection, the effects of the family social drama on the formation of personality, and interpersonal (hence social) psychotherapy whose ultimate goal is the "re-education of personality" – all cognitive processes with social underpinnings – one would be inclined to conceive of Freud as a trailblazer of social cognition. Since this is hardly the received view – why is it not? I must begin my commentary by challenging the premise implicitly espoused . . . that a conceptual divide exists between "psychodynamics" and "social cognition." At the manifest level no divide exists and no bridges (interfaces, etc.) need to be built. All that is needed is the abandonment of artificial barriers, which, having no logical merit, can be understood only in terms of latent agendas (Erdelyi, 1994, p. 669-670).

This is not to argue that a rapprochement has occurred, as Strauman (1994) observed: "It would be erroneous, of course, to presume a greater degree of convergence and agreement between the schools (not to mention *within* each school) than is actually the case" (p. 454). What seems to have been the case was a psychology marked by "petty provincialisms" which had little to do with substantive issues:

> Perhaps there is a distinction, but one that is methodological rather than conceptual: The psychodynamic tradition arose from the clinic, the social cognition one from the laboratory. . . . In any case, whatever held in the past, the clinical and experimental arenas are converging and, at least logically, need not be distinct, . . . quantification and methodology are no longer the privileged preserve of traditional laboratory scientists; except for their goals, the laboratory and the clinic are not formally distinct (even if in practice they usually are), and so a distinction between psychodynamics and social cognition riding on a clinical–laboratory dissociation is tenuous, unnecessary, and lacking a future. (Erdelyi, 1994, pp. 676-678)

(Erdelyi's comments also speak to another apparent divide in our discipline: The divide between science and practice in clinical psychology; this important issue is discussed further in Appendix B.)

Recent reinterpretations of transference from information-processing perspectives (Singer, 1985, 1988; Westen, 1988, 1991) are further indications of the not-so-great divide between the two traditions. In fact, as the 1980s began, when psychologists were rediscovering the centrality of affect, Zajonc (1980) made an interesting acknowledgement in his influential paper:

> I began this paper with a quotation from Wundt, and it must be apparent that another spirit has emerged as I have developed my arguments – that of Freud. The separation of affect and cognition, the dominance and primacy of affective reactions, and their ability to influence responses when ordinary perceptual recognition is at chance level are all very much in the spirit of Freud, the champion of the unconscious. (p. 172)

Thus, as psychology recovered its mind in the 1960s and 70s, and recovered its heart in the 1980s, the way was paved for the scientific study of transference and alliance, two of the cornerstones of psychoanalytic theory.

Transference and Interpersonal Relationships

Interpersonal needs. Psychotherapy is many things. Perhaps first and foremost, it is a human relationship, most often between a patient and therapist. Thus, it is useful to review what is currently known about the nature of interpersonal relationships. Long before psychology emerged as a formal discipline, people have considered the nature of human relatedness, recently termed *belongingness* (Baumeister & Leary, 1995).

Baumeister and Leary proposed that the need to belong consists of frequent interpersonal interactions marked by a stable, emotional bond. Their formulation differs from classical psychodynamic theory (and Bowlby's early attachment theory) in that primacy is not necessarily solely accorded to early infant-caregiver relationships. Rather, the need to belong may be derived from and extend to other interpersonal relationships over the life span. Their position is similar to that of Harry Stack Sullivan (1953), who argued that human personality development and change is quintessentially interpersonal, and that of contemporary attachment theorists (Ainsworth, 1989; Bowlby, 1988). After a comprehensive review of the literature, Baumeister and Leary

drew conclusions that have far-reaching implications for psychology, especially for the study of psychotherapy:

> At present it seems fair to conclude that human beings are fundamentally and pervasively motivated by a need to belong, that is, by a strong desire to form and maintain enduring interpersonal attachments. People seek frequent, affectively positive interactions within the context of long-term, caring relationships. As a speculative point of theory or impressionistic observation, the need to belong is not a new idea; indeed, we noted a variety of previous psychological theorists who have proposed it in one form or another. *What is new, however, is the existence of a large body of empirical evidence with which to evaluate that hypothesis.* If psychology has erred with regard to the need to belong, in our view, the error has not been to deny the existence of such a motive so much as to underappreciate it. . . . The desire for interpersonal attachment may well be one of the most far-reaching and integrative constructs currently available to understand human nature. (Baumeister & Leary, 1995, p. 522, emphasis added)

In an independent review, Berscheid (1994) drew essentially similar conclusions, that

> an individual's security orientation may reflect the individual's current relationship experiences as much as a chronic security disposition. . . . [An] array of theories and evidence on security and trust strongly suggests that expectations concerning whether care will be received from the relationship partner in response to need may be an important component of most relationship schemas. It may even be the central component – one that is present in every developed relationship schema and one that will exert special influence on all other components of the schema" (pp. 102-104).

Berscheid's conjecture, that belongingness is central in our mental representations (schemas) of relationships is explored further in the next section. Before leaving the topic of belongingness, it is important to also realize that many forms of psychological disturbance can be understood as the outcome of failures in belongingness:

> Deprivation of stable, good relationships has been linked to a large array of aversive and pathological consequences. People who lack belongingness suffer high levels of mental and physical illness and are relatively highly prone to a broad range of behavioral problems, ranging from traffic accidents to criminality to suicide. Some of these findings may be subject to alternative explanations, and for some the direction of causality has not been established; however, the weight of evidence suggests that the lack of belongingness is a primary cause of multiple and diverse problems. . . . Furthermore, a great deal of neurotic, maladaptive, and destructive behavior seems to reflect either desperate attempts to establish or maintain relationships with other people or sheer frustration and purposelessness when one's need to belong goes unmet. (Baumeister & Leary, 1995, pp. 511, 521)

Never before has there been better empirical evidence for the belongingness hypothesis. An important implication is that any future account of human development and disturbance will be seriously flawed if the belongingness hypothesis does not occupy a central explanatory role. For the present purposes, the theoretical implication is that the

need to belong is crucial in understanding why transference, the influence of one's interpersonal past on the interpersonal present, occurs: Transference can be understood as a (fallible) process for maintaining interpersonal relatedness. The practical implication is that psychotherapy, as it has been conceptualized in this thesis, seeks to amend failures in human relatedness through a relational process of learning (i.e., relearning, unlearning). Because such learning involves processes of representation, cognition, and emotion, it is useful to review the literature on how people think and feel about relationships.

Transference and Social Cognition

Social cognition as a field of inquiry preceded what came to be known as the cognitive revolution in psychology (Schneider, 1991). From the 1920s until the 1950s, social cognition favored a "soft" approach, emphasizing conscious experience and structural explanations. As the cognitive revolution gained prominence, social cognition adopted the "hard" approach of its sister subdiscipline, emphasizing the microprocessing of information. At present, social cognition appears to have the best of both worlds, "the rigor of hard social cognition and the focused attention to the social worlds fostered by the older, soft approach" (Schneider, 1991, p. 555).

Thus, investigators are in an excellent position for finding out how people think about their relationships. Because thinking is for doing (S. T. Fiske, 1992) and "social understanding operates in the service of social interaction" (Berscheid, 1994, p. 84), it has been proposed that people may often represent their social world in terms of the kinds of relationships they have with others (A. P. Fiske, Haslam, & Fiske, 1991). However, recent work in social cognition "has largely neglected the impact of internally represented interpersonal information, . . . with research choosing instead to focus on the perception of self and other persons in isolation." (Baldwin, 1992, p. 461)

Interpersonal cognition. Placed in the context of attachment theory, the schema[5] concept—generically defined as a cognitive representation or knowledge structure which guides information processing and resultant action (Bartlett, 1932)—provides a useful starting point for understanding interpersonal cognition.

[5] See Singer and Salovey (1991) for a review of the numerous variations in defining this concept.

Because the construction of the self occurs in a social context (Harter, 1983; Sroufe, 1990), the nature of the infant's interpersonal relationships is paramount in the consolidation of identity. In the primary context of human relationships during the first three years of life, the child develops a sense of his or her body, self-worth, and competence (Bowlby, 1988). Over time, the developing infant begins to tacitly extract and abstract *relational schemas* from repeated interactions with attachment figures (Safran, 1990a; Stern, 1985). As the individual develops from infancy into adulthood, these schemas function as working models for maintaining relatedness, a process that is, as discussed in the previous section, inherently biological and survival-oriented (Bowlby, 1988; Greenberg & Safran, 1987). The establishment in the infant's mind of an emotionally secure relationship with the primary caregiver or attachment figure serves as a "secure base" from which the infant can explore and elaborate working models of self and intimate other, as well as the world the infant occupies (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1979). Further, these (primarily unconscious or tacit) models or schemas of self, other, and the world become increasingly resistant to change with the confirmation of experience, accelerating as the child becomes a more active participant in selecting and creating his or her environment (Bowlby, 1988; Sroufe, 1987). Thus the central theoretical idea

> is that people develop working models of their relationships that function as cognitive maps to help them navigate their social world. These cognitive structures are hypothesized to include images of self and other, along with a script for an expected pattern of interaction, derived through generalization from repeated similar interpersonal experiences. (Baldwin, 1992, p. 462)

After an extensive review of the literature, Baldwin (1992) concludes:

> Although there are some critical differences among the models reviewed [symbolic interactionist, social psychological, object relational, and interpersonal], the commonality of perspective is remarkable. Most of the writers agree that people develop cognitive maps, representational worlds, or working models to navigate their social environment. (p. 467)

This conclusion can be related to the essential process described in the previous section on interpersonal relationship research, the belongingness construct, and their implications for clinical practice. Safran (1990a) provides a summary:

> . . . a person's maladaptive interactional patterns persist because they are based upon working models of interpersonal relationships that are consistently confirmed by the interpersonal consequences of his or her own behavior. One's interpersonal schemas

> shape the perception of the interpersonal world and lead to various plans, strategies, and behaviors, which in turn shape the environment in a manner that confirms the working model. There is, thus, a self-perpetuating *cognitive-interpersonal cycle* . . . the psychologically maladjusted individual has relatively negative and rigid beliefs about the characteristics of others and rigid and constricting beliefs about the way he or she must be in order to maintain interpersonal relatedness. (p. 97, emphasis in original, Safran's citations deleted)

Implicit interpersonal cognition. An important aspect of interpersonal cognition is worth emphasizing. Greenwald and Banaji (1995) have recently drawn attention to considerable evidence corroborating the related idea that social behavior often operates in an implicit or unconscious manner:

> The signature of implicit cognition is that traces of past experience affect some performance, even though the influential earlier experience is not remembered in the usual sense – that is, it is unavailable to self-report or introspection. (pp. 4-5)

Implications of this phenomenon for the study of transference are made clearer in their concept of *implicit attitudes*, defined as "introspectively unidentified (or inaccurately identified) traces of past experience that mediate favorable or unfavorable feeling, thought, or action toward social objects" (p. 8). Thus, transference can be thought of as one example of a larger class of implicit attitudes. Moreover, the concept of *immediate* transference can be thought of as one example of implicit *instant attitudes*, the "near-immediate liking or dislike for a novel object on first encounter with it" (Greenwald & Banaji, 1995, p. 10). That is, an individual's first encounter with a person who has never been met before is influenced by the individual's previous interpersonal relationships. By subsuming affect under the heading of implicit cognition, Greenwald and Banaji evince an earlier time in psychology, when the discipline was rediscovering the importance of affect in understanding human nature. It has been known for some time that affective reactions can occur without introspection, that "preferences need no inferences" (Zajonc, 1980) :

> The evolutionary origins of affective reactions that point to their survival value, their distinctive freedom from attentive control, their speed, the importance of affective discriminations for the individual, the extreme forms of action that affect can recruit – all of these suggest something special about affect. People do not get married or divorced, commit murder or suicide, or lay down their lives for freedom upon a detailed cognitive analysis of the pros and cons of their actions. (p. 172)

In this regard, the underlying process of implicit social cognition is not new. What is

new is its encompassing of feeling, thinking, and behavior, its extension into the interpersonal realm, and its corroboration by considerable evidence (Bornstein & Pittman, 1992; Greenwald, 1992; Kihlstrom, 1987).

Chapter Summary

Because the need for relatedness is fundamental, individuals develop relational schemas to navigate their social world in search of this relatedness. In this effort, both positive and negative interpersonal patterns – guided by interpersonal or relational schemas – tend to persist or transfer in an implicit fashion across relationships in a cyclical, often self-defeating manner; this process is the essence of transference.

Theoretical Summary

The present theoretical framework can be summarized as a series of seven tenets:

1. The need for belongingness is a fundamental human motivation (Ainsworth, 1989; Baumeister & Leary, 1995; Berscheid, 1994; Bowlby, 1988).

2. When this need is insufficiently met, disturbance and maladjustment tend to follow (Baumeister & Leary, 1995; Bowlby, 1988).

3. An individual's efforts to sustain this need are played out across different relationships over the life span, from which the individual abstracts relational schemas or transference patterns (Baldwin, 1992; Bowlby, 1988; Luborsky & Crits-Christoph, 1990; Safran, 1990a; Stern, 1985) which tend to be unconscious, inaccessible to introspection (Baldwin, 1992; Greenwald & Banaji, 1995).

4. An individual's efforts to sustain these needs can become maladaptive when behaviors which were adaptive in earlier contexts are unwittingly transferred to newer, inappropriate contexts, including the therapeutic relationship (Baumeister & Leary, 1995; Benjamin, 1993a; Safran, 1990a; Strupp & Binder, 1984).

5. These maladaptive efforts at sustaining relatedness can develop into a self-propagating pattern or vicious cycle which becomes increasingly resistant to change and thus, pervasive and longstanding (Henry & Strupp, 1994; Safran, 1990a; Strupp, 1986; Wachtel, 1977, 1987).

6. Interruptions in this vicious interpersonal cycle can elicit new interpersonal patterns, which may be more adaptive and need-fulfilling; if such interruptions occur during psychotherapy, positive outcomes tend to follow (Benjamin, 1993a; Henry & Strupp, 1994; Safran, 1990b; Strupp, 1989).

7. Perpetuations of the cycle lead to increases in disturbance and maladjustment; if such perpetuations occur during psychotherapy, negative outcomes tend to follow (Henry & Strupp, 1994).

Just as this theoretical framework has been empirically grounded in basic psychological research in this chapter, the research method is conceptually grounded in basic methodological tenets in the next chapter.

Chapter Three
Conceptual Foundations of the Research Method

An analogy offered by Wampold and colleagues (1990) is a useful guide:

> If a researcher uses a strong rope to lower himself or herself from theory to research hypotheses to statistical hypotheses and finally to the results of a study, then he or she will be able to climb back with the results so that a valid statement about theory can be made. If the rope is fatally frayed at some point, the results picked up at the bottom will be of little value (and may become burdensome weight) for the return journey. (p. 367)

The Importance of Conceptual Congruence

A perennial problem with much of the extant psychotherapy research involves the conceptualization of the clinical problem, the treatment, and the clinical outcome (Strupp, Schacht, & Henry, 1988). The traditional approach to describing the problem has been ascribing a diagnostic category; sometimes various self-report measures are used as well. The treatment often has no clear theoretical relationship to the way the problem or the clinical outcome is conceptualized. Moreover, it is frequently unclear, given a positive outcome, what it was about the treatment that brought about the effect. The usual approach of correlating ratings of interventions on yet another measure with outcome scores still fails to address the central problem: The lack of theoretical coherence between the separate measures. Within studies that have attempted the latter, a further problem is that the measures of problem (P), treatment (T), and outcome (O) are not at the same level of description, making the interpretation of the findings difficult. Strupp et al. (1988) make a convincing case for P–T–O congruence which

> *proposes that the intelligibility of psychotherapy research is a function of the similarity, isomorphism, or congruence among how we conceptualize and measure the clinical problem (P), the processes of therapeutic change (T), and the clinical outcome (O).* . . .That is, therapeutic outcome should be characterized in the same form and units of analysis as the clinical problem; and the language used to describe both the problem and the outcome should lend itself to formulation of cogent theoretical links among the problem, intervention process, and the therapeutic outcome. (p. 7, emphasis in original)

When operationalizing a theoretical framework into research hypotheses, it is important to preserve the integrity of that framework as much as possible. This means selecting research measures which are conceptually congruent with the theory under investigation.

Measuring Transference

In recent years, methods for extracting the client's underlying patterns of conflictual, maladaptive relationship patterns have proliferated. There are currently no less than fifteen published approaches to measuring transference (see reviews by Barber & Crits-Christoph, 1993; Henry et al., 1994; and Luborsky et al., 1993).

The Core Conflictual Relationship Theme (CCRT) method. Of the major approaches to formulating the client's pervasive relationship patterns (i.e., interpersonal schemas), the first reliable measure was Luborsky's (1977) *core conflictual relationship theme (CCRT)* method; since its inception, it has generated the lion's share of such research (summarized in Luborsky & Crits-Christoph, 1990). The method utilises (at least 10) narratives—spontaneously told by the client during therapy sessions—scored for the three CCRT components: (a) wishes, intentions, or goals (Ws); (b) responses of others (ROs); and (c) responses of self (RSs). The most recurrent components across session narratives form the CCRT.

Recently, Luborsky, Barber, and Diguer (1992) reviewed the major observations arising from the narrative as an observational unit for psychotherapy research. For the present research, two of their higher-order conclusions are central. First, within the narratives told by the client during therapy is embedded a *"general relationship pattern or schema with structural or trait-like properties"* (p. 287, emphasis in original). Operationally, the CCRT is pervasive across narratives, has a lasting quality, occurs across different states of mind (e.g., awake and in dreams), occurs both in and out of session, and includes the therapeutic relationship.

Second, *"the curative factors in psychotherapy are intimately involved with the content of the relationship narratives"* (p. 288). The relative pervasiveness and valence of the CCRT components change in the narratives of clients who benefit from psychotherapy. While the client's Ws remain stable during therapy, the ROs and RSs show a change from negative to positive (e.g., from rejection to acceptance). Moreover, the closer the focus of the therapist's interventions on the CCRT, the better the client's outcome (Crits-Christoph, Barber, & Kurcias, 1993; Crits-Christoph, Cooper, & Luborsky, 1988). Clearly, this extensive body of research suggests both the promise of

the client's narratives as units of study for psychotherapy research and of the CCRT as a guiding framework for research and practice. In recent work, the CCRT method has been extended by Crits-Christoph and colleagues (1990) into a new procedure, described next.

The Quantitative Assessment of Interpersonal Themes (QUAINT) method. The QUAINT method diverges from the original CCRT method in several ways. First, the QUAINT method employs a list of *standard categories* for the CCRT components; the original CCRT method allowed judges to generate their own categories. The standard categories consisted of 32 Ws, 30 ROs, and 29 RSs; these were developed to aid in reliability studies of the CCRT by eliminating the problem of variations in wordings between judges (see Luborsky & Crits-Christoph, 1990). Second, there is a difference in the sampling of narratives: The initial QUAINT study (Crits-Christoph et al., 1990) identified a total of 150 acceptable narratives across a 31-session therapy, in contrast to the minimum of 10 narratives utilised in the CCRT method, usually sampled in restricted segments of the therapy. Third, all categories are rated on a 1 to 5 scale (1=*not present*, 5=*strongly present*) for every narrative, rather than simply requiring the judgement of presence or absence, as in the original CCRT method.

These changes to the original CCRT method presented new advantages as well as limitations. Advantages included the presentation of a fuller range of possible categories (which had a tendency of being restricted by judges not thinking about certain potential categories), the use of a common language for rating, the ability to rate categories on a continuous (vs. a dichotomous) scale, and the amenability of quantitative ratings for more sophisticated data analysis. Limitations included the restriction of content to the standard categories and the wide range in reliability (.00 to .92) of the categories. Regarding the latter, after retaining only the categories with a reliability of .50 or more, the final dataset in the initial QUAINT study consisted of 20 Ws, 23 ROs, and 19 RSs, with median interjudge reliabilities of .69, .68, and .67, respectively (Crits-Christoph et al., 1990). The most recent version of the QUAINT method now employs categories derived from Benjamin's (1993b) Structural Analysis of Social Behavior (Crits-Christoph, Demorest, Muenz, & Baranackie, 1994).

Two other important findings in the initial QUAINT study were (a) supporting evidence of the structural or trait-like properties of relationship themes (similar to the CCRT findings) and (b) divergent evidence of complex and multiple relationship themes in a single case (in contrast to the single, central relationship theme assumed by the CCRT method). The question of whether single or multiple formulations are more predictive of outcome has yet to be empirically addressed.

Finally, both CCRT and QUAINT methods have been restricted to the *content* of the client's relationship narratives. To reiterate a point made earlier in this thesis, one of the highest future CCRT research priorities is investigation at the level of *process*, the comparison of "actual *enactments of relationship events between patient and therapist in the session* with the usual *narratives told to the therapist about relationship events*" ((Luborsky, Popp, Luborsky, & Mark, 1994, pp. 181-182). The foregoing methods, findings and recommendations inspired the development of a new transference measure, a synthesis of the original CCRT and QUAINT methods. This measure—the *Revised CCRT method*—was used in the present study (and is extensively described in the Research Method section). At this point, because the CCRT database consists of narratives told by the patient during therapy sessions, it is worth discussing narrative forms of inquiry.

The Importance of Narratives

> Clinical diagnoses are important since they give the doctor a certain orientation; but they do not help the patient. *The crucial thing is the story.* For it alone shows the human background and the human suffering, and only at that point can the doctor's therapy begin to operate. (Carl Jung, 1961, p. 124, emphasis added)

The general rationale for the use of narratives centers on the power of the method to obtain more valid self-reports than can be obtained from structured interviews or questionnaires (Berscheid, 1994); this is congruent with Greenwald and Banaji's (1995) recommendations for indirect measurement of implicit constructs. In terms of studying transference, as noted in an earlier section, the client's relationship narratives in therapy are the natural source of data for inferring the interpersonal schemas of the client (Luborsky et al., 1992). Berscheid (1994) notes that the

> reconstructive quality of autobiographical memories [are useful in learning] how people make sense out of past relationship events. The meaning individuals accord to these events is presumed to have a number of implications for their future behavior in that relationship or others, whether or not their memories are congruent with other evidence. *Account narrative* is used here to refer to the stories people construct of relationship events that span a considerable period of time and are presented in relatively unstructured formats . . . [Moreover] account narratives are believed to reflect and maintain current relationship orientations (pp. 96-97).

In this context, Berscheid quotes one of the founders of the cognitive revolution, Jerome Bruner, a leading proponent of narrative forms of inquiry in psychological science:

> Let me tell you first what I and my friends thought the revolution was about back there in the late 1950s. It was we thought, an all out effort to establish meaning as the central concept of psychology – not stimuli and responses, not overtly observable behavior, not biological drives and their transformation, but meaning. . . . Its aim was to discover and describe formally the meanings that human beings created out of their encounters with the world, and then to propose hypotheses about what meaning-making processes were implicated. It focused upon the symbolic activities that human beings employed in constructing and in making sense not only of the world, but of themselves. Its aim was to prompt psychology to join forces with its sister interpretive disciplines in the humanities and in the social sciences. . . . [But] very early on . . . emphasis began shifting from "meaning" to "information," from the construction of meaning to the processing of information. . . . Information is indifferent with respect to meaning. (1990, pp. 2-4)

Berscheid (1994) observes that "[in] the quest to understand human relationships, these two approaches to human cognition, meaning-making and information processing, are meeting up with each other again, so far amicably" (p. 100). This is especially apparent in the CCRT approach to studying implicit social cognition, i.e., the process whereby clients construct meaning out of their world, a world that is quintessentially interpersonal. This relational view has important implications for research design.

The Importance of Single-Case Designs

In earlier sections it was asserted that psychotherapy consists of the therapist's efforts to influence the quality of the patient's experience in relation to the therapist as a significant other (see also Appendix A). If therapy is best viewed in such a manner, then hypothesis validity demands that traditional emphases on group comparisons based on population means need to be complemented by the intensive study of individual client-therapist dyads. Because the theory which guides most psychotherapy research is expressed at the dyadic level, so too must the hypotheses, and thus, the

research design. Hilliard (1993) provides a useful framework by which such research can be organized, emphasizing that a more valid approach would be the systematic collection and comparison of single cases (which include client-therapist dyads). Only when a sufficient understanding of intradyadic process is attained can such cases be meaningfully grouped and statistically analyzed using traditional procedures based on population means. Patterns across clients, therapists, and outcomes can then lead to empirically-based principles of therapeutic change.

Shoham-Salomon (1990) offers an appealing transactional model wherein intensive single-case designs and subsequent controlled hypothesis-testing group designs interact in an iterative, cyclical, and mutually elucidating pattern across studies. Similarly, Hill (1990) reminds us that much of present research is still in the initial stages of clinical description and observation, and that sufficient data must be generated before formal group hypotheses can be tested. The essential point is that group comparisons are premature when intradyadic process has not been satisfactorily described by empirical study at the single case level.

The issue of generality tends to be raised as a limitation of single-case research. However, external validity is not always the scientific goal of a particular study; sometimes an investigator asks whether something *can* happen, rather than whether it typically does happen: This approach asks whether a particular case does what theory specifies, and whether the study gives the theory a fair hearing (Mook, 1983).

Of course, a longer-term objective is determining the generality of a set of findings from a single-case paradigm. Hilliard (1993) cites Thorngate's (1986) concise description of this approach:

> To find out what people do in general, we must first discover what each person does in particular, then determine what, if anything, these particulars have in common. . . . Nomothetic laws lie at the intersection of idiographic laws; the former can be discovered only after we find the latter. (pp. 75-76, [Thorngate's citations omitted])

Thus, generality would be determined not by group aggregation, but by replication on a case-by-case basis, which may be *direct replication* (with subjects that are similar in terms of the individual-difference variables related to the construct of interest) or *systematic replication* (with subjects that differ in terms of the individual-difference variable).

Hilliard (1993) proposes three basic categories of single-case research: (a) *single-case experiments*, designs that involve quantitative data and direct manipulation of the independent variable; (b) *single-case quantitative analyses*, designs in which quantitative techniques are applied without the direct manipulation of any of the variables studied; and (c) *case studies*, designs using qualitative data and passive observation. The latter two designs may be further distinguished as confirmatory (hypothesis-testing) or exploratory (hypothesis-generating). Moreover, there is also the possibility that both quantitative and qualitative data are assessed within the same single-case study (Gaston & Marmar, 1989; Rice & Greenberg, 1984).

Chapter Summary

The CCRT method was selected as a theoretically congruent measure of transference in psychotherapy. Implicit in this selection is a regard for the client's narratives as the database of choice for inferring interpersonal schemas. Finally, given the dyadic focus of the present research questions, it was argued that a single-case paradigm was the most appropriate design for maintaining hypothesis validity. Further related discussion is presented in Appendix B (see Appendix B).

Chapter Four
The Research Method

Research Setting

The present study took place at the Psychological Service Centre (PSC) at the University of Manitoba (U of M), Winnipeg, Manitoba, Canada. The PSC is a community mental health clinic on the U of M campus with a twofold mandate: (a) the provision of assessment and psychotherapy to clients from the university and surrounding community and (b) the training of students in the Clinical Psychology and Social Work Training Programs at the U of M.

Screening criteria. All clients accepted for treatment at the PSC must meet several exclusion criteria, including: (a) absence of florid psychosis or severe organic impairment, (b) absence of severe suicidal ideation, and (c) absence of pending or ongoing legal involvement. At intake all clients sign a consent form for session observation (usually audiovisual recording, for supervision) prior to a semi-structured intake interview by an evaluating student clinician and attending clinical faculty member. In general, therapists are advanced psychology and social work students.

Participants

Client. The client is a single female in her mid-30s, currently completing an undergraduate university degree. Over the course of her life, she has had extensive contact with the mental health care delivery system. She was self-referred to the PSC for emotional and interpersonal conflicts arising from previous and current abusive relationships, including childhood physical and sexual abuse by siblings. Associated problems included anxiety, depression, helplessness–hopelessness, depersonalization–derealization, anger, traumatic intrusions, guilt, and self-blame, meeting DSM-IV criteria for posttraumatic stress disorder. She was seen at the PSC by a male therapist for 41 sessions prior to a transfer to the present therapist studied in this research.

Therapist. The therapist is a single male clinical psychology graduate student in his mid-20s. At the time the client was transferred to him, he had completed two general practica at the PSC. Psychodynamic-interpersonal therapy with the client was

guided by theory and techniques derived from Benjamin (1993b), Bowlby (1988), Luborsky (1984), and Strupp and Binder (1984). The CCRT approach was used to draw a clinical formulation of the client's presenting problems as an initial guideline for interventions. This formulation emphasized the cyclical relationship pattern discussed in the theoretical section of this thesis. Technique emphasized the therapeutic relationship as a secure, supportive, and empathic environment for interpersonal learning. A focus was placed on disconfirming the negative interpersonal patterns as they emerged in the therapeutic relationship and exploring ways by which the client could alter these patterns in other current relationships. Therapy sessions were on a once-weekly basis. Supervision of the therapy was generally on a once-weekly or once-biweekly basis.

Supervisor. The supervisor is a married, male clinical psychologist and professor in the clinical psychology training program. He has had well over 30 years of clinical experience with a wide range of clinical problems, approaching therapy from a psychodynamic and systems perspective consonant with the theoretical framework described in this thesis. Supervision involved review of session videotapes, and emphasized the therapeutic principles described above in the therapist section.

Raters. The four raters (3 female, 1 male) are all in their mid-20s. At the time of the study all held bachelor-level degrees (2 in psychology, 1 in political science, 1 in fine arts). They were selected as raters by the therapist because of their intelligence, general interest in psychology, and most of all, their empathic ability, given that the Revised CCRT method implicitly draws upon the interpersonal reactions of the raters to the data at both the narrative content and in-session process levels. At the time of the study, no raters had any clinical training, and were therefore regarded as clinically naive.

Instrument: The Revised CCRT Method [6]

Background. To review, it was considered essential to use research measures which demonstrate theoretical congruence (i.e., problem–treatment–outcome congruence; see Chapter 3) and focus on the complex, interpersonal nature of psychotherapy as it

[6] Thanks to John Schallow and my classmates in the Clinical Research Design seminar for their contributions to the developments described in this section.

unfolds over time within a given client-therapist dyad. The Revised CCRT method is an extension of both the original CCRT and QUAINT methods described earlier. As such it makes the same fundamental theoretical assumption as its predecessors: Much of what defines an interpersonal schema may be procedural knowledge and inaccessible to conscious awareness, thereby limiting the usefulness of self-report measures (Baldwin, 1992). Attempts at a self-report CCRT instrument (see Luborsky & Crits-Christoph, 1990), for example, encountered a number of problems in this regard. Moreover, earlier it was argued that one major reason for the clinical problem is the client's lack of awareness regarding the maladaptive relationship pattern. In other words:

> direct measures – that is, measures that presume accurate introspection – are necessarily inadequate for [the study of implicit social cognition or transference]. Rather, investigations of implicit cognition require indirect measures, which neither inform the subject of what is being assessed nor request self-report concerning it . . . in studying implicit cognition, indirect measures are theoretically essential. (Greenwald and Banaji, 1995, p. 5)

Thus, the Revised CCRT method is an observer-based, quantitative measure for operationalizing the clinical problem, therapeutic process[7] , and clinical outcome. In general, the method makes no a priori assumptions regarding who may best act as observer; current thinking holds therapist, client, and independent observer as mutually informing perspectives on process and outcome (Lambert & Hill, 1994). However, as noted above, the client may have the least direct access to measuring transference. Thus, the current study employed independent observers as raters.

Database. The Revised CCRT method requires two basic types of data: (a) transcripts of *relationship narratives* told by the client during therapy, regarding interpersonal events in the client's life, and (b) transcripts of *client–therapist dialogue* during therapy. The *content* of the relationship narratives are used for scoring the clinical problem, yielding a quantitative CCRT profile; changes in the pattern and levels of this profile constitute outcome. The client-therapist dialogue is scored at the level of *process* using the same CCRT categories as in the problem and outcome profiles, following the principle of problem–treatment–outcome congruence.

[7] Alliance measures abound (see Henry et al., 1994; Horvath & Greenberg, 1994). However, to improve theoretical and methodological congruence, the Revised CCRT method measures both content and process. Future research should compare the method with extant alliance measures.

Scaling. In an effort to improve upon its predecessors, the Revised CCRT method employs the CCRT Standard Category Clusters (Luborsky & Crits-Christoph, 1990, pp. 49-50). These 24 categories (8 each of Ws, ROs, and RSs; see Table 1) were derived by Luborsky and colleagues from a cluster analysis of the larger list of 91 standard categories employed in the first QUAINT study (Crits-Christoph et al., 1990). The shortened list of categories has several appealing qualities beyond those used in the QUAINT method, including a reduced burden for raters, reduction of redundancies among the standard categories, and potential improvements in interrater reliability. Although the clusters may appear to sacrifice comprehensiveness for simplicity, there is convincing evidence that interpersonal relationships are mentally represented by a relatively small number of implicit categorical forms (Haslam, 1994). CCRT raters score the data on all categories for presence or absence.

Sampling and units of analysis. For the present study, in terms of Kiesler's (1973) definitions, the *scoring unit*—the portion of verbal material that is coded and counted—was the relationship narrative (for content raters) and turns-at-talk in the dialogue (for process raters). The *context unit* —the portion of verbal material which is available in assigning the scoring unit— included all material in the session transcript preceding the scoring unit. The *summarizing unit* —the portion of verbal material that is actually analyzed and from which conclusions are drawn—was at two levels, session and phase (two adjacent sessions from early and late periods of the therapy).

Scoring the problem and outcome profiles. Like the original CCRT, the Revised CCRT method requires a minimum of 10 relationship narratives (or episodes) for scoring the problem (baseline) profile. The narratives may be derived from the intake interview, as well as from the earliest therapy sessions. Regarding rater selection, either clinically experienced or clinically naive raters may be employed for the Revised CCRT method, following previous success with both groups in studies using the original CCRT and QUAINT methods.[8]

Unlike the CCRT method, however, and like the QUAINT method, the Revised CCRT method does not presuppose that a single relationship theme dominates. Rather,

[8] An interesting possibility for future research would be to also include clients as participant observers in rating their own session transcripts.

the client's maladaptive patterns are viewed as a *profile* of the CCRT categories. To the extent that client in-session reports of the status of interpersonal problems are valid indicators of outcome (and arguably the most common form of indicator used by the therapist), these reports may be considered valid outcome variables in research.

Thus, in the Revised CCRT method, outcome is measured using narratives told by the client at successive stages in therapy and at termination and is indexed by changes in baseline CCRT *pervasiveness* (i.e., the number of relationship episodes a CCRT component is coded as present divided by the total number of relationship episodes for the summarizing unit; Crits-Christoph & Luborsky, 1990, p. 136).

Scoring the therapy process profile. Therapy session or therapy event transcripts (selected and segmented by the researcher), are scored as follows. Client segments are scored for Ws (in relation to the therapist), and RSs, while therapist segments are scored as ROs. These segments may be reversed if the research focus is on the therapist (e.g., countertransference). Raters are instructed to make judgements as follows. For Ws, raters ask themselves, "What does the client appear to be requesting, implicitly or explicitly, from the therapist in this segment?" For ROs, raters ask themselves, "How does the therapist respond to the client in this segment?" Finally, for RSs, raters ask themselves, "How does the client respond to the therapist's intervention in this segment?" As with the problem-outcome scoring, CCRT process raters score each segment for all categories for presence or absence. Process *pervasiveness* scores may also be derived (the number of turns-at-talk with a given CCRT component divided by the total number of turns-at-talk). Emerging evidence with similar process measures suggests that an *intermediate* level of aggregation (e.g., turns-at-talk summed over the first and second halves of a given therapy session), attending to therapy phase and context, is most informative and predictive of outcome (Messer, Tishby, & Spillman, 1992). Thus, this level was selected as most informative for the present research.[9]

[9] Uniformity myths pervaded earlier process and outcome research (Kiesler, 1966). Recent work recognizes that process varies over time, with different processes having different meanings in different in-session contexts (Greenberg, 1986; Shoham-Salomon, 1990); that random sampling and context-naive raters are often inappropriate (see the *events paradigm* of Rice & Greenberg, [1984] wherein episodes of interest which preserve context are selected for analysis); and that raters provided with more context and who are aware of the research hypotheses need not be experimentally biased (Messer et al., 1992).

Data analysis. Having been successfully used with the QUAINT method, profile correlation analysis (Nunnally, 1978)—a Pearson coefficient (i.e., product-moment *r*) computed to compare the degree of similarity between the patterns of two profiles—is also used with the Revised CCRT method. The analysis is useful for both CCRT problem profiles (e.g., to determine the relative stability of the CCRT during the course of therapy) and CCRT process (e.g., to assess the stability of treatment over time). It is particularly useful when the summarizing unit is at the level of a session or phase (Skinner, 1978).

Summary. The Revised CCRT method approaches (a) the relationship narratives told by clients during therapy as valid indices of problem and outcome and (b) the dialogue between therapist and client (treatment process) as a unique form of relationship pattern (i.e., the client's wishes regarding the therapist, interventions as responses of other, and immediate outcomes as responses of self). The CCRT categories are thus scored at these two levels of content and process, and constitute operationalizations of the process of outcome in psychotherapy.

Design and Procedure

Design. In terms of Hilliard's (1993) single-case framework, the present study is a *confirmatory single-case quantitative analysis* [10], testing whether the client's CCRT and the therapeutic process followed theory-driven predictions.

Selection of the client. The client was the first that the therapist accepted for treatment following his introduction to the CCRT approach. Because plans for this study began several months after this acceptance, she was not invited to participate in the present study until her 43rd session of therapy. The client gave her signed informed consent for the use of her session transcripts in the research program (see sample forms in Appendix C), with the proviso that the therapist transcribe the sessions personally.

Selection of sessions. Sessions 1 and 2 were selected to represent the early phase of therapy, and Sessions 41 and 42 for the late phase of therapy. The early phase was conceptualized as the baseline measure and the late phase as the effect measure. Each

[10] Because the baseline measure of the dependent variable (the CCRT profile) was obtained after treatment commenced, the study cannot be considered a true single-case *experiment.*

session was 60 minutes in duration. The 40 sessions between early and late phases constituted the treatment phase; this duration of treatment also permitted CCRT comparisons of the present single-case client with the larger group of patients studied in the Penn Psychotherapy Project (Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988), wherein the median length of treatment was 43 sessions.

Transcription and segmentation. As requested by the client, the therapist alone viewed and transcribed the therapy sessions. Transcription followed the recommended guidelines and notation published by Mergenthaler and Stinson (1992). After the initial transcription, the therapist verified all transcripts for accuracy, rereading the transcript as the recording was replayed. All identifying information (e.g., names, places) and possible indicators of treatment phase (e.g., approximately the first and last three minutes of conversation in Session 1) were deleted from the transcripts.

To maintain independence between content data and process data, each session transcript was divided into halves (first 30 min and second 30 min) between content and process raters. Content raters coded the first halves of Sessions 1 and 41, and the second halves of Sessions 2 and 42. Relationship episodes in these content transcripts were identified and demarcated by the therapist-researcher prior to delivery to raters. Process raters coded the second halves of Sessions 1 and 41 and the first halves of Sessions 2 and 42. No further notations were added to these process transcripts, because the scoring unit (turns-at-talk) was the same as the transcript format.

Rater training. The first pair of raters (LB and CK) were individually trained by the therapist to make *content* ratings of the relationship episodes in the transcripts, using the Revised CCRT method, following the general guidelines in the CCRT manual (Luborsky & Crits-Christoph, 1990), and the revisions described above. The content raters were instructed that their task involved independently scoring "the way a client describes her relationships with others."

The second pair of raters (EL and KT) were individually trained by the therapist to make *process* ratings of the client–therapist dialogue, using the Revised CCRT method, following the instructions described above. These raters were instructed that their task involved scoring "the way the client and therapist are relating to each other, rather than

what is simply being talked about. The focus is on their manner of interaction."

Prior to rating the study data, all raters were given CCRT rating scales; practice materials from the CCRT manual were given to the content raters and materials collected by the therapist-researcher were given to the process raters. Criterion reliability was established for the content raters with a published transcript of a female client's intake interview, previously rated by Luborsky, Popp, Luborsky, and Mark (1994); their expert W, RO, and RS ratings served as the reliability criterion (rater LB = .81, .82, .80; rater CK = .81, .76, .92; interrater reliabilities = .67, .76, .87). Because the CCRT as a process measure is new, no comparable criterion was available for training the process raters. Thus, the therapist-researcher completed W, RO, and RS ratings on a series of written dialogues and the process raters were trained to this criterion (rater EL = .73, .84, .67; rater KT = .74, .80, .81; interrater reliabilities = .97, .92, .71).

CCRT rating procedure. Relationship episodes in the content transcripts were identified and demarcated (Session 1, $N = 10$; Session 2, $N = 20$; Session 41, $N = 22$; Session 42, $N = 5$) by the therapist-researcher, based on the person (or persons) described in the narrative (e.g., friend, spouse, co-workers, etc.). As in the original CCRT method, the CCRT content raters were instructed to underline the specific material in the transcript that was used for coding, and to write the CCRT categories above each of the underlined segments. As noted in an earlier section, the process transcripts were not demarcated further, given that the process scoring unit consisted of client and therapist turns-at-talk, the format that transcription had followed (Mergenthaler & Stinson, 1992). The process raters were instructed to score the entire series of turns-at-talk (Session 1, $N = 60$; Session 2, $N = 55$; Session 41, $N = 65$; Session 42, $N = 49$) in the process transcripts.

Once comfortable with the rating process and trained to criterion and interrater reliability, raters were given their respective transcript copies, and proceeded to make their ratings. Particular care was given to keeping the raters unaware of the therapist's theoretical framework, research hypotheses, and therapeutic approach. No information was given to raters other than the session transcript and the training instructions for the Revised CCRT method. All the raters made their ratings independently, and were kept

unaware of the nature of the other raters' ratings. To forestall rater drift, the raters were instructed to make their ratings over comfortable periods of time, to stop when fatigued, and to resume at their convenience.

Ratings were completed in two blocks: A (Sessions 1 and 2), and B (Sessions 41 and 42). One of each rater pair rated A, then B, while the other rated B, then A. Raters were not informed as to which session and treatment phase each transcript was drawn from. All raters were instructed to make their ratings as they read through the transcript and not to read ahead of their ratings. Ratings were made directly on the transcript pages. Finally, they were instructed not to discuss their ratings with others and to maintain strict confidentiality regarding the transcript contents. Upon completion, all transcripts were returned to the therapist.

Rater debriefing. Shortly after data were analyzed, all raters were separately interviewed (about 30 min each) by the therapist. These interviews checked whether raters had inferred the research hypotheses and other potentially confounding information. No such confound nor any deviation from training was found. All raters were then informed of the study's purpose, design, hypotheses, and findings.

Research and Statistical Hypotheses

Listed below are (a) the research hypotheses—operationalized predictions derived from the theoretical framework discussed in the first two chapters, and (b) statistical hypotheses—predicted numerical relationships and intervals that would corroborate (or refute) the research hypotheses.

H1. ***The relational schema hypothesis:*** (a) This hypothesis asserts that CCRT components in the problem profile will show high stability across sessions 1 and 2. (b) Profile correlations (between sessions 1 and 2) of .70 or more will provide strong corroboration; correlations of .50 to .70 will provide moderate corroboration; and correlations of less than .50 will refute the relational schema hypothesis.

H2. ***The alliance transfer hypothesis:*** (a) This hypothesis asserts that the maladaptive, negative CCRT comes to resemble the positive therapy process over time. (b) To corroborate this hypothesis, coefficients for ROs and RSs should steadily

approach values of + 1.0 over time, indicating the growing similarity of the transference to the alliance. The closer the later coefficients are to + 1.0, the stronger the corroboration. If coefficients steadily approach – 1.0, this would refute the alliance transfer hypothesis, and indicate that the transference and alliance patterns had become increasingly dissimilar over time.

H3. ***The resolution hypothesis vs. the stability hypothesis:*** (a) The stability hypothesis asserts that CCRT problem profiles will show high stability following psychotherapy, whereas the resolution hypothesis asserts that the problem profile changes for the better after therapy. (b) Profile correlations (between early and late treatment phases) of .70 or more will strongly corroborate the stability hypothesis, correlations of .50 to .70 will moderately corroborate the stability hypothesis, and correlations of .20 to .50 will partially corroborate the stability hypothesis. However, correlations of less than 0 (negative *r*) will corroborate (moderately to strongly as *r* approaches – 1.0) the resolution hypothesis; correlations of 0 to .20 will partially corroborate the resolution hypothesis.

Because very large changes in CCRT component pervasiveness are required to produce large changes in CCRT pattern, CCRT pattern stability over time may still subsume changes in CCRT pervasiveness. Therefore, pervasiveness scores were also examined for clinically significant changes between early and late treatment phases.

Finally, to place the study in broader perspective, the findings were compared to the findings of the Penn Psychotherapy Project. This large-scale group study shares some similarities of design with the present single-case study.

Chapter Summary

The research hypotheses were tested in a confirmatory single–case quantitative analysis using independent transcript ratings of a client's early CCRT (clinical problem), the psychotherapy process between this client and her therapist (treatment), and the client's CCRT after 40 sessions of psychotherapy (clinical outcome). For the Revised CCRT Method, scoring units included (a) relationship narratives told by the client during therapy sessions (for scoring the CCRT) and (b) client and therapist turns-at-talk during

therapy sessions (for scoring the therapy process). Context units included all preceding material in the session transcript. Finally, summarizing units for data analysis included (a) sessions (1, 2, 41, 42) and (b) phases (early and late in therapy). The results of the problem–treatment–outcome profile analyses are presented in the next chapter.

Chapter Five
Results and Discussion

Interrater Reliability of the Revised CCRT Method

Reliability of problem and outcome profiles. Study interrater reliability ranged from good to excellent (.67 to .95): Reliability coefficients (Pearson product-moment *r*) for sessions and phases are presented in Table 2 (see Table 2). Mean session coefficients are as follows: Ws = .76, ROs = .80, and RSs = .74. Mean phase coefficients are as follows: Ws = .78, ROs = .92, and RSs = .76. Thus, the Revised CCRT method shows comparable reliability to the original CCRT and QUAINT methods. Across six major CCRT reliability studies (summarized in Luborsky & Diguer, 1995, p. 238), mean weighted kappas ranged from fair to good[11]: .63 for Ws, .66 for ROs, and .69 for RSs. The original QUAINT method (Crits-Christoph et al., 1990) yielded median intraclass correlations (ICC) of .69 for Ws, .68 for ROs, and .67 for RSs, after eliminating 39 Standard Categories which fell below .50. The latest version of the QUAINT method (Crits-Christoph et al., 1994) yielded median ICCs of .72 for Ws, .75 for ROs, and .74 for RSs, after eliminating 66 QUAINT categories which fell below .65.

Reliability of therapy process profiles. Study interrater reliability ranged from good to excellent (.68 to .96): Reliability coefficients (Pearson product-moment *r*) for sessions and phases are presented in Table 3 (see Table 3). Mean session coefficients are as follows: Ws = .75, ROs = .85, RSs = .86. Mean phase coefficients are as follows: Ws = .85, ROs = .86, and RSs = .88.

Because reliabilities for the problem, outcome, and process profiles were adequate, individual rater scores were averaged across each *session* (e.g., mean profile for session 1 = average of rater 1's scores and rater 2's scores for session 1) and within each *phase* (e.g., mean profile for early phase = average of the sum of rater 1's scores for sessions 1–2 and the sum of rater 2's scores for the same sessions). These four mean session profiles (1, 2, 41, 42) and two mean phase profiles (early = 1 and 2; late = 41 and 42) constituted the summarizing units for data analyses.

---

[11] According to Landis and Koch (1977), the ranges of strength of agreement for kappa are as follows: 0 to .39, poor; .40 to .74, fair to good; .75 to 1.0, excellent.

What is the Nature of the Transference Pattern?

Evidence for the relational schema hypothesis. To test the stability of the CCRT pattern during the early treatment phase (1-week), profile correlations were computed between sessions 1 and 2: Ws were moderately stable (.52), and ROs (.69) and RSs (.76) were both highly stable. Pervasiveness scores for individual CCRT categories are presented in Table 4. The client's early CCRT comprised (a) primary wishes to be distant and avoid conflict, and to feel good and comfortable; secondary wishes to assert herself and be independent, and to be loved and understood; (b) primarily negative ROs (rejecting/opposing, upset, controlling, and bad); and (c) primarily negative RSs (helpless, disappointed and depressed, and unreceptive) (see Table 4).

Treatment Stability

To test the stability of the therapy process over time, profile correlations were computed for three time periods: within the early phase (1 week), between early and late phases (40 weeks), and within the late phase (1 week). Stability coefficients were very high for all time periods: Ws = .97, .86, .87; ROs = .95, 1.0, .97; RSs = .97, .87, .97. Process pervasiveness scores for individual CCRT categories are presented in Table 5. Based on these scores, the therapy process (alliance) comprised (a) the client's wishes for relatedness with the therapist (to be close and accepted, to be liked and understood) and to feel better; (b) primarily positive therapist responses to the client's wishes (helpful, understanding); and (c) primarily positive client responses of self (feeling open and understood, feeling respected and accepted) (see Table 5). Thus, the client's relationship pattern with the therapist was stable and positive (i.e., nonconflictual), in contrast to the client's negative CCRT (and contrary to the transference concept).

How Does the Alliance Influence the Transference Pattern?

To test whether the CCRT pattern became more similar to the alliance pattern over time, profile correlations between CCRT and process were computed for each session and phase and are presented in Table 6. To corroborate the alliance transfer hypothesis, coefficients for ROs and RSs should approach values of + 1.0 over time,

indicating the growing similarity of the transference to the alliance. The closer the later coefficients are to + 1.0, the stronger the corroboration. If coefficients steadily approach – 1.0, this would refute the alliance transfer hypothesis, and indicate that the transference and alliance patterns had become increasingly dissimilar over time.

Evidence for (and against) the alliance transfer hypothesis. An examination of the correlation patterns in Table 6 shows wide variation in profile similarity across sessions, with a linear pattern emerging for only one CCRT component: Positive ROs in the CCRT steadily and increasingly came to resemble the alliance pattern (see Table 6). For the other CCRT components, more complex patterns emerged, suggesting large shifts in similarity and dissimilarity over therapy. For example, negative RSs appeared to alternate between high similarity and dissimilarity across therapy (see Table 6).

Across early and late treatment phases, three different change patterns emerged: (a) *independence,* i.e., the transference and alliance are stable and dissimilar to each other (Ws = .12, – .08; positive RSs = – .88, – .91); (b) *moderate change,* i.e., the transference pattern becomes moderately more similar to the alliance pattern, but with large pattern differences between the two (negative ROs = – .58, – .01; negative RSs = – .57, – .09); and (c) *strong change,* i.e., transference pattern becomes very similar to the alliance pattern (positive ROs = – .98, .83) (see Table 6). It must be emphasized that no causal inferences can be drawn from these correlational data. At best, these correlations partially corroborate the alliance transfer hypothesis and resolution hypothesis: A positive client–therapist alliance correlates with positive changes in the client's CCRT. At worst, they strongly corroborate the relational schema and stability hypotheses: A positive client–therapist alliance weakly correlates with positive changes in the client's CCRT. The data indicate that the wishes and negative components of the CCRT pattern may be slow to improve, and that a positive RS pattern may be slow to emerge, even in the presence of a positive therapeutic alliance. They also indicate a need to search for other correlates of CCRT pattern change (e.g., accuracy of therapist interpretations, Crits-Christoph et al., 1988).

What Happens to the Transference Pattern Following Therapy?

Changes in CCRT pattern: Evidence for the stability hypothesis. Profile correlations were computed between early and late treatment phases: Ws were highly stable (.79), as were RSs (.71), but less so ROs (.54). Over this 40-week period, the overall CCRT pattern endured. In the client's late phase CCRT, her wishes were still predominantly met by negative ROs, followed primarily by negative RSs on the part of the client (see Table 4). In general, the results converge with earlier findings and further corroborate the theory that the CCRT has schema or trait-like properties, suggestive of an enduring personality structure, its components retaining their relative relationships over time (Crits-Christoph & Luborsky, 1990). However, important changes occurred in the *pervasiveness* of components in the client's CCRT.

Changes in CCRT pervasiveness: Clinical significance and the resolution hypothesis reconsidered. The largest effects[12] for the client were reduced negative RSs ($ES = -.87\ SD$) and increased positive ROs ($ES = +1.47\ SD$); medium effects were reduced negative ROs ($ES = -.40\ SD$) and increased positive RSs ($ES = +.46\ SD$). Scores for wishes decreased, but negligibly ($ES = -.18\ SD$). The changes in ROs and RSs may indicate a pattern suggesting the beginning of conflict resolutions in the CCRT: Such a pattern can assessed by examining the clinical significance of these changes.

Jacobson and Truax (1991) have recently proposed two criteria for assessing clinical significance: (a) following treatment, clients should move from a dysfunctional population to a functional population, crossing an established cutoff score on assessment measures; and (b) the change must be reliable. The latter is determined by calculating a *reliable change index (RCI)* (the difference between test scores divided by the standard error of difference between the two test scores); an RCI greater than 1.96 suggests that changes are not due to random fluctuations in test scores ($p < .05$). For a client meeting both criteria (i.e., outcome score beyond the cutoff and an RCI score greater than 1.96), the change is identified as clinically significant. Speer (1992) has suggested the Edwards–Nunnally method as an alternative to the Jacobson–Truax method if statistical regression (reversion of scores toward the mean or toward less extreme scores) is present in the data, to avoid capitalizing on errors in measurement.

[12] Computed following Busk and Serlin's (1992) adaptation of Cohen's d for single-case data.

For the present client, correlations between the early phase scores and the early to late phase difference scores (for Ws, negative ROs, negative RSs, positive ROs, and positive RSs) indicated evidence of regression to the mean. Thus, early phase scores were adjusted using formulas presented in Speer (1992). RCIs were then calculated for each variable (using the adjusted early phase scores). Each late phase score was then examined to determine whether it fell below the Edwards–Nunnally cutoff scores (i.e., two standard errors of measurement in the direction of the functional population).

Changes in negative RSs and positive ROs were clinically significant, meeting both criteria: Scores were greater than functional cutoff scores and RCI scores (2.91 and 2.19) indicated changes were reliable. Changes in wishes and negative ROs were not clinically significant, with RCI scores below 1.96 (.52 and .48) and late phase scores below the functional cutoff scores. Although the late phase score for positive RSs was greater than the functional cutoff score, the RCI score (1.56) suggested this change may be unreliable.

It should also be noted that a fuller assessment of clinical significance requires normative data (Jacobson & Truax, 1991)—CCRT scores from the general population—data presently unavailable. Moreover, cutoff scores for all measures of clinical significance need to be recognized as somewhat arbitrary (Kazdin, 1994).

Comparison of the client with patients from the Penn Psychotherapy Project. The present client's CCRT data are compared with the Penn CCRT data in Table 7. Effect sizes for the Penn study were computed from published data (Crits-Christoph & Luborsky, 1990, p. 139). Effect sizes for Ws, negative ROs and RSs, and positive ROs and RSs are similar to those observed in the Penn Psychotherapy Project: Following a median of 43 sessions of psychodynamic psychotherapy (guided by Luborsky, 1984), the pervasiveness of Ws remained relatively stable, whereas negative ROs and RSs decreased in pervasiveness, and positive ROs and RSs increased. In the Penn study, changes in CCRT pervasiveness also correlated with changes on standardized outcome measures of symptomatology (Hopkins Symptom Checklist) and global psychological functioning (Health–Sickness Rating Scale).

The convergence between the single-case data and the group data suggests that the treatment effects observed in the Penn sample (n = 33 patients) were replicated in

the present single-case (see Table 7): Apparently, what occurred in general across the Penn subjects also occurred in the particular, within a single-case subject. This may be due, in part, to the similarity (e.g., age, gender, diagnosis) of the single-case client to the 33 patients in the Penn study, the similarity of the form and length of treatment in both studies, and the similarity of methodology. However, the logic of single-case research requires that generality be demonstrated through case-by-case replication (Hilliard, 1993); this would strengthen the conclusions drawn from the present findings. Moreover, there is no guarantee that the present client would have shown similar changes on the Penn outcome measures.

To summarize the outcome findings, at one level of analysis (overall CCRT profile pattern) the CCRT remained highly stable over the course of 40 sessions of therapy, corroborating the relational schema and stability hypotheses. However, at a different level of analysis (CCRT pervasiveness), clinically significant outcomes—reduced negative RSs and increased positive ROs—were evident, partially corroborating the resolution hypothesis.

The enduring dissimilarity between the client's CCRT pattern and her relationship pattern with the therapist contrasts sharply with the transference concept. For this client, no immediate transference was apparent—at least to independent observers of the therapy process—in the early therapy phase. Further, no emergent transference was apparent in the late therapy phase. To the extent that these phases are representative of the therapy process, the implication is that, in some instances, the client may *never* displace earlier relationship patterns upon the therapist. The data suggest some possible mediating and moderating variables for future study. The early development of a positive alliance may play a key role in preventing transference in the client–therapist relationship. A client's previous therapeutic relationships may also be important: Recall that the present client had previously completed 41 sessions with a different therapist, which may have influenced the relationship with the present therapist.

In the next chapter, the research findings are discussed in wider contexts of theory, research, and practice. Afterwards, the strengths and limitations of the study are considered. The chapter concludes with an eye toward the future.

Chapter Six
Conclusion

The present study began with three research questions: (a) What is the nature of the transference pattern? (b) How does the alliance influence the transference pattern? and (c) What happens to the transference pattern following treatment? In this final chapter, the findings are related to clinical theory, research, and practice, followed by a discussion of the strengths of the study, a critical appraisal of the study's design, and a look toward the future.

Theoretical, Research, and Practical Implications

The persistence of relational schemas. Regarding the first and last questions, the evidence suggests that the transference pattern, as operationalized by the CCRT, can be understood as a stable, trait-like personality schema or structure. After 40 sessions of psychotherapy, the general pattern of the client's CCRT persisted, replicating the CCRT pattern stability observed in the Penn Psychotherapy Project patients. In terms of research, long-term intraindividual studies (Hilliard, 1993), both of persons in therapy and in the general population, are required to elucidate change patterns at the relational schematic level. In terms of practice, this suggests that if enduring change at structural levels of personality is the therapeutic goal, short–term therapy approaches may fall short of the challenge (Mahoney, 1991; Messer & Warren, 1995).

As discussed in Chapter 1, another important area for future research concerns the influence of the transference pattern on the therapeutic relationship, centering on the debate between immediate and emergent perspectives on the transference pattern. To date, the immediate transference perspective lacks support from extant psychotherapy research, while the emergent transference perspective is supported by studies of transference at the declarative (or narrative) level. These studies reveal transference regarding the therapist in the client's narratives from later stages of therapy (Crits-Christoph et al., 1990; Crits-Christoph et al., 1994; Fried et al., 1992), and accord with findings from social cognition research, wherein

> [the] consensus is that schema-relevant information, whether consistent or inconsistent, will be better recalled and recognized than schema-irrelevant behavior. . . .

> [Moreover,] relational schemas may organize and construct memory in such a way as to assimilate new relationship information to seem more consistent with past experiences. (Baldwin, 1992, p. 475)

Similar conclusions were recently made by the Basic Behavioral Science Task Force of the National Advisory Mental Health Council (BBSTF–NAMHC) (1996). Yet the present findings suggest that, under some conditions, transference (at the behavioral level) with the therapist may not occur at all.

Furthermore, the relationship between transference in the therapeutic relationship and therapeutic outcome has been overlooked by extant psychotherapy research. Theoretically, if the negative relationship pattern eventually encompasses the therapist, and is reenacted in the therapeutic relationship, negative outcomes should follow (Benjamin, 1993b; Safran, 1990a), as found in the Vanderbilt I study, where negative interpersonal process clearly distinguished between cases of good and bad outcome (Henry & Strupp, 1994). Yet in the Penn Psychotherapy Project, despite the emergent inclusion of the therapist into the client's CCRT (Fried et al., 1992), overall changes in CCRT pervasiveness correlated with positive clinical outcome (Crits-Christoph & Luborsky, 1990), suggesting that emergent transference may not adversely influence outcome, at least on standardized measures of symptomatology and psychological functioning. Microanalytic studies of interpersonal process should be conducted with the transcripts used in the CCRT research to test for transference in the therapeutic relationship at the behavioral (process) level, and then relate this to outcome.

In practical terms, the extant research suggests that if a therapist becomes entangled in the client's negative relationship pattern, the client's relational schema (e.g., CCRT) may tend to assimilate the new relationship information from the developing therapeutic relationship in a way that resembles the CCRT. This phenomenon was clearly seen in what may be the first *experimental* demonstrations of transference (Andersen & Baum, 1994; Andersen & Cole, 1990). Participants in Andersen's controlled laboratory studies came to regard new target persons as they did significant others in their lives. Kihlstrom (1994) raised an important issue:

> [The results of Andersen's research are] a great advance, but in the final analysis one wants to know whether it is anything more than a case of stimulus generalization. Is the whole apparatus of psychoanalytic theory needed to predict this result? Or will this simple precept do – that the best predictor of behavior in a new situation is the person's behavior in similar situations in the past? (p. 690)

This issue was also raised decades ago by Dollard and Miller (1950). If it is true that, according to Freud, "there are four concepts so basic that, if one accepted them, one would be practicing psychoanalysis *even if one disagreed with Freud in every other respect.* These concepts are the unconscious, repression, transference, and resistance" (Karon & Widener, 1995, p. 25, emphasis added), then critics may need to agree to disagree, regarding terminology but not underlying processes.[13] Further, dismissing transference as stimulus generalization sidesteps the more important question: Under what interpersonal conditions does such stimulus generalization occur (or fail to occur)? This is one of the important questions for future research (BBSTF–NAMHC, 1996).

The importance of the therapeutic relationship. Regarding the second question, the findings partially corroborated the hypothesis that therapeutic change is associated with positive interpersonal process between client and therapist. Further analysis of the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program data (Blatt, Zuroff, Quinlan, & Pilkonis, 1996) strongly supported the interpersonal process perspective:

> . . . therapeutic change is more a consequence of interpersonal dimensions than the mechanics of the type of therapy provided. These findings raise questions about the usefulness of attempts to compare the effectiveness of different therapeutic interventions conducted according to specified manuals. The paucity of significant differences in outcome among various types of treatment, however, does not necessarily indicate that various brief treatments for depression all have a general effect and that it does not matter what the therapist is doing. Quite to the contrary, the results of our analyses suggest that *treatment outcome is a consequence of particular qualities of the patient and the therapist and of the interaction of these qualities in establishing a therapeutic relationship.* (Blatt et al., 1996, p. 169, emphasis added)

---

[13] Given the evidence, denying the existence of the unconscious is untenable (Kihlstrom, 1987); similarly compelling evidence is emerging for transference (see discussion above), repression (see Singer, 1990, for a review) and resistance, that is, the defense mechanisms (see Cramer, 1991, for a review). The issue to be resolved is whether these four concepts are indeed the four cornerstones of psychoanalysis, which is not an empirical question, but a theoretical one.

Recent laboratory evidence shows that "the more a particular kind of social knowledge is primed by a person's environment, the more likely it is to be used" (BBSTF–NAMHC, 1996, p. 480). The essential theoretical point is that, relationally, what we get (social experience) is what we see (social cognition). Thus, maladaptive relational schemas theoretically emerge from negative interpersonal experiences (Bowlby, 1988; Benjamin, 1993b; Luborsky & Crits-Christoph, 1990) and may be changed through positive interpersonal experiences in psychotherapy (Henry & Strupp, 1994; Safran, 1990a).[14]

In terms of practice, approaches that focus close attention to the client's relational schemas and unfolding relationship with the therapist are well–informed. A crucial area for future research and training (Henry & Strupp, 1994) is how best to teach this relational focus to therapists without the unexpected outcome of the Vanderbilt II project—improved technical competence, but with unacceptable increases in negative interpersonal process during therapy (Henry, Strupp, Butler, Schacht, & Binder, 1993).

Study Strengths

Minimized threats to internal validity. Several of the major threats to internal validity (history, maturation, testing, instrumentation, statistical regression; see Cook & Campbell, 1979; Kazdin, 1981) were minimized. Previous research (Luborsky & Crits-Christoph, 1990) suggested that the CCRT shows high stability across adulthood, helping to rule out historical events (e.g., family processes, job experiences) and maturational processes (e.g., decreased depression as a function of the passage of time or death of a relative) as rival hypotheses. However, additional stability information about the course of transference—drawn from sources outside the therapeutic context—and replication across cases, would more strongly rule out these rival hypotheses.

The twofold mandate (training and service) of the clinic in which the present research was conducted—although not traditionally a research clinic—permitted some

[14] As far as back as Ferenczi and Rank (1925), and later in Alexander and French (1946), it was asserted that the change process involved corrective emotional experiences with the therapist. Their arguments for short-term approaches have been recently revived in the new generation of brief dynamic therapies (see Barber & Crits-Christoph, 1995; Binder, Strupp, & Henry, 1995; Crits-Christoph & Barber, 1991; Messer & Warren, 1995). However, the present findings suggest that changes at the relational schematic level may occur slowly, if at all.

design advantages for this research.[15] First, because the clinic's therapists are under different levels of training, therapy rooms are equipped with standard recording equipment for supervision purposes, permitting continuous, objective measurement of therapy process with minimal reactivity. Moreover, because the client had already been in therapy with another therapist at the same clinic (prior to being transferred to the present therapist), it is fair to say that she was relatively accustomed to being recorded during sessions.[16] These features, along with the help of reliable, independent raters and statistical procedures for measuring clinical significance, helped rule out testing (repeated exposure to the assessment procedures), instrumentation (changes in the scoring or criteria over time), and statistical regression (reversion of scores toward the mean or toward less extreme scores) as rival hypotheses.

Increased ecological validity. The client who consented to participate in this study gave this consent after completing over 40 sessions of therapy with the therapist in this study. The sessions studied may therefore be regarded as fairly representative of psychotherapy, focusing on the process with a real client in a real clinical setting. Because plans for the study began after the client commenced therapy, it is unlikely she viewed this therapy within a research context. However, the same cannot be ensured regarding the therapist– researcher, whose in–session behaviors may have been influenced by planning the research. Further, ecological validity may have also been limited by the clinical experience level of the therapist.

Study Limitations: A Critical Appraisal

Limited baseline measure of the clinical problem. Baseline measures of the client's CCRT were derived from the first two sessions of therapy, so there is a possibility that the therapist influenced the client narratives from which the CCRT was derived. However, recent evidence shows a high similarity between CCRTs obtained from pretreatment RAP interviews and CCRTs obtained from sessions 3 and 5 for the

[15] These advantages may preclude studies conducted by private practitioners, who may not use recording equipment, nor have access to research assistants such as those employed in the present study—only two of many obstacles to empirical clinical practice (see Appendix B).

[16] However, little is known about the effect of recording on therapy process and outcome in clinical research settings, much less in non-research clinical settings (Lambert & Hill, 1994).

same patients (Barber, Luborsky, Diguer, & Crits-Christoph, 1995). This suggests that the form of the client's CCRT predates the first interactions with the therapist, and is stable during the early phase of therapy.

One possibility for future research is the use of the RAP interview as a paper and pencil measure, yielding descriptions to be scored for CCRTs. Such an investigation may be limited, however, by the patients' level of introspective access to their own relationship themes, which proved a hindrance to initial efforts toward a self-report CCRT measure (Luborsky & Crits-Christoph, 1990). In the present research, it is unclear how aware the patient was, either of her CCRT or of the larger interactional process with the therapist. A method for tapping this awareness is now under development (Luborsky, Crits-Christoph, Friedman, Mark, & Schaffler, 1991).

Limited process measure and process data. The Revised CCRT method requires extensive validation as a psychotherapy process measure. Its measurement sensitivity is unknown, particularly for negative interpersonal process, which was rated infrequently in the present study. Process raters described inferential difficulties with the sole use of written data. It is clear that much data is lost when the therapy process is not directly seen and heard, and recommendations for the use of transcript and videotape (Lambert & Hill, 1994) are well-made.

Further, whether conceptualizing psychotherapy as a special form of relationship theme (Ws toward the therapist, interventions as ROs, and client RSs) , and applying the CCRT categories as descriptors of the therapeutic process raises incremental validity (compared to extant alliance measures) requires cross–validational studies with established observer-based measures, e.g., Benjamin's (1993b) Structural Analysis of Social Behavior system. And given that the client's perceptions of the therapeutic alliance are powerful predictors of outcome (Horvath & Luborsky, 1993; Orlinsky et al., 1994), comparisons with self-report alliance measures are also required.

Limited outcome measure. Far more research is required to relate CCRT change to other measures of clinical outcome, including (but not limited to) other interpersonal change measures. Luborsky and Crits-Christoph (1990) and colleagues have made the first necessary steps in this direction. It would be useful, for example, to know how the

RS category of "disappointed and depressed" relates to extant measures of depression, such as those employed in the NIMH Treatment of Depression study (Elkin, 1994).

Limited external validity. As noted earlier (and despite similarity to patients in the Penn Psychotherapy Project), the present findings require case–by–case replication (direct and systematic), followed by group studies, before they can be generalized (Hilliard, 1993). Further, the length of treatment in the present study (40 sessions) rests near or beyond the boundaries of most definitions of short–term therapy (under 50 sessions, Henry et al., 1994; 25 sessions or less, Koss & Shiang, 1994). Because most psychotherapy research is short–term psychotherapy research (Lambert & Bergin, 1994), it is difficult to relate the present findings thereto.

The displeasing possibility. The final study limitation may center on an apparent study strength. Every effort to integrate research with practice is a welcome one (see Appendix B). The present researcher participated in all aspects of the study: (a) in the primary data, as a participant in the interpersonal process under study; (b) in data preparation, as transcriber and segmenter of session recordings; (c) in data collection, as trainer of the Revised CCRT raters; and (d) in data analysis and interpretation, as researcher. It is possible that the shared variance in the findings are derived from this shared method variance (i.e., the presence of the therapist-researcher across all phases of research), rather than from empirical relationships among the variables! Ultimately, the internal validity of the findings rests on whether the research design has ruled out alternative explanations (Kazdin, 1994), for example, with the help of independent, reliable raters (e.g., unaware of the hypotheses and design), and the use of objective, nonreactive, quantitative measures (e.g., transcribed videorecordings, guided rating method). Further aspects of improving internal validity were considered in earlier sections, as has the issue of external validity, which rests on the outcome of future efforts at replication.

The Larger Picture

Relatedness and individuality. Each self encloses relational–dialogical processes (Hermans, Kempen, & van Loon, 1992). Indeed, the CCRT approach focuses on these

relational representations within specific individuals. Although the theoretical emphasis in this thesis has been on relational processes, it must be realized that both personal identity and social identity are crucial to mental health (BBSTF–NAMHC, 1996). Each human life consists of intertwining processes of individuation and relatedness:

> a dialectical system in which achievements in one sphere make possible further developments in the other. It is apparent, for example that an increasingly differentiated, integrated, and mature sense of self is contingent on establishing satisfying interpersonal relationships; conversely, the development of mature relationships is contingent on the development of mature self-identity. These two developmental processes evolve in an interactive, reciprocally balanced, mutually facilitating fashion from birth through senescence. (Guisinger & Blatt, 1994, p. 108; see also Hermans & Hermans-Janzen, 1995)

This is the same dialectical process that occurs within and between the participants in the therapeutic relationship. Ultimately, the importance of psychotherapy rests in its power to restore and sustain the client's twofold sense of uniqueness and belongingness.

Looking Ahead

Future theoretical work needs to elaborate patterns of stability and change in the CCRT, and be continually informed by several areas of research. Specification of the relationship between the interpersonal process within therapy, the internalization of this process by the client over time, and its theorized generalization (or "transfer") to important relationships outside therapy is theoretically crucial. Moreover, this generalization needs to be validated with direct studies of these outside relationships. Little has been said in this thesis about the client's actual relationships per se, as much as their internal *representations* as the client's CCRT.

Future research needs to relate these theorized processes with direct observations of the therapeutic relationship and extratherapeutic relationships. Participant-observer (self-report) measures of transference—for both client and therapist—also require development and comparison with observation. Further, the Revised CCRT process measure urgently needs more extensive convergent and discriminant validation. It is likely that it would be improved through the use of both transcripts and audio- or videotape, and with the help of clinically experienced raters. These are a few of the

necessary steps toward understanding the interpersonal conditions (e.g., the quality of previous therapy relationships, the early development of the alliance) that may predispose or forestall transference with the therapist as well as the client's internalization of the therapeutic relationship.

Future practice rests on a solid foundation of efficacy and effectiveness research (Seligman, 1994, 1995). This research consistently points to the powerful role of the relationship between client and therapist in this effectiveness (Horvath & Greenberg, 1994; Lambert & Bergin, 1994; Orlinsky et al., 1994). As the millennium approaches, much recent discussion in clinical psychology centers on the future of psychotherapy (Cummings, 1995; Mahoney, 1995). Some have questioned (a) the form and duration of its delivery in the current health care era (Broskowski, 1995); (b) the current emphasis on cost–effectiveness rather than client well–being (Karon, 1995; Messer & Warren, 1995), and (c) its very place in the profession of clinical psychology (Humphreys, 1996). However, there is little doubt, at least among experts in the field, that psychotherapy will continue to be needed and valued (Norcross, Alford, & DeMichele, 1992). The "intrepid practitioner of the twenty-first century" (Mahoney, 1995) faces many challenges ahead in a rapidly changing world. But the central challenge—understanding the relationship between client and therapist—will outlast all others.

References

Ainsworth, M. D. S. (1989). Attachments beyond infancy. *American Psychologist, 44,* 709-716.

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Alexander, F., & French, T. M. (1946). *Psychoanalytic therapy.* New York: Ronald Press.

Andersen, S. M., & Baum, A. (1994). Transference in interpersonal relations: Inferences and affect based on significant-other representations. *Journal of Personality, 62,* 459-497.

Andersen, S. M., & Cole, S. W. (1990). "Do I know you?": The role of significant others in general social perception. *Journal of Personality and Social Psychology, 59,* 384-399.

Baguet, J., Gerin, P., Sali, M., & Marie-Cardine, M. (1984). Evolution des thèmes transferentials individuals dans une psychotherapie de groupe [Evolution of individual transferential themes in group psychotherapy]. *Psychotherapies, 1-2,* 43-49.

Baldwin, M. W. (1992). Relational schemas and the processing of social information. *Psychological Bulletin, 112,* 461-484.

Barber, J. P., & Crits-Christoph, P. (1993). Advances in measures of psychodynamic formulations. *Journal of Consulting and Clinical Psychology, 61,* 574-585.

Barber, J. P., & Crits-Christoph, P. (Eds.). (1995). *Dynamic therapies for psychiatric disorders (Axis I).* New York: Basic Books.

Barber, J. P., Luborsky, L., Diguer, L., & Crits-Christoph, P. (1995). A comparison of Core Conflictual Relationship Themes before psychotherapy and during early sessions. *Journal of Consulting and Clinical Psychology, 63,* 145-148.

Barlow, D. H. (1981). On the relation of clinical research to clinical practice: Current issues, new directions. *Journal of Consulting and Clinical Psychology, 49,* 147-155.

Barlow, D. H., & Hersen, M. (1984). *Single case experimental designs: Strategies for studying behavior change* (2nd ed.). New York: Pergamon Press.

Bartlett, F. C. (1932). *Remembering.* London: Cambridge University Press.

Basic Behavioral Science Task Force of the National Advisory Mental Health Council. (1996). Basic behavioral science research for mental health: Social influence and social cognition. *American Psychologist, 51,* 478-484.

Baumeister, R. F., & Leary, M. R. (1995). The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin, 117,* 497-529.

Benjamin, L. S. (1974). Structural analysis of social behavior. *Psychological Review, 81,* 392-425.

Benjamin, L. S. (1993a). Every psychopathology is a gift of love. *Psychotherapy Research, 3,* 1-24.

Benjamin, L. S. (1993b). *Interpersonal diagnosis and treatment of personality disorders.* New York: Guilford Press.

Bergin, A. E., & Garfield, S. L. (1994). Overview, trends, and future issues. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 821-830). New York: Wiley.

Berscheid, E. (1994). Interpersonal relationships. *Annual Review of Psychology, 45,* 79-129.

Beutler, L. E. (1991). Have all won and must all have prizes? Revisiting Luborsky et al.'s verdict. *Journal of Consulting and Clinical Psychology, 59,* 226-232.

Binder, J. L., Strupp, H. H., & Henry, W. P. (1995). Psychodynamic therapies in practice: Time-limited dynamic psychotherapy. In B. Bongar & L. E. Beutler (Eds.), *Comprehensive textbook of psychotherapy: Theory and practice* (pp. 48-63). New York: Oxford University Press.

Blatt, S. J., Zuroff, D. C., Quinlan, D. M., & Pilkonis, P. A. (1996). Interpersonal factors in brief treatment of depression: Further analyses of the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 64,* 162-171.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy, 16,* 252-260.

Bornstein, R. F., & Pittman, T. S. (Eds.). (1992). *Perception without awareness: Cognitive, clinical, and social perspectives.* New York: Guilford Press.

Bowers, K. S., & Meichenbaum, D. (Eds.). (1984). *The unconscious reconsidered.* New York: Wiley.

Bowlby, J. (1979). *The making and breaking of affectional bonds.* London: Tavistock.

Bowlby, J. (1988). *A secure base.* New York: Basic Books.

Bruner, J. (1990). *Acts of meaning.* Cambridge: Harvard University Press.

Buber, M. (1970). *I and thou* (W. Kaufmann, Trans.). New York: Charles Scribner's Sons. (Original work published 1923)

Busk, P. L., & Serlin, R. C. (1992). Meta-analysis for single case research. In T. R. Kratochwill & J. R. Levin (Eds.), *Single-case research design and analysis* (pp. 93-131). Hillsdale, NJ: Lawrence Erlbaum Associates.

Butler, S. F., & Strupp, H. H. (1986). Specific and nonspecific factors in psychotherapy: A problematic paradigm for psychotherapy research. *Psychotherapy, 23,* 30-40.

Chassan, J. B. (1967). *Research design in clinical psychology and psychiatry.* New York: Appleton-Century-Crofts.

Clement, P. W. (1994). Quantitative evaluation of 26 years of private practice. *Professional Psychology: Research & Practice, 25,* 173-176.

Cohen, L. H., Sargent, M. M., & Sechrest, L. B. (1986). Use of psychotherapy research by professional psychologists. *American Psychologist, 41,* 198-206.

Collins, W., & Messer, S. B. (1991). Extending the Plan Formulation Method to an object relations perspective: Reliability, stability, and adaptability. *Psychological Assessment, 3,* 75-81.

Cook, T. D., & Campbell, D. T. (1979). *Quasi-experimentation: Design and analysis issues for field settings.* Chicago: Rand-McNally.

Cramer, P. (1991). *The development of defense mechanisms: Theory, research, and assessment.* New York: Springer-Verlag.

Crits-Christoph, P., & Barber, J. P. (Eds.). (1991). *Handbook of short-term dynamic therapy.* New York: Basic Books.

Crits-Christoph, P., Barber, J. P., & Kurcias, J. S. (1993). The accuracy of therapists' interpretations and the development of the therapeutic alliance. *Psychotherapy Research, 3,* 25-35.

Crits-Christoph, P., Cooper, A., & Luborsky, L. (1988). The accuracy of therapists' interpretations and the outcome of dynamic psychotherapy. *Journal of Consulting and Clinical Psychology, 56,* 490-495.

Crits-Christoph, P., Demorest, A., & Connolly, M. B. (1990). Quantitative assessment of interpersonal themes over the course of psychotherapy. *Psychotherapy, 27,* 513-521.

Crits-Christoph, P., Demorest, A., Muenz, L. R., & Baranackie, K. (1994). Consistency of interpersonal themes for patients in psychotherapy. *Journal of Personality, 62,* 499-526.

Crits-Christoph, P., & Luborsky, L. (1990). Changes in CCRT pervasiveness during psychotherapy. In L. Luborsky & P. Crits-Christoph (Eds.), *Understanding transference: The CCRT method* (pp. 133-146). New York: Basic Books.

Cummings, N. A. (1995). Impact of managed care on employment and training: A primer for survival. *Professional Psychology: Research & Practice, 26,* 10-15.

Davanloo, H. (Ed.) (1980). *Short-term dynamic psychotherapy.* New York: Jason Aronson.

Dollard, J., & Miller, N. E. (1950). *Personality and psychotherapy.* New York: McGraw-Hill.

Ekstein, R. (1956). Psychoanalytic techniques. In D. Brower & L. E. Abt (Eds.), *Progress in clinical psychology* (Vol. 2, pp. 79-99). New York: Grune & Stratton.

Elkin, I. (1994). The NIMH Treatment of Depression Collaborative Research Program: Where we began and where we are. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 114-139). New York: Wiley.

Elliott, R., & Anderson, C. (1994). Simplicity and complexity in psychotherapy research. In R. L. Russell (Ed.), *Reassessing psychotherapy research* (pp. 65-113). New York: Guilford Press.

Elliott, R., & Morrow-Bradley, C. (1994). Developing a working marriage between psychotherapists and psychotherapy researchers: Identifying shared purposes. In P. F. Talley, H. H. Strupp, & S. F. Butler (Eds.), *Psychotherapy research and practice: Bridging the gap* (pp. 124-142). New York: Basic Books.

Elliott, R., Stiles, W. B., & Shapiro, D. A. (1993). "Are some psychotherapies more equivalent than others?" In T. R. Giles (Ed.), *Handbook of effective psychotherapy* (pp. 455-479). New York: Plenum Press.

Epstein, S. F. (1994). Integration of the cognitive and psychodynamic unconscious. *American Psychologist, 49,* 709-724.

Erdelyi, M. H. (1994). Commentary: Integrating a dissociation-prone psychology. *Journal of Personality, 62,* 669-680.

Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology, 16,* 319-324.

Eysenck, H. J. (1993). Forty years on: The outcome problem in psychotherapy revisited. In T. R. Giles (Ed.), *Handbook of effective psychotherapy* (pp. 3-20). New York: Plenum Press.

Ferenczi, S., & Rank, O. (1925). *The development of psychoanalysis.* New York and Washington, DC: Nervous and Mental Diseases Publishing Company.

Fiske, A. P., Haslam, N., & Fiske, S. T. (1991). Confusing one person with another: What errors reveal about the elementary forms of social relations. *Journal of Personality and Social Psychology, 60,* 656-674.

Fiske, S. T. (1992). Thinking is for doing: Portraits of social cognition from daguerreotype to laserphoto. *Journal of Personality and Social Psychology, 63,* 877-889.

Fitzgerald, F. S. (1986). *The great Gatsby.* New York: Macmillan. (Original work published 1925)

Fonagy, P., & Moran, G. (1993). Selecting single case research designs for clinicians. In N. E. Miller, L. Luborsky, J. P., Barber, & J. P. Docherty (Eds.), *Psychodynamic treatment research: A handbook for clinical practice* (pp. 62-95). New York: Basic Books.

Forsyth, D. R. , & Strong, S. R. (1986). The scientific study of counseling and psychotherapy: A unificationist view. *American Psychologist, 41,* 113-119.

Freud, S. (1953). Fragment of an analysis of a case of hysteria. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 7, pp. 15-122). London: Hogarth Press. (Original work published 1905)

Freud, S. (1955). Studies on hysteria. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 2, pp. 3-305). London: Hogarth Press. (Original work published 1895)

Freud, S. (1958). The dynamics of transference. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 99-108). London: Hogarth Press. (Original work published 1912)

Freud, S. (1963). Transference. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 16, pp. 431-447). London: Hogarth Press. (Original work published 1917)

Freud, S. (1964). An outline of psychoanalysis. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 23, pp. 141-207). London: Hogarth Press. (Original work published 1940)

Fried, D., Crits-Christoph, P., & Luborsky, L. (1992). The first empirical demonstration of transference. *Journal of Nervous and Mental Disease, 180,* 326-331.

Gaston, L. (1990). The concept of the alliance and its role in psychotherapy: Theoretical and empirical considerations. *Psychotherapy, 27,* 143-153.

Gaston, L., & Marmar, C. R. (1989). Quantitative and qualitative analyses for psychotherapy research: Integration through time-series designs. *Psychotherapy, 26,* 169-176.

Gill, M. M. (1982). *Analysis of transference.* New York: International Universities Press.

Goldfried, M. R. (1984). Training the clinician as scientist-professional. *Professional Psychology: Research & Practice, 15,* 477-481.

Goldstein, A. P., Heller, K. H., & Sechrest, L. B. (1966). *Psychotherapy and the psychology of behavior change.* New York: Wiley.

Greenacre, P. (1954). The role of transference: Practical considerations in relation to psychoanalytic therapy. *Journal of the American Psychoanalytic Association, 2,* 671-684.

Greenberg, L. S. (1986). Change process research. *Journal of Consulting and Clinical Psychology, 54,* 4-9.

Greenberg, L. S., & Safran, J. D. (1987). *Emotion in psychotherapy.* New York: Guilford Press.

Greenson, R. R. (1965). The working alliance and the transference neuroses. *Psychoanalytic Quarterly, 34,* 155-181.

Greenwald, A. G. (1992). New Look 3: Unconscious cognition reclaimed. *American Psychologist, 47,* 766-779.

Greenwald, A. G., & Banaji, M. R. (1995). Implicit social cognition: Attitudes, self-esteem, and stereotypes. *Psychological Review, 102,* 4-27.

Grünbaum, A. (1984). *The foundations of psychoanalysis: A philosophical critique.* Berkeley: University of California Press.

Guisinger, S., & Blatt, S. J. (1994). Individuality and relatedness: Evolution of a fundamental dialectic. *American Psychologist, 49,* 104-111.

Harrist, R. S., Quintana, S. M., Strupp, H. H., & Henry, W. P. (1994). Internalization of interpersonal process in time-limited dynamic psychotherapy. *Psychotherapy, 31,* 49-57.

Harter, S. (1983). Developmental perspectives on the self-system. In E. M. Hetherington (Ed.), *Handbook of child psychology: Socialization, personality, and social development* (pp. 275-386). New York: Wiley.

Hartley, D. (1991). Assessing interpersonal behavior patterns using Structural Analysis of Social Behavior (SASB). In M. J. Horowitz (Ed.), *Person schemas and maladaptive interpersonal patterns* (pp. 221-260). Chicago: University of Chicago Press.

Haslam, N. (1994). Mental representation of social relationships: Dimensions, laws, or categories? *Journal of Personality and Social Psychology, 67,* 575-584.

Hayes, S. C. (1981). Single case experimental design and empirical clinical practice. *Journal of Consulting and Clinical Psychology, 49,* 193-211.

Henry, W. P., Schacht, T. E., & Strupp, H. H. (1990). Patient and therapist introject, interpersonal process, and differential therapeutic outcome. *Journal of Consulting and Clinical Psychology, 58,* 768-774.

Henry, W. P., & Strupp, H. H. (1994). The therapeutic alliance as interpersonal process. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, practice* (pp. 51-84). New York: Wiley.

Henry, W. P., Strupp, H. H., Butler, S. F., Schacht, T. E., & Binder, J. L. (1993). Effects of training in time-limited dynamic psychotherapy: Changes in therapist behavior. *Journal of Consulting and Clinical Psychology, 61,* 434-440.

Henry, W. P., Strupp, H. H., Schacht, T. E., & Gaston, L. (1994). Psychodynamic approaches. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 467-508). New York: Wiley.

Hermans, H. J. M., Kempen, H. J. G., & van Loon, R. J. P. (1992). The dialogical self: Beyond individualism and rationalism. *American Psychologist, 47,* 23-33.

Hermans, H. J. M., & Hermans-Janzen, E. (1995). *Self-narratives: The construction of meaning in psychotherapy.* New York: Guilford Press.

Hersch, L. (1995). Adapting to health care reform and managed care: Three strategies for survival and growth. *Professional Psychology: Research & Practice, 26,* 16-26.

Higginbotham, H. N., West, S. G., & Forsyth, D. R. (1988). *Psychotherapy and behavior change: Social, cultural, and methodological perspectives.* New York: Pergamon Press.

Hill, C. E. (1990). Exploratory in-session process research in individual psychotherapy: A review. *Journal of Consulting and Clinical Psychology, 58,* 288-294.

Hilliard, R. B. (1993). Single-case methodology in psychotherapy process and outcome research. *Journal of Consulting and Clinical Psychology, 61,* 373-380.

Horowitz, L. M. (1994). Pschemas, psychopathology, and psychotherapy research. *Psychotherapy Research, 4,* 1-19.

Horowitz, M. J. (1986). *Stress response syndromes* (2nd ed.). Northvale, NJ: Jason Aronson.

Horowitz, M. J. (Ed.). (1991). *Person schemas and maladaptive interpersonal patterns.* Chicago: University of Chicago Press.

Horvath, A. O., & Greenberg, L. S. (Eds.). (1994). *The working alliance: Theory, research, and practice.* New York: Wiley.

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology, 61,* 561-573.

Humphreys, K. (1996). Clinical psychologists as psychotherapists: History, future, and alternatives. *American Psychologist, 51,* 190-197.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59,* 12-19.

Jayaratne, S., & Levy, R. L. (1979). *Empirical clinical practice.* New York: Columbia University Press.

Jung, C. G. (1961). *Memories, dreams, reflections.* New York: Random House.

Jung, C. G. (1970). *The collected works of C. G. Jung: Vol. 10. Civilization in transition* (H. Read, M. Fordham, G. Adler, & W. McGuire, Eds.; R. F. C. Hull, Trans.). Princeton, NJ: Princeton University Press. (Originally published 1934)

Karon, B. P. (1995). Provision of psychotherapy under managed health care: A growing crisis and national nightmare. *Professional Psychology: Research & Practice, 26,* 5-9.

Karon, B. P., & Widener, A. J. (1995). Psychodynamic therapies in historical perspective: "Nothing human do I consider alien to me." In B. Bongar & L. E. Beutler (Eds.), *Comprehensive textbook of psychotherapy: Theory and practice* (pp. 24-47). New York: Oxford University Press.

Kazdin, A. E. (1981). Drawing valid inferences from case studies. *Journal of Consulting and Clinical Psychology, 49,* 183-192.

Kazdin, A. E. (1994). Methodology, design, and evaluation in psychotherapy research. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 19-71). New York: Wiley.

Kiesler, D. J. (1966). Some myths of psychotherapy research and the search for a paradigm. *Psychological Bulletin, 65,* 110-136.

Kiesler, D. J. (1973). *The process of psychotherapy.* Chicago: Aldine.

Kiesler, D. J. (1981). Empirical clinical psychology: Myth or reality? *Journal of Consulting and Clinical Psychology, 49,* 212-215.

Kiesler, D. J. (1995). Research classic: "Some myths of psychotherapy research and the search for a paradigm": Revisited. *Psychotherapy Research, 5,* 91-101.

Kihlstrom, J. F. (1987). The cognitive unconscious. *Science, 237,* 1445-1452.

Kihlstrom, J. F. (1994). Commentary: Psychodynamics and social cognition–notes on the fusion of psychoanalysis and psychology. *Journal of Personality, 62,* 681-696.

Kihlstrom, J. F., & Cunningham, R. L., (1991). Mapping interpersonal space. In M. J. Horowitz (Ed.), *Person schemas and maladaptive interpersonal patterns* (pp. 311-336). Chicago: University of Chicago Press.

Koss, M. P., & Shiang, J. (1994). Research on brief psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 664-700). New York: Wiley.

Krumboltz, J. D. (1966). *Resolution in counseling: Impacts of behavioral science.* Boston, MA: Houghton-Mifflin.

Lambert, M. J., & Bergin, A. E. (1994). The effectiveness of psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 143-189). New York: Wiley.

Lambert, M. J., & Hill, C. E. (1994). Assessing psychotherapy outcomes and processes. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 72-113). New York: Wiley.

Landis, J. R., & Koch, G. G. (1977). The measurement of observer agreement for categorical data. *Biometrics, 33,* 159-174.

Lerner, G. F. J. (1952). Defining psychotherapy. *American Psychologist, 7,* 547.

Luborsky, L. (1969). Research cannot influence clinical practice. *International Journal of Psychiatry, 7,* 135-140.

Luborsky, L. (1972). Research cannot yet influence clinical practice. In A. Bergin & H. H. Strupp (Eds.), *Changing frontiers in the science of psychotherapy* (pp. 120-127). Chicago: Aldine.

Luborsky, L. (1976). Helping alliances in psychotherapy. In J. L. Claghorn (Ed.), *Successful psychotherapy* (pp. 92-116). New York: Brunner-Mazel.

Luborsky, L. (1977). Measuring a pervasive psychic structure in psychotherapy: The core conflictual relationship theme. In N. Freedman & S. Grand (Eds.), *Communicative structures and psychic structures* (pp.367-395). New York: Plenum Press.

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment.* New York: Basic Books.

Luborsky, L. (1987). Research can now affect clinical practice: A happy turn-around. *Clinical Psychologist, 40,* 50-60.

Luborsky, L. (1994). Therapeutic alliances as predictors of psychotherapy outcomes: Factors explaining the predictive success. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 38-50. New York: Wiley.

Luborsky, L., Barber, J. P., Binder, J., Curtis, J., Dahl, H., Horowitz, L. M., Horowitz, M., Perry, J. C., Schacht, T., Silberschatz, G., & Teller, V. (1993). Transference-related measures: A new class based on psychotherapy sessions. In N. E. Miller, L. Luborsky, J. P., Barber, & J. P. Docherty (Eds.), *Psychodynamic treatment research: A handbook for clinical practice* (pp. 326-341). New York: Basic Books.

Luborsky, L., Barber, J. P., and Diguer, L. (1992). The meanings of narratives told during psychotherapy: The fruits of a new observational unit. *Psychotherapy Research, 2,* 277-290.

Luborsky, L., & Crits-Christoph, P. (Eds.). (1990). *Understanding transference: The CCRT method.* New York: Basic Books.

Luborsky, L., Crits-Christoph, P., Friedman, S. H., Mark, D., & Schaffler, P. (1991). Freud's transference template compared with the Core Conflictual Relationship Theme (CCRT): Illustrations by the two specimen cases. In M. J. Horowitz (Ed.), *Person schemas and maladaptive interpersonal patterns* (pp. 167-195). Chicago: University of Chicago Press.

Luborsky, L., Crits-Christoph, P., Mintz, J., & Auerbach, A. (1988). *Who will benefit from psychotherapy? Predicting therapeutic outcomes.* New York: Basic Books.

Luborsky, L., & Diguer, L. (1995). A novel CCRT reliability study: Reply to Zander et al. *Psychotherapy Research, 5,* 237-241.

Luborsky, L., Docherty, J. P., Miller, N. E., & Barber, J. P. (1993). What's here and what's ahead in dynamic therapy research and practice. In N. E. Miller, L. Luborsky, J. P., Barber, & J. P. Docherty (Eds.), *Psychodynamic treatment research: A handbook for clinical practice* (pp. 536-553). New York: Basic Books.

Luborsky, L., Popp, C., & Barber, J. P. (1994). Common and special factors in different transference-related measures. *Psychotherapy Research, 4,* 277-286.

Luborsky, L., Popp, C., Luborsky, E., & Mark, D. (1994). The Core Conflictual Relationship Theme. *Psychotherapy Research, 4,* 172-183.

Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that "Everyone has won and all must have prizes"? *Archives of General Psychiatry, 32,* 995-1008.

Mahoney, M. J. (1978). Experimental methods and outcome evaluation. *Journal of Consulting and Clinical Psychology, 46,* 660-672.

Mahoney, M. J. (1991). *Human change processes: The scientific foundations of psychotherapy.* New York: Basic Books.

Mahoney, M. J. (1995). The modern psychotherapist and the future of psychotherapy. In B. Bongar & L. E. Beutler (Eds.), *Comprehensive textbook of psychotherapy: Theory and practice* (pp. 474-488). New York: Oxford University Press.

Mahoney, M. J., & Norcross, J. C. (1993). Relationship styles and therapeutic choices: A commentary on the preceding four articles. *Psychotherapy, 30,* 423-426.

Mann, J. (1973). *Time-limited psychotherapy.* Cambridge: Harvard University Press.

Marten, P. A., & Heimberg, R. G. (1995). Toward an integration of independent practice and clinical research. *Professional Psychology: Research & Practice, 26,* 48-53.

Mergenthaler, E., & Stinson, C. H. (1992). Psychotherapy transcription standards. *Psychotherapy Research, 2,* 125-142.

Messer, S. B., Tishby, O., & Spillman, A. (1992). Taking context seriously in psychotherapy research: Relating therapist interventions to patient progress in brief psychodynamic therapy. *Journal of Consulting and Clinical Psychology, 60,* 678-688.

Messer, S. B., & Warren, C. S. (1995). *Models of brief psychodynamic therapy: A comparative approach.* New York: Guilford Press.

Miller, N. E., Luborsky, L., Barber, J. P., & Docherty, J. P. (Eds.). (1993). *Psychodynamic treatment research: A handbook for clinical practice.* New York: Basic Books.

Mook, D. G. (1983). In defense of external invalidity. *American Psychologist, 38,* 379-387.

Moras, K., and Hill, C. E. (1991). Rater selection for psychotherapy process research: An evaluation of the state of the art. *Psychotherapy Research, 1,* 113-123.

Morrow-Bradley, C., & Elliott, R. (1986). Utilization of psychotherapy research by practicing psychotherapists. *American Psychologist, 41,* 188-197.

Norcross, J. D., Alford, B. A., & DeMichele, J. T. (1992). The future of psychotherapy: Delphi data and concluding observations. *Psychotherapy, 29,* 150-158.

Norcross, J. D., & Goldfried, M. R. (Eds.). (1992). *Handbook of psychotherapy integration.* New York: Basic Books.

Nunnally, J. C. (1978). *Psychometric theory.* New York: McGraw-Hill.

Orlinsky, D. E. (1994). Research-based knowledge as the emergent foundation for clinical practice in psychotherapy. In P. F. Talley, H. H. Strupp, & S. F. Butler (Eds.), *Psychotherapy research and practice: Bridging the gap* (pp. 99-123). New York: Basic Books.

Orlinsky, D. E., Geller, J. D., Tarragona, M., & Farber, B. (1993). Patients' representations of psychotherapy: A new focus for psychodynamic research. *Journal of Consulting and Clinical Psychology, 61,* 596-610.

Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy – noch einmal. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 270-376). New York: Wiley.

Orlinsky, D. E., & Russell, R. L. (1994). Tradition and change in psychotherapy research: Notes on the fourth generation. In R. L. Russell (Ed.), *Reassessing psychotherapy research* (pp. 185-214). New York: Guilford Press.

Parloff, M. B. (1986). Placebo controls in psychotherapy research: A sine qua non or a placebo for research problems? *Journal of Consulting and Clinical Psychology, 54,* 79-87.

Paul, G. L. (1967). Strategy of outcome research in psychotherapy. *Journal of Consulting and Clinical Psychology, 31,* 109-118.

Pfeffer, A. (1963). The meaning of the analyst after analyses: A contribution to the theory of therapeutic results. *Journal of the American Psychoanalytic Association, 11,* 229-244.

Popper, K. (1963). *Conjectures and refutations.* New York: Basic Books.

Quintana, S. M., & Meara, N. M. (1990). Internalization of therapeutic relationships in short–term psychotherapy. *Journal of Counseling Psychology, 37,* 123-130.

Rachman, S. J., & Wilson, G. T. (1980). *The effects of psychological therapy.* London: Pergamon Press.

Raimy, V. (Ed.). (1950). *Training in clinical psychology.* New York: Prentice-Hall.

Rice, L. N., and Greenberg, L. S. (Eds.). (1984). *Patterns of change: Intensive analysis of psychotherapy process.* New York: Guilford Press.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21,* 95-103.

Russell, R. L. (1994). Critically reading psychotherapy process research: A brief enactment. In R. L. Russell (Ed.), *Reassessing psychotherapy research* (pp. 166-184). New York: Guilford Press.

Safran, J. D. (1990a). Towards a refinement of cognitive therapy in light of interpersonal theory: I. Theory. *Clinical Psychology Review, 10,* 87-105.

Safran, J. D. (1990b). Towards a refinement of cognitive therapy in light of interpersonal theory: II. Practice. *Clinical Psychology Review, 10,* 107-121.

Safran, J. D., Greenberg, L. S., & Rice, L. N. (1988). Integrating psychotherapy research and practice: Modeling the change process. *Psychotherapy, 25,* 1-17.

Safran, J. D., & Segal, Z. V. (1990). *Interpersonal process in cognitive therapy.* New York: Basic Books.

Sandler, J., Holder, A., Kawenoka, M., Kennedy, H. E., & Neurath, L. (1969). Notes on some theoretical and clinical aspects of transference. *International Journal of Psychoanalysis, 50,* 633-645.

Sanford, N. (1953). Clinical methods: Psychotherapy. *Annual Review of Psychology, 4,* 317-342.

Schlessinger, N., & Robbins, F. (1975). The psychoanalytic process: Recurrent patterns of conflict and changes in ego. *Journal of the American Psychoanalytic Association, 23,* 761-782.

Schneider, D. J. (1991). Social cognition. *Annual Review of Psychology, 42,* 527-561.

Seitz, P. (1966). The consensus problem in psychoanalytic research. In L. Gottschalk & A. Auerbach (Eds.), *Methods of research in psychotherapy* (pp. 209-225). New York: Appleton-Century-Crofts.

Seligman, M. E. P. (1994). *What you can change and what you can't.* New York: Knopf.

Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The *Consumer Reports* study. *American Psychologist, 50,* 965-974.

Shakow, D. (1976). What is clinical psychology? *American Psychologist, 31,* 553-560.

Shapiro, D. A. (1995). Finding out how psychotherapies help people change. *Psychotherapy Research, 5,* 1-21.

Shoham-Salomon, V. (1990). Interrelating research processes of process research. *Journal of Consulting and Clinical Psychology, 58,* 295-303.

Sifneos, P. (1979). *Short-term dynamic psychotherapy: Evaluation and technique.* New York: Plenum Press.

Singer, J. L. (1985). Transference and the human condition: A cognitive-affective perspective. *Psychoanalytic Psychology, 2,* 189-219.

Singer, J. L. (1988). Reinterpreting the transference. In D. C. Turk & P. Salovey (Eds.), *Reasoning, inference, and judgement in clinical psychology* (pp. 182-205). New York: Free Press.

Singer, J. L. (Ed.). (1990). *Repression and dissociation: Implications for personality theory, psychopathology, and health.* Chicago: University of Chicago Press.

Singer, J. L., & Salovey, P. (1991). Organized knowledge structures and personality: Person schemas, self schemas, prototypes, and scripts. In M. J. Horowitz (Ed.), *Person schemas and maladaptive interpersonal patterns* (pp. 33-79). Chicago: University of Chicago Press.

Skinner, H. A. (1978). Differentiating the contribution of elevation scatter and shape in profile similarity. *Educational and Psychological Measurement, 38,* 297-308.

Sloane, R. B., Staples, F. R., Cristol, A. H., Yorkton, N. J., & Whipple, K. (1975). *Psychotherapy vs. behavior therapy.* Cambridge, MA: Harvard University Press.

Smith, B., & Sechrest, L. (1991). Treatment of aptitude × treatment interactions. *Journal of Consulting and Clinical Psychology, 59,* 233-244.

Smith, M. L., Glass, G. V., & Miller, T. I. (1980). *The benefits of psychotherapy.* Baltimore, MD: Johns Hopkins University Press.

Speer, D. C. (1992). Clinically significant change: Jacobson and Truax (1991) revisited. *Journal of Consulting and Clinical Psychology, 60,* 402-408.

Sroufe, L. A. (1987). The role of infant-caregiver attachment in development. In J. Belsky & M. T. Nezworski (Eds.), *Clinical implications of attachment* (pp. 22-23). Hillsdale, NJ: Lawrence Erlbaum Associates.

Sroufe, L. A. (1990). An organizational perspective on self. In D. Cicchetti & M. Beeghly (Eds.), *The self in transition: Infancy to childhood* (pp. 281-307). Chicago: University of Chicago Press.

Sterba, R. (1934). The fate of the ego in analytic therapy. *International Journal of Psychoanalysis, 15,* 117-126.

Stern, D. N. (1985). *The interpersonal world of the infant.* New York: Basic Books.

Stiles, W. B. (1994). Views of the chasm between psychotherapy research and practice. In P. F. Talley, H. H. Strupp, & S. F. Butler (Eds.), *Psychotherapy research and practice: Bridging the gap* (pp. 154-166). New York: Basic Books.

Stiles, W. B., & Shapiro, D. A. (1994). Disabuse of the drug metaphor: Psychotherapy process-outcome correlations. *Journal of Consulting and Clinical Psychology, 62,* 955-959.

Stiles, W. B., Shapiro, D. A., & Elliott, R. (1986). "Are all psychotherapies equivalent?" *American Psychologist, 41,* 165-180.

Strauman, T. J. (1994). Introduction: Social cognition, psychodynamic psychology, and the representation and processing of emotionally significant information. *Journal of Personality, 62,* 451-458.

Stricker, G. (1992). The relationship of research to practice. *American Psychologist, 47,* 543-549.

Strupp, H. H. (1986). Psychotherapy: Research, practice, and public policy (how to avoid dead ends). *American Psychologist, 41,* 120-130.

Strupp, H. H. (1989). Psychotherapy: Can the practitioner learn from the researcher? *American Psychologist, 44,* 717-724.

Strupp, H. H., & Binder, J. L. (1984). *Psychotherapy in a new key: A guide to time-limited dynamic psychotherapy.* New York: Basic Books.

Strupp, H. H., Schacht, T. E., & Henry, W. P. (1988). Problem-treatment-outcome congruence: A principle whose time has come. In H. Dahl, H. Kachele, & H. Thoma (Eds.), *Psychoanalytic process research strategies* (pp. 1-14). New York: Springer-Verlag.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry.* New York: Norton.

Talley, P. F., Strupp, H. H., & Butler, S. F. (Eds.). (1994). *Psychotherapy research and practice: Bridging the gap.* New York: Basic Books.

Thorngate, W. (1986). The production, detection, and explanation of behavior patterns. In J. Valsiner (Ed.), *The individual subject and scientific psychology* (pp. 71-93). New York: Plenum Press.

Wachtel, P. L. (1977). *Psychoanalysis and behavior therapy: Toward an integration.* New York: Basic Books.

Wachtel, P. L. (1987). *Action and insight.* New York: Guilford Press.

Wampold, B. E., Davis, B., & Good, R. H. (1990). Hypothesis validity of clinical research. *Journal of Consulting and Clinical Psychology, 58,* 360-367.

Weiss, J. (1993). *How psychotherapy works: Process and technique.* New York: Guilford Press.

Westen, D. (1988). Transference and information processing. *Clinical Psychology Review, 8,* 161-179.

Westen, D. (1991). Social cognition and object relations. *Psychological Bulletin, 109,* 429-455.

Yeaton, W. H., & Sechrest, L. (1981). Critical dimensions in the choice and maintenance of successful treatments: Strength, integrity, and effectiveness. *Journal of Consulting and Clinical Psychology, 49,* 156-167.

Zajonc, R. B. (1980). Feeling and thinking: Preferences need no inferences. *American Psychologist, 35,* 151-175.

Zetzel, E. (1956). Current concepts of transference. *International Journal of Psychoanalysis, 37,* 369-375.

Appendix A
Psychotherapy Research: The Current Scene

Modern psychotherapy, like psychology, has had a relatively brief history (about 100 years). Unlike psychology, research in psychotherapy (that is, research in the modern sense) did not begin until midway through its history, during the 1950s. The earlier part of the century was spent setting the stage for scientific research, demonstrating "how the complex personal phenomena of psychotherapy could be brought out of the private consulting room into the purview of scientific study without disrupting these phenomena beyond recognition" (Orlinsky & Russell, 1994, pp.191-192). Following the gauntlet thrown down by Eysenck (1952)—the charge of clinical inefficacy and scientific illegitimacy—the next major task of the field was to establish the clinical value of psychotherapy and its viability as a focus of scientific inquiry. The second generation of researchers undertook this twofold task. By the end of the 1970s a series of research teams had marshalled evidence establishing large effect sizes for a spectrum of theoretical approaches to psychotherapy (Luborsky, Singer, & Luborsky, 1975; Sloane, Staples, Cristol, Yorkton, & Whipple, 1975; Smith, Glass, & Miller, 1980).

Currently, there is a general consensus that the effects of psychotherapy exceed spontaneous remission (contrary to Eysenck's charge) and are generally positive and enduring for a wide range of psychological problems (Lambert & Bergin, 1994). However, these conclusions– drawn from meta-analyses of hundreds of empirical studies–still have their critics (e.g., Rachman & Wilson, 1980), with Eysenck (1993) virtually unmoved from his original position after forty years.

New Questions

Thus, over the last three decades a fundamental shift has occurred in the field, from investigating *whether* psychotherapy works to investigating *how* psychotherapy works (Shapiro, 1995). As Kiesler (1995) observes, beginning in the mid-1960s, psychotherapy researchers were poised and ready for this new *zeitgeist*, which initially appeared in various forms:

> . . . which therapist behaviors are most effective with which types of patients? (Kiesler, 1966, p. 113)

> . . . which procedures and techniques, when used to accomplish what kinds of behavior change, are most effective with what kinds of clients when applied by what kind of counselor? (Krumboltz, 1966, p. 22)

> *What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, under *which* set of circumstances? (Paul, 1967, p. 111).

Paul's (1967) formulation became especially cited, and was eventually christened as the *litany* (Stiles, Shapiro, & Elliott, 1986). It is unclear why earlier versions of the litany went largely unheard. Kiesler (1995) cites one example: A decade before the *zeitgeist*, Sanford (1953) had asserted: "From the point of view of science, the question 'Does psychotherapy do any good?' has little interest because it is virtually meaningless . . . The question is which people, in what circumstances, responding to what psychotherapeutic stimuli" (pp. 335-336). In recent years, the litany has become more refined. Essentially, researchers seek to specify the therapist operations, therapeutic contexts, and immediate client performances which lead to therapeutic change (Greenberg, 1986; Rice & Greenberg, 1984). Kiesler (1995) offered perhaps the most distilled version to date:

> What package of which specific therapist miniature interventions, in what optimal sequence, applied by therapists demonstrating what level of expertise within what relational context, will successfully engage which proximate and ultimate mechanisms of patient change toward the alleviation of what specific pattern of DSM patient maladjustment? (p. 100)

Deciding how to go about addressing this question (i.e., by which measures and methods) is almost as complex as the phenomena itself, and may account for the methodological pluralism that characterizes modern psychotherapy research (Bergin & Garfield, 1994; Kazdin, 1994) in its struggle to strike to strike a balance between simplicity and complexity (see Elliott & Anderson, 1994) in its constructs and designs. An important aspect of the foregoing shift has been the critical reappraisal of longstanding assumptions concerning both metatheory and methodology.

Metatheoretical and Methodological Dilemmas

Outdated analogies. The question of what constitutes therapeutic change (psychotherapy outcome) and how it comes about (psychotherapy process) has always

been the fundamental focus of psychotherapy research (Strupp, 1986). Because of the initial perception of psychotherapy as a form of medical treatment, virtually all psychotherapy research to date has implicitly subscribed to this paradigm, dubbed the *drug metaphor* by Stiles and Shapiro (1994): the view of psychotherapy as comprising "active ingredients", supplied by the therapist to the client. These active ingredients are process components (i.e., techniques such as interpretation or reflection). Within this medical or pharmacological analogy, it is asserted that if a component is an active ingredient, then administering a high level of it is supposed to yield a positive outcome. Ingredients which fail to do so are presumed to be inert, akin to the concept of *placebo* in pharmacological research. Russell (1994) takes a critical stance with this analogy, particularly as it is exemplified by Yeaton and Sechrest's (1981) concepts of strength and integrity of treatment. *Strength* is analogous to drug dosage whereas *integrity* is analogous to drug purity. Higher levels of both are generally held as leading to better outcomes. Implicit in the drug metaphor is that it makes sense to think of psychotherapy as composed of substances which can be isolated and applied in measurable quantities, and independent of the context of administration.

An associated assumption is the hypothesis asserting the separability of specific (technique) and nonspecific (relationship) contributions to therapy process and outcome. Butler and Strupp (1986) argued that, unlike drugs, psychotherapeutic interventions concern *meaning*, and are thus inherently dependent on the conscious, active participation of both therapist and client, with their idiosyncratic meaning systems. These authors offered a compelling case for rejecting the specific–nonspecific dichotomy, in light of its misappropriation of the medical paradigm to psychotherapy:

> Psychotherapy is *not* a medical technology that can be administered to a passive patient, and that somehow eradicates an illness or syndrome, leaving the patient "cured" . . . Yet since psychotherapy, like medicine, attempts to alleviate human suffering, the medical analogy persists . . . the search for specific "active ingredients" of psychotherapy as one would investigate a drug . . . implies that research should ultimately produce a "psychotherapy antibiotic," a *contextless* agent capable of bringing about the desired result regardless of the persons involved. (1986, p. 32)

Conceptually, this analysis underscores the identity of psychotherapy with its interpersonal context (Mahoney & Norcross, 1993; Strupp, 1986). The search for the conceptually inappropriate "active ingredients" of change, shifts to an explication of

how "therapist qualities interact with patient characteristics to produce, or fail to produce, the interpersonal conditions necessary for therapeutic change" (Butler & Strupp, 1986, p. 30). Therapist techniques, far from comprising a disembodied repertoire operating independently of context, are recast as the therapist's efforts to influence the quality of the patient's experience in relation to the therapist as a significant other (Strupp & Binder, 1984). Psychotherapy becomes transfigured as the *"systematic use of a human relationship for therapeutic purposes"* (Butler and Strupp, 1986, p. 36, emphasis in original).

Another limitation implicit in the drug metaphor is that the "inert ingredients" are often regarded as placebos (or "nonspecific" effects). Here the problem is that one treatment model's active ingredients is another treatment model's placebo: The placebo concept has no universal meaning (Elliott, Stiles, & Shapiro, 1993). Moreover, given that placebos in drug research comprise *psychological* effects, the term becomes nonsensical within the psychological context of psychotherapy. It has been roundly suggested that both the drug metaphor and the placebo concept be retired (Parloff, 1986; Russell, 1994; Stiles & Shapiro, 1994; Strupp, 1986), with so-called placebos specified as more meaningful comparison groups, such as alternative treatments (Elliott et al., 1993; Lambert & Bergin, 1994).

To date, one of the most exemplary instances of such a study has been the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program (see Elkin, 1994, for a summary), a well-publicized and rigorous multisite group comparison of two brief psychotherapies and pharmacotherapy; it virtually set the standard for subsequent studies. However, the NIMH study was also exemplary of the drug metaphor, perhaps by virtue of its design (randomized clinical trial). Most evident was the inseparability of therapist from therapy: Unlike the pharmacological treatments, the administration of the comparison psychotherapies were highly dependent on the site of administration and on the therapists involved (i.e., the interpersonal context) (Elkin, 1994).

The importance of theoretical and hypothesis validity. In addition to the more familiar forms of erroneous conclusions (Type I and II errors), another pervasive problem

involves the Type III error: The completion of the *wrong experiment*, wherein

> faulty measurements, experimental designs, or conceptualization of crucial variables prohibit meaningful interpretation of experimental results. . . .This oversight is serious because Type III errors override both Type I and Type II errors. Who cares if a hypothesis is erroneously accepted or rejected if the hypothesis is misspecified to begin with? (Smith & Sechrest, 1991, p. 237)

Smith and Sechrest discuss this point following Mahoney's (1978) concept of *theoretical validity*, the degree to which (a) a study has some logical bearing on a specific hypothesis or theory, and thus (b) the adequacy of the researcher's understanding of the study variables. Closely related is the concept of *hypothesis validity*, the congruence between theory, research hypotheses, statistical hypotheses, and statistical tests (Wampold, Davis, & Good, 1990). Thus, a study with adequate hypothesis validity yields results which are informative about theory, the nature of the relation between constructs. Hypothesis validity is threatened by theoretically inconsequential or ambiguous research hypotheses, noncongruence of research and statistical hypotheses, and diffuse statistical hypotheses and tests. Type III errors appear endemic in much extant psychotherapy research (Smith & Sechrest, 1991); conceptually inappropriate methods abound. The methodological dilemma can be illustrated by examples from both the early and more recent eras of psychotherapy research.

Illustrations. During the 1960s, process research was predominated by the labours of researchers from the client-centered tradition (Orlinsky & Russell, 1994). The central objective was to provide empirical support for the validity of Carl Rogers's (1957) necessary and sufficient conditions of therapeutic change (therapist empathy, warmth, and self-congruence). "Paradoxically, although Rogers's theory emphasized the *client's experience* of the "facilitative conditions" . . . positivist methodological biases led most researchers to use objectified, nonparticipant-observational measures of therapist behavior" (Orlinsky & Russell, 1994, p. 194, emphasis added). In other words, a Type III error had been committed.

Unfortunately, in this regard little has changed in the decades that followed. By way of illustration, let us return to the exemplary NIMH collaborative study. While acknowledging its sophistication and rigour, Beutler (1991) noted similar problems therein, most notably the complete absence of a theoretical framework. This

shortcoming was especially evident in the sample selection of the study; patients were selected without regard to any theoretical differentiation among treatments; theoretical and hypothesis validity gave way to diagnostic reliability. (In defense of the study, certain measures *were* selected to reflect differential change processes among treatments.)

The importance of theoretical guidance. In this regard, it is worth quoting again from Smith and Sechrest (1991):

> We believe strongly that if psychotherapeutic interventions are going to improve substantially, . . . better theory is going to be required, and that theory will have to have its basis in fundamental psychological research. Twenty-five years ago, Goldstein, Heller, and Sechrest (1966) proposed that psychotherapy should be, first and foremost, *psychological,* and that meant grounding theory and practice in the basic concepts and findings of the field. They did not believe that much progress could be made by trying to develop what would be a separate, isolated discipline of psychotherapy. . . . Despite a good bit of assent from others at the time, even some acclaim, the main thesis . . . has been, we think, largely ignored . . . for the most part current literature on psychotherapy appears to pay scant attention to research on basic behavioral and conceptual processes. (p. 239, emphasis in original)

It is indeed unusual that the field of psychotherapy should be so removed from its parent discipline. Repeated calls for grounding psychotherapy research in basic findings from related areas of psychology (Forsyth & Strong, 1986; Higginbotham, West, & Forsyth, 1988; Smith & Sechrest, 1991) appear to have gone largely unheard; the era of atheoreticality continues (Bergin & Garfield, 1994). Yet the question of how psychotherapy works begins as a theoretical question. Russell (1994) argues

> that the quest for an observational language free from any and all theoretical influence . . . has in fact failed, and in principle *must* fail. . . . Thus, in order to capture the world as it is outside of our symbolic nets, realist assumptions tend to result in the need to advocate for a language that does not mediate in any way – ironically, for a language that is not a language. (pp. 173, 176)

Russell exhorts psychotherapy researchers, indeed all scientists, to "each articulate as best as possible [their] particular frames of reference and systems of description, and. . . volunteer to serve as one another's severest critics . . . informed by an agreement to disagree, knowing that knowledge increases through the bittersweet clash of ideas" (p. 181-182). Indeed, this thesis has devoted much space to such theoretical articulation.

Appendix B
Further Methodological Issues in Psychotherapy Research

Issues in the Process of Process Rating

Current thinking holds measures taken from the perspectives of client, therapist, and independent observer as mutually informing, with none holding a privileged position of validity (Lambert & Hill, 1994; Orlinsky et al., 1994). Kihlstrom (1994; Kihlstrom & Cunningham, 1991) argued that one can never be sure of the validity of psychotherapy process ratings made by independent observers, which may very well reflect raters' own predispositions, assumptions, and biases, even with the presence of high interobserver reliability. Reliability, although a prerequisite for validity, does not ensure it. Kihlstrom's position is supported by findings of high interobserver reliabilities within but not across independent research groups using identical methods (Collins & Messer, 1991). Moreover, surprisingly little research has been conducted on the process of psychotherapy process rating (Moras & Hill, 1991), despite the central role the method has played in the field. Attempts at reducing measurement error have usually involved acquiring ratings from large panels of judges (see L. M. Horowitz, 1994; Weiss, 1993). Nevertheless, without replication across research *groups*, one can never be sure about the problem Kihlstrom (1994) raised. This problem worsens when considering research conducted in everyday clinical practice, which may not have access to either the sheer number of judges, nor the resources to train them adequately.

Integrating Research and Practice: Validity Issues

Integration problems. Because the therapy studied in this thesis took place in a university training clinic, one employing videorecordings of sessions for supervision purposes, these recordings presented an opportunity to compare independent ratings of verbatim transcripts of recorded sessions collected over the course of the therapy. The present study employed a small group of trained, independent, clinically naive raters who were unfamiliar with the patient, unaware of the therapist's research hypotheses, and unapprised of the patient's clinical outcome. Moreover, because the research was conducted in a training clinic wherein a limited amount of research is conducted, limited

resources were available to the therapist for research, a logistic situation that is representative of a large proportion of practitioners who are supportive of research, but are logistically hindered in carrying it out (Cohen, Sargent, & Sechrest, 1986; Morrow-Bradley & Elliot, 1986). If systematic research could be conducted with acceptable levels of scientific rigor within such a context, it could also point toward a model bridging the much lamented chasm between research and practice.

The foregoing proposition is not a new one. A chorus of voices have continually sung the praises of merging clinical research and practice ever since the scientist-practitioner model was accepted by our discipline (Barlow, 1981; Goldfried, 1984; Hayes, 1981; Kiesler, 1981; Lerner, 1952; Raimy, 1950; Shakow, 1976; Stricker, 1992; Strupp, 1989). After nearly half a century, a pessimistic view is that these voices have largely gone unheard, given that each ensuing decade has begun with renewed calls for integrating clinical psychology's two disciplines (e.g., Chassan, 1967; Kazdin, 1981), followed by relatively few sustained efforts and continued separation of science and service among practitioners (Cohen et al., 1986; Morrow-Bradley & Elliot, 1986).

Despite ethical and professional prescriptions to the contrary, most private practitioners do not conduct process-outcome studies of their practices. In the last several decades, the total number of published empirical investigations of private practice consists of a single study, Clement's (1995) quantitative evaluation of his 26 years of private practice. Clement could find only one other published report in this vein, which inspired him to do the same as he began his own practice in 1966.

Integration potentials. A more optimistic view is that, at present, clinical psychology has never been in a better position to reconcile the "troubled marriage" between the two subdisciplines (Elliott & Morrow-Bradley, 1994; Hilliard, 1993; Marten & Heimberg, 1995; Miller, Luborsky, Barber, & Docherty, 1993). The distinguished contributors to a recent volume addressing this separation seem to share this optimistic view (Talley, Strupp, & Butler, 1994). Who better to ask (and provide answers to) the key research questions of clinicians than clinicians themselves? In the idealized model, research and practice interact and mutually inform: The present study is one of many recent efforts toward the goal of *empirical clinical practice* (Jayaratne & Levy, 1979).

One remedy for the lack of research could involve modifications of the methods employed in the present study. With clients' consent, practitioners could record sessions and enlist the aid of like-minded (research-oriented) colleagues as research judges in a collaborative investigation of their respective practices. Given the rise of group practices in recent years, this approach has become increasingly feasible. One obstacle to such empirical research within group practices might involve the difficulty in keeping one another unaware of research hypotheses. However, recent evidence suggests that experimenter and rater biases need not be necessary consequences of awareness of hypotheses (Messer et al., 1992). More importantly, with accountability being the watchword of the present service delivery system, empirical clinical practice will soon become essential (Cummings, 1995; Hersch, 1995; Karon, 1995).

Although the measures employed in this study are informed by psychodynamic, interpersonal, and sociocognitive perspectives, the methods and design of single-case research are theory-free (Hayes, 1981; Hilliard, 1993), and present one of the most traffic-free avenues to empirical clinical practice (Barlow & Hersen, 1984; Fonagy & Moran, 1994). Marten and Heimberg (1995) suggest that the collective wisdom of the thousands of independent practitioners represents an enormous storehouse of knowledge awaiting systematic study.

The majority of clinicians describe the enormous influence of clinical experience (both personal and published) on their own clinical practice, in contrast to the relatively minimal influence of clinical research. Over two decades ago, Luborsky (1969, 1972) found this position justified by the lack of relevant research. However, not only can research now influence clinical practice (Luborsky, 1987; Luborsky, Docherty, Miller, & Barber, 1993), the time has come for research to consistently *accompany* clinical practice (Safran, Greenberg, & Rice, 1988). An analogy might be drawn between the research-practice relationship and the findings of the present study. With frequent positive interactions over time, a mutual transference of knowledge could occur, resulting in the development of a productive working alliance between science and service (Elliott & Morrow-Bradley, 1994).

Appendix C
Research Forms

Information Sheet for Prospective Research Participants

THE UNIVERSITY OF MANITOBA PSYCHOLOGICAL SERVICE CENTRE Winnipeg, Manitoba Canada R3T 2N2

Tel: (204) 474-9222
FAX: (204) 474-6297

Information Sheet for Prospective Research Participants

Introduction

Hi! We need your help! In a moment we will describe a program of research that will take place at the Psychological Service Centre (PSC) over the next few years. This research program will try to understand how therapy helps people with their concerns and problems. One approach is for the participants of therapy (that is, the client and the therapist) to fill out questionnaires about their experiences during therapy sessions. This kind of research is already taking place at the PSC; perhaps you may have already participated in this research. A second approach is for the researchers to observe how the therapist and client interact during a therapy session. Observing might mean actually sitting in during a live session; another way is for the researchers to listen to tape recordings of sessions or to read written transcripts of what each person said to each other during therapy sessions. This is the kind of research we're inviting you to participate in.

Why is the Research Important?

As a PSC client you'll remember how your therapy sessions are recorded (usually on videotape, but sometimes on audiotape instead) so that your therapist could be supervised by more experienced clinical psychologists. Once a client decides to stop coming for therapy, the therapist closes up their file and erases all of the session recordings. Being able to watch themselves in a session is extremely helpful for students to learn to be better therapists. It would be equally helpful for therapists in general to know what kinds of things tend to help their clients. This is where research can play a big part. By studying how a client and a therapist talk and interact during a session, researchers may find some general principles to improve the way therapy is practiced in the future.

What Would You Like Me to Do?

This letter is an invitation to you. We would like your permission to use the recordings of your sessions at the PSC for the research program we are developing. Since your therapist is also a part of the sessions, we will be asking his or her permission also. Right now you might be wondering how the recordings would be used in the research. There are at least three different ways. The first way is to use the full recording (sound and pictures) for research. The researchers and their assistants would study the tape, observing how the therapist and client interacted during the session, looking for what seemed particularly helpful. The second way is to use just the sound recordings (audiotape) for research. Like the first way, researchers would listen to the tape recordings, but could not see the people who were speaking. The third way is to use transcripts: These are the sessions in written form. In this case, a research assistant listens to the tapes and writes down what each person says during a session. These written transcripts are then used for the research.

What About Confidentiality?

As you may know, all research conducted at the university is approved before the research begins. For our department (Psychology), this is done by the Human Ethical Review Committee. Their job is to ensure that everyone who participates in research is treated ethically. A big concern is keeping research materials *confidential*. Most people agree that what a therapist and client talk about in a session is especially private. This is why we need both you *and* your therapist to give informed consent. Both are needed: If either person does not give their consent, then the research is not allowed to be done. If permission is given by both people, then the researchers promise that their recordings will be kept confidential, and that no one outside of the researchers and their assistants would have access to the recordings. As before, all recordings will remain securely stored in PSC file cabinets. Some people are more comfortable with the researchers using written transcripts. That way, the research assistant can remove information (such as names or places) from the research material, making it even more confidential. Other people are comfortable with the researchers being able to listen to (but not see) the therapist and client talking in a recording. There are other people who are comfortable with their videotapes as research material. All three types of recording are useful. As you make your decision, you should only agree to what you feel comfortable with.

What If I Don't Feel Comfortable?

It's perfectly natural to feel this way. In the past, both clients and therapists have felt similarly. Other clients and therapists feel that it's alright, especially because research is important. Different people just have different preferences. You should do what *you* feel is best. We also want to emphasize that, even if you decide not to give your permission, it will not affect your being seen at the PSC, in any way. If you do agree to participate, it is also okay to talk about it with your therapist afterwards. You should also feel free to telephone the researchers (our phone numbers are listed below) if you would like to know more about the research. Also, if after agreeing to participate, you later decide to withdraw your participation, you are completely free to do so.

So, What Exactly Are You Researching?

Currently, the research focuses on how what the therapist says affects the client's progress in therapy. For example, we are investigating the importance of *what* the two people talk about (e.g., feelings, thoughts, memories) and the importance of *how* it is talked about (e.g., in a warm, supportive way). Many different things often happen during therapy, including talking about feelings, thinking of new ways of coping with problems and trying them out, and so on. If we had a better understanding (through research) of which particular things were especially helpful, then we could improve the way therapy is practiced later on. It's probably safe to say that most people seeking therapy would like to know that there is some good scientific evidence for the effectiveness of the therapy. Most researchers and therapists seem to agree that therapy *is* effective for a lot of people. Now we are trying to find an answer for people who ask us *how* it works and *why* it is effective. One of the best ways to answer this question is to see what actually goes on in the therapy of actual clients and therapists.

Where Do I Go From Here?

On the next page we ask you to give your permission to use your session recordings for research. We also ask you to check off which type of recording you are comfortable with (video and audio, audio only, written only). By giving your signature on this consent form you confirm that you have read the information above and are comfortable with the research described. Please keep the first two pages for your own reference and give the signed consent form to either your therapist or to the PSC secretary at the Front Desk. The form will then be given to the researchers. When some study results are found, the general findings will be reported to you. These findings will not be connected with any identifying information (e.g., names of participants).

Thank you very much for taking some time to read our letter. Again, we would like you to phone either of us if you would like to talk some more about the research program.

Sincerely yours,

Robert G. Santos, B. A. (Adv.)
Graduate Student, Clinical Psychology — Tel: (204) 474-9222 (message)

Marvin J. Brodsky, Ph.D., C. Psych.
Research Advisor, Associate Professor of Psychology — Tel: (204) 474-9626 or 474-9338 (message)

(this research is approved by):

David G. Martin, Ph.D., C. Psych.
Director, Psychological Service Centre

Informed Consent and Confidentiality Contract

THE UNIVERSITY OF MANITOBA PSYCHOLOGICAL SERVICE CENTRE Winnipeg, Manitoba Canada R3T 2N2

Tel: (204) 474-9222
FAX: (204) 474-6297

INFORMED CONSENT and CONFIDENTIALITY CONTRACT

As a prospective research participant, I have:

(1) Read the Information Sheet for Prospective Research Participants included in this package and understood the information contained therein, including the safeguards for keeping session recordings and research findings confidential, with the exception of the researchers (Rob Santos and Dr. Marvin Brodsky) and their research assistants;

(2) Agreed to indicate below, with my signature, the type(s) of session recordings (if any) I would feel comfortable with being used for research purposes;

(3) Understood that deciding not to participate in the research described above will not affect my being seen at the PSC in any way, whatsoever;

(4) Understood that if I decide to participate in the research described above, I am free to withdraw my participation, at any time afterwards.

Read and agreed to:

Name of Client (please print) : **Date:**

_____ _____

Please indicate your choice(s) of recording by signing your full name beside your choice:

Full recording (sound and pictures, includes transcript): _____

Audio recording (sound only, includes transcript): _____

Transcript (written version of session conversation): _____

* If you would like identifying information (e.g., names) removed from the transcript, place your initials here: _____

I choose not to give permission for the use of my session recordings for research: _____

Table 1

Core Conflictual Relationship Theme (CCRT) Standard Category Clusters

	Wishes (Ws)		Responses of Others (ROs)		Responses of Self (RSs)
W1	TO ASSERT MYSELF & BE INDEPENDENT to have self-control, to be my own person	RO1	STRONG independent, happy	RS1	HELPFUL amopen, understand
W2	TO OPPOSE, HURT, & CONTROL OTHERS	RO2	CONTROLLING strict	RS2	UNRECEPTIVE don't understand, am not open, dislike others
W3	TO BE CONTROLLED, HURT, & NOT RESPONSIBLE not obligated, not helped, to be like others	RO3	UPSET hurt, dependent, anxious, angry, out of control	RS3	RESPECTED & ACCEPTED feel comfortable, happy, loved, feel like others
W4	TO BE DISTANT & AVOID CONFLICTS to not be hurt	RO4	BAD not trustworthy	RS4	OPPOSE & HURT OTHERS
W5	TO BE CLOSE & ACCEPTING to respect others, to be open, to have trust, to be opened up to,	RO5	REJECTING & OPPOSING doesn't trust me, doesn't respect me, is not understanding, dislikes me, is distant, unhelpful, hurts me	RS5	SELF-CONTROLLED & SELF-CONFIDENT independent, in control
W6	TO BE LOVED & UNDERSTOOD to be respected, accepted, liked	RO6	HELPFUL cooperative	RS6	HELPLESS out of control, uncertain, dependent
W7	TO FEEL GOOD & COMFORTABLE to have stability, to feel happy, to feel good about myself	RO7	LIKES ME respects me, loves me, gives me independence	RS7	DISAPPOINTED & DEPRESSED angry, unloved, jealous
W8	TO ACHIEVE & HELP OTHERS to better myself, to be good	RO8	UNDERSTANDING open, accepting	RS8	ANXIOUS & ASHAMED guilty

Note. From Luborsky and Crits-Christoph (1990, pp. 49-50).

Table 2

Interrater Reliability Coefficients: CCRT Problem and Outcome Profiles

	Summarizing unit					
	Session				Phase	
CCRT component	1	2	41	42	Early	Late
Wishes	.77	.67	.71	.87	.82	.75
Responses of others	.77	.83	.84	.77	.95	.90
Responses of self	.76	.75	.71	.73	.82	.71

Note. CCRT = Core Conflictual Relationship Theme.

Table 3

Interrater Reliability Coefficients: CCRT Therapy Process Profiles

	Summarizing unit					
	Session				Phase	
CCRT component	1	2	41	42	Early	Late
Wishes	.83	.69	.68	.79	.96	.74
Responses of others	.84	.80	.91	.87	.82	.90
Responses of self	.85	.96	.91	.72	.96	.80

Note. CCRT = Core Conflictual Relationship Theme.

Table 4

The Client's Transference Pattern: Pervasiveness Scores of CCRT Categories

	Summarizing unit					
	Session				Phase	
CCRT component	1	2	41	42	Early	Late
			Wishes			
To assert myself and be independent	.30	.37	.45	.40	.35	.44
To oppose, hurt, and control	.00	.25	.27	.20	.17	.26
To be controlled, hurt, and not responsible	.10	.22	.05	.20	.18	.07
To be distant and avoid conflicts	.25	.57	.45	.50	.47	.46
To be close and accepting	.25	.25	.11	.10	.25	.11
To be loved and understood	.40	.32	.23	.20	.35	.22
To feel good and comfortable	.50	.45	.34	.60	.47	.39
To achieve and help	.20	.22	.16	.10	.22	.15
M	.25	.33	.26	.29	.31	.26
SD	.16	.13	.15	.19	.12	.15
			Positive ROs			
Helpful	.15	.05	.16	.40	.08	.20
Liking	.20	.05	.20	.10	.10	.19
Understanding	.15	.02	.27	.40	.07	.30
M	.17	.04	.21	.30	.08	.23
SD	.03	.01	.06	.17	.02	.06

			Positive RSs			
Open and understood	.15	.02	.07	.00	.07	.06
Respected and accepted	.20	.00	.16	.10	.07	.15
Oppositional	.15	.30	.36	.30	.25	.35
Self-controlled and self-confident	.50	.17	.39	.00	.28	.31
M	.25	.12	.24	.10	.17	.22
SD	.17	.14	.16	.14	.11	.14
			Negative ROs			
Controlling	.50	.47	.07	.40	.48	.13
Upset	.25	.65	.16	.60	.52	.24
Bad	.35	.47	.52	.20	.43	.46
Rejecting/opposing	.70	.47	.43	.50	.55	.44
M	.45	.52	.30	.43	.49	.32
SD	.20	.09	.22	.17	.05	.16
			Negative RSs			
Unreceptive	.55	.55	.39	.60	.55	.43
Helpless	.75	.52	.14	.70	.60	.24
Disappointed and depressed	.60	.60	.45	.40	.60	.44
Anxious and ashamed	.50	.22	.11	.30	.32	.15
M	.60	.48	.27	.50	.50	.35
SD	.11	.17	.17	.18	.12	.14

Note. CCRT = Core Conflictual Relationship Theme, ROs = responses from others, RSs = responses of self.

Table 5

The Client–Therapist Process: Pervasiveness Scores of CCRT Categories

	Summarizing unit					
	Session				Phase	
CCRT component	1	2	41	42	Early	Late
	Wishes toward the therapist					
To assert myself and be independent	.02	.05	.17	.04	.03	.11
To oppose, hurt, and control	.00	.00	.00	.00	.00	.00
To be controlled, hurt, and not responsible	.02	.00	.00	.00	.01	.00
To be distant and avoid conflicts	.02	.01	.01	.03	.02	.02
To be close and accepting	.43	.39	.17	.43	.41	.29
To be loved and understood	.37	.47	.57	.57	.42	.57
To feel good and comfortable	.10	.17	.32	.34	.13	.33
To achieve and help	.02	.01	.15	.08	.01	.12
M	.12	.14	.17	.19	.13	.18
SD	.18	.19	.20	.23	.18	.20
	Positive ROs from the therapist					
Helpful	.44	.29	.39	.38	.37	.39
Liking	.02	.05	.08	.01	.03	.05
Understanding	.48	.56	.62	.42	.52	.53
M	.32	.30	.37	.27	.31	.32
SD	.26	.26	.27	.22	.25	.25

Positive client RSs						
Open and understood	.45	.42	.37	.59	.44	.48
Respected and accepted	.18	.25	.56	.59	.44	.48
Oppositional	.00	.00	.00	.00	.00	.00
Self-controlled and self-confident	.02	.02	.04	.03	.02	.04
M	.16	.17	.25	.30	.17	.27
SD	.21	.20	.27	.33	.20	.30
Negative ROs from the therapist						
Controlling	.01	.01	.01	.02	.01	.01
Upset	.00	.00	.00	.00	.00	.00
Bad	.00	.00	.00	.00	.00	.00
Rejecting/opposing	.00	.00	.00	.00	.00	.00
M	.002	.002	.002	.005	.001	.002
SD	.004	.005	.005	.01	.002	.005
Negative client RSs						
Unreceptive	.02	.01	.01	.01	.01	.01
Helpless	.06	.02	.02	.02	.04	.02
Disappointed and depressed	.02	.01	.00	.00	.02	.00
Anxious and ashamed	.02	.07	.00	.00	.04	.00
M	.03	.03	.007	.008	.03	.007
SD	.02	.03	.009	.01	.01	.01

Note. CCRT = Core Conflictual Relationship Theme, ROs = responses from others, RSs = responses of self.

Table 6

The Client's Core Conflictual Relationship Theme and the Therapeutic Relationship: Content–Process Profile Correlations

	Summarizing unit					
	Session				Phase	
CCRT component	1	2	41	42	Early	Late
Wishes	.40	− .09	.02	− .10	.12	− .08
Negative ROs	− .40	− .58	− .05	.20	− .58	− .01
Negative RSs	.97	− .99	− .32	.95	− .57	− .09
Positive ROs	− .99	− .88	.53	.99	− .98	.83
Positive RSs	− .46	− .86	− .86	− .44	− .88	− .91

Note. CCRT = Core Conflictual Relationship Theme, ROs = responses of others, RSs = responses of self.

Table 7

CCRT Pervasiveness in Early and Late Treatment Phases: Comparison of Single-Case Data with Penn Psychotherapy Project Data

	Single-case[a] (N = 1)			Penn[b] (N = 33)		
CCRT component	Early		Late	Early		Late
Wishes						
M	30.75		26.25	66.3		61.9
SD	12.10		15.19	15.0		25.0
ES		− .18			− .29	
Negative ROs						
M	49.50		31.75	40.7		28.5
SD	5.20		15.97	14.0		18.0
ES		− .40			− .87	
Negative RSs						
M	50.00		34.75	41.7		22.8
SD	12.36		13.52	14.0		18.0
ES		− .87			− 1.35	
Positive ROs						
M	8.33		23.00	8.6		18.7
SD	1.53		6.08	10.0		12.0
ES		+ 1.47			+ 1.01	
Positive RSs						
M	16.75		21.75	13.4		19.1
SD	11.32		13.60	12.0		16.0
ES		+ .46			+ .47	

Note. CCRT = Core Conflictual Relationship Theme, ROs = responses of others, RSs = responses of self. Pervasiveness scores are presented as percentages.

[a] *ES* is the ratio of adjusted mean difference and pooled standard deviation.

[b] Data are from Crits-Christoph and Luborsky (1990, p.139). *ES* is Cohen's *d*.